NEW **Network for nationwide coverage.** See pg. 8

PacificSource HEALTH PLANS

2024 Individual and Family Plans

Doing what's **right,** not just what's required

Your health plan may only do what's required. **Unless your health plan is PacificSource.**

Whether it's our Northwest-based human service, our no-referrals-required policy, or our covering more no-cost prescription drugs than the law requires, PacificSource has always worked to do what's right, not just what's required—for you and your family.

PacificSource is a **not-for-profit community health plan**. We don't answer to shareholders, but to members, providers, producers, and employers—the people who depend on our products and services.

Health plans that focus on the right things: you, your doctor, and your community

Members first, since 1933

PacificSource is different. We're a local health insurer that works closely with highly rated providers to deliver exceptional member experience.

Integrated care that revolves around members

This patient-centered approach is enabled by close collaboration with our provider partners, supported by best-in-class data analytics.

High-value care and lower costs

We strive to compensate providers fairly, based on quality of outcomes and overall value—not volume.

Ongoing investment in community health

PacificSource continually invests in our own neighborhoods, through financial aid and access to healthcare for diverse populations and those most in need.

Benefits that go beyond what's required

Local, human service

No automated phone trees or offshore call centers. The people who help you are right here in the Northwest. And we answer your calls in less than 30 seconds on average, according to internal call reports.

Convenient telehealth coverage

Members can see a doctor without leaving home. You'll get the care you need, when and where you need it.

No referrals required with any plan

Our plans don't require members to visit a primary care doctor before seeing a specialist. (Some specialists may have their own referral requirements.)

No-cost preventive care and preventive drugs

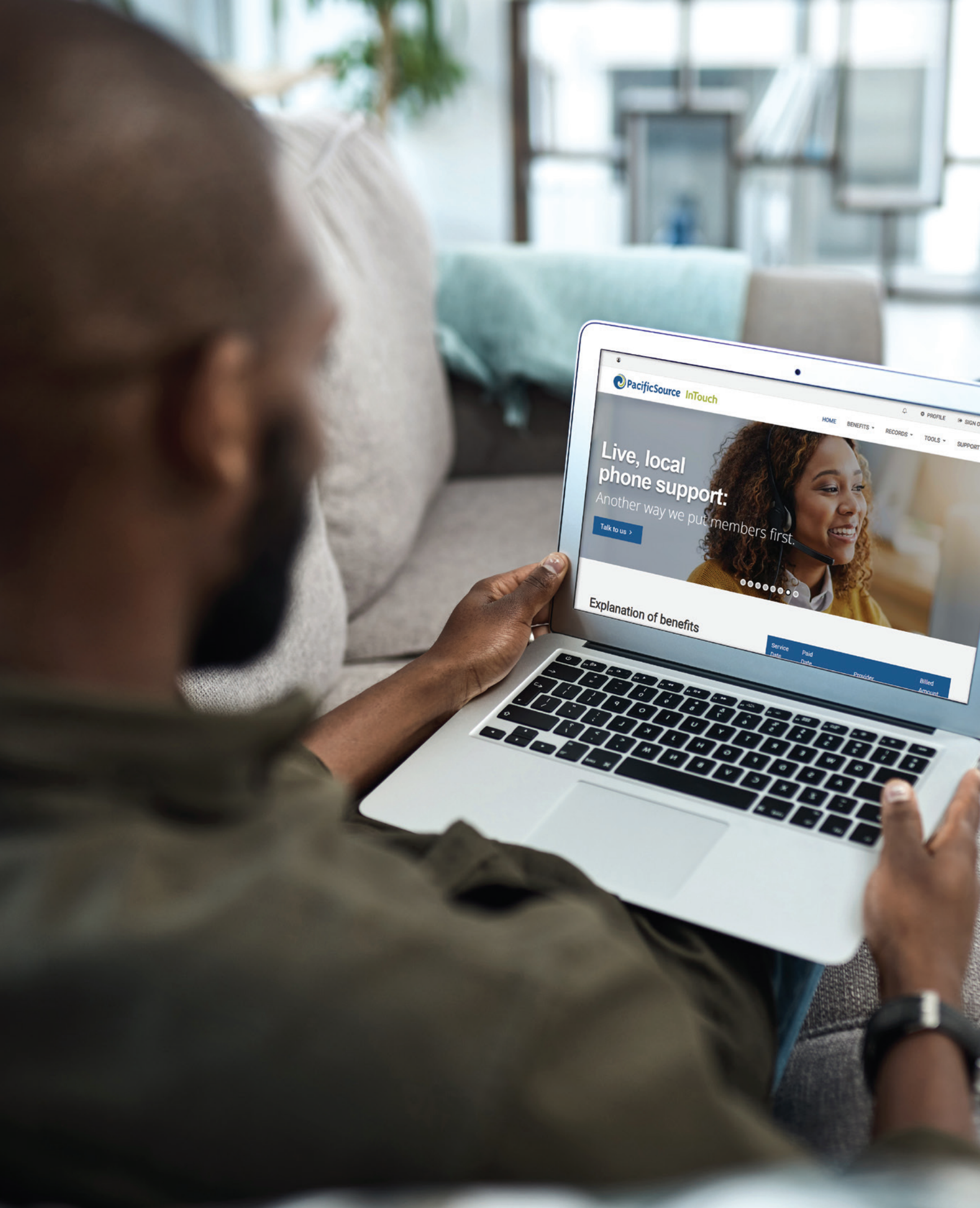
We're pleased to offer $0 copays on:

