

INDEPENDENT HEALTH'S 2026

SMALL GROUP PORTFOLIO

THIRD QUARTER

Our RedShirtsSM Are Here To Help.

Rely on our experienced RedShirtsSM to help you get the right plans for your employees and the answers you need — making it easier for you to focus on the health of your business. Just like we have for over 45 years as WNY's local health plan.

That's what you can continue to count on. That's your RedShirt[®] Treatment.



WE HAVE YOU COVERED.

A Comprehensive National Network With New Low-Cost Plans — All Backed by Your Local RedShirt Team.

NEW for 2026

FlexFit® Gold

No Deductible with Copays

Lower Cost Alternate to Platinum

GOLD LEVEL

NEW for 2026

iDirect® Bronze MV

Lowest Cost Plan for 2026

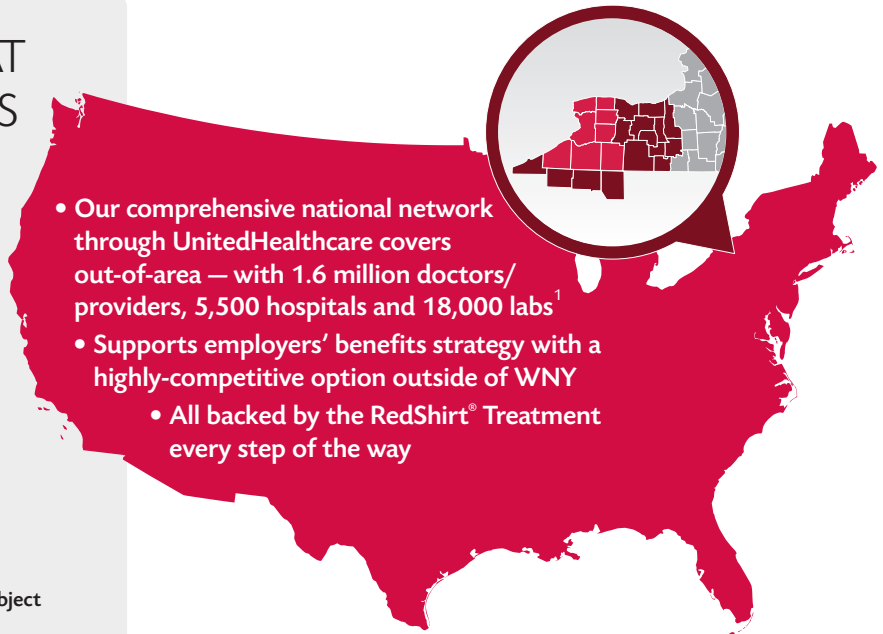
BRONZE LEVEL

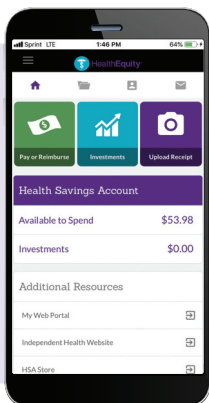
PEACE OF MIND AT HOME *and* ACROSS THE COUNTRY.

Our local and national network agreements have your employees covered when and where they need it — regardless of their location, no matter where they live or travel.

Our local network covers the 8 counties of WNY, plus 15 surrounding counties in NY/PA.

Data is current as of publication and is subject to change without notification.

- 
- Our comprehensive national network through UnitedHealthcare covers out-of-area — with 1.6 million doctors/providers, 5,500 hospitals and 18,000 labs¹
 - Supports employers' benefits strategy with a highly-competitive option outside of WNY
 - All backed by the RedShirt® Treatment every step of the way



The HealthEquity® HSA is built into all HSA-qualified (HSAQ) plans.

The convenient way to enjoy all the pre-tax benefits of paying for qualified health care expenses directly through members' HSA account.

Everything is automated and integrated with your Independent Health plan, including enrollment, claims, payment and tracking and a variety of investment options — all with no monthly administration fee.

HealthEquity®

1. UnitedHealthcare network analysis.

2026 Small Group Plans



PLATINUM LEVEL

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

Q3 RATES

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

	FlexFit Platinum	NEW! iDirect Platinum Coinsurance	NEW! Passport Plan Local Platinum ⁴
	N/A	N/A	N/A
	\$0	\$125/\$250 (T)	\$125/\$250 (T)
	0%	20%	20%
	\$5,500/\$11,000 (E)	\$5,250/\$10,500 (E)	\$5,250/\$10,500 (E)
	\$5,000/\$10,000 (T)	\$5,000/\$10,000 (T)	\$5,000/\$10,000 (T)
	Deductible then 20%	Deductible then 50%	Deductible then 50%
	\$10,000/\$20,000 (E)	\$10,000/\$20,000 (E)	\$10,000/\$20,000 (E)
	\$10	Deductible then 20%	Deductible then 20%
	\$40	Deductible then 20%	Deductible then 20%
	\$0	\$0	\$0
	\$100	Deductible then 20%	Deductible then 20%
	\$250	Deductible then 20%	Deductible then 20%
	\$250	Deductible then 20%	Deductible then 20%
	\$300	Deductible then 20%	Deductible then 20%
	\$500	Deductible then 20%	Deductible then 20%
	\$5/ \$45/50%	\$5/\$50/50%	\$5/\$50/50%
	Health Extras SM or Nutrition	Health ExtrasSM or Nutrition	Health ExtrasSM or Nutrition
	IHC	IHC	IHC + United Nationally
	\$1,127.77	\$1,062.84	\$1,158.51
	\$1,917.21	\$1,806.83	\$1,969.47
	\$2,255.54	\$2,125.68	\$2,317.02
	\$3,214.14	\$3,029.09	\$3,301.75

