PacificSource HEALTH PLANS

2024 Montana Navigator Large Group Medical Plans

	500+20_20		750+20_20		1000+20_20		1500+20_20		2000+20_30	
	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	$3,000 / $6,000	$750 / $1,500	$5,000 / $10,000	$1,000 / $2,000	$5,000 / $10,000	$1,500 / $3,000	$5,000 / $10,000	$2,000 / $4,000	$7,500 / $15,000
Out-of-Pocket Maximum Individual / Family	$2,000 / $4,000	$10,000 / $20,000	$3,000 / $6,000	$10,000 / $20,000	$4,000 / $8,000	$10,000 / $20,000	$5,000 / $10,000	$10,000 / $20,000	$5,000 / $10,000	$15,000 / $30,000
	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	50%‡	Covered in full	50%‡	Covered in full	50%‡	Covered in full	50%‡	Covered in full	55%‡
	AFTER DEDUCTIBLE, MEMBER PAYS:		AFTER DEDUCTIBLE, MEMBER PAYS:		AFTER DEDUCTIBLE, MEMBER PAYS:		AFTER DEDUCTIBLE, MEMBER PAYS:		AFTER DEDUCTIBLE, MEMBER PAYS:	
Telehealth	$20*	50%	$20*	50%	$20*	50%	$20*	50%	$20*	55%
Office Visits: Primary (including behavioral health), **Urgent Care, and Specialist**	$20*	50%	$20*	50%	$20*	50%	$20*	50%	$20*	55%
Inpatient Hospital	20%	50%	20%	50%	20%	50%	20%	50%	30%	55%
Lab / X-ray	20%	50%	20%	50%	20%	50%	20%	50%	30%	55%
Physical, Occupational, and Speech Therapy	20%	50%	20%	50%	20%	50%	20%	50%	30%	55%
Chiropractic / Acupuncture 15 visits combined per benefit period	$20*	50%	$20*	50%	$20*	50%	$20*	50%	$20*	55%
Outpatient Surgery	20%	50%	20%	50%	20%	50%	20%	50%	30%	55%
Emergency Services Copay waived if admitted	$100 plus 20%	$100 plus 20%	$100 plus 20%	$100 plus 20%	$100 plus 20%	$100 plus 20%	$100 plus 20%	$100 plus 20%	$100 plus 30%	$100 plus 30%
Prescription (Rx) Drug Coverage	For prescription drug coverage, choose from two no-deductible options of copay-style plans. One option offers copays on all four tiers; a second option offers Tier 1 with a $10 copay, Tiers 2 and 3 at 50% copay, and Tier 4 at $150 or 50%, whichever is less.									

*Not subject to deductible.

‡Out-of-network well-baby and well-child care, preventive physicals, and prostate cancer screenings are not subject to deductible. Out-of network well-woman visits, preventive mammograms, and immunizations are covered in full.

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. This is a brief summary. Contact us at **866-722-7720,** MontanaSales@PacificSource.com, or go to PacificSource.com for details or to see a plan's Summary of Benefits.
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PacificSource HEALTH PLANS

2024 Montana Navigator Large Group Medical Plans

	2500+20_30		3000+20		4000+20_30		9400+50+Rx	
	IN NETWORK	OUT OF NETWORK	IN NETWORK	OUT OF NETWORK	IN NETWORK	OUT OF NETWORK	IN NETWORK	OUT OF NETWORK
Deductible Individual / Family	$2,500 / $5,000	$7,500 / $15,000	$3,000 / $6,000	$7,500 / $15,000	$4,000 / $8,000	$10,000 / $20,000	$9,400 / $18,800	$15,000 / $30,000
Out-of-Pocket Maximum Individual / Family	$7,000 / $14,000	$15,000 / $30,000	$3,000 / $6,000	$15,000 / $30,000	$8,000 / $16,000	$20,000 / $40,000	$9,400 / $18,800	$30,000 / $60,000
	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	55%‡	Covered in full	55%‡	Covered in full	55%‡	Covered in full	55%‡
	AFTER DEDUCTIBLE, MEMBER PAYS:		AFTER DEDUCTIBLE, MEMBER PAYS:		AFTER DEDUCTIBLE, MEMBER PAYS:		AFTER DEDUCTIBLE, MEMBER PAYS:	
Telehealth	$20*	55%	$20*	55%	$20*	55%	$50*	55%
Office Visits: Primary (including behavioral health), **Urgent Care, and Specialist**	$20*	55%	$20*	55%	$20*	55%	$50*	55%
Inpatient Hospital	30%	55%	Covered in full	55%	30%	55%	Covered in full	55%
Lab / X-ray	30%	55%	Covered in full	55%	30%	55%	Covered in full	55%
Physical, Occupational, and Speech Therapy	30%	55%	Covered in full	55%	30%	55%	Covered in full	55%
Chiropractic / Acupuncture 15 visits combined per benefit period	$20*	55%	$20*	55%	$20*	55%	$50*	55%
Outpatient Surgery	30%	55%	Covered in full	55%	30%	55%	Covered in full	55%
Emergency Services Copay waived if admitted	$100 plus 30%	$100 plus 30%	Covered in full	Covered in full	$100 plus 30%	$100 plus 30%	Covered in full	Covered in full
Prescription (Rx) Drug Coverage	For prescription drug coverage, choose from two no-deductible options of copay-style plans. One option offers copays on all four tiers; a second option offers Tier 1 with a $10 copay, Tiers 2 and 3 at 50% copay, and Tier 4 at $150 or 50%, whichever is less.						Covered in full	90%

*Not subject to deductible.

