

	Platinum 500 PD <sup>^</sup>	
	IN NETWORK	OUT OF NETWORK
<b>Deductible</b> Individual / Family	<b>\$500 / \$1,000</b>	<b>\$5,000 / \$10,000</b>
<b>Out-of-Pocket Maximum</b> Individual / Family	<b>\$3,000 / \$6,000</b>	<b>\$7,500 / \$15,000</b>
<b>Preventive Services</b>	Covered in full	50% after deductible
<b>Preventive Drug Coverage</b>	Covered in full	90% after deductible
<b>Office Visits: Primary, Urgent Care, and Specialist</b>	Primary/Urgent: \$10 no deductible Specialist: \$20 no deductible	50% after deductible
<b>Telehealth</b>	\$10 no deductible	50% after deductible
<b>Inpatient Hospital</b>	10% after deductible	50% after deductible
<b>Lab / X-ray</b>	10% no deductible	50% after deductible
<b>Physical, Occupational, and Speech Therapy</b>	\$10 no deductible	50% after deductible
<b>Outpatient Surgery</b>	10% after deductible	50% after deductible
<b>Emergency Services</b>	\$250 plus 10% after deductible	
<b>Chiropractic / Acupuncture</b> Visits per benefit period: Chiro: 12 / Acu: 12	\$10 no deductible	50% after deductible
<b>Prescription (Rx) Drug Coverage</b> Out-of-network: 30-day max fill, no more than 3 per year	Tier 1: \$5 no deductible Tier 2: \$15 no deductible Tier 3 & 4: 20% no deductible	90% after deductible

<sup>^</sup>Adult vision included on this plan.

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# 2024 Washington Navigator Small Group Medical Plans

	Gold 1000 PD <sup>^</sup>	Gold 1500 PD <sup>^</sup>	Gold 2000 PD <sup>^</sup>	Gold 2500 PD <sup>^</sup>	Gold 3500 PD <sup>^</sup>	
	IN NETWORK	IN NETWORK	IN NETWORK	IN NETWORK	IN NETWORK	OUT OF NETWORK
<b>Deductible</b> Individual / Family	\$1,000 / \$2,000	\$1,500 / \$3,000	\$2,000 / \$4,000	\$2,500 / \$5,000	\$3,500 / \$7,000	\$5,000 / \$10,000
<b>Out-of-Pocket Maximum</b> Individual / Family	\$7,900 / \$15,800	\$7,900 / \$15,800	\$7,900 / \$15,800	\$7,900 / \$15,800	\$7,900 / \$15,800	\$8,000 / \$16,000
<b>Preventive Services</b>	Covered in full					50% after deductible
<b>Preventive Drug Coverage</b>	Covered in full					90% after deductible
<b>Office Visits: Primary, Urgent Care, and Specialist</b>	Primary/Urgent: \$25 no deductible Specialist: \$60 no deductible					50% after deductible
<b>Telehealth</b>	\$25 no deductible					50% after deductible
<b>Inpatient Hospital</b>	25% after deductible	20% after deductible	20% after deductible	20% after deductible	20% after deductible	50% after deductible
<b>Lab / X-ray</b>	25% no deductible	20% no deductible	20% no deductible	20% no deductible	20% no deductible	50% after deductible
<b>Physical, Occupational, and Speech Therapy</b>	\$25 no deductible					50% after deductible
<b>Outpatient Surgery</b>	25% after deductible	20% after deductible	20% after deductible	20% after deductible	20% after deductible	50% after deductible
<b>Emergency Services</b>	\$250 plus 25% after deductible	\$250 plus 20% after deductible	\$250 plus 20% after deductible	\$250 plus 20% after deductible	\$250 plus 20% after deductible	Same as in-network
<b>Chiropractic / Acupuncture</b> Visits per benefit period: Chiro: 12 / Acu: 12	\$25 no deductible					50% after deductible
<b>Prescription (Rx) Drug Coverage</b> 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 & 4: 30% no deductible					90% after deductible

<sup>^</sup>Adult vision included on this plan.

