



2023 Medical Plans for **Montana Individuals and Families**

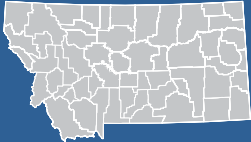


2023 Montana | Navigator Individual and Family Medical Plans

													HSA-QUALIFIED PLANS				MONTANA STANDARD PLANS					
	Gold 1500		Silver 3000†		Silver 4000†		Silver 5000		Bronze 7000		Bronze 9100		Silver HSA 3500		Bronze HSA 7050		Standard Gold		Standard Silver		Standard Expanded Bronze	
	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	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	IN NETWORK	OUT OF NETWORK
Deductible Individual / Family	\$1,500 / \$3,000	\$3,000 / \$6,000	\$3,000 / \$6,000	\$6,000 / \$12,000	\$4,000 / \$8,000	\$8,000 / \$16,000	\$5,000 / \$10,000	\$10,000 / \$20,000	\$7,000 / \$14,000	\$14,000 / \$28,000	\$9,100 / \$18,200	\$18,200 / \$36,400	\$3,500 / \$7,000	\$7,000 / \$14,000	\$7,050 / \$14,100	\$14,100 / \$28,200	\$2,000 / \$4,000	\$4,000 / \$8,000	\$5,800 / \$11,600	\$11,600 / \$23,200	\$7,500 / \$15,000	\$15,000 / \$30,000
Out-of-Pocket Maximum Individual / Family	\$7,000 / \$14,000	\$25,000 / \$50,000	\$9,100 / \$18,200	\$25,000 / \$50,000	\$9,100 / \$18,200	\$25,000 / \$50,000	\$7,600 / \$15,200	\$25,000 / \$50,000	\$8,550 / \$17,100	\$25,000 / \$50,000	\$9,100 / \$18,200	\$25,000 / \$50,000	\$6,700 / \$13,400	\$25,000 / \$50,000	\$7,050 / \$14,100	\$25,000 / \$50,000	\$8,700 / \$17,400	\$25,000 / \$50,000	\$8,900 / \$17,800	\$25,000 / \$50,000	\$9,000 / \$18,000	\$25,000 / \$50,000
Preventive Services	Covered in full	25% after deductible^	Covered in full	25% after deductible^	Covered in full	25% after deductible^	Covered in full	25% after deductible^	Covered in full	25% after deductible^	Covered in full	25% after deductible^	Covered in full	25% after deductible^	Covered in full	25% after deductible^	Covered in full	25% no deductible^	Covered in full	25% no deductible^	Covered in full	25% no deductible^
Preventive Drug Coverage	Covered in full	50% after deductible	Covered in full	50% after deductible	Covered in full	50% after deductible	Covered in full	50% after deductible	Covered in full	50% after deductible	Covered in full	50% after deductible	Covered in full	50% after deductible	Covered in full	50% after deductible	Only for drugs on the Standard Preventive No-Cost Drug List (Affordable Care Act) In Network: Covered in full, Out of Network: 50% after deductible					
Accident Benefit	Covered in full up to \$500, within 90 days of accident		Covered in full up to \$500, within 90 days of accident		Covered in full up to \$500, within 90 days of accident		Covered in full up to \$500, within 90 days of accident		Covered in full up to \$500, within 90 days of accident		Covered in full up to \$500, within 90 days of accident		Covered in full up to \$500, within 90 days of accident		Covered in full up to \$500, within 90 days of accident		Not Covered		Not Covered		Not Covered	
Office Visits Primary (including behavioral health), Urgent Care, and Specialist	10% after deductible	50% after deductible	Primary/Urgent: \$35 no deductible Specialist: 40% after deductible	50% after deductible	Primary/Urgent: \$20 no deductible Specialist: \$40 no deductible	50% after deductible	Primary/Urgent: \$35 no deductible Specialist: \$70 no deductible	50% after deductible	Primary/Urgent: \$35 no deductible Specialist: 40% after deductible	50% after deductible	0% after deductible	50% after deductible	25% after deductible	50% after deductible	0% after deductible	50% after deductible	Primary: \$30 no deductible Urgent: \$45 no deductible Specialist: \$60 no deductible	50% after deductible	Primary: \$40 no deductible Urgent: \$60 no deductible Specialist: \$80 no deductible	50% after deductible	Primary: \$50 no deductible Urgent: \$75 no deductible Specialist: \$100 no deductible	50% after deductible
Telehealth	Covered in full	50% after deductible	Covered in full	50% after deductible	Covered in full	50% after deductible	Covered in full	50% after deductible	Covered in full	50% after deductible	Covered in full	50% after deductible	25% after deductible	50% after deductible	0% after deductible	50% after deductible	\$30 no deductible	50% after deductible	\$40 no deductible	50% after deductible	\$50 no deductible	50% after deductible
Inpatient Hospital	10% after deductible	50% after deductible	40% after deductible	50% after deductible	30% after deductible	50% after deductible	30% after deductible	50% after deductible	40% after deductible	50% after deductible	0% after deductible	50% after deductible	25% after deductible	50% after deductible	0% after deductible	50% after deductible	25% after deductible	50% after deductible	40% after deductible	50% after deductible	50% after deductible	50% after deductible
