2024 Small Group Plans

PLATINUM LEVEL

PLATINUM LEVEL PLANS CONTINUED ON NEXT PAGE »

Independent Health

	FlexFit Platinum	FlexFit Platinum Option 2	Choice Plus Platinum[3]
IN-NETWORK (IN)			
First Dollar Coverage	N/A	N/A	N/A
Deductible	$0	$0	A: $0 B: $1,500/$3,000 (T)
Coinsurance	0%	0%	A: 0% B: Deductible then 50%
Out-of-Pocket Max.	$5,250/$10,500 (E)	$3,500/$7,000 (E)	A: $4,500/$9,000 (E) B: $4,500/$9,000 (E)
OUT-OF-NETWORK (OON)[1]			
Deductible	$5,000/$10,000 (T)	$5,000/$10,000 (T)	$5,000/$10,000 (T)
Coinsurance	Deductible then 20%	Deductible then 20%	Deductible then 50%
Out-of-Pocket Max.	$10,000/$20,000 (E)	$10,000/$20,000 (E)	$10,000/$20,000 (E)
MEDICAL SERVICES			
Primary Care Office Visit	$10	**$10**	A: $10 B: Deductible then 50%
Specialist Office Visit	$40	$25	A: $40 B: Deductible then 50%
Telemedicine — General Medical & Behavioral Health Services (participating Teladoc® providers only) For Dermatology telemedicine refer to the plan's benefit summary	$0	$0	$0
Urgent Care	$75	$75	A: $75 B: Deductible then 50%
Emergency Room Services	$150	$150	A: $150 B: $150
Outpatient Procedures Performed in an Ambulatory Surgery Center	$75	$75	A: $50 B: Deductible then 50%
Outpatient Procedures Performed in a Hospital	$100	$100	A: $75 B: Deductible then 50%
Inpatient Hospital Services (per admission)	$500	$500	A: $500 B: Deductible then 50%
PRESCRIPTION DRUGS			
Pharmacy[2]	$5/$30/50%	$5/$30/$100	$5/$30/50%
PRODUCT DETAILS			
Wellness Benefits	Health Extras℠ or Nutrition	Health Extras℠ or Nutrition	Health Extras℠ or Nutrition
Network	IHC	IHC	Choice Plus
Q3 RATES			
Employee Rate	$811.62	$831.39	$747.13
Employee & Child(ren) Rate	$1,379.75	$1,413.36	$1,270.12
Employee & Spouse Rate	$1,623.24	$1,662.78	$1,494.26
Family Rate	$2,313.12	$2,369.46	$2,129.32

1. OON coverage applies to non-participating providers outside Independent Health's service area.
2. All pharmacy copays/coinsurance accumulate to out-of-pocket maximums.
3. Offered in Erie and Niagara counties only.
4. Specific qualifications must be met.
5. Subscribers must reside within Independent Health's 23-county network area.
6. Deductible does not apply to first visit.

(E) = Embedded Deductible
(T) = True Family (Non Embedded) Deductible

Bolded items indicate updated changes since the 2023 plan year.

2024 Small Group Plans

PLATINUM LEVEL

(CONTINUED)

Independent Health

	Passport Plan National Platinum	Passport Plan Local Platinum[5]
IN-NETWORK (IN)		
First Dollar Coverage	N/A	N/A
Deductible	$0	$0
Coinsurance	0%	0%
Out-of-Pocket Max.	**$6,000/$12,000 (E)**	**$6,000/$12,000 (E)**
OUT-OF-NETWORK (OON)[1]		
Deductible	$5,000/$10,000 (T)	$5,000/$10,000 (T)
Coinsurance	Deductible then 50%	Deductible then 50%
Out-of-Pocket Max.	$10,000/$20,000 (E)	$10,000/$20,000 (E)
MEDICAL SERVICES		
Primary Care Office Visit	**$15**	**$15**
Specialist Office Visit	**$45**	**$45**
Telemedicine — General Medical & Behavioral Health Services (participating Teladoc® providers only) For Dermatology telemedicine refer to the plan's benefit summary	$0	$0
Urgent Care	$75	$75
Emergency Room Services	$150	$150
Outpatient Procedures Performed in an Ambulatory Surgery Center	$75	$75
Outpatient Procedures Performed in a Hospital	$100	$100
Inpatient Hospital Services (per admission)	$500	$500
PRESCRIPTION DRUGS		
Pharmacy[2]	$5/$30/50%	$5/$30/50%
PRODUCT DETAILS		
Wellness Benefits	Health Extras℠	Health Extras℠ or Nutrition
Network	IHC + **United** National	IHC + **United** National
Q3 RATES		
Employee Rate	$1,134.17	$844.09
Employee & Child(ren) Rate	$1,928.09	$1,434.95
Employee & Spouse Rate	$2,268.34	$1,688.18
Family Rate	$3,232.38	$2,405.66

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5. Subscribers must reside within Independent Health's 23-county network area.
6. Deductible does not apply to first visit.

(E) = Embedded Deductible
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