



Independent Health's

# 2024 SMALL GROUP PORTFOLIO

THIRD QUARTER

## Independent Health Is the Smart Business Decision

**Making it easy for the health of your business and your employees with low-cost plans and less hassle. All with the RedShirt® Treatment.**

With an average of nearly 20 years' experience<sup>1</sup>, our tenured Sales team works hard to get the answers you need and make things easier so you can concentrate on the health of your business. Just like we have for **over 40 years as WNY's locally-focused** health plan.



# AN ENHANCED NATIONAL NETWORK, A LOCAL TEAM AND THE REDSHIRT TREATMENT.

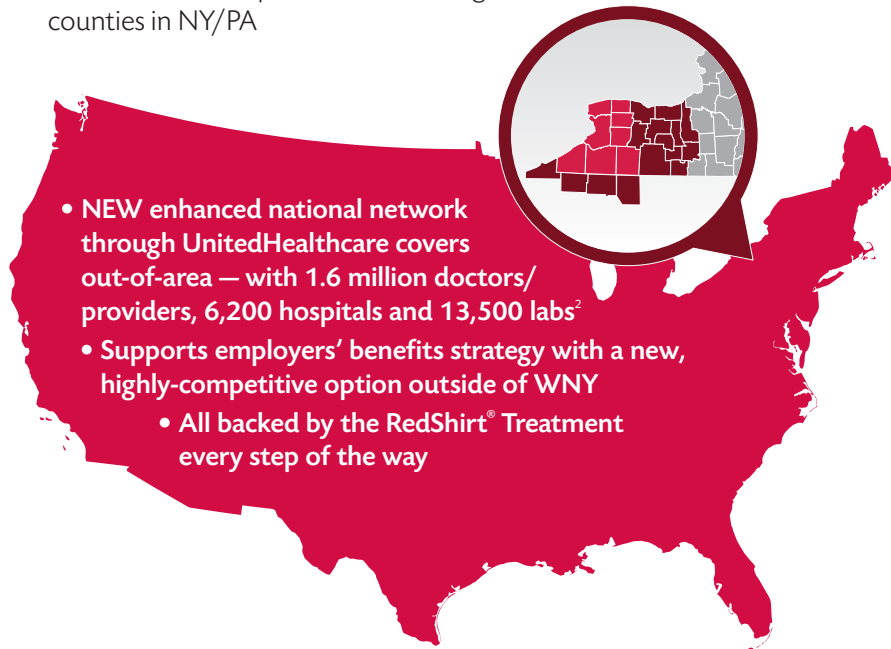
## THERE ARE EVEN MORE REASONS TO CHOOSE INDEPENDENT HEALTH.

Our local and national network agreements have your employees covered when and where they need it, regardless of their location. Plus access to tools, resources, member discounts, community programs and a wide range of unique health benefits. And it's all backed by the RedShirt® Treatment.

## OUR PROVIDER NETWORK HAS MEMBERS COVERED

### No Matter Where They Live or Travel

- Our local network covers the eight counties of WNY, plus 15 surrounding counties in NY/PA



- NEW enhanced national network through UnitedHealthcare covers out-of-area — with 1.6 million doctors/providers, 6,200 hospitals and 13,500 labs<sup>2</sup>
- Supports employers' benefits strategy with a new, highly-competitive option outside of WNY
  - All backed by the RedShirt® Treatment every step of the way

## NEW FOR 2024

### IDIRECT® SILVER COPAY OPTION 2

Lower Cost Alternative to Platinum or Gold Tier

Lower Deductible

Copayments on Rx

**9 OUT OF 10**  
MEMBERS ARE SATISFIED<sup>3</sup>

**9 OUT OF 10**  
EMPLOYERS WOULD RECOMMEND INDEPENDENT HEALTH<sup>3</sup>

**100%**  
OF BROKERS WOULD RECOMMEND INDEPENDENT HEALTH<sup>3</sup>

1. Independent Health commercial sales.

2. UnitedHealthcare network analysis, March 31, 2023.

3. 2022 Consumer and Employer Third Party Blinded Stakeholder Studies and 2023 Broker Stakeholder Study. Data subject to change without notification.

