PacificSource HEALTH PLANS

2025 Montana Navigator Individual and Family Medical Plans

	Gold 1500	
	IN-NETWORK	OUT-OF-NETWORK
Deductible Individual / Family	**$1,500 / $3,000**	**$30,000 / $60,000**
Out-of-Pocket Maximum Individual / Family	**$7,000 / $14,000**	**$36,800 / $73,600**
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.

This is a brief summary. Contact a Coverage Advisor at **855-673-7200** or by email at CoverageAdvisors@PacificSource.com. Go to PacificSource.com for details or to see a plan's Summary of Benefits.

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PacificSource HEALTH PLANS

2025 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**	**$30,000 / $60,000**
Out-of-Pocket Maximum Individual / Family	**$9,200 / $18,400**	**$9,200 / $18,400**	**$8,200 / $16,400**	**$6,700 / $13,400**	**$36,800 / $73,600**
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: $30 no deductible Urgent Care: $30 no deductible Specialist: $60 after deductible	Primary: $20 no deductible Urgent Care: $20 no deductible Specialist: $40 no deductible	Primary: $25 no deductible Urgent Care: $25 no deductible Specialist: $50 no deductible	25% after deductible	50% after deductible
Telehealth	$30 no deductible	$20 no deductible	$25 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	$30 no deductible	$20 no deductible	$25 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

Plans are available to residents statewide.

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†Available only on direct basis

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PacificSource HEALTH PLANS

2025 Montana Navigator Individual and Family Medical Plans

	Bronze 9200	Bronze HSA 8050	
	IN-NETWORK	IN-NETWORK	OUT-OF-NETWORK
Deductible Individual / Family	**$9,200 / $18,400**	**$8,050 / $16,100**	**$36,800 / $73,600**
Out-of-Pocket Maximum Individual / Family	**$9,200 / $18,400**	**$8,050 / $16,100**	**$36,800 / $73,600**
Preventive Services	Covered in full		0% after deductible^
Preventive Drug Coverage	Covered in full		0% after deductible
Accident Benefit	Covered in full up to $500, within 90 days of accident		
Office Visits: Primary, Urgent Care, and Specialist	0% after deductible		
Telehealth	0% after deductible	0% after deductible	0% after deductible
Inpatient Hospital	0% after deductible	0% after deductible	0% after deductible
Lab / X-ray	0% after deductible	0% after deductible	0% after deductible
Physical, Occupational, and Speech Therapy	0% after deductible	0% after deductible	0% after deductible
Outpatient Surgery	0% after deductible	0% after deductible	0% after deductible
Emergency Services	0% after deductible	0% after deductible	0% after deductible
Chiropractic / Acupuncture Visits per benefit period: Chiro: 10 / Acu: 12	0% 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	0% after deductible	0% after deductible	0% 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 0%		Same as in-network

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PacificSource HEALTH PLANS

2025 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**	**$5,000 / $10,000**	**$7,500 / $15,000**	**$30,000 / $60,000**
Out-of-Pocket Maximum Individual / Family	**$7,800 / $15,600**	**$8,000 / $16,000**	**$9,200 / $18,400**	**$36,800 / $73,600**
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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