



2022 Medical Plans for **Montana Small Groups** | 1–50



2022 Montana | Navigator 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		Bronze 8700		Gold HSA 3000		Silver HSA 3000		Silver HSA 4500		Silver HSA 5500		Bronze HSA 7000			
	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	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	\$8,700 / \$17,400	\$17,400 / \$34,800	\$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	\$7,000 / \$14,000	\$14,000 / \$28,000		
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	\$8,700 / \$17,400	\$17,400 / \$34,800	\$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	\$7,000 / \$14,000	\$14,000 / \$28,000		
	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:	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	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 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	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.		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:		AFTER DEDUCTIBLE, MEMBER PAYS:			
Telehealth (including behavioral health for adults)	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	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: \$70*	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: \$80*	Covered in Full	Covered in Full	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	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	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	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	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	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	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	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	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	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	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	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	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: \$50* 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: \$60* 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%	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	Covered in Full	20%	50%	Covered in Full	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. ¹Well-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.

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Availability Map **by County**



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