2024 Small Group Plans

SILVER LEVEL

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Independent Health

	Activate Silver	iDirect Silver Copay	**NEW! iDirect Silver Copay Option 2**	iDirect Silver Copay HSAQ
IN-NETWORK (IN)				HealthEquity
First Dollar Coverage	$500/$1,000	N/A	**N/A**	N/A
Deductible	$3,100/$6,200 (E)	$2,000/$4,000 (T)	**$2,100/$4,200 (E)**	$2,000/$4,000 (T)
Coinsurance	40% Coinsurance after first dollar and deductible	0%	**0%**	0%
Out-of-Pocket Max.	**$8,500/$17,000 (E)**	**$8,000/$16,000 (E)**	**$9,450/$18,900 (E)**	**$7,500/$15,000 (E)**
OUT-OF-NETWORK (OON)[1]				
Deductible	$5,000/$10,000 (E)	$5,000/$10,000 (T)	**$5,000/$10,000 (E)**	$5,000/$10,000 (T)
Coinsurance	Deductible then 50%	Deductible then 50%	**Deductible then 50%**	Deductible then 50%
Out-of-Pocket Max.	$10,000/$20,000 (E)	$10,000/$20,000 (E)	**$10,000/ $20,000 (E)**	$10,000/$20,000 (E)
MEDICAL SERVICES				
Primary Care Office Visit	$35 Copayment after first dollar and deductible	Deductible then $35	**Deductible then $30[6]**	Deductible then $35
Specialist Office Visit	$60 Copayment after first dollar and deductible	Deductible then $60	**Deductible then $65[6]**	Deductible then $60
Telemedicine — General Medical & Behavioral Health Services (participating Teladoc® providers only) For Dermatology telemedicine refer to the plan's benefit summary	$0	$0	**$0**	Deductible then $0
Urgent Care	$75 Copayment after first dollar and deductible	$75	**Deductible then $70**	Deductible then $75
Emergency Room Services	40% Coinsurance after first dollar and deductible	Deductible then $250	**Deductible then $500**	Deductible then $250
Outpatient Procedures Performed in an Ambulatory Surgery Center	40% Coinsurance after first dollar and deductible	Deductible then $175	**Deductible then $150**	Deductible then $175
Outpatient Procedures Performed in a Hospital	40% Coinsurance after first dollar and deductible	Deductible then $200	**Deductible then $150**	Deductible then $200
Inpatient Hospital Services (per admission)	40% Coinsurance after first dollar and deductible	Deductible then $1,000	**Deductible then $1,500**	Deductible then $1,000
PRESCRIPTION DRUGS				
Pharmacy[2]	$15/40%/50% after first dollar and deductible	$15/$50/50%	**$15/$40/$75**	Deductible then $15/$50/50%
PRODUCT DETAILS				
Wellness Benefits	Health Extras℠ or Nutrition	Health Extras℠ or Nutrition	**Health Extras℠ or Nutrition**	Health Extras℠ or Nutrition
Network	IHC	IHC	**IHC**	IHC
Q3 RATES				
Employee Rate	$571.48	$614.85	**$622.32**	$603.63
Employee & Child(ren) Rate	$971.52	$1,045.25	**$1,057.94**	$1,026.17
Employee & Spouse Rate	$1,142.96	$1,229.70	**$1,244.64**	$1,207.26
Family Rate	$1,628.72	$1,752.32	**$1,773.61**	$1,720.35

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

SILVER LEVEL

(CONTINUED)

	iDirect Silver Coinsurance HSAQ	Choice Plus Silver HSAQ[3]	Passport Plan National Silver HSAQ	Passport Plan Local Silver HSAQ[5]
IN-NETWORK (IN)	HealthEquity	HealthEquity	HealthEquity	HealthEquity
First Dollar Coverage	N/A	N/A	N/A	N/A
Deductible	$3,000/$6,000 (T)	A: $2,000/$4,000 (T) B: $3,500/$7,000 (T)	$3,000/$6,000 (E)	$3,000/$6,000 (E)
Coinsurance	Deductible then 20%	A: 0% B: Deductible then 50%	Deductible then 20%	Deductible then 20%
Out-of-Pocket Max.	**$7,500/$15,000 (E)**	A: $6,950/$13,900 (E) B: $6,950/$13,900 (E)	**$7,500/$15,000 (E)**	**$7,500/$15,000 (E)**
OUT-OF-NETWORK (OON)[1]				
Deductible	$5,000/$10,000 (T)	$5,000/$10,000 (T)	$5,000/$10,000 (E)	$5,000/$10,000 (E)
Coinsurance	Deductible then 50%	Deductible then 50%	Deductible then 50%	Deductible then 50%
Out-of-Pocket Max.	$10,000/$20,000 (E)	$10,000/$20,000 (E)	$10,000/$20,000 (E)	$10,000/$20,000 (E)
MEDICAL SERVICES				
Primary Care Office Visit	Deductible then 20%	Deductible then A: $35 B: 50%	Deductible then 20%	Deductible then 20%
Specialist Office Visit	Deductible then 20%	Deductible then A: $60 B: 50%	Deductible then 20%	Deductible then 20%
Telemedicine — General Medical & Behavioral Health Services (participating Teladoc® providers only) For Dermatology telemedicine refer to the plan's benefit summary	Deductible then $0	Deductible then $0	Deductible then $0	Deductible then $0
Urgent Care	Deductible then 20%	Deductible then A: $75 B: 50%	Deductible then 20%	Deductible then 20%
Emergency Room Services	Deductible then 20%	Deductible then A: $250 B: $250	Deductible then 20%	Deductible then 20%
Outpatient Procedures Performed in an Ambulatory Surgery Center	Deductible then 20%	Deductible then A: $175 B: 50%	Deductible then 20%	Deductible then 20%
Outpatient Procedures Performed in a Hospital	Deductible then 20%	Deductible then A: $200 B: 50%	Deductible then 20%	Deductible then 20%
Inpatient Hospital Services (per admission)	Deductible then 20%	Deductible then A: $1,000 B: 50%	Deductible then 20%	Deductible then 20%
PRESCRIPTION DRUGS				
Pharmacy[2]	Deductible then **$15**/20%/50%	Deductible then $15/$50/50%	Deductible then **$15**/20%/50%	Deductible then **$15**/20%/50%
PRODUCT DETAILS				
Wellness Benefits	Health Extras℠ or Nutrition	Health Extras℠ or Nutrition	Health Extras℠	Health Extras℠ or Nutrition
Network	IHC	Choice Plus	IHC + **United** National	IHC + **United** National
Q3 RATES				
Employee Rate	$559.33	$557.97	$776.18	$586.59
Employee & Child(ren) Rate	$950.86	$948.55	$1,319.51	$997.20
Employee & Spouse Rate	$1,118.66	$1,115.94	$1,552.36	$1,173.18
Family Rate	$1,594.09	$1,590.21	$2,212.11	$1,671.78

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