PacificSource HEALTH PLANS

2024 Oregon Navigator Large Group Medical Plans

	500+20_20		750+20_20		1000+25_20		1500+25_20 1500+25_30	
	IN NETWORK	OUT OF NETWORK	IN NETWORK	OUT OF NETWORK	IN NETWORK	OUT OF NETWORK	IN NETWORK	OUT OF NETWORK
Deductible Individual / Family	**$500 / $1,000**	**$1,000 / $2,000**	**$750 / $1,500**	**$1,500 / $3,000**	**$1,000 / $2,000**	**$2,000 / $4,000**	**$1,500 / $3,000**	**$3,000 / $6,000**
Out-of-Pocket Maximum Individual / Family	**$3,000 / $6,000**	**$6,000 / $12,000**	**$3,500 / $7,000**	**$6,000 / $12,000**	**$4,000 / $8,000**	**$8,000 / $16,000**	**$4,000 / $8,000**	**$8,000 / $16,000**
	NO DEDUCTIBLE, MEMBER PAYS:	AFTER DEDUCTIBLE, MEMBER PAYS:	NO DEDUCTIBLE, MEMBER PAYS:	AFTER DEDUCTIBLE, MEMBER PAYS:	NO DEDUCTIBLE, MEMBER PAYS:	AFTER DEDUCTIBLE, MEMBER PAYS:	NO DEDUCTIBLE, MEMBER PAYS:	AFTER DEDUCTIBLE, MEMBER PAYS:
Preventive Services	Covered in full	50%	Covered in full	50%	Covered in full	50%	Covered in full	50%
	AFTER DEDUCTIBLE, MEMBER PAYS:		AFTER DEDUCTIBLE, MEMBER PAYS:		AFTER DEDUCTIBLE, MEMBER PAYS:		AFTER DEDUCTIBLE, MEMBER PAYS:	
Office Visits: Primary & Telehealth (including behavioral health)	First 3 combined visits $5, then $20*	50%	First 3 combined visits $5, then $20*	50%	First 3 combined visits $5, then $25*	50%	First 3 combined visits $5, then $25*	50%
Urgent Care and Specialist	$20*	50%	$20*	50%	$25*	50%	$25*	50%
Inpatient Hospital	20%	50%	20%	50%	20%	50%	20% or 30%	50%
Lab / X-ray	No deductible up to $500, then 20%	50%	No deductible up to $500, then 20%	50%	No deductible up to $500, then 20%	50%	No deductible up to $500, then 20% or 30%	50%
Physical, Occupational, and Speech Therapy	$20*	50%	$20*	50%	$25*	50%	$25*	50%
Chiropractic / Acupuncture Visits per benefit period: Chiro: 20 / Acu: 12	$20*	50%	$20*	50%	$25*	50%	$25*	50%
Outpatient Surgery	20%	50%	20%	50%	20%	50%	20% or 30%	50%
Emergency Services	$250 plus 20%*	$250 plus 20%*	$250 plus 20%*	$250 plus 20%*	$250 plus 20%*	$250 plus 20%*	$250 plus 20%* or 30%*	$250 plus 20%* or 30%*
Prescription (Rx) Drug Coverage	For more details on prescription drug coverage, search Pharmacy Plans at PacificSource.com.							

*Not subject to deductible.

Plans are available to businesses statewide.

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 us at **888-377-1646,** OregonSales@PacificSource.com, or go to PacificSource.com for details or to see a plan's Summary of Benefits.
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PacificSource HEALTH PLANS