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

(E) = Embedded Deductible or Out-of-Pocket Maximum
 (T) = True Family (Non Embedded) Deductible or Out-of-Pocket Maximum

Bolded items indicate updated changes since the 2025 plan year.

2026 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)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

Q3 RATES

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

	Activate Gold	NEW! FlexFit Gold	iDirect Gold Copay
First Dollar Coverage	\$750/\$1,500	N/A	N/A
Deductible	\$1,700/\$3,400 (E)	\$0	\$1,500/\$3,000 (T)
Coinsurance	25% Coinsurance after first dollar and deductible	0%	0%
Out-of-Pocket Max.	\$7,950/\$15,900 (E)	\$8,500/\$17,000 (E)	\$6,750/\$13,500 (E)
Deductible	\$7,500/\$15,000 (E)	\$7,500/\$15,000 (T)	\$7,500/\$15,000 (T)
Coinsurance	Deductible then 50%	Deductible then 50%	Deductible then 50%
Out-of-Pocket Max.	\$15,000/\$30,000 (E)	\$15,000/\$30,000 (E)	\$15,000/\$30,000 (E)
Primary Care Office Visit	\$20 Copayment after first dollar and deductible	\$40	\$20
Specialist Office Visit	\$50 Copayment after first dollar and deductible	\$75	Deductible then \$50
Telemedicine	\$0	\$0	\$0
Urgent Care	\$75 Copayment after first dollar and deductible	\$100	\$75
Emergency Room Services	25% Coinsurance after first dollar and deductible	\$300	Deductible then \$200
Outpatient Procedures Performed in an Ambulatory Surgery Center	25% Coinsurance after first dollar and deductible	\$950	Deductible then \$325
Outpatient Procedures Performed in a Hospital	25% Coinsurance after first dollar and deductible	\$1,000	Deductible then \$375
Inpatient Hospital Services (per admission)	25% Coinsurance after first dollar and deductible	\$3,000	Deductible then \$1,000
Pharmacy ²	\$10/25%/50% after first dollar and deductible	\$10/\$40/50%	\$10/\$40/\$100
Wellness Benefits	Health Extras SM or Nutrition	Health ExtrasSM or Nutrition	Health Extras SM or Nutrition
Network	IHC	IHC	IHC
Employee Rate	\$917.04	\$997.07	\$986.60
Employee & Child(ren) Rate	\$1,558.97	\$1,695.02	\$1,677.22
Employee & Spouse Rate	\$1,834.08	\$1,994.14	\$1,973.20
Family Rate	\$2,613.56	\$2,841.65	\$2,811.81

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

(E) = Embedded Deductible or Out-of-Pocket Maximum
 (T) = True Family (Non Embedded) Deductible or Out-of-Pocket Maximum

Bolded items indicate updated changes since the 2025 plan year.

2026 Small Group Plans



GOLD LEVEL

(CONTINUED)

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
Q3 RATES
Employee Rate
Employee & Child(ren) Rate
Employee & Spouse Rate
Family Rate

iDirect Gold Copay Option 3	iDirect Gold Copay HSAQ	NEW! iDirect Gold Copay HSAQ Option 2
HealthEquity		HealthEquity
N/A	N/A	N/A
\$775/\$1,550 (T)	\$1,700/\$3,400 (T)	\$1,950/\$3,900 (T)
0%	0%	0%
\$7,500/\$15,000 (E)	\$5,500/\$11,000 (E)	\$6,000/\$12,000 (E)
OUT-OF-NETWORK (OON) ¹		
\$7,500/\$15,000 (T)	\$7,500/\$15,000 (T)	\$7,500/\$15,000 (T)
Deductible then 50%	Deductible then 50%	Deductible then 50%
\$15,000/\$30,000 (E)	\$15,000/\$30,000 (E)	\$15,000/\$30,000 (E)
MEDICAL SERVICES		
Deductible then \$25	Deductible then \$20	Deductible then \$20
Deductible then \$40	Deductible then \$50	Deductible then \$50
\$0	Deductible then \$0	Deductible then \$0
Deductible then \$75	Deductible then \$75	Deductible then \$75
Deductible then \$250	Deductible then \$200	Deductible then \$200
Deductible then \$300	Deductible then \$325	Deductible then \$325
Deductible then \$350	Deductible then \$375	Deductible then \$375
Deductible then \$1,000	Deductible then \$750	Deductible then \$750
PRESCRIPTION DRUGS		
\$10/\$35/50%	Deductible then \$10/\$40/50%	Deductible then \$10/\$40/50%
PRODUCT DETAILS		
Health Extras SM or Nutrition	Health Extras SM or Nutrition	Health ExtrasSM or Nutrition
IHC	IHC	IHC
Q3 RATES		
\$974.51	\$935.33	\$916.20
\$1,656.67	\$1,590.06	\$1,557.54
\$1,949.02	\$1,870.66	\$1,832.40
\$2,777.35	\$2,665.69	\$2,611.17

