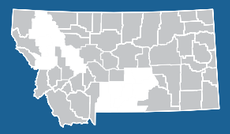
Availability Maps **by County**

More for less from our **Navigator** products

Navigator is our coordinated care product, where a member's personal provider is navigating care within a coordinated network of health professionals. Navigator promotes better member engagement and shared decision making with providers.

Navigator is available for purchase by people living in the following counties: Carbon, Flathead, Lake, Lewis and Clark, Missoula, Musselshell, Park, Stillwater, Sweet Grass, and Yellowstone.



Freedom to choose with our **Voyager** products

Voyager products use our preferred provider network, and are suited for a person who prefers a more self-directed experience.

Voyager is available for purchase by people living in the following counties: Beaverhead, Big Horn, Blaine, Broadwater, Carter, Cascade, Chouteau, Custer, Daniels, Dawson, Deer Lodge, Fallon, Fergus, Gallatin, Garfield, Glacier, Golden Valley, Granite, Hill, Jefferson, Judith Basin, Liberty, Lincoln, Madison, McCone, Meagher, Mineral, Petroleum, Phillips, Pondera, Powder River, Powell, Prairie, Ravalli, Richland, Roosevelt, Rosebud, Sanders, Sheridan, Silver Bow, Teton, Toole, Treasure, Valley, Wheatland, and Wibaux.

For more information contact a Coverage Advisor at **(855) 330-2792** or by email at **coverageadvisors@pacificsource.com.**

IFP99_0819

2020 Medical Plans for **Montana** Individuals and Families

PacificSource HEALTH PLANS

2020 Montana | Individual and Family Medical Plans

	NON-HSA QUALIFIED PLANS										HSA QUALIFIED PLANS			
Product	**Gold** 1500		**Silver** 3000†		**Silver** 4000†		**Silver** 5000		**Bronze** 7000		**Silver** HSA 3500		**Bronze** HSA 6750	
	Navigator or Voyager		Navigator or Voyager		Navigator or Voyager		Navigator or Voyager		Navigator or Voyager		Navigator or Voyager		Navigator or Voyager	
	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	$1,500 / $3,000	$3,000 / $6,000	$3,000 / $6,000	$6,000 / $12,000	$4,000 / $8,000	$8,000 / $16,000	$5,000 / $10,000	$10,000 / $20,000	$7,000 / $14,000	$14,000 / $28,000	$3,500 / $7,000	$7,000 / $14,000	$6,750 / $13,500	$13,500 / $27,000
Out-of-Pocket Maximum Individual / Family	$5,000 / $10,000	$25,000 / $50,000	$8,150 / $16,300	$25,000 / $50,000	$7,000 / $14,000	$25,000 / $50,000	$8,150 / $16,300	$25,000 / $50,000	$8,150 / $16,300	$25,000 / $50,000	$6,750 / $13,500	$25,000 / $50,000	$6,750 / $13,500	$25,000 / $50,000
	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:
Preventive Services	Covered in Full	25%^	Covered in Full	25%^	Covered in Full	25%^	Covered in Full	25%^	Covered in Full	25%^	Covered in Full	25%^	Covered in Full	25%^
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%
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	
	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:	
Telemedicine (including behavioral health for adults)	10%	35%	$10*	25%	$10*	25%	$10*	25%	$10*	25%	25%	50%	Covered in Full	25%
Office Visits Primary, Urgent Care, and Specialist	10%	35%	Primary/Urgent Care: $35* Specialist: 40%	Primary/Urgent Care: 25% Specialist: 65%	Primary/Urgent Care: $20* Specialist: $40*	25%	Primary/Urgent Care: $35* Specialist: $70*	25%	Primary/Urgent Care: $35* Specialist: 40%	Primary/Urgent Care: 25% Specialist: 65%	25%	50%	Covered in Full	25%
Inpatient Hospital	10%	35%	40%	65%	30%	55%	30%	55%	40%	65%	25%	50%	Covered in Full	25%
Lab / X-ray	10%	35%	40%	65%	30%	55%	30%	55%	40%	65%	25%	50%	Covered in Full	25%
Physical, Occupational, and Speech Therapy	10%	35%	40%	65%	30%	55%	30%	55%	40%	65%	25%	50%	Covered in Full	25%
Outpatient Surgery	10%	35%	40%	65%	30%	55%	30%	55%	40%	65%	25%	50%	Covered in Full	25%
Emergency Services	10%	10%	40%	40%	30%	30%	30%	30%	40%	40%	25%	25%	Covered in Full	Covered in Full
Chiropractic / Acupuncture Visits per benefit period: Chiro: 10 / Acu: 12	10%	35%	$35*	25%	$20*	25%	$35*	25%	$35*	25%	25%	50%	Covered in Full	25%
Prescription (Rx) Drug Coverage Out-of-network: 30-day max fill, no more than 3 per year	Tier 1: $15* Tier 2: $50* Tier 3: $75* Tier 4: $250*	50%	Tier 1: $15* Tier 2: $60* Tier 3: $100* Tier 4: $250*	50%	30%	50%	30%	50%	40%	50%	25%	50%	Covered in Full	50%
Pediatric Eye Exam One exam per benefit period	Covered in Full*	Covered in full up to $40*	Covered in Full*	Covered in full up to $40*	Covered in Full*	Covered in full up to $40*	Covered in Full*	Covered in full up to $40*	Covered in Full*	Covered in full up to $40*	Covered in Full*	Covered in full up to $40*	Covered in Full*	Covered in full up to $40*
Pediatric Vision Hardware One item per benefit period	Covered in full* up to $150 then subject to in-network deductible and 10%		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 40%		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	

* Not subject to deductible. ^ Well baby/well child care services are not subject to deductible. Preventive mammograms are not subject to deductible and are covered in full both in and out of network. † Available when purchased from sources other than the exchange.This is a brief summary. Contact a Coverage Advisor at (855) 330-2792 or by email at **coverageadvisors@pacificsource.com.** Go to **PacificSource.com** for details or to see a plan's Summary of Benefits.