2024 Oregon Navigator Large Group Medical Plans

	2000+25_20 2000+25_30		2500+30_20 2500+30_30		3000+30_20 3000+30_30		3500+35_30	
	IN NETWORK	OUT OF NETWORK	IN NETWORK	OUT OF NETWORK	IN NETWORK	OUT OF NETWORK	IN NETWORK	OUT OF NETWORK
Deductible Individual / Family	$2,000 / $4,000	$4,000 / $8,000	$2,500 / $5,000	$5,000 / $10,000	$3,000 / $6,000	$6,000 / $12,000	$3,500 / $7,000	$7,000 / $14,000
Out-of-Pocket Maximum Individual / Family	$5,000 / $10,000	$10,000 / $20,000	$6,000 / $12,000	$12,000 / $24,000	$6,500 / $13,000	$13,000 / $26,000	$7,500 / $15,000	$15,000 / $30,000
	NO DEDUCTIBLE, MEMBER PAYS:	AFTER DEDUCTIBLE, MEMBER PAYS:	NO DEDUCTIBLE, MEMBER PAYS:	AFTER DEDUCTIBLE, MEMBER PAYS:	NO DEDUCTIBLE, MEMBER PAYS:	AFTER DEDUCTIBLE, MEMBER PAYS:	NO DEDUCTIBLE, MEMBER PAYS:	AFTER DEDUCTIBLE, MEMBER PAYS:
Preventive Services	Covered in full	50%	Covered in full	50%	Covered in full	50%	Covered in full	50%
	AFTER DEDUCTIBLE, MEMBER PAYS:		AFTER DEDUCTIBLE, MEMBER PAYS:		AFTER DEDUCTIBLE, MEMBER PAYS:		AFTER DEDUCTIBLE, MEMBER PAYS:	
Office Visits: Primary & Telehealth (including behavioral health)	First 3 combined visits $5, then $25*	50%	First 3 combined visits $5, then $30*	50%	First 3 combined visits $5, then $30*	50%	First 3 combined visits $5, then $35*	50%
Urgent Care and Specialist	$25*	50%	$30*	50%	$30*	50%	$35*	50%
Inpatient Hospital	20% or 30%	50%	20% or 30%	50%	20% or 30%	50%	30%	50%
Lab / X-ray	No deductible up to $500, then 20% or 30%	50%	No deductible up to $500, then 20% or 30%	50%	No deductible up to $500, then 20% or 30%	50%	No deductible up to $500, then 30%	50%
Physical, Occupational, and Speech Therapy	$25*	50%	$30*	50%	$30*	50%	$35*	50%
Chiropractic / Acupuncture Visits per benefit period: Chiro: 20 / Acu: 12	$25*	50%	$30*	50%	$30*	50%	$35*	50%
Outpatient Surgery	20% or 30%	50%	20% or 30%	50%	20% or 30%	50%	30%	50%
Emergency Services	$250 plus 20%* or 30%*	$250 plus 20%* or 30%*	$250 plus 20%* or 30%*	$250 plus 20%* or 30%*	$250 plus 20%* or 30%*	$250 plus 20%* or 30%*	30%	30%
Prescription (Rx) Drug Coverage	For more details on prescription drug coverage, search Pharmacy Plans at PacificSource.com.							

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PacificSource HEALTH PLANS

2024 Oregon Navigator Large Group Medical Plans

	4000+35_20 4000+35_30		4500+35_30		5000+35_30	
	IN NETWORK	OUT OF NETWORK	IN NETWORK	OUT OF NETWORK	IN NETWORK	OUT OF NETWORK
Deductible Individual / Family	$4,000 / $8,000	$8,000 / $16,000	$4,500 / $9,000	$9,000 / $18,000	$5,000 / $10,000	$10,000 / $20,000
Out-of-Pocket Maximum Individual / Family	$7,000 / $14,000	$14,000 / $28,000	$7,500 / $15,000	$15,000 / $30,000	$7,500 / $15,000	$15,000 / $30,000
	NO DEDUCTIBLE, MEMBER PAYS:	AFTER DEDUCTIBLE, MEMBER PAYS:	NO DEDUCTIBLE, MEMBER PAYS:	AFTER DEDUCTIBLE, MEMBER PAYS:	NO DEDUCTIBLE, MEMBER PAYS:	AFTER DEDUCTIBLE, MEMBER PAYS:
Preventive Services	Covered in full	50%	Covered in full	50%	Covered in full	50%
	AFTER DEDUCTIBLE, MEMBER PAYS:		AFTER DEDUCTIBLE, MEMBER PAYS:		AFTER DEDUCTIBLE, MEMBER PAYS:	
Office Visits: Primary & Telehealth (including behavioral health)	First 3 combined visits $5, then $35*	50%	First 3 combined visits $5, then $35*	50%	First 3 combined visits $5, then $35*	50%
Urgent Care and Specialist	$35*	50%	$35*	50%	$35*	50%
Inpatient Hospital	20% or 30%	50%	30%	50%	30%	50%
Lab / X-ray	No deductible up to $500, then 20% or 30%	50%	No deductible up to $500, then 30%	50%	No deductible up to $500, then 30%	50%
Physical, Occupational, and Speech Therapy	$35*	50%	$35*	50%	$35*	50%
Chiropractic / Acupuncture Visits per benefit period: Chiro: 20 / Acu: 12	$35*	50%	$35*	50%	$35*	50%
Outpatient Surgery	20% or 30%	50%	30%	50%	30%	50%
Emergency Services	20% or 30%	20% or 30%	30%	30%	30%	30%
Prescription (Rx) Drug Coverage	For more details on prescription drug coverage, search Pharmacy Plans at PacificSource.com.					