# 2024 Small Group Plans



## PLATINUM LEVEL

PLATINUM LEVEL PLANS CONTINUED ON NEXT PAGE »

### IN-NETWORK (IN)

First Dollar Coverage
Deductible
Coinsurance
Out-of-Pocket Max.

### OUT-OF-NETWORK (OON)<sup>1</sup>

Deductible
Coinsurance
Out-of-Pocket Max.

### MEDICAL SERVICES

Primary Care Office Visit
Specialist Office Visit
Telemedicine — General Medical & Behavioral Health Services (participating Teladoc® providers only) For Dermatology telemedicine refer to the plan's benefit summary
Urgent Care
Emergency Room Services
Outpatient Procedures Performed in an Ambulatory Surgery Center
Outpatient Procedures Performed in a Hospital
Inpatient Hospital Services (per admission)

### PRESCRIPTION DRUGS

Pharmacy <sup>2</sup>
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### PRODUCT DETAILS

Wellness Benefits
Network

### Q3 RATES

Employee Rate
Employee & Child(ren) Rate
Employee & Spouse Rate
Family Rate

### FlexFit Platinum

### FlexFit Platinum Option 2

### Choice Plus Platinum<sup>3</sup>

IN-NETWORK (IN)	FlexFit Platinum	FlexFit Platinum Option 2	Choice Plus Platinum <sup>3</sup>
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) <sup>1</sup>	FlexFit Platinum	FlexFit Platinum Option 2	Choice Plus Platinum <sup>3</sup>
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	FlexFit Platinum	FlexFit Platinum Option 2	Choice Plus Platinum <sup>3</sup>
Primary Care Office Visit	\$10	<b>\$10</b>	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	FlexFit Platinum	FlexFit Platinum Option 2	Choice Plus Platinum <sup>3</sup>
Pharmacy <sup>2</sup>	\$5/\$30/50%	\$5/\$30/\$100	\$5/\$30/50%
PRODUCT DETAILS	FlexFit Platinum	FlexFit Platinum Option 2	Choice Plus Platinum <sup>3</sup>
Wellness Benefits	Health Extras <sup>SM</sup> or Nutrition	Health Extras <sup>SM</sup> or Nutrition	Health Extras <sup>SM</sup> or Nutrition
Network	IHC	IHC	Choice Plus
Q3 RATES	FlexFit Platinum	FlexFit Platinum Option 2	Choice Plus Platinum <sup>3</sup>
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

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 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)

### Passport Plan National Platinum

### Passport Plan Local Platinum<sup>5</sup>

	Passport Plan National Platinum	Passport Plan Local Platinum <sup>5</sup>
<b>IN-NETWORK (IN)</b>		
First Dollar Coverage	N/A	N/A
Deductible	\$0	\$0
Coinsurance	0%	0%
Out-of-Pocket Max.	<b>\$6,000/\$12,000 (E)</b>	<b>\$6,000/\$12,000 (E)</b>
<b>OUT-OF-NETWORK (OON)<sup>1</sup></b>		
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)
<b>MEDICAL SERVICES</b>		
Primary Care Office Visit	<b>\$15</b>	<b>\$15</b>
Specialist Office Visit	<b>\$45</b>	<b>\$45</b>
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
<b>PRESCRIPTION DRUGS</b>		
Pharmacy <sup>2</sup>	\$5/\$30/50%	\$5/\$30/50%
<b>PRODUCT DETAILS</b>		
Wellness Benefits	Health Extras <sup>SM</sup>	Health Extras <sup>SM</sup> or Nutrition
Network	IHC + <b>United</b> National	IHC + <b>United</b> National
<b>Q3 RATES</b>		
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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# 2024 Small Group Plans



## GOLD LEVEL

GOLD LEVEL PLANS CONTINUED ON NEXT PAGE »

### IN-NETWORK (IN)

First Dollar Coverage
Deductible
Coinsurance
Out-of-Pocket Max.