- Well-baby and well-child care
- Annual checkups
- Prenatal consultations
- Preventive mammograms and colonoscopies
- Immunizations
- Dozens of preventive drugs—including 82 more than the law requires (Note: Standard and Cascade plans only use the Standard ACA drug list.)

We cover more than **41,000** individual members and their families across the Greater Northwest.

PacificSource covers people just like you, who get their health insurance independently, not from an employer.

Source: monthly enrollment report, March 2023


PacificSource InTouch
HOME
BENEFITS
RECORDS
TOOLS
SUPPORT
PROFILE
Live, local phone support:
Another way we put members first.
Talk to us
Explanation of benefits
Service Date
Paid Date
Provider
Billed Amount

InTouch puts you in charge

Manage your benefits from your computer, phone, or tablet—24/7.

With InTouch, you can:

Display your member ID card

Schedule doctor visits—physical and behavioral health—through Teladoc®

Review what's covered by your plan

Read Explanation of Benefits statements

Check your deductible status

Search for a doctor

Select your primary care provider

Call our free 24-Hour NurseLine

Work toward health goals with our health and wellness portal

Reach our Customer Service team

Quantity and quality – our networks deliver both

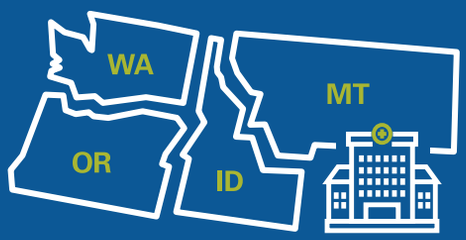
We know how important a robust provider network is when shopping for health insurance. That's why we contract with thousands of highly rated healthcare professionals, **including 19 five-star medical facilities.***

With PacificSource, you have in-network access to providers across our four-state region (Idaho, Montana, Oregon, and Washington) and nationwide.

Wherever you live, work, or travel, you can count on:

- An extensive choice of doctors and facilities
- Specialist care without a referral
- Care that focuses on quality outcomes and patient engagement
- Empowering self-management tools

*Source: Centers for Medicare & Medicaid Services, Hospital Ratings, January 23, 2023.



In-network access to doctors and hospitals across the Northwest...

