

Focus on **Vision**



Our vision plans focus on wellness and prevention.

Vision for kids

All of our medical plans include full coverage for in-network pediatric eye exams. Out-of-network eye exams are covered up to a maximum of \$40 with no deductible. After that, member pays 100%. **Pediatric vision hardware is covered in full up to \$150.** After that, it's subject to in-network deductible and then a member co-insurance up to 50%, depending on the plan.

Vision for adults

Many of our medical plans include coverage for adult eye exams and vision hardware. When visiting an in-network provider, **eye exams are covered in full.** Out-of-network eye exams are covered up a maximum of \$40 with no deductible. After that, member pays 100%. **Adult vision hardware is covered in full up to \$150.**

For more details on our vision benefits, please contact your broker or our team at the contact information listed on the back of this document.



Availability Maps **by County**

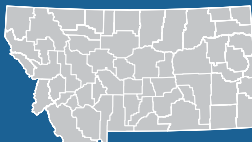
More for less from our **Navigator** products



Navigator is our coordinated care product, where a member's care is navigated within a coordinated network of health professionals. Navigator promotes better member engagement and shared decision making with providers.

Navigator is available for purchase by businesses headquartered in the following counties: Broadwater, Carbon, Custer, Deer Lodge, Flathead, Gallatin, Granite, Jefferson, Lake, Lewis and Clark, Missoula, Musselshell, Park, Powell, Ravalli, Silver Bow, Stillwater, Sweet Grass, and Yellowstone.

Freedom to choose with our **Voyager** products



Voyager uses our preferred provider network, and is suited for a company culture that prefers a more self-directed experience.

Voyager is available for purchase by businesses headquartered in all Montana counties.

Contact your broker or our team for a quote. We're happy to help, Monday through Friday from 8:00 a.m. to 5:00 p.m.