Lab / X-ray	10% after deductible	50% after deductible	40% after deductible	50% after deductible	30% after deductible	50% after deductible	30% after deductible	50% after deductible	40% after deductible	50% after deductible	0% after deductible	50% after deductible	25% after deductible	50% after deductible	0% after deductible	50% after deductible	25% after deductible	50% after deductible	40% after deductible	50% after deductible	50% after deductible	50% after deductible
Physical, Occupational, and Speech Therapy	10% after deductible	50% after deductible	40% after deductible	50% after deductible	30% after deductible	50% after deductible	30% after deductible	50% after deductible	40% after deductible	50% after deductible	0% after deductible	50% after deductible	25% after deductible	50% after deductible	0% after deductible	50% after deductible	\$30 no deductible	50% after deductible	\$40 no deductible	50% after deductible	\$50 no deductible	50% after deductible
Outpatient Surgery	10% after deductible	50% after deductible	40% after deductible	50% after deductible	30% after deductible	50% after deductible	30% after deductible	50% after deductible	40% after deductible	50% after deductible	0% after deductible	50% after deductible	25% after deductible	50% after deductible	0% after deductible	50% after deductible	25% after deductible	50% after deductible	40% after deductible	50% after deductible	50% after deductible	50% after deductible
Emergency Services	10% after deductible	10% after deductible	40% after deductible	40% after deductible	30% after deductible	30% after deductible	30% after deductible	30% after deductible	40% after deductible	40% after deductible	0% after deductible	0% after deductible	25% after deductible	25% after deductible	0% after deductible	0% after deductible	25% after deductible	25% after deductible	40% after deductible	40% after deductible	50% after deductible	50% after deductible
Chiropractic / Acupuncture Visits per benefit period: Chiro: 10 / Acu: 12	10% after deductible	50% after deductible	\$35 no deductible	50% after deductible	\$20 no deductible	50% after deductible	\$35 no deductible	50% after deductible	\$35 no deductible	50% after deductible	0% after deductible	50% after deductible	25% after deductible	50% after deductible	0% after deductible	50% after deductible	\$30 no deductible	50% after deductible	\$40 no deductible	50% after 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: \$15 no deductible Tier 2: \$50 no deductible Tier 3: \$75 no deductible Tier 4: \$250 no deductible	50% after deductible	Tier 1: \$15 no deductible Tier 2: \$60 no deductible Tier 3: \$100 no deductible Tier 4: \$250 no deductible	50% after deductible	30% after deductible	50% after deductible	30% after deductible	50% after deductible	40% after deductible	50% after deductible	0% after deductible	50% after deductible	25% after deductible	50% after deductible	0% after deductible	50% after deductible	Tier 1: \$15 no deductible Tier 2: \$30 no deductible Tier 3: \$60 no deductible Tier 4: \$250 no deductible	50% after deductible	Tier 1: \$20 no deductible Tier 2: \$40 no deductible Tier 3: \$80 after deductible Tier 4: \$350 after deductible	50% after deductible	Tier 1: \$25 no deductible Tier 2: \$50 after deductible Tier 3: \$100 after deductible Tier 4: \$500 after deductible	50% after deductible
Pediatric Eye Exam One exam per benefit period	Covered in full	Covered in full up to \$40	Covered in full	Covered in full up to \$40	Covered in full	Covered in full up to \$40	Covered in full	Covered in full up to \$40	Covered in full	Covered in full up to \$40	Covered in full	Covered in full up to \$40	Covered in full	Covered in full up to \$40	Covered in full	Covered in full up to \$40	Covered in full	Covered in full up to \$40	Covered in full	Covered in full up to \$40	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 10%		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 30%		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 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 and 25%		Covered in full up to \$150 then subject to in-network deductible		Covered in full up to \$150 then subject to in-network deductible and 25%		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 50%	

^Well-baby/well-child care and preventive mammograms are covered in full both in and out of network.
†Available only on direct basis
This is a brief summary. Contact a Coverage Advisor at **855-330-2792** or by email at CoverageAdvisors@PacificSource.com. Go to [PacificSource.com](https://www.pacificsource.com) for details or to see a plan’s Summary of Benefits. Accessibility help: for assistance reading this table or the rest of the document, please call us at **888-977-9299**, TTY: 711. We accept all relay calls.

Availability map **by county**



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