Idaho

St. Luke's Health Partners
PQA Patient Quality Alliance
IRMC Eastern Idaho Regional Medical Center
Idaho Falls Community Hospital
Mountain View Hospital
Bingham Memorial Hospital
KootenaiCareNetwork

Montana

Billings Clinic
Providence St. Patrick Hospital
St. Peter's Health
SCL Health
Community Medical Center
Logan Health

Oregon

Legacy Health
St. Charles Health System
Central Oregon Independent Practice Association
OHSU Health
Legacy Health Partners
McKenzie-Willamette Medical Center
Praxis Health
PeaceHealth
Asante
Samaritan Health Services

Washington

Legacy Health
MultiCare
MultiCare Connected Care
PeaceHealth
Vancouver Clinic
PSW a population health company
UW Medicine

This is not a complete list of providers for your state, and in-network availability is based on member's plan and network. To search our provider directory, visit PacificSource.com/find-a-doctor.

...and across the nation.

You are covered nationwide through **Aetna Signature Administrators® PPO** (outside Idaho, Montana, Oregon, and Washington).

NEW aetna®

Vision care for kids

Pediatric vision benefits for members through age 18

All of our medical plans include pediatric vision coverage. This includes routine eye exams at no cost when seeing an in-network doctor. See plan comparison chart for details.

Decide on dental

Good dental health can lead to better overall health

You can:

- Add one of our dental plans to your health plan
- Select dental-only
- Purchase these plans year-round, not just during open enrollment

For more details, search individual and family plans at PacificSource.com. For assistance with dental or medical coverage, contact a Coverage Advisor at **855-330-2792** or by email at CoverageAdvisors@PacificSource.com.

Finding the right plan

One factor as you decide on a plan will be whether you want one that can be paired with a health savings account (HSA). Here are things to consider.

All plans	**All our health plans** include coverage for preventive care, $0 annual physicals from in-network providers, $0 copays on many preventive drugs, and most vaccinations.
HSA	**HSA-qualified plans** help you save for healthcare expenses like deductibles and coinsurance. The plans require that all major benefits be subject to your deductible. With HSA plans, you'll set up a dedicated bank account, contributions to which are 100% tax deductible (up to a maximum), like an IRA. Another benefit: withdrawals from your HSA account to pay for qualified medical expenses are tax-free.
Non-HSA	**Non-HSA plans** allow you to use some benefits for a copay prior to meeting your deductible (such as primary care, urgent care, or pharmacy).

Ten more ways PacificSource gives you more

Access to highly rated hospitals and urgent care centers

Affordable gym memberships through Active&Fit Direct™

Global emergency services from Assist America®

Help quitting tobacco

Home-delivered pharmacy orders

24-Hour NurseLine at no cost

No-cost care management for chronic conditions

Prenatal resources for expectant parents

Up to $150 reimbursement for health & wellness classes

Weight Watchers® program discounts

Additional benefits are not considered insurance.

Next steps:

Select a health plan

Decide on dental

Shop and enroll:

Contact your broker

Online at Shop.PacificSource.com/individual

Or call us at **855-983-8844,**

TTY: 711

We accept all relay calls

We're here to help.

It's natural to have questions about a topic as important as your health. We understand, and we're happy to speak with you by phone or email.

855-983-8844, TTY: 711
We accept all relay calls
Monday through Friday from 8:00 a.m. to 5:00 p.m.