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	Gold HSA 3200 PD	
	IN NETWORK	OUT OF NETWORK
<b>Deductible</b> Individual / Family	\$3,200 / \$6,400	\$5,000 / \$10,000
<b>Out-of-Pocket Maximum</b> Individual / Family	\$3,200 / \$6,400	\$7,500 / \$15,000
<b>Preventive Services</b>	Covered in full	50% after deductible
<b>Preventive Drug Coverage</b>	Covered in full	90% after deductible
<b>Office Visits: Primary, Urgent Care, and Specialist</b>	0% after deductible	50% after deductible
<b>Telehealth</b>	0% after deductible	50% after deductible
<b>Inpatient Hospital</b>	0% after deductible	50% after deductible
<b>Lab / X-ray</b>	0% after deductible	50% after deductible
<b>Physical, Occupational, and Speech Therapy</b>	0% after deductible	50% after deductible
<b>Outpatient Surgery</b>	0% after deductible	50% after deductible
<b>Emergency Services</b>	0% after deductible	Same as in-network
<b>Chiropractic / Acupuncture</b> Visits per benefit period: Chiro: 12 / Acu: 12	0% after deductible	50% after deductible
<b>Prescription (Rx) Drug Coverage</b> Out-of-network: 30-day max fill, no more than 3 per year	0% after deductible	90% after deductible

^Adult vision included on this plan.

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# 2024 Washington Navigator Small Group Medical Plans

	Silver 3000 PD	Silver 4500 PD <sup>^</sup>	Silver 5500 PD <sup>^</sup>	Silver 6500 PD <sup>^</sup>	
	IN NETWORK	IN NETWORK	IN NETWORK	IN NETWORK	OUT OF NETWORK
<b>Deductible</b> Individual / Family	\$3,000 / \$6,000	\$4,500 / \$9,000	\$5,500 / \$11,000	\$6,500 / \$13,000	Silver 3000 & 6500: <b>\$10,000 / \$20,000</b> Silver 4500 & 5500: <b>\$7,500 / \$15,000</b>
<b>Out-of-Pocket Maximum</b> Individual / Family	\$9,100 / \$18,200	\$9,100 / \$18,200	\$9,100 / \$18,200	\$9,100 / \$18,200	Silver 3000 & 6500: <b>\$15,000 / \$30,000</b> Silver 4500 & 5500: <b>\$11,250 / \$22,500</b>
<b>Preventive Services</b>	Covered in full				50% after deductible
<b>Preventive Drug Coverage</b>	Covered in full				90% after deductible
<b>Office Visits: Primary, Urgent Care, and Specialist</b>	Primary/Urgent: \$50 no deductible Specialist: \$100 no deductible				50% after deductible
<b>Telehealth</b>	\$50 no deductible				50% after deductible
<b>Inpatient Hospital</b>	40% after deductible	35% after deductible	30% after deductible	30% after deductible	50% after deductible
<b>Lab / X-ray</b>	40% after deductible	35% after deductible	30% after deductible	30% after deductible	50% after deductible
<b>Physical, Occupational, and Speech Therapy</b>	40% after deductible	35% after deductible	30% after deductible	30% after deductible	50% after deductible
<b>Outpatient Surgery</b>	40% after deductible	35% after deductible	30% after deductible	30% after deductible	50% after deductible
<b>Emergency Services</b>	40% after deductible	\$250 plus 35% after deductible	\$250 plus 30% after deductible	\$250 plus 30% after deductible	Same as in-network
<b>Chiropractic / Acupuncture</b> Visits per benefit period: Chiro: 12 / Acu: 12	40% after deductible	\$50 no deductible	\$50 no deductible	\$50 no deductible	50% after deductible
<b>Prescription (Rx) Drug Coverage</b> Out-of-network: 30-day max fill, no more than 3 per year	Tier 1: \$20 no deductible Tier 2: \$60 no deductible Tier 3 & 4: 40% no deductible	Tier 1: \$20 no deductible Tier 2: \$60 no deductible Tier 3 & 4: 35% no deductible	Tier 1: \$20 no deductible Tier 2: \$60 no deductible Tier 3 & 4: 30% no deductible	Tier 1: \$20 no deductible Tier 2: \$60 no deductible Tier 3 & 4: 30% no deductible	90% after deductible

<sup>^</sup>Adult vision included on this plan.

