PacificSource HEALTH PLANS

2026 Montana Navigator Small Group Medical Plans

	Platinum 500^	
	IN-NETWORK	OUT-OF-NETWORK
Deductible Individual / Family	**$500 / $1,000**	**$18,400 / $36,800**
Out-of-Pocket Maximum Individual / Family	**$3,000 / $6,000**	**$27,600 / $55,200**
Preventive Services	Covered in full	25% after deductible[1]
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: $10 no deductible Specialist: $20 no deductible	50% after deductible
Telehealth	$10 no deductible	50% after deductible
Inpatient Hospital	20% after deductible	50% after deductible
Lab / X-ray	20% after deductible	50% after deductible
Physical, Occupational, and Speech Therapy	20% after deductible	50% after deductible
Outpatient Surgery	20% after deductible	50% after deductible
Emergency Services	$250 plus 20% after deductible	
Chiropractic / Acupuncture Visits per benefit period: Chiro: 10 / Acu: 12	$10 no deductible	50% after deductible
Prescription (Rx) Drug Coverage Out-of-network: 30-day max fill, no more than 3 per year	Tier 1: $5 no deductible Tier 2: $15 no deductible Tier 3: $50 no deductible Tier 4: $250 no deductible	50% after deductible

^This plan available with or without adult vision exam and hardware benefit.

[1] Well-baby/well-child care and preventive mammograms are not subject to a deductible when using an out-of-network provider.

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.

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	Gold 1000^	Gold 2000^	Gold 3000^		Gold HSA 3400	
	IN-NETWORK	IN-NETWORK	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK
Deductible Individual / Family	**$1,000 / $2,000**	**$2,000 / $4,000**	**$3,000 / $6,000**	**$18,400 / $36,800**	**$3,400 / $6,800**	**$27,600 / $55,200**
Out-of-Pocket Maximum Individual / Family	**$6,000 / $12,000**	**$6,000 / $12,000**	**$6,500 / $13,000**	**$27,600 / $55,200**	**$3,400 / $6,800**	**$27,600 / $55,200**
Preventive Services	Covered in full			25% after deductible[1]	Covered in full	0% after deductible[1]
Preventive Drug Coverage	Covered in full			50% after deductible	Covered in full	0% 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	
Office Visits: Primary, Urgent Care, and Specialist	Primary/Urgent: $30 no deductible Specialist: $60 no deductible	Primary/Urgent: $30 no deductible Specialist: $60 no deductible	Primary/Urgent: $35 no deductible Specialist: $70 no deductible	50% after deductible	0% after deductible	0% after deductible
Telehealth	$30 no deductible	$30 no deductible	$35 no deductible	50% after deductible	0% after deductible	0% after deductible
Inpatient Hospital	30% after deductible	30% after deductible	30% after deductible	50% after deductible	0% after deductible	0% after deductible
Lab / X-ray	30% after deductible	30% after deductible	30% after deductible	50% after deductible	0% after deductible	0% after deductible
Physical, Occupational, and Speech Therapy	30% after deductible	30% after deductible	$35 no deductible	50% after deductible	0% after deductible	0% after deductible
Outpatient Surgery	30% after deductible	30% after deductible	30% after deductible	50% after deductible	0% after deductible	0% after deductible
Emergency Services	$250 plus 30% after deductible				0% after deductible	0% after deductible
Chiropractic / Acupuncture Visits per benefit period: Chiro: 10 / Acu: 12	$30 no deductible	$30 no deductible	$35 no deductible	50% after deductible	0% after deductible	0% 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: $35 no deductible Tier 3: $60 no deductible Tier 4: $250 no deductible	Tier 1: $10 no deductible Tier 2: $35 no deductible Tier 3: $60 no deductible Tier 4: $250 no deductible	Tier 1: $10 no deductible Tier 2: $35 no deductible Tier 3: $60 no deductible Tier 4: $250 no deductible	50% after deductible	0% after deductible	0% after deductible

^This plan available with or without adult vision exam and hardware benefit.

[1] Well-baby/well-child care and preventive mammograms are not subject to a deductible when using an out-of-network provider.

