

2023 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)¹

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 ²

PRODUCT DETAILS

Wellness Benefits
Network

Q1 RATES

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

	FlexFit Platinum	FlexFit Platinum Option 2	Choice Plus Platinum ³
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)
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)
Primary Care Office Visit	\$10	\$5	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%
Pharmacy ²	\$5/\$30/50%	\$5/\$30/\$100	\$5/\$30/50%
Wellness Benefits	Health Extras SM or Nutrition	Health Extras SM or Nutrition	Health Extras SM or Nutrition
Network	IHC	IHC	Choice Plus
Employee Rate	\$683.70	\$697.21	\$650.12
Employee & Child(ren) Rate	\$1,162.29	\$1,185.26	\$1,105.20
Employee & Spouse Rate	\$1,367.40	\$1,394.42	\$1,300.24
Family Rate	\$1,948.55	\$1,987.05	\$1,852.84

1. OON coverage only applies to non-participating providers outside the 8 counties of WNY.

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. Members must reside in the 8 counties of WNY.

6. Members must reside or work in Erie County.

7. thRed subscriber is eligible for \$200 in account activation rewards and up to \$300 in wellness rewards, while a spouse is eligible for a \$50 account activation reward.

8. **Deductible does not apply to first visit**

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

Bolded items indicate updated changes since the 2022 plan year.

2023 Small Group Plans



PLATINUM LEVEL

(CONTINUED)

	Passport Plan National Platinum	Passport Plan Local Platinum ⁵	thRed Platinum ⁶
IN-NETWORK (IN)			
First Dollar Coverage	N/A	N/A	N/A
Deductible	\$0	\$0	\$0
Coinsurance	0%	0%	0%
Out-of-Pocket Max.	\$5,250/ \$10,500 (E)	\$5,250/ \$10,500 (E)	\$5,250/ \$10,500 (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	\$10	\$10	\$0
Specialist Office Visit	\$40	\$40	\$40
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	\$100
Emergency Room Services	\$150	\$150	\$150
Outpatient Procedures Performed in an Ambulatory Surgery Center	\$75	\$75	\$75
Outpatient Procedures Performed in a Hospital	\$100	\$100	\$100
Inpatient Hospital Services (per admission)	\$500	\$500	\$500
PRESCRIPTION DRUGS			
Pharmacy ²	\$5/\$30/50%	\$5/\$30/50%	\$5/\$30/50%
PRODUCT DETAILS			
Wellness Benefits	Health Extras SM	Health Extras SM or Nutrition	Health Extras SM and \$50 for completing onboarding process ⁷
Network	IHC + First Health Nationally	IHC + First Health Nationally	thRed
Q1 RATES			
Employee Rate	\$838.94	\$696.92	\$625.19
Employee & Child(ren) Rate	\$1,426.20	\$1,184.76	\$1,062.82
Employee & Spouse Rate	\$1,677.88	\$1,393.84	\$1,250.38
Family Rate	\$2,390.98	\$1,986.22	\$1,781.79

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