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PacificSource HEALTH PLANS

2024 Oregon Navigator Large Group Medical Plans

	HSA 1600_20+Rx Non-embedded		HSA 3200_50+Rx		HSA 3200+Rx		HSA 4000+Rx		HSA 5000+Rx	
	IN NETWORK	OUT OF NETWORK	IN NETWORK	OUT OF NETWORK	IN NETWORK	OUT OF NETWORK	IN NETWORK	OUT OF NETWORK	IN NETWORK	OUT OF NETWORK
Deductible Individual / Family	$1,600 / $3,200	$7,500 / $15,000	$3,200 / $6,400	$7,500 / $15,000	$3,200 / $6,400	$7,500 / $15,000	$4,000 / $8,000	$10,000 / $20,000	$5,000 / $10,000	$10,000 / $20,000
Out-of-Pocket Maximum Individual / Family	$4,500 / $6,850	$15,000 / $30,000	$6,350 / $12,700	$15,000 / $30,000	$3,200 / $6,400	$15,000 / $30,000	$4,000 / $8,000	$20,000 / $40,000	$5,000 / $10,000	$20,000 / $40,000
	NO DEDUCTIBLE, MEMBER PAYS:	AFTER DEDUCTIBLE, MEMBER PAYS:	NO DEDUCTIBLE, MEMBER PAYS:	AFTER DEDUCTIBLE, MEMBER PAYS:	NO DEDUCTIBLE, MEMBER PAYS:	AFTER DEDUCTIBLE, MEMBER PAYS:	NO DEDUCTIBLE, MEMBER PAYS:	AFTER DEDUCTIBLE, MEMBER PAYS:	NO DEDUCTIBLE, MEMBER PAYS:	AFTER DEDUCTIBLE, MEMBER PAYS:
Preventive Services	Covered in full	50%	Covered in full	50%	Covered in full	50%	Covered in full	50%	Covered in full	50%
	AFTER DEDUCTIBLE, MEMBER PAYS:		AFTER DEDUCTIBLE, MEMBER PAYS:		AFTER DEDUCTIBLE, MEMBER PAYS:		AFTER DEDUCTIBLE, MEMBER PAYS:		AFTER DEDUCTIBLE, MEMBER PAYS:	
Office Visits: Primary & Telehealth (including behavioral health)	First three visits $0, then 20%	50%	First three visits $0, then 50%	50%	Covered in full	50%	Covered in full	50%	Covered in full	50%
Urgent Care and Specialist	20%	50%	50%	50%	Covered in full	50%	Covered in full	50%	Covered in full	50%
Inpatient Hospital	20%	50%	50%	50%	Covered in full	50%	Covered in full	50%	Covered in full	50%
Lab / X-ray	20%	50%	50%	50%	Covered in full	50%	Covered in full	50%	Covered in full	50%
Physical, Occupational, and Speech Therapy	20%	50%	50%	50%	Covered in full	50%	Covered in full	50%	Covered in full	50%
Chiropractic / Acupuncture Visits per benefit period: Chiro: 20 / Acu: 12	20%	50%	50%	50%	Covered in full	50%	Covered in full	50%	Covered in full	50%
Outpatient Surgery	20%	50%	50%	50%	Covered in full	50%	Covered in full	50%	Covered in full	50%
Emergency Services	20%	20%	50%	50%	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full
Prescription (Rx) Drug Coverage	20%	90%	50%	90%	Covered in full	90%	Covered in full	90%	Covered in full	90%

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