

	Platinum 500^	
	IN NETWORK	OUT OF NETWORK
Deductible Individual / Family	\$500 / \$1,000	\$10,000 / \$20,000
Out-of-Pocket Maximum Individual / Family	\$3,000 / \$6,000	\$15,000 / \$30,000
Preventive Services	Covered in full	50% after deductible
Preventive Drug Coverage	Covered in full	50% after deductible
Accident Benefit	Covered in full up to \$500, within 90 days of accident	
Office Visits: Primary, Urgent Care, and Specialist (including behavioral health for adults)	Primary/Urgent Care: \$10 no deductible Specialist: \$20 no deductible	50% after deductible
Telehealth	\$10 no deductible	50% after deductible
Inpatient Hospital	20% after deductible	50% after deductible
Lab / X-ray	20% after deductible	50% after deductible
Physical, Occupational, and Speech Therapy 20 visits per benefit period	\$10 no deductible	50% after deductible
Outpatient Surgery	20% after deductible	50% after deductible
Emergency Services	\$250 plus 20% after deductible	
Chiropractic / Acupuncture 18 visits combined per benefit period	\$10 no deductible	50% after deductible
Prescription (Rx) Drug Coverage 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: \$50 no deductible Tier 4: \$250 no deductible	50% after deductible

^Adult vision included on this plan.

**Includes adult vision exams.

Plans are available to businesses statewide.

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2024 Idaho Navigator Small Group Medical Plans

	Gold 1000 [^]		Gold 2000 [^]		Gold HSA 3200 ^{**}	
	IN NETWORK	IN NETWORK	OUT OF NETWORK	IN NETWORK	OUT OF NETWORK	
Deductible Individual / Family	\$1,000 / \$2,000	\$2,000 / \$4,000	\$10,000 / \$20,000	\$3,200 / \$6,400	\$10,000 / \$20,000	
Out-of-Pocket Maximum Individual / Family	\$6,600 / \$13,200	\$5,500 / \$11,000	\$15,000 / \$30,000	\$3,200 / \$6,400	\$15,000 / \$30,000	
Preventive Services	Covered in full		50% after deductible	Covered in full	50% after deductible	
Preventive Drug Coverage	Covered in full		50% after deductible	Covered in full	50% after deductible	
Accident Benefit	Covered in full up to \$500, within 90 days of accident			Covered in full up to \$500, within 90 days of accident		
Office Visits: Primary, Urgent Care, and Specialist (including behavioral health for adults)	Primary/Urgent Care: \$30 no deductible Specialist: \$60 no deductible		50% after deductible	0% after deductible	50% after deductible	
Telehealth	\$30 no deductible		50% after deductible	0% after deductible	50% after deductible	
Inpatient Hospital	25% after deductible		50% after deductible	0% after deductible	50% after deductible	
Lab / X-ray	25% after deductible		50% after deductible	0% after deductible	50% after deductible	
Physical, Occupational, and Speech Therapy 20 visits per benefit period	\$30 no deductible		50% after deductible	0% after deductible	50% after deductible	
Outpatient Surgery	25% after deductible		50% after deductible	0% after deductible	50% after deductible	
Emergency Services	\$250 plus 25% after deductible			0% after deductible		
Chiropractic / Acupuncture 18 visits combined per benefit period	\$30 no deductible		50% after deductible	0% after deductible	50% after deductible	
Prescription (Rx) Drug Coverage Out-of-network: 30-day max fill, no more than 3 per year	Tier 1: \$15 no deductible Tier 2: \$45 no deductible Tier 3: 20% no deductible Tier 4: 20% no deductible		50% after deductible	0% after deductible	50% after deductible	

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2024 Idaho Navigator Small Group Medical Plans

