PacificSource HEALTH PLANS

2024 Washington Navigator Individual and Family Medical Plans

	Gold 2000 PD†	
	IN NETWORK	OUT OF NETWORK
Deductible Individual / Family	**$2,000 / $4,000**	**$10,000 / $20,000**
Out-of-Pocket Maximum Individual / Family	**$6,000 / $12,000**	**$25,000 / $50,000**
Preventive Services	Covered in full	50% after deductible
Preventive Drug Coverage	Covered in full	90% after deductible
Office Visits: Primary, Urgent Care, and Specialist	Primary / Urgent Care: $20 no deductible Specialist: $40 no deductible	50% after deductible
Telehealth	$20 no deductible	50% after deductible
Inpatient Hospital	20% after deductible	50% after deductible
Lab / X-ray	20% after deductible	50% after deductible
Physical, Occupational, and Speech Therapy Combined 30 visits per year	20% after deductible	50% after deductible
Outpatient Surgery	20% after deductible	50% after deductible
Emergency Services	20% after deductible	20% after deductible
Chiropractic / Acupuncture Visits per benefit period: Chiro: 12 / Acu: 12	$20 no deductible	50% after deductible
Prescription (Rx) Drug Coverage Out-of-network: 30-day max fill, no more than 3 per year	Tier 1: $15 no deductible Tier 2: $70 no deductible Tier 3: 20% no deductible Tier 4: 20% no deductible	90% after deductible
Pediatric Eye Exam	Covered in full	Covered in full up to $40
Pediatric Vision Hardware	Covered in full up to $150, then subject to in-network deductible and 20%	
Pediatric Dental Included	Yes	

Plans are available to residents of Clark, Pierce, Spokane, and Thurston Counties.

**Available only through Washington Healthplanfinder.
†Pediatric dental coverage is sold separately for plans purchased through Washington Healthplanfinder.
^Available only on a direct basis.

Out-of-network services are covered up to an allowed amount. After that amount is reached, members may be subject to balance billing. This is a brief summary. Contact a Coverage Advisor at **855-767-2312** or by email at CoverageAdvisors@PacificSource.com. Go to PacificSource.com for details or to see a plan's Summary of Benefits.

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PacificSource HEALTH PLANS

2024 Washington Navigator Individual and Family Medical Plans

	Silver 3500 PD^	Silver 5000 PD†	
	IN NETWORK	IN NETWORK	OUT OF NETWORK
Deductible Individual / Family	**$3,500 / $7,000**	**$5,000 / $10,000**	**$10,000 / $20,000**
Out-of-Pocket Maximum Individual / Family	**$9,300 / $18,600**	**$7,750 / $15,500**	**$25,000 / $50,000**
Preventive Services	Covered in full		50% after deductible
Preventive Drug Coverage	Covered in full		90% after deductible
Office Visits: Primary, Urgent Care, and Specialist	Primary / Urgent Care: $40 no deductible Specialist: $80 after deductible	Primary / Urgent Care: $15 no deductible Specialist: $30 no deductible	50% after deductible
Telehealth	$40 no deductible	$15 no deductible	50% after deductible
Inpatient Hospital	35% after deductible	30% after deductible	50% after deductible
Lab / X-ray	35% after deductible	30% after deductible	50% after deductible
Physical, Occupational, and Speech Therapy Combined 30 visits per year	35% after deductible	30% after deductible	50% after deductible
Outpatient Surgery	35% after deductible	30% after deductible	50% after deductible
Emergency Services	35% after deductible	30% after deductible	Same as in-network
Chiropractic / Acupuncture Visits per benefit period: Chiro: 12 / Acu: 12	$40 no deductible	$15 no deductible	50% after deductible
Prescription (Rx) Drug Coverage Out-of-network: 30-day max fill, no more than 3 per year	Tier 1: $20 no deductible Tier 2: $80 no deductible Tier 3: 35% no deductible Tier 4: 35% no deductible	30% after deductible	90% after deductible
Pediatric Eye Exam	Covered in full		Covered in full up to $40
Pediatric Vision Hardware	Covered in full up to $150, then subject to in-network deductible and 35%	Covered in full up to $150, then subject to in-network deductible and 30%	Same as in-network
Pediatric Dental Included	Yes		