### OUT-OF-NETWORK (OON)<sup>1</sup>

Deductible
Coinsurance
Out-of-Pocket Max.

### MEDICAL SERVICES

Primary Care Office Visit
Specialist Office Visit
Telemedicine — General Medical & Behavioral Health Services (participating Teladoc® providers only) For Dermatology telemedicine refer to the plan's benefit summary
Urgent Care
Emergency Room Services
Outpatient Procedures Performed in an Ambulatory Surgery Center
Outpatient Procedures Performed in a Hospital
Inpatient Hospital Services (per admission)

### PRESCRIPTION DRUGS

Pharmacy <sup>2</sup>
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### PRODUCT DETAILS

Wellness Benefits
Network

### Q3 RATES

Employee Rate
Employee & Child(ren) Rate
Employee & Spouse Rate
Family Rate

	Activate Gold	Standard Healthy NY Gold <sup>4</sup>	iDirect Gold Copay	iDirect Gold Copay Option 2
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)	\$1,250/\$2,500 (T)
Coinsurance	25% Coinsurance after first dollar and deductible	0%	0%	0%
Out-of-Pocket Max.	\$7,950/\$15,900 (E)	<b>\$5,900/\$11,800 (E)</b>	\$6,750/\$13,500 (E)	<b>\$6,750/\$13,500 (E)</b>
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)
Primary Care Office Visit	\$20 Copayment after first dollar and deductible	Deductible then \$25	\$20	\$20
Specialist Office Visit	\$50 Copayment after first dollar and deductible	Deductible then \$40	Deductible then \$50	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	\$0
Urgent Care	\$75 Copayment after first dollar and deductible	Deductible then \$60	\$75	\$75
Emergency Room Services	25% Coinsurance after first dollar and deductible	Deductible then \$150	Deductible then \$150	Deductible then \$150
Outpatient Procedures Performed in an Ambulatory Surgery Center	25% Coinsurance after first dollar and deductible	Deductible then \$100	Deductible then \$100	Deductible then \$100
Outpatient Procedures Performed in a Hospital	25% Coinsurance after first dollar and deductible	Deductible then \$100	Deductible then \$125	Deductible then \$125
Inpatient Hospital Services (per admission)	25% Coinsurance after first dollar and deductible	Deductible then \$1,000	Deductible then \$1,000	Deductible then \$750
Pharmacy <sup>2</sup>	\$10/25%/50% after first dollar and deductible	\$10/\$35/\$70	\$10/\$40/50%	\$10/\$40/\$100
Wellness Benefits	Health Extras <sup>SM</sup> or Nutrition	Health Extras <sup>SM</sup> or Nutrition	Health Extras <sup>SM</sup> or Nutrition	Health Extras <sup>SM</sup> or Nutrition
Network	IHC	IHC	IHC	IHC
Employee Rate	\$660.74	\$598.83	\$695.61	\$707.12
Employee & Child(ren) Rate	\$1,123.26	\$1,018.01	\$1,182.54	\$1,202.10
Employee & Spouse Rate	\$1,321.48	\$1,197.66	\$1,391.22	\$1,414.24
Family Rate	\$1,883.11	\$1,706.67	\$1,982.49	\$2,015.29

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 (E) = Embedded Deductible  
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# 2024 Small Group Plans



## GOLD LEVEL

(CONTINUED)

