PacificSource HEALTH PLANS

2024 Montana Navigator Individual and Family Medical Plans

	Gold 1500	
	IN NETWORK	OUT OF NETWORK
Deductible Individual / Family	**$1,500 / $3,000**	**$3,000 / $6,000**
Out-of-Pocket Maximum Individual / Family	**$7,000 / $14,000**	**$25,000 / $50,000**
Preventive Services	Covered in full	25% after deductible^
Preventive Drug Coverage	Covered in full	50% after deductible
Accident Benefit	Covered in full up to $500, within 90 days of accident	
Office Visits: Primary, Urgent Care, and Specialist	10% after deductible	50% after deductible
Telehealth	10% after deductible	50% after deductible
Inpatient Hospital	10% after deductible	50% after deductible
Lab / X-ray	10% after deductible	50% after deductible
Physical, Occupational, and Speech Therapy	10% after deductible	50% after deductible
Outpatient Surgery	10% after deductible	50% after deductible
Emergency Services	10% after deductible	
Chiropractic / Acupuncture Visits per benefit period: Chiro: 10 / Acu: 12	10% after 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
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 10%	

Plans are available to residents statewide.

^Well-baby/well-child care and preventive mammograms are covered in full both in and out of network.
†Available only on direct basis

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 Montana Navigator Individual and Family Medical Plans

	Silver 3000†	Silver 4000†	Silver 5000	Silver HSA 3500	
	IN NETWORK	IN NETWORK	IN NETWORK	IN NETWORK	OUT OF NETWORK
Deductible Individual / Family	**$3,000 / $6,000**	**$4,000 / $8,000**	**$5,000 / $10,000**	**$3,500 / $7,000**	Silver 3000: **$6,000 / $12,000** Silver 4000: **$8,000 / $16,000** Silver 5000: **$10,000 / $20,000** Silver HSA 3500: **$7,000 / $14,000**
Out-of-Pocket Maximum Individual / Family	**$9,400 / $18,800**	**$9,400 / $18,800**	**$7,600 / $15,200**	**$6,700 / $13,400**	**$25,000 / $50,000**
Preventive Services	Covered in full				25% after deductible^
Preventive Drug Coverage	Covered in full				50% after deductible
Accident Benefit	Covered in full up to $500, within 90 days of accident				
Office Visits: Primary, Urgent Care, and Specialist	Primary: $35 no deductible Urgent Care: $35 no deductible Specialist: $70 after deductible	Primary: $20 no deductible Urgent Care: $20 no deductible Specialist: $40 no deductible	Primary: $35 no deductible Urgent Care: $35 no deductible Specialist: $70 no deductible	25% after deductible	50% after deductible
Telehealth	$35 no deductible	$20 no deductible	$35 no deductible	25% after deductible	50% after deductible
Inpatient Hospital	40% after deductible	30% after deductible	30% after deductible	25% after deductible	50% after deductible
Lab / X-ray	40% after deductible	30% after deductible	30% after deductible	25% after deductible	50% after deductible
Physical, Occupational, and Speech Therapy	40% after deductible	30% after deductible	30% after deductible	25% after deductible	50% after deductible
Outpatient Surgery	40% after deductible	30% after deductible	30% after deductible	25% after deductible	50% after deductible
Emergency Services	40% after deductible	30% after deductible	30% after deductible	25% after deductible	Same as in-network
Chiropractic / Acupuncture Visits per benefit period: Chiro: 10 / Acu: 12	$35 no deductible	$20 no deductible	$35 no deductible	25% after 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: $60 no deductible Tier 3: $100 no deductible Tier 4: $250 no deductible	30% after deductible	30% after deductible	25% after deductible	50% 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 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 25%	Same as in-network

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†Available only on direct basis

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PacificSource HEALTH PLANS

2024 Montana Navigator Individual and Family Medical Plans

	Bronze 7000	Bronze 9400	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**	Bronze 7000: **$14,000 / $28,000** Bronze 9400: **$18,800 / $37,600** Bronze HSA 7500: **$15,000 / $30,000**
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			25% after deductible^
Preventive Drug Coverage	Covered in full			50% after deductible
Accident Benefit	Covered in full up to $500, within 90 days of accident			
Office Visits: Primary, Urgent Care, and Specialist	Primary/Urgent: $35 no deductible Specialist: $70 after deductible	0% after deductible	0% after deductible	50% after deductible
Telehealth	$35 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	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: 10 / Acu: 12	$35 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	50% 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%	Covered in full up to $150, then subject to in-network deductible and 0%	Same as in-network

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PacificSource HEALTH PLANS

2024 Montana Navigator Individual and Family Medical Plans

	Standard Gold	Standard Silver	Standard Expanded Bronze	
	IN NETWORK	IN NETWORK	IN NETWORK	OUT OF NETWORK
Deductible Individual / Family	**$1,500 / $3,000**	**$5,900 / $11,800**	**$7,500 / $15,000**	Std. Gold: **$4,000 / $8,000** Std. Silver: **$11,800 / $23,600** Std. Expanded Bronze: **$15,000 / $30,000**
Out-of-Pocket Maximum Individual / Family	**$8,700 / $17,400**	**$9,100 / $18,200**	**$9,400 / $18,800**	**$25,000 / $50,000**
Preventive Services	Covered in full			25% after deductible^
Preventive Drug Coverage	Covered in full			50% after deductible
Accident Benefit	Not Covered			
Office Visits: Primary, Urgent Care, and Specialist	Primary: $30 no deductible Urgent Care: $45 no deductible Specialist: $60 no deductible	Primary: $40 no deductible Urgent Care: $60 no deductible Specialist: $80 no deductible	Primary: $50 no deductible Urgent Care: $75 no deductible Specialist: $100 no deductible	50% after deductible
Telehealth	$30 no deductible	$40 no deductible	$50 no deductible	50% after deductible
Inpatient Hospital	25% after deductible	40% after deductible	50% after deductible	50% after deductible
Lab / X-ray	25% after deductible	40% after deductible	50% after deductible	50% after deductible
Physical, Occupational, and Speech Therapy	$30 no deductible	$40 no deductible	$50 no deductible	50% after deductible
Outpatient Surgery	25% after deductible	40% after deductible	50% after deductible	50% after deductible
Emergency Services	25% after deductible	40% after deductible	50% after deductible	Same as in-network
Chiropractic / Acupuncture Visits per benefit period: Chiro: 10 / Acu: 12	$30 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: $15 no deductible Tier 2: $30 no deductible Tier 3: $60 no deductible Tier 4: 250 no deductible	Tier 1: $20 no deductible Tier 2: $40 no deductible Tier 3: $80 after deductible Tier 4: $350 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	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 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%	Same as in-network

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