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PacificSource HEALTH PLANS

2024 Washington Navigator Individual and Family Medical Plans

	Bronze 7000 PD†	Bronze HSA 7500 PD†	
	IN NETWORK	IN NETWORK	OUT OF NETWORK
Deductible Individual / Family	**$7,000 / $14,000**	**$7,500 / $15,000**	**$10,000 / $20,000**
Out-of-Pocket Maximum Individual / Family	**$8,700 / $17,400**	**$7,500 / $15,000**	**$25,000 / $50,000**
Preventive Services	Covered in full		50% after deductible
Preventive Drug Coverage	Covered in full		90% after deductible
Office Visits: Primary, Urgent Care, and Specialist	Primary / Urgent Care: $35 no deductible Specialist: $50 after deductible	0% after deductible	50% after deductible
Telehealth	$35 no deductible	0% after deductible	50% after deductible
Inpatient Hospital	40% after deductible	0% after deductible	50% after deductible
Lab / X-ray	40% after deductible	0% after deductible	50% after deductible
Physical, Occupational, and Speech Therapy Combined 30 visits per year	40% after deductible	0% after deductible	50% after deductible
Outpatient Surgery	40% after deductible	0% after deductible	50% after deductible
Emergency Services	40% after deductible	0% after deductible	Same as in-network
Chiropractic / Acupuncture Visits per benefit period: Chiro: 12 / Acu: 12	$35 no deductible	0% after deductible	50% after deductible
Prescription (Rx) Drug Coverage Out-of-network: 30-day max fill, no more than 3 per year	40% after deductible	0% after deductible	90% after deductible
Pediatric Eye Exam	Covered in full		Covered in full up to $40
Pediatric Vision Hardware	Covered in full up to $150, then subject to in-network deductible and 40%	Covered in full up to $150, then subject to in-network deductible and 0%	Same as in-network
Pediatric Dental Included	Yes		

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PacificSource HEALTH PLANS

2024 Washington Navigator Individual and Family Medical Plans

	Cascade Gold**†	Cascade Silver**†	Cascade Bronze**†	
	IN NETWORK	IN NETWORK	IN NETWORK	OUT OF NETWORK
Deductible Individual / Family	**$600 / $1,200**	**$2,500 / $5,000**	**$6,000 / $12,000**	**$10,000 / $20,000**
Out-of-Pocket Maximum Individual / Family	**$6,100 / $12,200**	**$9,200 / $18,400**	**$9,200 / $18,400**	**$25,000 / $50,000**
Preventive Services	Covered in full			50% after deductible
Preventive Drug Coverage	Covered in full			90% after deductible
Office Visits: Primary, Urgent Care, and Specialist	Primary: $15 no deductible Urgent: $35 no deductible Specialist: $40 no deductible	Primary/telehealth combined visits 1-2: $1, visits 3+: $30 no deductible Urgent/Specialist: $65 no deductible	Primary/telehealth combined visits 1-2: $1, visits 3+: $50 no deductible Urgent/Specialist: $100 no deductible	50% after deductible
Telehealth	$15 no deductible			50% after deductible
Inpatient Hospital	$525 no deductible (per day limit of 5 copays per stay)	$800 after deductible (per day limit of 5 copays per stay)	40% after deductible	50% after deductible
Lab / X-ray	$30 no deductible	$65 no deductible	40% after deductible	50% after deductible
Physical, Occupational, and Speech Therapy Combined 30 visits per year	$25 no deductible	$40 no deductible	40% after deductible	50% after deductible
Outpatient Surgery	$350 after deductible	$600 after deductible	40% after deductible	50% after deductible
Emergency Services	$450 after deductible	$800 after deductible	40% after deductible	Same as in-network
Chiropractic / Acupuncture Visits per benefit period: Chiro: 12 / Acu: 12	$15 no deductible	$30 no deductible	$50 no deductible	50% after deductible
Prescription (Rx) Drug Coverage Out-of-network: 30-day max fill, no more than 3 per year	Tier 1: $10 no deductible Tier 2: $60 no deductible Tier 3 & 4: $100 no deductible	Tier 1: $25 no deductible Tier 2: $75 no deductible Tier 3 & 4: $250 after deductible	Tier 1: $32 no deductible Tier 2, 3, & 4: 40% after deductible	90% after deductible
Pediatric Eye Exam	Covered in full			Covered in full up to $40
Pediatric Vision Hardware	Covered in full			Covered in full up to $40
Pediatric Dental Included	No			

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