CoverageAdvisors@PacificSource.com

PacificSource.com

PSIB.ID.0124
PSIP.ID.HMO.0124
PSIP.ID.PPO.0124
PSIP.ID.DENTAL.0124

IFP226_1023

PacificSource HEALTH PLANS

2024 Oregon Navigator Individual and Family Medical Plans

	Gold 500 Direct†	Gold 1500 Direct†	
	IN NETWORK	IN NETWORK	OUT OF NETWORK
Deductible Individual / Family	**$500 / $1,000**	**$1,500 / $3,000**	**$10,000 / $20,000**
Out-of-Pocket Maximum Individual / Family	**$8,250 / $16,500**	**$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
Accident Benefit	Covered in full up to $500, within 90 days of accident		
Office Visits: Primary, Urgent Care, and Specialist	Primary/telehealth combined visits 1-3: $5 no deductible, visits 4+ and Urgent Care: $25 no deductible Specialist: $50 no deductible		50% after deductible
Telehealth			50% after deductible
Inpatient Hospital	30% after deductible	20% after deductible	50% after deductible
Lab / X-ray	30% after deductible	20% after deductible	50% after deductible
Physical, Occupational, and Speech Therapy Combined 30 visits per year	30% after deductible	20% after deductible	50% after deductible
Outpatient Surgery	30% after deductible	20% after deductible	50% after deductible
Emergency Services	30% after deductible	20% after deductible	Same as in-network
Chiropractic / Acupuncture Visits per benefit period: Chiro: 20 / Acu: 12	$25 no deductible		50% after deductible
Prescription (Rx) Drug Coverage Out-of-network: 30-day max fill, no more than 3 per year	Tier 1: $25 no deductible Tier 2: $50 no deductible Tier 3 & 4: 30% no deductible	Tier 1: $25 no deductible Tier 2: $50 no deductible Tier 3 & 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 30%	Covered in full up to $150 then subject to in-network deductible and 20%	Same as in-network

Plans are available to residents statewide, but please check PacificSource.com/Find-a-Doctor to ensure your provider is in-network.

†Adult vision included on this plan.

Out-of-network services are covered up to an allowed amount. After that amount is reached, members may be subject to balance billing.

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PacificSource HEALTH PLANS

2024 Oregon Navigator Individual and Family Medical Plans

	Silver 3400 Direct	Silver 3900 Direct	Silver 5400 Direct	
	IN NETWORK	IN NETWORK	IN NETWORK	OUT OF NETWORK
Deductible Individual / Family	**$3,400 / $6,800**	**$3,900 / $7,800**	**$5,400 / $10,800**	**$10,000 / $20,000**
Out-of-Pocket Maximum Individual / Family	**$9,400 / $18,800**	**$9,100 / $18,200**	**$9,400 / $18,800**	**$25,000 / $50,000**
Preventive Services	Covered in full			50% after deductible
Preventive Drug Coverage	Covered in full			90% after deductible
Accident Benefit	Covered in full up to $500, within 90 days of accident			
Office Visits: Primary, Urgent Care, and Specialist	Primary and Urgent Care: $50 no deductible Specialist: $100 no deductible	Primary and Urgent Care: $30 no deductible Specialist: $60 no deductible	Primary: $40 no deductible Urgent Care: $70 no deductible Specialist: $80 no deductible	50% after deductible
Telehealth	$50 no deductible	$30 no deductible	$40 no deductible	50% after deductible
Inpatient Hospital	50% after deductible	30% after deductible	30% after deductible	50% after deductible
Lab / X-ray	50% after deductible	30% after deductible	30% after deductible	50% after deductible
Physical, Occupational, and Speech Therapy Combined 30 visits per year	50% after deductible	30% after deductible	$40 no deductible if provided in an office setting	50% after deductible
Outpatient Surgery	50% after deductible	30% after deductible	30% after deductible	50% after deductible
Emergency Services	50% after deductible	30% after deductible	30% after deductible	Same as in-network
Chiropractic / Acupuncture Visits per benefit period: Chiro: 20 / Acu: 12	$50 no deductible	$30 no deductible	$40 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: $50 no deductible Tier 3 & 4: 50% no deductible	30% after deductible	Tier 1: $20 no deductible Tier 2: $50 no deductible Tier 3 & 4: 50% 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 50%	Covered in full up to $150 then subject to in-network deductible and 30%	Covered in full up to $150 then subject to in-network deductible and 30%	Same as in-network

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†Adult vision included on this plan.