	Silver 3000 [^]	Silver 4500 [^]	Silver 5500 [^]	Silver 6500 [^]	
	IN NETWORK	IN NETWORK	IN NETWORK	IN NETWORK	OUT OF NETWORK
Deductible Individual / Family	\$3,000 / \$6,000	\$4,500 / \$9,000	\$5,500 / \$11,000	\$6,500 / \$13,000	\$10,000 / \$20,000
Out-of-Pocket Maximum Individual / Family	\$9,100 / \$18,200	\$9,100 / \$18,200	\$9,400 / \$18,800	\$9,100 / \$18,200	\$15,000 / \$30,000
Preventive Services	Covered in full				50% after deductible
Preventive Drug Coverage	Covered in full				50% after deductible
Accident Benefit	Covered in full up to \$500, within 90 days of accident				
Office Visits: Primary, Urgent Care, and Specialist (including behavioral health for adults)	Primary/Urgent Care: \$50 no deductible Specialist: \$100 no deductible	Primary/Urgent Care: \$40 no deductible Specialist: \$80 no deductible	Primary/Urgent Care: \$35 no deductible Specialist: \$70 no deductible	Primary/Urgent Care: \$35 no deductible Specialist: \$70 no deductible	50% after deductible
Telehealth	\$50 no deductible	\$40 no deductible	\$35 no deductible	\$35 no deductible	50% after deductible
Inpatient Hospital	40% after deductible	35% after deductible	30% after deductible	30% after deductible	50% after deductible
Lab / X-ray	40% after deductible	35% after deductible	30% after deductible	30% after deductible	50% after deductible
Physical, Occupational, and Speech Therapy 20 visits per benefit period	\$50 no deductible	\$40 no deductible	\$35 no deductible	\$35 no deductible	50% after deductible
Outpatient Surgery	40% after deductible	35% after deductible	30% after deductible	30% after deductible	50% after deductible
Emergency Services	\$250 plus 40% after deductible	\$250 plus 35% after deductible	\$250 plus 30% after deductible	\$250 plus 30% after deductible	Same as in-network
Chiropractic / Acupuncture 18 visits combined per benefit period	\$50 no deductible	\$40 no deductible	\$35 no deductible	\$35 no deductible	50% after deductible
Prescription (Rx) Drug Coverage Out-of-network: 30-day max fill, no more than 3 per year	Tier 1: \$15 no deductible Tier 2: \$90 no deductible Tier 3: 40% no deductible Tier 4: 40% no deductible	Tier 1: \$15 no deductible Tier 2: \$70 no deductible Tier 3: 35% no deductible Tier 4: 35% no deductible	Tier 1: \$15 no deductible Tier 2: \$70 no deductible Tier 3: 30% no deductible Tier 4: 30% no deductible	Tier 1: \$15 no deductible Tier 2: \$70 no deductible Tier 3: 30% no deductible Tier 4: 30% no deductible	50% after deductible

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^{**}Includes adult vision exams.

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	Silver HSA 3500**	Silver HSA 5100**	
	IN NETWORK	IN NETWORK	OUT OF NETWORK
Deductible Individual / Family	\$3,500 / \$7,000	\$5,100 / \$10,200	\$10,000 / \$20,000
Out-of-Pocket Maximum Individual / Family	\$7,500 / \$15,000	\$5,100 / \$10,200	\$15,000 / \$30,000
Preventive Services	Covered in full	Covered in full	50% after deductible
Preventive Drug Coverage	Covered in full	Covered in full	50% after deductible
Accident Benefit	Covered in full up to \$500, within 90 days of accident		
Office Visits: Primary, Urgent Care, and Specialist (including behavioral health for adults)	20% after deductible	0% after deductible	50% after deductible
Telehealth	20% after deductible	0% after deductible	50% after deductible
Inpatient Hospital	20% after deductible	0% after deductible	50% after deductible
Lab / X-ray	20% after deductible	0% after deductible	50% after deductible
Physical, Occupational, and Speech Therapy 20 visits per benefit period	20% after deductible	0% after deductible	50% after deductible
Outpatient Surgery	20% after deductible	0% after deductible	50% after deductible
Emergency Services	20% after deductible	0% after deductible	Same as in-network
Chiropractic / Acupuncture 18 visits combined per benefit period	20% after deductible	0% after deductible	50% after deductible
Prescription (Rx) Drug Coverage Out-of-network: 30-day max fill, no more than 3 per year	20% after deductible	0% after deductible	50% after deductible

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2024 Idaho Navigator Small Group Medical Plans

	Bronze 6800 [^]	Bronze 9400 [^]	Bronze HSA 7500 ^{**}	
	IN NETWORK	IN NETWORK	IN NETWORK	OUT OF NETWORK
Deductible Individual / Family	\$6,800 / \$13,600	\$9,400 / \$18,800	\$7,500 / \$15,000	\$10,000 / \$20,000
Out-of-Pocket Maximum Individual / Family	\$8,600 / \$17,200	\$9,400 / \$18,800	\$7,500 / \$15,000	\$15,000 / \$30,000
Preventive Services	Covered in full			50% after deductible
Preventive Drug Coverage	Covered in full			50% after deductible
Accident Benefit	Covered in full up to \$500, within 90 days of accident			
Office Visits: Primary, Urgent Care, and Specialist (including behavioral health for adults)	Primary/Urgent Care: \$35 no deductible Specialist: \$70 after deductible	Primary/Urgent Care: \$50 no deductible Specialist: \$100 no deductible	0% after deductible	50% after deductible
Telehealth	\$35 no deductible	\$50 no deductible	0% after deductible	50% after deductible
Inpatient Hospital	40% after deductible	0% after deductible	0% after deductible	50% after deductible
Lab / X-ray	40% after deductible	0% after deductible	0% after deductible	50% after deductible
Physical, Occupational, and Speech Therapy 20 visits per benefit period	40% after deductible	0% after deductible	0% after deductible	50% after deductible
Outpatient Surgery	40% after deductible	0% after deductible	0% after deductible	50% after deductible
Emergency Services	\$500 plus 40% after deductible	0% after deductible	0% after deductible	Same as in-network
Chiropractic / Acupuncture 18 visits combined per benefit period	\$35 no deductible	\$50 no deductible	0% after deductible	50% after deductible
Prescription (Rx) Drug Coverage Out-of-network: 30-day max fill, no more than 3 per year	40% after deductible	\$20 no deductible Tier 2, 3, & 4: 0% after deductible	0% after deductible	50% after deductible

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