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	Silver 3000	Silver 4500^	Silver 5500^	Silver 6500^	
	IN-NETWORK	IN-NETWORK	IN-NETWORK	IN-NETWORK	OUT-OF-NETWORK
Deductible Individual / Family	**$3,000 / $6,000**	**$4,500 / $9,000**	**$5,500 / $11,000**	**$6,500 / $13,000**	**$18,400 / $36,800**
Out-of-Pocket Maximum Individual / Family	**$8,600 / $17,200**	**$9,100 / $18,200**	**$10,000 / $20,000**	**$10,600 / $21,200**	**$27,600 / $55,200**
Preventive Services	Covered in full				25% after deductible[1]
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: $30 no deductible Specialist: $60 after deductible	Primary/Urgent: $35 no deductible Specialist: $70 no deductible	Primary/Urgent: $40 no deductible Specialist: $60 no deductible	Primary/Urgent: $50 no deductible Specialist: $80 no deductible	50% after deductible
Telehealth	$30 no deductible	$35 no deductible	$40 no deductible	$50 no deductible	50% after deductible
Inpatient Hospital	40% after deductible	30% after deductible	30% after deductible	30% after deductible	50% after deductible
Lab / X-ray	40% after deductible	30% after deductible	30% after deductible	30% after deductible	50% after deductible
Physical, Occupational, and Speech Therapy	40% after deductible	30% after deductible	30% after deductible	30% after deductible	50% after deductible
Outpatient Surgery	40% after deductible	30% after deductible	30% after deductible	30% after deductible	50% after deductible
Emergency Services	$250 plus 40% after deductible	$250 plus 30% after deductible	$250 plus 30% after deductible	$250 plus 30% after deductible	Same as in-network
Chiropractic / Acupuncture Visits per benefit period: Chiro: 10 / Acu: 12	$30 no deductible	$35 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: $60 no deductible Tier 3: $100 no deductible Tier 4: $250 no deductible	Tier 1: $15 no deductible Tier 2: $60 no deductible Tier 3: $100 no deductible Tier 4: $250 no deductible	Tier 1: $15 no deductible Tier 2: $60 no deductible Tier 3: $100 no deductible Tier 4: $250 no deductible	Tier 1: $20 no deductible Tier 2: $60 no deductible Tier 3: $100 no deductible Tier 4: $250 no deductible	50% after deductible

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	Silver HSA 3500		Silver HSA 6000	
	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK
Deductible Individual / Family	**$3,500 / $7,000**	**$18,400 / $36,800**	**$6,000 / $12,000**	**$27,600 / $55,200**
Out-of-Pocket Maximum Individual / Family	**$7,500 / $15,000**	**$27,600 / $55,200**	**$6,000 / $12,000**	**$27,600 / $55,200**
Preventive Services	Covered in full	25% after deductible[1]	Covered in full	0% after deductible[1]
Preventive Drug Coverage	Covered in full	50% after deductible	Covered in full	0% 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	
Office Visits: Primary, Urgent Care, and Specialist	20% after deductible	50% after deductible	0% after deductible	0% after deductible
Telehealth	20% after deductible	50% after deductible	0% after deductible	0% after deductible
Inpatient Hospital	20% after deductible	50% after deductible	0% after deductible	0% after deductible
Lab / X-ray	20% after deductible	50% after deductible	0% after deductible	0% after deductible
Physical, Occupational, and Speech Therapy	20% after deductible	50% after deductible	0% after deductible	0% after deductible
Outpatient Surgery	20% after deductible	50% after deductible	0% after deductible	0% after deductible
Emergency Services	20% after deductible	20% after deductible	0% after deductible	0% after deductible
Chiropractic / Acupuncture Visits per benefit period: Chiro: 10 / Acu: 12	20% after deductible	50% after deductible	0% after deductible	0% after deductible
Prescription (Rx) Drug Coverage Out-of-network: 30-day max fill, no more than 3 per year	20% after deductible	50% after deductible	0% after deductible	0% after deductible

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	Bronze 7500		Bronze 10600^	Bronze HSA 8300	
	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	IN-NETWORK	OUT-OF-NETWORK
Deductible Individual / Family	**$7,500 / $15,000**	**$18,400 / $36,800**	**$10,600 / $21,200**	**$8,300 / $16,600**	**$27,600 / $55,200**
Out-of-Pocket Maximum Individual / Family	**$10,600 / $21,200**	**$27,600 / $55,200**	**$10,600 / $21,200**	**$8,300 / $16,600**	**$27,600 / $55,200**
Preventive Services	Covered in full	25% after deductible[1]	Covered in full		0% after deductible[1]
Preventive Drug Coverage	Covered in full	50% after deductible	Covered in full		0% 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		
Office Visits: Primary, Urgent Care, and Specialist	Primary/Urgent: $40 no deductible Specialist: $100 no deductible	50% after deductible	Primary/Urgent: $60 no deductible Specialist: $120 no deductible	0% after deductible	0% after deductible
Telehealth	$40 no deductible	50% after deductible	$60 no deductible	0% after deductible	0% after deductible
Inpatient Hospital	30% after deductible	50% after deductible	0% after deductible	0% after deductible	0% after deductible
Lab / X-ray	30% after deductible	50% after deductible	0% after deductible	0% after deductible	0% after deductible
Physical, Occupational, and Speech Therapy	30% after deductible	50% after deductible	0% after deductible	0% after deductible	0% after deductible
Outpatient Surgery	30% after deductible	50% after deductible	0% after deductible	0% after deductible	0% after deductible
Emergency Services	30% after deductible	30% after deductible	0% after deductible	0% after deductible	0% after deductible
Chiropractic / Acupuncture Visits per benefit period: Chiro: 10 / Acu: 12	$40 no deductible	50% after deductible	$60 no deductible	0% after deductible	0% after deductible
Prescription (Rx) Drug Coverage Out-of-network: 30-day max fill, no more than 3 per year	30% after deductible	50% after deductible	Tier 1: $30 no deductible Tier 2: $100 no deductible Tier 3: $200 no deductible Tier 4: $500 no deductible	0% after deductible	0% after deductible

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