	iDirect Gold Copay Option 3	iDirect Gold Copay HSAQ	Passport Plan National Gold HSAQ	Passport Plan Local Gold HSAQ <sup>5</sup>
<b>IN-NETWORK (IN)</b>				
First Dollar Coverage	N/A	N/A	N/A	N/A
Deductible	\$600/\$1,200 (T)	<b>\$1,600/\$3,200 (T)</b>	<b>\$1,600/\$3,200 (T)</b>	<b>\$1,600/\$3,200 (T)</b>
Coinsurance	0%	0%	Deductible then 20%	Deductible then 20%
Out-of-Pocket Max.	<b>\$5,900/\$11,800 (E)</b>	\$4,500/\$9,000 (E)	\$6,750/\$13,500 (E)	\$6,750/\$13,500 (E)
<b>OUT-OF-NETWORK (OON)<sup>1</sup></b>				
Deductible	\$5,000/\$10,000 (T)	\$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%	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)
<b>MEDICAL SERVICES</b>				
Primary Care Office Visit	Deductible then \$25	Deductible then \$20	Deductible then 20%	Deductible then 20%
Specialist Office Visit	Deductible then \$40	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	\$0	Deductible then \$0	Deductible then \$0	Deductible then \$0
Urgent Care	Deductible then \$75	Deductible then \$75	Deductible then 20%	Deductible then 20%
Emergency Room Services	Deductible then \$150	Deductible then \$150	Deductible then 20%	Deductible then 20%
Outpatient Procedures Performed in an Ambulatory Surgery Center	Deductible then \$75	Deductible then \$100	Deductible then 20%	Deductible then 20%
Outpatient Procedures Performed in a Hospital	Deductible then \$100	Deductible then \$125	Deductible then 20%	Deductible then 20%
Inpatient Hospital Services (per admission)	Deductible then \$1,000	Deductible then \$750	Deductible then 20%	Deductible then 20%
<b>PRESCRIPTION DRUGS</b>				
Pharmacy <sup>2</sup>	\$10/\$35/50%	Deductible then \$10/\$40/50%	Deductible then <b>\$10</b> /20%/50%	Deductible then <b>\$10</b> /20%/50%
<b>PRODUCT DETAILS</b>				
Wellness Benefits	Health Extras <sup>SM</sup> or Nutrition	Health Extras <sup>SM</sup> or Nutrition	Health Extras <sup>SM</sup>	Health Extras <sup>SM</sup> or Nutrition
Network	IHC	IHC	IHC + <b>United</b> National	IHC + <b>United</b> National
<b>Q3 RATES</b>				
Employee Rate	\$713.08	\$670.84	\$878.81	\$662.91
Employee & Child(ren) Rate	\$1,212.24	\$1,140.43	\$1,493.98	\$1,126.95
Employee & Spouse Rate	\$1,426.16	\$1,341.68	\$1,757.62	\$1,325.82
Family Rate	\$2,032.28	\$1,911.89	\$2,504.61	\$1,889.29

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 (T) = True Family (Non Embedded) Deductible

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# 2024 Small Group Plans



## SILVER LEVEL

SILVER LEVEL PLANS CONTINUED ON NEXT PAGE >

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

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 (E) = Embedded Deductible  
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# 2024 Small Group Plans



## SILVER LEVEL

(CONTINUED)

IN-NETWORK (IN)
First Dollar Coverage
Deductible
Coinsurance
Out-of-Pocket Max.
OUT-OF-NETWORK (OON) <sup>1</sup>
Deductible
Coinsurance
Out-of-Pocket Max.
MEDICAL SERVICES
Primary Care Office Visit
Specialist Office Visit
Telemedicine — General Medical & Behavioral Health Services (participating Teladoc® providers only) For Dermatology telemedicine refer to the plan's benefit summary
Urgent Care
Emergency Room Services
Outpatient Procedures Performed in an Ambulatory Surgery Center
Outpatient Procedures Performed in a Hospital
Inpatient Hospital Services (per admission)
PRESCRIPTION DRUGS
Pharmacy <sup>2</sup>
PRODUCT DETAILS
Wellness Benefits
Network
Q3 RATES
Employee Rate
Employee & Child(ren) Rate
Employee & Spouse Rate
Family Rate