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PacificSource HEALTH PLANS

2024 Oregon Navigator Individual and Family Medical Plans

	Bronze 7000 Direct	Bronze 9400 Direct	Bronze HSA 7500	
	IN NETWORK	IN NETWORK	IN NETWORK	OUT OF NETWORK
Deductible Individual / Family	**$7,000 / $14,000**	**$9,400 / $18,800**	**$7,500 / $15,000**	**$10,000 / $20,000**
Out-of-Pocket Maximum Individual / Family	**$9,400 / $18,800**	**$9,400 / $18,800**	**$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
Accident Benefit	Covered in full up to $500, within 90 days of accident			
Office Visits: Primary, Urgent Care, and Specialist	Primary/telehealth combined visits 1-3: $5 no deductible, visits 4+ and Urgent Care: $50 no deductible Specialist: $100 no deductible	Primary/telehealth combined visits 1-3: $5 no deductible, visits 4+: 0% after deductible Urgent Care/Specialist: 0% after deductible	0% after deductible	50% after deductible
Telehealth			0% after deductible	50% after deductible
Inpatient Hospital	40% after deductible	0% after deductible	0% after deductible	50% after deductible
Lab / X-ray	40% after deductible	0% after deductible	0% after deductible	50% after deductible
Physical, Occupational, and Speech Therapy Combined 30 visits per year	40% after deductible	0% after deductible	0% after deductible	50% after deductible
Outpatient Surgery	40% after deductible	0% after deductible	0% after deductible	50% after deductible
Emergency Services	40% after deductible	0% after deductible	0% after deductible	Same as in-network
Chiropractic / Acupuncture Visits per benefit period: Chiro: 20 / Acu: 12	$50 no deductible	0% after 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	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	Covered in full up to $150 then subject to in-network deductible	Same as in-network

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PacificSource HEALTH PLANS

2024 Oregon Navigator Individual and Family Medical Plans

	Standard Gold	Standard Silver	Standard Bronze	
	IN NETWORK	IN NETWORK	IN NETWORK	OUT OF NETWORK
Deductible Individual / Family	**$1,800 / $3,600**	**$5,500 / $11,000**	**9,450 / $18,900**	**$10,000 / $20,000**
Out-of-Pocket Maximum Individual / Family	**$7,550 / $15,100**	**$9,450 / $18,900**	**9,450 / $18,900**	**$25,000 / $50,000**
Preventive Services	Covered in full			50% after deductible
Preventive Drug Coverage	Covered in full			50% after deductible
Accident Benefit	Not covered			
Office Visits: Primary, Urgent Care, and Specialist	Primary/telehealth combined visits 1-3: $5 no deductible, visits 4+: $20 no deductible Urgent Care: $60 no deductible Specialist: $40 no deductible	Primary/telehealth combined visits 1-3: $5 no deductible, visits 4+: $40 no deductible Urgent Care: $70 no deductible Specialist: $80 no deductible	Primary/telehealth combined visits 1-3: $5 no deductible, visits 4+: $50 no deductible Urgent Care: $100 no deductible Specialist: $150 no deductible	50% after deductible
Telehealth				50% after deductible
Inpatient Hospital	20% after deductible	30% after deductible	0% after deductible	50% after deductible
Lab / X-ray	20% after deductible	30% after deductible	0% after deductible	50% after deductible
Physical, Occupational, and Speech Therapy Combined 30 visits per year	$20 no deductible if provided in an office setting	$40 no deductible if provided in an office setting	$50 no deductible if provided in an office setting	50% after deductible
Outpatient Surgery	20% after deductible	30% after deductible	0% after deductible	50% after deductible
Emergency Services	20% after deductible	30% after deductible	0% after deductible	Same as in-network
Chiropractic / Acupuncture Visits per benefit period: Chiro: 20 / Acu: 12	$20 no deductible	$40 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: $30 no deductible Tier 3: 50% Coinsurance no deductible Tier 4: 50% Coinsurance no deductible, $500 max/script	Tier 1: $15 no deductible Tier 2: $60 no deductible Tier 3 & 4: 50% Coinsurance no deductible	Tier 1: $25 no deductible Tier 2, 3, & 4: 0% after deductible	90% after deductible
Pediatric Eye Exam One exam per benefit period	Covered in full			Covered in full up to $40
Pediatric Vision Hardware One item per benefit period	Covered in full up to $150 then subject to in-network deductible and 20%	Covered in full up to $150 then subject to in-network deductible and 30%	Covered in full up to $150 then subject to in-network deductible	Same as in-network

Plans are available to residents statewide, but please check PacificSource.com/Find-a-Doctor to ensure your provider is in-network.

