

2026 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, 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 more details on prescription drug coverage, search Pharmacy Plans at PacificSource.com .									

*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](https://www.pacificsource.com) for details or to see a plan's Summary of Benefits.

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	2500+20_30		3000+20		4000+20_30		9200+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	\$9,200 / \$18,400	\$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	\$9,200 / \$18,400	\$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, 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 more details on prescription drug coverage, search Pharmacy Plans at PacificSource.com .						Covered in full	90%

*Not subject to deductible.

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	HSA 3400_50+Rx		HSA 3400+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	\$3,400 / \$6,800	\$7,500 / \$15,000	\$3,400 / \$6,800	\$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	\$8,000 / \$16,000	\$15,000 / \$30,000	\$3,400 / \$6,800	\$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, 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	50%	90%	Covered in full	90%	Covered in full	90%	Covered in full	90%

*Not subject to deductible.

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	HSA 2600_30+Rx Non-embedded		HSA 6000+Rx		HSA 7000+Rx		HSA 8500+Rx	
	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK
Deductible Individual / Family	\$2,600 / \$5,200	\$10,000 / \$20,000	\$6,000 / \$12,000	\$10,000 / \$20,000	\$7,000 / \$14,000	\$10,000 / \$20,000	\$8,500 / \$17,000	\$10,000 / \$20,000
Out-of-Pocket Maximum Individual / Family	\$5,000 / \$10,000	\$20,000 / \$40,000	\$6,000 / \$12,000	\$20,000 / \$40,000	\$7,000 / \$14,000	\$20,000 / \$40,000	\$8,500 / \$17,000	\$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	55% [‡]	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	30%	55%	Covered in full	25%	Covered in full	25%	Covered in full	25%
Office Visits: Primary, Behavioral Health, Urgent Care, and Specialist	30%	55%	Covered in full	25%	Covered in full	25%	Covered in full	25%
Inpatient Hospital	30%	55%	Covered in full	25%	Covered in full	25%	Covered in full	25%
Lab / X-ray	30%	55%	Covered in full	25%	Covered in full	25%	Covered in full	25%
Physical, Occupational, and Speech Therapy	30%	55%	Covered in full	25%	Covered in full	25%	Covered in full	25%
Chiropractic / Acupuncture 15 visits combined per benefit period	30%	55%	Covered in full	25%	Covered in full	25%	Covered in full	25%
Outpatient Surgery	30%	55%	Covered in full	25%	Covered in full	25%	Covered in full	25%
Emergency Services	30%	30%	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full
Prescription (Rx) Drug Coverage	Tier 1: \$15 Tier 2: \$45 Tier 3&4: 35%	90%	Covered in full	90%	Covered in full	90%	Covered in full	90%

*Not subject to deductible.

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