iDirect Silver Coinsurance HSAQ	Choice Plus Silver HSAQ <sup>3</sup>	Passport Plan National Silver HSAQ	Passport Plan Local Silver HSAQ <sup>5</sup>
HealthEquity	HealthEquity	HealthEquity	HealthEquity
N/A	N/A	N/A	N/A
\$3,000/\$6,000 (T)	A: \$2,000/\$4,000 (T) B: \$3,500/\$7,000 (T)	\$3,000/\$6,000 (T)	\$3,000/\$6,000 (T)
Deductible then 20%	A: 0% B: Deductible then 50%	Deductible then 20%	Deductible then 20%
<b>\$7,500/\$15,000 (E)</b>	A: \$6,950/\$13,900 (E) B: \$6,950/\$13,900 (E)	<b>\$7,500/\$15,000 (E)</b>	<b>\$7,500/\$15,000 (E)</b>
\$5,000/\$10,000 (T)	\$5,000/\$10,000 (T)	\$5,000/\$10,000 (E)	\$5,000/\$10,000 (E)
Deductible then 50%	Deductible then 50%	Deductible then 50%	Deductible then 50%
\$10,000/\$20,000 (E)	\$10,000/\$20,000 (E)	\$10,000/\$20,000 (E)	\$10,000/\$20,000 (E)
Deductible then 20%	Deductible then A: \$35 B: 50%	Deductible then 20%	Deductible then 20%
Deductible then 20%	Deductible then A: \$60 B: 50%	Deductible then 20%	Deductible then 20%
Deductible then \$0	Deductible then \$0	Deductible then \$0	Deductible then \$0
Deductible then 20%	Deductible then A: \$75 B: 50%	Deductible then 20%	Deductible then 20%
Deductible then 20%	Deductible then A: \$250 B: \$250	Deductible then 20%	Deductible then 20%
Deductible then 20%	Deductible then A: \$175 B: 50%	Deductible then 20%	Deductible then 20%
Deductible then 20%	Deductible then A: \$200 B: 50%	Deductible then 20%	Deductible then 20%
Deductible then 20%	Deductible then A: \$1,000 B: 50%	Deductible then 20%	Deductible then 20%
Deductible then <b>\$15/20%/50%</b>	Deductible then \$15/\$50/50%	Deductible then <b>\$15/20%/50%</b>	Deductible then <b>\$15/20%/50%</b>
Health Extras <sup>SM</sup> or Nutrition	Health Extras <sup>SM</sup> or Nutrition	Health Extras <sup>SM</sup>	Health Extras <sup>SM</sup> or Nutrition
IHC	Choice Plus	IHC + <b>United</b> National	IHC + <b>United</b> National
\$559.33	\$557.97	\$776.18	\$586.59
\$950.86	\$948.55	\$1,319.51	\$997.20
\$1,118.66	\$1,115.94	\$1,552.36	\$1,173.18
\$1,594.09	\$1,590.21	\$2,212.11	\$1,671.78

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



## BRONZE LEVEL

BRONZE LEVEL PLANS CONTINUED ON NEXT PAGE >

IN-NETWORK (IN)
First Dollar Coverage
Deductible
Coinsurance
Out-of-Pocket Max.
OUT-OF-NETWORK (OON) <sup>1</sup>
Deductible
Coinsurance
Out-of-Pocket Max.
MEDICAL SERVICES
Primary Care Office Visit
Specialist Office Visit
Telemedicine — General Medical & Behavioral Health Services (participating Teladoc® providers only) For Dermatology telemedicine refer to the plan's benefit summary
Urgent Care
Emergency Room Services
Outpatient Procedures Performed in an Ambulatory Surgery Center
Outpatient Procedures Performed in a Hospital
Inpatient Hospital Services (per admission)
PRESCRIPTION DRUGS
Pharmacy <sup>2</sup>
PRODUCT DETAILS
Wellness Benefits
Network
Q3 RATES
Employee Rate
Employee & Child(ren) Rate
Employee & Spouse Rate
Family Rate