Phone: (406) 422-1008 | (855) 422-1008

Email: montanasales@pacificsource.com

PacificSource.com



2021 Medical Plans for **Montana** Small Groups | 1–50

2021 Montana | Small Group Medical Plans

	NON-HSA QUALIFIED PLANS																HSA QUALIFIED PLANS									
Product	Platinum 500^		Gold 1000^		Gold 2000^		Silver 3000		Silver 4500^		Silver 5500^		Silver 6500^		Bronze 8150		Gold HSA 3000		Silver HSA 3000		Silver HSA 4500		Silver HSA 5500		Bronze HSA 6900	
	Navigator or Voyager		Navigator or Voyager		Navigator or Voyager		Navigator or Voyager		Navigator or Voyager		Navigator or Voyager		Navigator or Voyager		Navigator or Voyager		Navigator or Voyager		Navigator or Voyager		Navigator or Voyager		Navigator or Voyager		Navigator or Voyager	
	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	IN NETWORK	OUT OF NETWORK	IN NETWORK	OUT OF NETWORK
Deductible Individual / Family	\$500 / \$1,000	\$1,000 / \$2,000	\$1,000 / \$2,000	\$2,000 / \$4,000	\$2,000 / \$4,000	\$4,000 / \$8,000	\$3,000 / \$6,000	\$6,000 / \$12,000	\$4,500 / \$9,000	\$9,000 / \$18,000	\$5,500 / \$11,000	\$11,000 / \$22,000	\$6,500 / \$13,000	\$13,000 / \$26,000	\$8,150 / \$16,300	\$16,300 / \$32,600	\$3,000 / \$6,000	\$6,000 / \$12,000	\$3,000 / \$6,000	\$6,000 / \$12,000	\$4,500 / \$9,000	\$9,000 / \$18,000	\$5,500 / \$11,000	\$11,000 / \$22,000	\$6,900 / \$13,800	\$13,800 / \$27,600
Out-of-Pocket Maximum Individual / Family	\$3,000 / \$6,000	\$6,000 / \$12,000	\$5,500 / \$11,000	\$11,000 / \$22,000	\$5,500 / \$11,000	\$11,000 / \$22,000	\$8,150 / \$16,300	\$16,300 / \$32,600	\$7,500 / \$15,000	\$15,000 / \$30,000	\$7,500 / \$15,000	\$15,000 / \$30,000	\$7,500 / \$15,000	\$15,000 / \$30,000	\$8,150 / \$16,300	\$16,300 / \$32,600	\$3,000 / \$6,000	\$6,000 / \$12,000	\$6,750 / \$13,500	\$13,500 / \$27,000	\$4,500 / \$9,000	\$9,000 / \$18,000	\$5,500 / \$11,000	\$11,000 / \$22,000	\$6,900 / \$13,800	\$13,800 / \$27,600
	NO DEDUCTIBLE, MEMBER PAYS:	AFTER DEDUCTIBLE, MEMBER PAYS:	NO DEDUCTIBLE, MEMBER PAYS:	AFTER DEDUCTIBLE, MEMBER PAYS:	NO DEDUCTIBLE, MEMBER PAYS:	AFTER DEDUCTIBLE, MEMBER PAYS:	NO DEDUCTIBLE, MEMBER PAYS:	AFTER DEDUCTIBLE, MEMBER PAYS:	NO DEDUCTIBLE, MEMBER PAYS:	AFTER DEDUCTIBLE, MEMBER PAYS:	NO DEDUCTIBLE, MEMBER PAYS:	AFTER DEDUCTIBLE, MEMBER PAYS:	NO DEDUCTIBLE, MEMBER PAYS:	AFTER DEDUCTIBLE, MEMBER PAYS:	NO DEDUCTIBLE, MEMBER PAYS:	AFTER DEDUCTIBLE, MEMBER PAYS:	NO DEDUCTIBLE, MEMBER PAYS:	AFTER DEDUCTIBLE, MEMBER PAYS:	NO DEDUCTIBLE, MEMBER PAYS:	AFTER DEDUCTIBLE, MEMBER PAYS:	NO DEDUCTIBLE, MEMBER PAYS:	AFTER DEDUCTIBLE, MEMBER PAYS:	NO DEDUCTIBLE, MEMBER PAYS:	AFTER DEDUCTIBLE, MEMBER PAYS:	NO DEDUCTIBLE, MEMBER PAYS:	AFTER DEDUCTIBLE, MEMBER PAYS:
Preventive Services	Covered in Full	25% ¹	Covered in Full	25% ¹	Covered in Full	25% ¹	Covered in Full	25% ¹	Covered in Full	25% ¹	Covered in Full	25% ¹	Covered in Full	25% ¹	Covered in Full	Covered in Full ¹	Covered in Full	Covered in Full ¹	Covered in Full	25% ¹	Covered in Full	Covered in Full ¹	Covered in Full	Covered in Full ¹	Covered in Full	Covered in Full
Preventive Drug Coverage	Covered in Full	50%	Covered in Full	50%	Covered in Full	50%	Covered in Full	50%	Covered in Full	50%	Covered in Full	50%	Covered in Full	50%	Covered in Full	Covered in Full	Covered in Full	Covered in Full	Covered in Full	Covered in Full	Covered in Full	Covered in Full	Covered in Full	Covered in Full	Covered in Full	Covered in Full
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.		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.	
	AFTER DEDUCTIBLE, MEMBER PAYS:		AFTER DEDUCTIBLE, MEMBER PAYS:		AFTER DEDUCTIBLE, MEMBER PAYS:		AFTER DEDUCTIBLE, MEMBER PAYS:		AFTER DEDUCTIBLE, MEMBER PAYS:		AFTER DEDUCTIBLE, MEMBER PAYS:		AFTER DEDUCTIBLE, MEMBER PAYS:		AFTER DEDUCTIBLE, MEMBER PAYS:		AFTER DEDUCTIBLE, MEMBER PAYS:		AFTER DEDUCTIBLE, MEMBER PAYS:		AFTER DEDUCTIBLE, MEMBER PAYS:		AFTER DEDUCTIBLE, MEMBER PAYS:		AFTER DEDUCTIBLE, MEMBER PAYS:	