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PacificSource HEALTH PLANS

2024 Oregon Navigator Individual and Family Medical Plans

	Gold 500 Exchange†	Gold 1500 Exchange†	
	IN NETWORK	IN NETWORK	OUT OF NETWORK
Deductible Individual / Family	**$500 / $1,000**	**$1,500 / $3,000**	**$10,000 / $20,000**
Out-of-Pocket Maximum Individual / Family	**$8,250 / $16,500**	**$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
Accident Benefit	Covered in full up to $500, within 90 days of accident		
Office Visits: Primary, Urgent Care, and Specialist	Primary and Urgent Care: $25 no deductible Specialist: $50 no deductible		50% after deductible
Telehealth	$25 no deductible	$25 no deductible	50% after deductible
Inpatient Hospital	30% after deductible	20% after deductible	50% after deductible
Lab / X-ray	30% after deductible	20% after deductible	50% after deductible
Physical, Occupational, and Speech Therapy Combined 30 visits per year	30% after deductible	20% after deductible	50% after deductible
Outpatient Surgery	30% after deductible	20% after deductible	50% after deductible
Emergency Services	30% after deductible	20% after deductible	Same as in-network
Chiropractic / Acupuncture Visits per benefit period: Chiro: 20 / Acu: 12	$25 no deductible		50% after deductible
Prescription (Rx) Drug Coverage Out-of-network: 30-day max fill, no more than 3 per year	Tier 1: $25 no deductible Tier 2: $50 no deductible Tier 3 & 4: 30% no deductible	Tier 1: $25 no deductible Tier 2: $50 no deductible Tier 3 & 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 30%	Covered in full up to $150 then subject to in-network deductible and 20%	Same as in-network

Plans are available to residents statewide, but please check PacificSource.com/Find-a-Doctor to ensure your provider is in-network.

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PacificSource HEALTH PLANS

2024 Oregon Navigator Individual and Family Medical Plans

	Silver 3500 Exchange	Silver 4000 Exchange	
	IN NETWORK	IN NETWORK	OUT OF NETWORK
Deductible Individual / Family	**$3,500 / $7,000**	**$4,000 / $8,000**	**$10,000 / $20,000**
Out-of-Pocket Maximum Individual / Family	**$9,400 / $18,800**	**$9,100 / $18,200**	**$25,000 / $50,000**
Preventive Services	Covered in full		50% after deductible
Preventive Drug Coverage	Covered in full		90% after deductible
Accident Benefit	Covered in full up to $500, within 90 days of accident		
Office Visits: Primary, Urgent Care, and Specialist	Primary and Urgent Care: $50 no deductible Specialist: $100 no deductible	Primary and Urgent Care: $30 no deductible Specialist: $60 no deductible	50% after deductible
Telehealth	$50 no deductible	$30 no deductible	50% after deductible
Inpatient Hospital	50% after deductible	30% after deductible	50% after deductible
Lab / X-ray	50% after deductible	30% after deductible	50% after deductible
Physical, Occupational, and Speech Therapy Combined 30 visits per year	50% after deductible	30% after deductible	50% after deductible
Outpatient Surgery	50% after deductible	30% after deductible	50% after deductible
Emergency Services	50% after deductible	30% after deductible	Same as in-network
Chiropractic / Acupuncture Visits per benefit period: Chiro: 20 / Acu: 12	$50 no deductible	$30 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: $50 no deductible Tier 3 & 4: 50% 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 50%	Covered in full up to $150 then subject to in-network deductible and 30%	Same as in-network

Plans are available to residents statewide, but please check PacificSource.com/Find-a-Doctor to ensure your provider is in-network.