iDirect Bronze Blended HSAQ	iDirect Bronze Coinsurance HSAQ	iDirect Bronze MV HSAQ
HealthEquity	HealthEquity	HealthEquity
N/A	N/A	N/A
\$6,000/\$12,000 (E)	\$5,600/\$11,200 (E)	<b>\$7,500/\$15,000 (E)</b>
Deductible then 30%	Deductible then 50%	0%
<b>\$7,500/\$15,000 (E)</b>	<b>\$7,500/\$15,000 (E)</b>	<b>\$7,500/\$15,000 (E)</b>
OUT-OF-NETWORK (OON) <sup>1</sup>	OUT-OF-NETWORK (OON) <sup>1</sup>	OUT-OF-NETWORK (OON) <sup>1</sup>
\$7,500/\$15,000 (E)	\$7,500/\$15,000 (E)	<b>\$10,000/\$20,000 (E)</b>
Deductible then 50%	Deductible then 50%	Deductible then 50%
\$15,000/\$30,000 (E)	\$15,000/\$30,000 (E)	<b>\$20,000/\$40,000 (E)</b>
MEDICAL SERVICES	MEDICAL SERVICES	MEDICAL SERVICES
Deductible then \$40	Deductible then 50%	Deductible then \$0
Deductible then \$60	Deductible then 50%	Deductible then \$0
Deductible then \$0	Deductible then \$0	Deductible then \$0
Deductible then \$75	Deductible then 50%	Deductible then \$0
Deductible then 30%	Deductible then 50%	Deductible then \$0
Deductible then 30%	Deductible then 50%	Deductible then \$0
Deductible then 30%	Deductible then 50%	Deductible then \$0
Deductible then 30%	Deductible then 50%	Deductible then \$0
PRESCRIPTION DRUGS	PRESCRIPTION DRUGS	PRESCRIPTION DRUGS
Deductible then \$20/30%/50%	Deductible then 50%	Deductible then \$0
PRODUCT DETAILS	PRODUCT DETAILS	PRODUCT DETAILS
Health Extras <sup>SM</sup> or Nutrition	Health Extras <sup>SM</sup> or Nutrition	Health Extras <sup>SM</sup> or Nutrition
IHC	IHC	IHC
Q3 RATES	Q3 RATES	Q3 RATES
\$512.11	\$505.74	\$511.74
\$870.59	\$859.76	\$869.96
\$1,024.22	\$1,011.48	\$1,023.48
\$1,459.51	\$1,441.36	\$1,458.46

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 (E) = Embedded Deductible  
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**Bolded items** indicate updated changes since the 2023 plan year.

# 2024 Small Group Plans



## BRONZE LEVEL

(CONTINUED)

IN-NETWORK (IN)
First Dollar Coverage
Deductible
Coinsurance
Out-of-Pocket Max.
OUT-OF-NETWORK (OON) <sup>1</sup>
Deductible
Coinsurance
Out-of-Pocket Max.
MEDICAL SERVICES
Primary Care Office Visit
Specialist Office Visit
Telemedicine – General Medical & Behavioral Health Services (participating Teladoc® providers only) For Dermatology telemedicine refer to the plan's benefit summary
Urgent Care
Emergency Room Services
Outpatient Procedures Performed in an Ambulatory Surgery Center
Outpatient Procedures Performed in a Hospital
Inpatient Hospital Services (per admission)
PRESCRIPTION DRUGS
Pharmacy <sup>2</sup>
PRODUCT DETAILS
Wellness Benefits
Network
Q3 RATES
Employee Rate
Employee & Child(ren) Rate
Employee & Spouse Rate
Family Rate

	Passport Plan National Bronze HSAQ	Passport Plan Local Bronze HSAQ <sup>5</sup>
	HealthEquity	HealthEquity
	N/A	N/A
	\$5,600/\$11,200 (E)	\$5,600/\$11,200 (E)
	Deductible then 50%	Deductible then 50%
	<b>\$7,500/\$15,000 (E)</b>	<b>\$7,500/\$15,000 (E)</b>
	\$7,500/\$15,000 (E)	\$7,500/\$15,000 (E)
	Deductible then 50%	Deductible then 50%
	\$15,000/\$30,000 (E)	\$15,000/\$30,000 (E)
	Deductible then 50%	Deductible then 50%
	Deductible then 50%	Deductible then 50%
	Deductible then \$0	Deductible then \$0
	Deductible then 50%	Deductible then 50%
	Deductible then 50%	Deductible then 50%
	Deductible then 50%	Deductible then 50%
	Deductible then 50%	Deductible then 50%
	Deductible then 50%	Deductible then 50%
	Deductible then 50%	Deductible then 50%
	Deductible then 50%	Deductible then 50%
	Health Extras <sup>SM</sup>	Health Extras <sup>SM</sup> or Nutrition
	IHC + <b>United</b> National	IHC + <b>United</b> National
	\$700.39	\$531.21
	\$1,190.66	\$903.06
	\$1,400.78	\$1,062.42
	\$1,996.11	\$1,513.95

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**Bolded items** indicate updated changes since the 2023 plan year.