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2024 Montana Navigator Large Group Medical Plans

	HSA 3200_50+Rx		HSA 3200+Rx		HSA 4000+Rx		HSA 5000+Rx	
	IN NETWORK	OUT OF NETWORK	IN NETWORK	OUT OF NETWORK	IN NETWORK	OUT OF NETWORK	IN NETWORK	OUT OF NETWORK
Deductible Individual / Family	$3,200 / $6,400	$7,500 / $15,000	$3,200 / $6,400	$7,500 / $15,000	$4,000 / $8,000	$10,000 / $20,000	$5,000 / $10,000	$10,000 / $20,000
Out-of-Pocket Maximum Individual / Family	$6,900 / $13,800	$15,000 / $30,000	$3,200 / $6,400	$15,000 / $30,000	$4,000 / $8,000	$20,000 / $40,000	$5,000 / $10,000	$20,000 / $40,000
	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%‡	Covered in full	25%‡	Covered in full	25%‡	Covered in full	25%‡
	AFTER DEDUCTIBLE, MEMBER PAYS:		AFTER DEDUCTIBLE, MEMBER PAYS:		AFTER DEDUCTIBLE, MEMBER PAYS:		AFTER DEDUCTIBLE, MEMBER PAYS:	
Telehealth	50%	75%	Covered in full	25%	Covered in full	25%	Covered in full	25%
Office Visits: Primary (including behavioral health), **Urgent Care, and Specialist**	50%	75%	Covered in full	25%	Covered in full	25%	Covered in full	25%
Inpatient Hospital	50%	75%	Covered in full	25%	Covered in full	25%	Covered in full	25%
Lab / X-ray	50%	75%	Covered in full	25%	Covered in full	25%	Covered in full	25%
Physical, Occupational, and Speech Therapy	50%	75%	Covered in full	25%	Covered in full	25%	Covered in full	25%
Chiropractic / Acupuncture 15 visits combined per benefit period	50%	75%	Covered in full	25%	Covered in full	25%	Covered in full	25%
Outpatient Surgery	50%	75%	Covered in full	25%	Covered in full	25%	Covered in full	25%
Emergency Services	50%	50%	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full
Prescription (Rx) Drug Coverage	Covered in full	90%	Covered in full	90%	Covered in full	90%	Covered in full	90%

*Not subject to deductible.

‡Out-of-network well-baby and well-child care, preventive physicals, and prostate cancer screenings are not subject to deductible. Out-of network well-woman visits, preventive mammograms, and immunizations are covered in full.

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PacificSource HEALTH PLANS

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	HSA 6000+Rx		HSA 8000+Rx	
	IN NETWORK	OUT OF NETWORK	IN NETWORK	OUT OF NETWORK
Deductible Individual / Family	$6,000 / $12,000	$10,000 / $20,000	$8,000 / $16,000	$10,000 / $20,000
Out-of-Pocket Maximum Individual / Family	$6,000 / $12,000	$20,000 / $40,000	$8,000 / $16,000	$20,000 / $40,000
	NO DEDUCTIBLE, MEMBER PAYS:	AFTER DEDUCTIBLE, MEMBER PAYS:	NO DEDUCTIBLE, MEMBER PAYS:	AFTER DEDUCTIBLE, MEMBER PAYS:
Preventive Services	Covered in full	25%‡	Covered in full	25%‡
	AFTER DEDUCTIBLE, MEMBER PAYS:		AFTER DEDUCTIBLE, MEMBER PAYS:	
Telehealth	Covered in full	25%	Covered in full	25%
Office Visits: Primary (including behavioral health), **Urgent Care, and Specialist**	Covered in full	25%	Covered in full	25%
Inpatient Hospital	Covered in full	25%	Covered in full	25%
Lab / X-ray	Covered in full	25%	Covered in full	25%
Physical, Occupational, and Speech Therapy	Covered in full	25%	Covered in full	25%
Chiropractic / Acupuncture 15 visits combined per benefit period	Covered in full	25%	Covered in full	25%
Outpatient Surgery	Covered in full	25%	Covered in full	25%
Emergency Services	Covered in full	Covered in full	Covered in full	Covered in full
Prescription (Rx) Drug Coverage	Covered in full	90%	Covered in full	90%

*Not subject to deductible.
‡Out-of-network well-baby and well-child care, preventive physicals, and prostate cancer screenings are not subject to deductible. Out-of network well-woman visits, preventive mammograms, and immunizations are covered in full.

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