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PacificSource HEALTH PLANS

2024 Oregon Navigator Individual and Family Medical Plans

	Bronze 7000 Exchange	Bronze 9400 Exchange	Bronze HSA 7500	
	IN NETWORK	IN NETWORK	IN NETWORK	OUT OF NETWORK
Deductible Individual / Family	**$7,000 / $14,000**	**$9,400 / $18,800**	**$7,500 / $15,000**	**$10,000 / $20,000**
Out-of-Pocket Maximum Individual / Family	**$9,400 / $18,800**	**$9,400 / $18,800**	**$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
Accident Benefit	Covered in full up to $500, within 90 days of accident			
Office Visits: Primary, Urgent Care, and Specialist	Primary and Urgent Care: $50 no deductible Specialist: $100 no deductible	0% after deductible	0% after deductible	50% after deductible
Telehealth	$50 no deductible	0% after deductible	0% after deductible	50% after deductible
Inpatient Hospital	40% after deductible	0% after deductible	0% after deductible	50% after deductible
Lab / X-ray	40% after deductible	0% after deductible	0% after deductible	50% after deductible
Physical, Occupational, and Speech Therapy Combined 30 visits per year	40% after deductible	0% after deductible	0% after deductible	50% after deductible
Outpatient Surgery	40% after deductible	0% after deductible	0% after deductible	50% after deductible
Emergency Services	40% after deductible	0% after deductible	0% after deductible	Same as in-network
Chiropractic / Acupuncture Visits per benefit period: Chiro: 20 / Acu: 12	$50 no deductible	0% after 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	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	Covered in full up to $150 then subject to in-network deductible	Same as in-network

Plans are available to residents statewide, but please check PacificSource.com/Find-a-Doctor to ensure your provider is in-network.

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Out-of-network services are covered up to an allowed amount. After that amount is reached, members may be subject to balance billing.

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PacificSource HEALTH PLANS

2024 Oregon Navigator Individual and Family Medical Plans

	Standard Gold	Standard Silver	Standard Bronze	
	IN NETWORK	IN NETWORK	IN NETWORK	OUT OF NETWORK
Deductible Individual / Family	$1,800 / $3,600	$5,500 / $11,000	9,450 / $18,900	$10,000 / $20,000
Out-of-Pocket Maximum Individual / Family	$7,550 / $15,100	$9,450 / $18,900	9,450 / $18,900	$25,000 / $50,000
Preventive Services	Covered in full			50% after deductible
Preventive Drug Coverage	Covered in full			50% after deductible
Accident Benefit	Not covered			
Office Visits: Primary, Urgent Care, and Specialist	Primary/telehealth combined visits 1-3: $5, no deductible Primary visits 4+: $20, no deductible Urgent Care: $60 no deductible Specialist: $40 no deductible	Primary/telehealth combined visits 1-3: $5, no deductible Primary visits 4+: $40 no deductible Urgent Care: $70 no deductible Specialist: $80 no deductible	Primary/telehealth combined visits 1-3: $5, no deductible Primary visits 4+: $50 no deductible Urgent Care: $100 no deductible Specialist: $150 no deductible	50% after deductible
Telehealth				50% after deductible
Inpatient Hospital	20% after deductible	30% after deductible	0% after deductible	50% after deductible
Lab / X-ray	20% after deductible	30% after deductible	0% after deductible	50% after deductible
Physical, Occupational, and Speech Therapy Combined 30 visits per year	$20 no deductible if provided in an office setting	$40 no deductible if provided in an office setting	$50 no deductible if provided in an office setting	50% after deductible
Outpatient Surgery	20% after deductible	30% after deductible	0% after deductible	50% after deductible
Emergency Services	20% after deductible	30% after deductible	0% after deductible	Same as in-network
Chiropractic / Acupuncture Visits per benefit period: Chiro: 20 / Acu: 12	$20 no deductible	$40 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: $30 no deductible Tier 3: 50% no deductible Tier 4: 50% no deductible $500 max/script	Tier 1: $15 no deductible Tier 2: $60 no deductible Tier 3 & 4: 50% no deductible	Tier 1: $25 no deductible Tier 2, 3, & 4: 0% after deductible	90% after deductible
Pediatric Eye Exam One exam per benefit period	Covered in full			Covered in full up to $40
Pediatric Vision Hardware One item per benefit period	Covered in full up to $150 then subject to in-network deductible and 20%	Covered in full up to $150 then subject to in-network deductible and 30%	Covered in full up to $150 then subject to in-network deductible	Same as in-network

Plans are available to residents statewide, but please check PacificSource.com/Find-a-Doctor to ensure your provider is in-network.

†Adult vision included on this plan.

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