Telemedicine (including behavioral health for adults)	\$10*	50%	\$10*	50%	\$10*	50%	\$10*	50%	\$10*	50%	\$10*	50%	\$10*	50%	\$10*	Covered in Full	Covered in Full	Covered in Full	20%	50%	Covered in Full	Covered in Full	Covered in Full	Covered in Full	Covered in Full	Covered in Full
Office Visits Primary, Urgent Care, and Specialist	Primary/Urgent Care: \$10* Specialist: \$20*	50%	Primary/Urgent Care: \$30* Specialist: \$60*	50%	Primary/Urgent Care: \$30* Specialist: \$60*	50%	Primary/Urgent Care: \$35* Specialist: 40%	50%	Primary/Urgent Care: \$35* Specialist: \$70*	50%	Primary/Urgent Care: \$30* Specialist: \$60*	50%	Primary/Urgent Care: \$30* Specialist: \$60*	50%	Primary/Urgent Care: \$40* Specialist: Covered in Full	Covered in Full	Covered in Full	Covered in Full	20%	50%	Covered in Full	Covered in Full	Covered in Full	Covered in Full	Covered in Full	Covered in Full
Inpatient Hospital	20%	50%	30%	50%	30%	50%	40%	50%	30%	50%	30%	50%	30%	50%	Covered in Full	Covered in Full	Covered in Full	Covered in Full	20%	50%	Covered in Full	Covered in Full	Covered in Full	Covered in Full	Covered in Full	Covered in Full
Lab / X-ray	20%	50%	30%	50%	30%	50%	40%	50%	30%	50%	30%	50%	30%	50%	Covered in Full	Covered in Full	Covered in Full	Covered in Full	20%	50%	Covered in Full	Covered in Full	Covered in Full	Covered in Full	Covered in Full	Covered in Full
Physical, Occupational, and Speech Therapy	20%	50%	30%	50%	30%	50%	40%	50%	30%	50%	30%	50%	30%	50%	Covered in Full	Covered in Full	Covered in Full	Covered in Full	20%	50%	Covered in Full	Covered in Full	Covered in Full	Covered in Full	Covered in Full	Covered in Full
Outpatient Surgery	20%	50%	30%	50%	30%	50%	40%	50%	30%	50%	30%	50%	30%	50%	Covered in Full	Covered in Full	Covered in Full	Covered in Full	20%	50%	Covered in Full	Covered in Full	Covered in Full	Covered in Full	Covered in Full	Covered in Full
Emergency Services Copay waived if admitted	\$250 plus 20%	\$250 plus 20%	\$250 plus 30%	\$250 plus 30%	\$250 plus 30%	\$250 plus 30%	\$250 plus 40%	\$250 plus 40%	\$250 plus 30%	\$250 plus 30%	\$250 plus 30%	\$250 plus 30%	\$250 plus 30%	\$250 plus 30%	Covered in Full	Covered in Full	Covered in Full	Covered in Full	20%	20%	Covered in Full	Covered in Full	Covered in Full	Covered in Full	Covered in Full	Covered in Full
Chiropractic / Acupuncture Visits per benefit period: Chiro: 10 / Acu: 12	\$10*	50%	\$30*	50%	\$30*	50%	\$35*	50%	\$35*	50%	\$30*	50%	\$30*	50%	\$40*	Covered in Full	Covered in Full	Covered in Full	20%	50%	Covered in Full	Covered in Full	Covered in Full	Covered in Full	Covered in Full	Covered in Full
Prescription (Rx) Drug Coverage Out-of-network: 30-day max fill, no more than 3 per year	Tier 1: \$5* Tier 2: \$15* Tier 3: \$60* Tier 4: \$250*	50%	Tier 1: \$10* Tier 2: \$35* Tier 3: \$60* Tier 4: \$250*	50%	Tier 1: \$10* Tier 2: \$35* Tier 3: \$100* Tier 4: \$250*	50%	Tier 1: \$15* Tier 2: \$60* Tier 3: \$100* Tier 4: \$250*	50%	Tier 1: \$15* Tier 2: \$60* Tier 3: \$100* Tier 4: \$250*	50%	Tier 1: \$15* Tier 2: \$60* Tier 3: \$100* Tier 4: \$250*	50%	Tier 1: \$15* Tier 2: \$60* Tier 3: \$100* Tier 4: \$250*	50%	Covered in Full	Covered in Full	Covered in Full	Covered in Full	20%	50%	Covered in Full	Covered in Full	Covered in Full	Covered in Full	Covered in Full	Covered in Full

^This plan available with or without adult vision. *Not subject to deductible. ¹ Well-baby and well-child care are not subject to deductible. Preventive mammograms are not subject to deductible and are covered in full both in- and out-of-network.

This is a brief summary. Contact us at montanasales@pacificsource.com or go to **PacificSource.com** for details or to see a plan's Summary of Benefits.

Accessibility help: For assistance reading this chart or the rest of the document, please call us at (888) 977-9299. TTY: 711 or (800) 735-3260.