# YOU GET MORE WITH THE REDSHIRT® TREATMENT.

The benefits of being an Independent Health member goes well beyond affordable, high-quality coverage. It's convenient access to tools, resources, member savings, community programs and a wide range of unique health benefits<sup>1</sup> — all backed by leading service and support.

## \$250 HEALTH EXTRAS<sup>SM</sup> VISA<sup>®</sup>

A debit card to pay for healthy goods and services.



## EARN \$1,000 BACK

Nutrition Benefit<sup>2</sup> pays members back for buying fresh fruits and vegetables.



## 600+ WELLNESS DISCOUNTS

Members can show their member ID card for exclusive health and wellness discounts — up to 30% off — at a wide range of local businesses.

## EARN UP TO \$30 IN REDSHIRT REWARDS<sup>SM</sup>

Get rewarded<sup>3</sup> for completing healthy actions like annual checkups, flu shots and health screenings — and choose a gift card at a wide range of retailers, including Amazon.com Gift Card, Target and more!

## \$0 PREVENTIVE CARE

More than 60 FREE services — from checkups and screenings to vaccines.



## \$0 PREVENTIVE RX

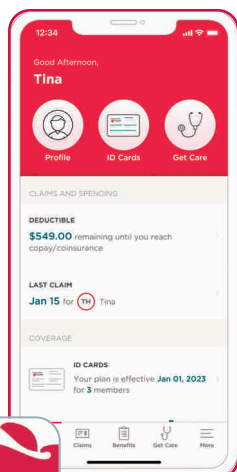
For cholesterol, blood pressure, diabetes, antidepressants and so much more.



**Plus** — Get **Vision Discounts** with EyeMed providers. Also available, **Dental Coverage** through Delta Dental.



## DIGITAL HEALTH TOOLS AND APPS



Download the **MyIH app** to get started with personalized plan information and access to a wide range of easy-to-use digital tools and resources. Chat with a RedShirt, search for a doctor or pharmacy, view member ID card, track balances and so much more.



Scan here to download the MyIH app

**It's all a tap away!** **Brook and Brook+** (health coaching, diabetes/weight management), **Compare Medical and Rx Costs** (online compare tools), **e-pay** (pay plan bills electronically) and more!

# CONNECT WITH OUR COMMUNITY

Our goal is to improve the health and well-being of every Western New Yorker, not just our members. That's why we partner with local organizations to offer programs and events that promote the importance of healthy choices and easy access to healthy activities. Bringing healthy to WNY — year-round:

- Buffalo Outer Harbor
- Buffalo P.A.L. PlayStreets
- Buffalo RiverWorks
- First Night® Buffalo
- Fitness for Kids Challenge
- Fitness in the Parks
- Good for the Neighborhood®
- Healthy Options®
- Kids Run
- Larkin Square Food Truck Tuesdays
- Reddy Bikeshare
- GObike Buffalo's SkyRide
- Soccer for Success
- Tifft Nature Preserve

To learn about community partnerships, visit [independenthealth.com/in-the-community](https://independenthealth.com/in-the-community).



**You Deserve the RedShirt Treatment.®**

Call our RedShirts<sup>SM</sup> today at **1-800-453-1910**.

Independent  
 Health<sup>®</sup>

[independenthealth.com](https://independenthealth.com)

1. Benefits vary by plan.

2. Canned or frozen fruits and vegetables are excluded. Money back is in the form of store credit for future purchases.

3. Rewards will be issued when Independent Health receives notification of a claim for each service, which may take up to 90 days for a provider to submit the claim(s). \$30.00 limit per eligible member (subscriber, spouse and dependents 18 years of age and older) per plan year.