PacificSource HEALTH PLANS

2026 Montana Core Individual and Family Medical Plans

	Gold 1500	
	IN-NETWORK	OUT-OF-NETWORK
Deductible Individual / Family	**$1,500 / $3,000**	**Not covered**
Out-of-Pocket Maximum Individual / Family	**$7,500 / $15,000**	**Not covered**
Preventive Services	Covered in full	Not covered
Preventive Drug Coverage	Covered in full	Not covered
Accident Benefit	Covered in full up to $500, within 90 days of accident	Not covered
Office Visits: Primary and Specialist	30% after deductible	Not covered
Telehealth	30% after deductible	
Urgent Care	30% after deductible	Same as in-network through Aetna Signature Administrators outside of ID, MT, OR, and Cowlitz and Clark counties in WA
Inpatient Hospital	30% after deductible	Not covered
Lab / X-ray	30% after deductible	Not covered
Physical, Occupational, and Speech Therapy	30% after deductible	Not covered
Outpatient Surgery	30% after deductible	Not covered
Emergency Services	30% after deductible	Same as in-network
Chiropractic / Acupuncture Visits per benefit period: Chiro: 10 / Acu: 12	30% after deductible	Not covered
Prescription (Rx) Drug Coverage Out-of-network: 30-day max fill, no more than 3 per year	Tier 1: $10 no deductible Tier 2: $20 no deductible Tier 3: $60 no deductible Tier 4: $250 no deductible	Not covered
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 30%	Same as in-network

*Available only on a direct basis

For Core plans, the in-network service area includes ID, MT, OR, and Cowlitz and Clark counties in WA only. Outside the in-network service area, urgent and emergency care are covered through Aetna Signature Administrators. Besides urgent and emergency care, Core plans do not offer out-of-network benefits.

Plans are available to residents statewide.

This is a brief summary. Contact the Inside Sales Team at **855-673-7200** or by email at IndividualInsideSales@PacificSource.com. Go to PacificSource.com for details or to see a plan's Summary of Benefits.

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PacificSource HEALTH PLANS

2026 Montana Core Individual and Family Medical Plans

	Silver 3500	Silver 4000*	Silver 5000	
	IN-NETWORK	IN-NETWORK	IN-NETWORK	OUT-OF-NETWORK
Deductible Individual / Family	**$3,500 / $7,000**	**$4,000 / $8,000**	**$5,000 / $10,000**	**Not covered**
Out-of-Pocket Maximum Individual / Family	**$10,600 / $21,200**	**$9,200 / $18,400**	**$8,600 / $17,200**	**Not covered**
Preventive Services	Covered in full			Not covered
Preventive Drug Coverage	Covered in full			Not covered
Accident Benefit	Covered in full up to $500, within 90 days of accident			Not covered
Office Visits: Primary and Specialist	Primary: $30 no deductible Specialist: $60 no deductible	Primary: $20 no deductible Specialist: $40 no deductible	Primary: $30 no deductible Specialist: $60 no deductible	Not covered
Telehealth	$30 no deductible	$20 no deductible	$30 no deductible	
Urgent Care	$30 no deductible	$20 no deductible	$30 no deductible	Same as in-network through Aetna Signature Administrators outside of ID, MT, OR, and Cowlitz and Clark counties in WA
Inpatient Hospital	30% after deductible	30% after deductible	40% after deductible	Not covered
Lab / X-ray	30% after deductible	30% after deductible	40% after deductible	Not covered
Physical, Occupational, and Speech Therapy	30% after deductible	30% after deductible	40% after deductible	Not covered
Outpatient Surgery	30% after deductible	30% after deductible	40% after deductible	Not covered
Emergency Services	30% after deductible	30% after deductible	40% after deductible	Same as in-network
Chiropractic / Acupuncture Visits per benefit period: Chiro: 10 / Acu: 12	30% after deductible	$20 no deductible	40% after deductible	Not covered
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 after deductible Tier 3: $60 after deductible Tier 4: $250 after deductible	30% after deductible	40% after deductible	Not covered
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 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 40%	Same as in-network

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PacificSource HEALTH PLANS

2026 Montana Core Individual and Family Medical Plans

	Bronze HSA 10600	Bronze HSA 8300	
	IN-NETWORK	IN-NETWORK	OUT-OF-NETWORK
Deductible Individual / Family	**$10,600 / $21,200**	**$8,300 / $16,600**	**Not covered**
Out-of-Pocket Maximum Individual / Family	**$10,600 / $21,200**	**$8,300 / $16,600**	**Not covered**
Preventive Services	Covered in full		Not covered
Preventive Drug Coverage	Covered in full		Not covered
Accident Benefit	Covered in full up to $500, within 90 days of accident		Not covered
Office Visits: Primary and Specialist	0% after deductible		Not covered
Telehealth	0% after deductible		
Urgent Care	0% after deductible		Same as in-network through Aetna Signature Administrators outside of ID, MT, OR, and Cowlitz and Clark counties in WA
Inpatient Hospital	0% after deductible		Not covered
Lab / X-ray	0% after deductible		Not covered
Physical, Occupational, and Speech Therapy	0% after deductible		Not covered
Outpatient Surgery	0% after deductible		Not covered
Emergency Services	0% after deductible		Same as in-network
Chiropractic / Acupuncture Visits per benefit period: Chiro: 10 / Acu: 12	0% after deductible		Not covered
Prescription (Rx) Drug Coverage Out-of-network: 30-day max fill, no more than 3 per year	0% after deductible		Not covered
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

2026 Montana Core Individual and Family Medical Plans

	Standard Gold	Standard Silver	Standard Expanded Bronze HSA	
	IN-NETWORK	IN-NETWORK	IN-NETWORK	OUT-OF-NETWORK
Deductible Individual / Family	**$2,000 / $4,000**	**$6,000 / $12,000**	**$7,500 / $15,000**	**Not covered**
Out-of-Pocket Maximum Individual / Family	**$8,200 / $16,400**	**$8,900 / $17,800**	**$10,000 / $20,000**	**Not covered**
Preventive Services	Covered in full			Not covered
Preventive Drug Coverage	Covered in full			Not covered
Accident Benefit	Not covered			Not covered
Office Visits: Primary and Specialist	Primary: $30 no deductible Specialist: $60 no deductible	Primary: $40 no deductible Specialist: $80 no deductible	Primary: $50 no deductible Specialist: $100 no deductible	Not covered
Telehealth	$30 no deductible	$40 no deductible	$50 no deductible	
Urgent Care	$45 no deductible	$60 no deductible	$75 no deductible	Same as in-network through Aetna Signature Administrators outside of ID, MT, OR, and Cowlitz and Clark counties in WA
Inpatient Hospital	25% after deductible	40% after deductible	50% after deductible	Not covered
Lab / X-ray	25% after deductible	40% after deductible	50% after deductible	Not covered
Physical, Occupational, and Speech Therapy	$30 no deductible	$40 no deductible	$50 no deductible	Not covered
Outpatient Surgery	25% after deductible	40% after deductible	50% after deductible	Not covered
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	25% after deductible	40% after deductible	50% after deductible	Not covered
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	Not covered
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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