PacificSource HEALTH PLANS

Washington 2024 Planes Médicos Individuales y Familiares Navigator

	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	

Estos planes están disponibles para residentes de los condados de Clark, Pierce, Spokane y Thurston.

**Disponible sólo a través de Washington Healthplanfinder.
†La cobertura dental pediátrica se contrata por separado para los planes adquiridos a través de Washington Healthplanfinder.
^Disponible sólo de forma directa.

Los servicios fuera de la red se cubren hasta el monto permitido. Una vez alcanzado ese monto, los miembros pudieran tener que pagar el saldo facturado. Este es un breve resumen. Póngase en contacto con un Asesor de Cobertura al teléfono **855-767-2312** o al email CoverageAdvisors@PacificSource.com. Visite PacificSource.com para obtener información detallada o consultar el Resumen de Beneficios del plan.

Ayuda con la accesibilidad: si necesita ayuda para leer esta gráfica o el resto del documento, por favor llámenos al teléfono 888-977-9299, TTY: 711. Aceptamos llamadas del servicio de retransmisión.

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Washington 2024 Planes Médicos Individuales y Familiares Navigator

	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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Washington 2024 Planes Médicos Individuales y Familiares Navigator

	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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Washington 2024 Planes Médicos Individuales y Familiares Navigator

	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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