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# 2024 Washington Navigator Small Group Medical Plans

	Silver HSA 3200 PD	Silver HSA 5100 PD	Silver HSA 5500 PD	
	IN NETWORK	IN NETWORK	IN NETWORK	OUT OF NETWORK
<b>Deductible</b> Individual / Family	\$3,200 / \$6,400	\$5,100 / \$10,200	\$5,500 / \$11,000	Silver HSA 3200: <b>\$5,000 / \$10,000</b> Silver HSA 5100 & 5500: <b>\$7,500 / \$15,000</b>
<b>Out-of-Pocket Maximum</b> Individual / Family	\$7,750 / \$15,500	\$5,100 / \$10,200	\$5,500 / \$11,000	Silver HSA 3200: <b>\$10,000 / \$20,000</b> Silver HSA 5100 & 5500: <b>\$11,250 / \$22,500</b>
<b>Preventive Services</b>	Covered in full			50% after deductible
<b>Preventive Drug Coverage</b>	Covered in full			90% after deductible
<b>Office Visits: Primary, Urgent Care, and Specialist</b>	20% after deductible	0% after deductible	0% after deductible	50% after deductible
<b>Telehealth</b>	20% after deductible	0% after deductible	0% after deductible	50% after deductible
<b>Inpatient Hospital</b>	20% after deductible	0% after deductible	0% after deductible	50% after deductible
<b>Lab / X-ray</b>	20% after deductible	0% after deductible	0% after deductible	50% after deductible
<b>Physical, Occupational, and Speech Therapy</b>	20% after deductible	0% after deductible	0% after deductible	50% after deductible
<b>Outpatient Surgery</b>	20% after deductible	0% after deductible	0% after deductible	50% after deductible
<b>Emergency Services</b>	20% after deductible	0% after deductible	0% after deductible	Same as in-network
<b>Chiropractic / Acupuncture</b> Visits per benefit period: Chiro: 12 / Acu: 12	20% after deductible	0% after deductible	0% after deductible	50% after deductible
<b>Prescription (Rx) Drug Coverage</b> Out-of-network: 30-day max fill, no more than 3 per year	20% after deductible	0% after deductible	0% after deductible	90% after deductible

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	Bronze 8700 PD	Bronze HSA 6000 PD	Bronze HSA 7500 PD	
	IN NETWORK	IN NETWORK	IN NETWORK	OUT OF NETWORK
<b>Deductible</b> Individual / Family	\$8,700 / \$17,400	\$6,000 / \$12,000	\$7,500 / \$15,000	Bronze HSA 6000: <b>\$7,500 / \$15,000</b> Bronze 8700 & HSA 7500: <b>\$10,000 / \$20,000</b>
<b>Out-of-Pocket Maximum</b> Individual / Family	\$8,700 / \$17,400	\$7,200 / \$14,400	\$7,500 / \$15,000	Bronze HSA 6000: <b>\$11,250 / \$22,500</b> Bronze 8700 & HSA 7500: <b>\$15,000 / \$30,000</b>
<b>Preventive Services</b>	Covered in full			50% after deductible
<b>Preventive Drug Coverage</b>	Covered in full			90% after deductible
<b>Office Visits: Primary, Urgent Care, and Specialist</b>	Primary/Urgent: \$50 no deductible Specialist: \$100 no deductible	50% after deductible	0% after deductible	50% after deductible
<b>Telehealth</b>	\$50 no deductible	50% after deductible	0% after deductible	50% after deductible
<b>Inpatient Hospital</b>	0% after deductible	50% after deductible	0% after deductible	50% after deductible
<b>Lab / X-ray</b>	0% after deductible	50% after deductible	0% after deductible	50% after deductible
<b>Physical, Occupational, and Speech Therapy</b>	0% after deductible	50% after deductible	0% after deductible	50% after deductible
<b>Outpatient Surgery</b>	0% after deductible	50% after deductible	0% after deductible	50% after deductible
<b>Emergency Services</b>	0% after deductible	50% after deductible	0% after deductible	Same as in-network
<b>Chiropractic / Acupuncture</b> Visits per benefit period: Chiro: 12 / Acu: 12	0% after deductible	50% after deductible	0% after deductible	50% after deductible
<b>Prescription (Rx) Drug Coverage</b> Out-of-network: 30-day max fill, no more than 3 per year	0% after deductible	50% after deductible	0% after deductible	90% after deductible

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