2025 Small Group Plans

PLATINUM LEVEL

PLATINUM LEVEL PLANS CONTINUED ON NEXT PAGE »

	FlexFit Platinum	FlexFit Platinum Option 2
IN-NETWORK (IN)		
First Dollar Coverage	N/A	N/A
Deductible	$0	$0
Coinsurance	0%	0%
Out-of-Pocket Max.	$5,250/$10,500 (E)	**$4,000/$8,000 (E)**
OUT-OF-NETWORK (OON)[1]		
Deductible	$5,000/$10,000 (T)	$5,000/$10,000 (T)
Coinsurance	Deductible then 20%	Deductible then 20%
Out-of-Pocket Max.	$10,000/$20,000 (E)	$10,000/$20,000 (E)
MEDICAL SERVICES		
Primary Care Office Visit	$10	$10
Specialist Office Visit	$40	$25
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	**$250**	**$250**
Outpatient Procedures Performed in an Ambulatory Surgery Center	**$150**	**$150**
Outpatient Procedures Performed in a Hospital	**$200**	**$200**
Inpatient Hospital Services (per admission)	$500	$500
PRESCRIPTION DRUGS		
Pharmacy[2]	$5/$30/50%	$5/$30/$100
PRODUCT DETAILS		
Wellness Benefits	Health Extras℠ or Nutrition	Health Extras℠ or Nutrition
Network	IHC	IHC
Q2 RATES		
Employee Rate	$951.95	$974.28
Employee & Child(ren) Rate	$1,618.32	$1,656.28
Employee & Spouse Rate	$1,903.90	$1,948.56
Family Rate	$2,713.06	$2,776.70

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

PLATINUM LEVEL

(CONTINUED)

	Passport Plan National Platinum	Passport Plan Local Platinum[4]
IN-NETWORK (IN)		
First Dollar Coverage	N/A	N/A
Deductible	$0	$0
Coinsurance	0%	0%
Out-of-Pocket Max.	**$4,500/$9,000 (E)**	**$4,500/$9,000 (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	**$200**	**$200**
Outpatient Procedures Performed in an Ambulatory Surgery Center	**$150**	**$150**
Outpatient Procedures Performed in a Hospital	**$200**	**$200**
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 Nationally	IHC + United Nationally
Q2 RATES		
Employee Rate	$1,381.03	$1,244.43
Employee & Child(ren) Rate	$2,347.75	$2,115.53
Employee & Spouse Rate	$2,762.06	$2,488.86
Family Rate	$3,935.94	$3,546.63

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.