

**2025**  
**Standard Silver Plan\_FINAL**

Benefit	2024 Standard Silver	2025 Standard Silver
<b>2025 Federal AV</b>	n/a	71.44%
Deductible	Medical: \$5,500 Drug: \$0	Medical: \$5,500 Drug: \$0
Maximum OOP	Combined Medical and Drug \$9,450	<b>Combined Medical and Drug \$9,200</b>
Family multiplier	2x Individual; Embedded Approach	2x Individual; Embedded Approach
Primary Care Visit to Treat an Injury or Illness	\$40(†)	\$40(†)
Specialist Visit	\$80	\$80
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	30% After Deductible	30% After Deductible
Outpatient Surgery Physician/Surgical Services	30% After Deductible	30% After Deductible
Inpatient Hospital Services (e.g., Hospital Stay)	30% After Deductible	30% After Deductible
Inpatient Physician and Surgical Services	30% After Deductible	30% After Deductible
Inpatient Rehabilitation Services	30% After Deductible	30% After Deductible
Inpatient Habilitation Services	30% After Deductible	30% After Deductible
Urgent Care Centers of Facilities	\$70	\$70
Emergency Room Services	30% After Deductible	30% After Deductible
Generic Drugs	\$15**	\$15**
Preferred Brand Drugs	\$60**	\$60**
Non-Preferred Brand Drugs	50%**	50%**
Specialty Drugs	50%**	50%**
Pediatric Vision	Exams at \$0 for these codes: 92002/92004, 92012/92014, S0620/S0621; for other codes cost shares may apply. Contact lenses - Actuarial equivalent of \$150 per year. Frames - Actuarial equivalent of \$150 per year. Lenses at \$0 for codes V2100-2299, V2300-2399, V2121, V2221, V2321; for other codes cost shares may apply.	Exams at \$0 for these codes: 92002/92004, 92012/92014, S0620/S0621; for other codes cost shares may apply. Contact lenses - Actuarial equivalent of \$150 per year. Frames - Actuarial equivalent of \$150 per year. Lenses at \$0 for codes V2100-2299, V2300-2399, V2121, V2221, V2321; for other codes cost shares may apply.
Outpatient Rehabilitation Services	\$40 (Applies to PT,OT, ST provided in an office setting); PT OT, ST provided in emergency room or urgent care setting is subject to applicable co-insurance.	\$40 (Applies to PT,OT, ST provided in an office setting); PT OT, ST provided in emergency room or urgent care setting is subject to applicable co-insurance.
Outpatient Habilitation Services	\$40 (Applies to PT,OT, ST provided in an office setting); PT OT, ST provided in emergency room or urgent care setting is subject to applicable co-insurance.	\$40 (Applies to PT,OT, ST provided in an office setting); PT OT, ST provided in emergency room or urgent care setting is subject to applicable co-insurance.
Biofeedback	\$40	\$40
Cardiac Rehabilitation	\$40	\$40
Imaging (CT/PET Scans, MRIs)	30% After Deductible	30% After Deductible
Preventive Benefits *	\$0	\$0
Diabetes Education	\$0	\$0
Nutritional Counseling	\$0	\$0
Diabetic Supplies	\$0	\$0
Laboratory Outpatient and Professional Services	30% After Deductible	30% After Deductible
X-rays and Diagnostic Imaging	30% After Deductible	30% After Deductible
Acupuncture	\$40 - limit 12 visits per year	\$40 - limit 12 visits per year
Chiropractic	\$40 - limit 20 visits per year	\$40 - limit 20 visits per year

\* Preventive Benefits include, but are not limited to, services a carrier is required to provide without cost sharing under Oregon Laws 2017, Chapter 721 (HB 3391).

\*\*ORS 743A.069 Limits cost-sharing for health benefit plan coverage of insulin prescribed for treatment of diabetes. **SB 1508 amends this to \$35 for each 30-day supply and \$105 for each 90-day supply.**

(†) First three primary care visits must be covered at \$5 copayment