2025 Small Group Plans

GOLD LEVEL

GOLD LEVEL PLANS CONTINUED ON NEXT PAGE »

Independent Health

	Activate Gold	Standard Healthy NY Gold[3]	iDirect Gold Copay	iDirect Gold Copay Option 3
IN-NETWORK (IN)				
First Dollar Coverage	$750/$1,500	N/A	N/A	N/A
Deductible	$1,500/$3,000 (E)	$600/$1,200 (E)	$1,250/$2,500 (T)	$600/$1,200 (T)
Coinsurance	25% Coinsurance after first dollar and deductible	0%	0%	0%
Out-of-Pocket Max.	$7,950/$15,900 (E)	**$7,900/$15,800 (E)**	$6,750/$13,500 (E)	**$6,250/$12,500 (E)**
OUT-OF-NETWORK (OON)[1]				
Deductible	$5,000/$10,000 (E)	$5,000/$10,000 (E)	$5,000/$10,000 (T)	$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	$20 Copayment after first dollar and deductible	Deductible then $25	$20	Deductible then $25
Specialist Office Visit	$50 Copayment after first dollar and deductible	Deductible then $40	Deductible then $50	Deductible then $40
Telemedicine — General Medical & Behavioral Health Services (participating Teladoc® providers only) For Dermatology telemedicine refer to the plan's benefit summary	$0	$0	$0	$0
Urgent Care	$75 Copayment after first dollar and deductible	Deductible then $60	$75	Deductible then $75
Emergency Room Services	25% Coinsurance after first dollar and deductible	Deductible then $150	**Deductible then $200**	**Deductible then $250**
Outpatient Procedures Performed in an Ambulatory Surgery Center	25% Coinsurance after first dollar and deductible	Deductible then $100	**Deductible then $200**	**Deductible then $200**
Outpatient Procedures Performed in a Hospital	25% Coinsurance after first dollar and deductible	Deductible then $100	**Deductible then $250**	**Deductible then $250**
Inpatient Hospital Services (per admission)	25% Coinsurance after first dollar and deductible	Deductible then $1,000	Deductible then $1,000	Deductible then $1,000
PRESCRIPTION DRUGS				
Pharmacy[2]	$10/25%/50% after first dollar and deductible	$10/$35/$70	$10/$40/**$100**	$10/$35/50%
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
Q1 RATES				
Employee Rate	$761.78	$690.78	$818.59	$821.51
Employee & Child(ren) Rate	$1,295.03	$1,174.33	$1,391.60	$1,396.57
Employee & Spouse Rate	$1,523.56	$1,381.56	$1,637.18	$1,643.02
Family Rate	$2,171.07	$1,968.72	$2,332.98	$2,341.30

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. Specific qualifications must be met.
4. Subscribers must reside within Independent Health's 23-county network area.

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

Bolded items indicate updated changes since the 2024 plan year.

2025 Small Group Plans

GOLD LEVEL

(CONTINUED)

Independent Health

	iDirect Gold Copay HSAQ	Passport Plan National Gold HSAQ	Passport Plan Local Gold HSAQ[4]
IN-NETWORK (IN)	HealthEquity	HealthEquity	HealthEquity
First Dollar Coverage	N/A	N/A	N/A
Deductible	**$1,650/$3,300 (T)**	**$1,650/$3,300 (T)**	**$1,650/$3,300 (T)**
Coinsurance	0%	Deductible then 20%	Deductible then 20%
Out-of-Pocket Max.	**$5,500/$11,000 (E)**	$6,750/$13,500 (E)	$6,750/$13,500 (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 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)
MEDICAL SERVICES			
Primary Care Office Visit	Deductible then $20	Deductible then 20%	Deductible then 20%
Specialist Office Visit	Deductible then $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
Urgent Care	Deductible then $75	Deductible then 20%	Deductible then 20%
Emergency Room Services	**Deductible then $200**	Deductible then 20%	Deductible then 20%
Outpatient Procedures Performed in an Ambulatory Surgery Center	**Deductible then $200**	Deductible then 20%	Deductible then 20%
Outpatient Procedures Performed in a Hospital	**Deductible then $250**	Deductible then 20%	Deductible then 20%
Inpatient Hospital Services (per admission)	Deductible then $750	Deductible then 20%	Deductible then 20%
PRESCRIPTION DRUGS			
Pharmacy[2]	Deductible then $10/$40/50%	Deductible then $10/20%/50%	Deductible then $10/20%/50%
PRODUCT DETAILS			
Wellness Benefits	Health Extras℠ or Nutrition	Health Extras℠	Health Extras℠ or Nutrition
Network	IHC	IHC + United Nationally	IHC + United Nationally
Q1 RATES			
Employee Rate	$773.56	$1,055.35	$952.42
Employee & Child(ren) Rate	$1,315.05	$1,794.10	$1,619.11
Employee & Spouse Rate	$1,547.12	$2,110.70	$1,904.84
Family Rate	$2,204.65	$3,007.75	$2,714.40

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(E) = Embedded Deductible
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