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

(E) = Embedded Deductible or Out-of-Pocket Maximum
 (T) = True Family (Non Embedded) Deductible or Out-of-Pocket Maximum

Bolded items indicate updated changes since the 2025 plan year.

2026 Small Group Plans



GOLD LEVEL

(CONTINUED)

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
Q3 RATES
Employee Rate
Employee & Child(ren) Rate
Employee & Spouse Rate
Family Rate

NEW! iDirect Gold Coinsurance HSAQ	Passport Plan National Gold HSAQ	Passport Plan Local Gold HSAQ ⁴
HealthEquity	HealthEquity	HealthEquity
N/A	N/A	N/A
\$1,700/\$3,400 (T)	\$1,700/\$3,400 (T)	\$1,700/\$3,400 (T)
20%	Deductible then 20%	Deductible then 20%
\$6,750/\$13,500 (E)	\$6,750/\$13,500 (E)	\$6,750/\$13,500 (E)
\$7,500/\$15,000 (T)	\$7,500/\$15,000 (T)	\$7,500/\$15,000 (T)
Deductible then 50%	Deductible then 50%	Deductible then 50%
\$15,000/\$30,000 (E)	\$15,000/\$30,000 (E)	\$15,000/\$30,000 (E)
Deductible then 20%	Deductible then 20%	Deductible then 20%
Deductible then 20%	Deductible then 20%	Deductible then 20%
Deductible then \$0	Deductible then \$0	Deductible then \$0
Deductible then 20%	Deductible then 20%	Deductible then 20%
Deductible then 20%	Deductible then 20%	Deductible then 20%
Deductible then 20%	Deductible then 20%	Deductible then 20%
Deductible then 20%	Deductible then 20%	Deductible then 20%
Deductible then 20%	Deductible then 20%	Deductible then 20%
Deductible then \$10/20%/50%	Deductible then \$10/20%/50%	Deductible then \$10/20%/50%
Health ExtrasSM or Nutrition	Health Extras SM	Health Extras SM or Nutrition
IHC	IHC + United Nationally	IHC + United Nationally
\$893.66	\$1,139.32	\$976.43
\$1,519.22	\$1,936.84	\$1,659.93
\$1,787.32	\$2,278.64	\$1,952.86
\$2,546.93	\$3,247.06	\$2,782.83

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

(E) = Embedded Deductible or Out-of-Pocket Maximum
 (T) = True Family (Non Embedded) Deductible or Out-of-Pocket Maximum

Bolded items indicate updated changes since the 2025 plan year.

2026 Small Group Plans



SILVER LEVEL

SILVER LEVEL PLANS CONTINUED ON NEXT PAGE >

	Activate Silver	iDirect Silver Copay	iDirect Silver Copay Option 2	iDirect Silver Copay HSAQ
IN-NETWORK (IN)				
First Dollar Coverage	\$500/\$1,000	N/A	N/A	N/A
Deductible	\$3,500/\$7,000 (E)	\$2,250/\$4,500 (T)	\$2,500/\$5,000 (E)	\$2,250/\$4,500 (T)
Coinsurance	40% Coinsurance after first dollar and deductible	0%	0%	0%
Out-of-Pocket Max.	\$9,200/\$18,400 (E)	\$10,150/\$20,300 (E)	\$9,200/\$18,400 (E)	\$8,300/\$16,600 (E)
OUT-OF-NETWORK (OON)¹				
Deductible	\$7,500/\$15,000 (E)	\$7,500/\$15,000 (T)	\$7,500/\$15,000 (E)	\$7,500/\$15,000 (T)
Coinsurance	Deductible then 50%	Deductible then 50%	Deductible then 50%	Deductible then 50%
Out-of-Pocket Max.	\$15,000/\$30,000 (E)	\$15,000/\$30,000 (E)	\$15,000/\$30,000 (E)	\$15,000/\$30,000 (E)
MEDICAL SERVICES				
Primary Care Office Visit	\$35 Copayment after first dollar and deductible	Deductible then \$35	Deductible then \$30	Deductible then \$35
Specialist Office Visit	\$65 Copayment after first dollar and deductible	Deductible then \$65	Deductible then \$65	Deductible then \$65
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	Deductible then \$75	Deductible then \$70	Deductible then \$75
Emergency Room Services	40% Coinsurance after first dollar and deductible	Deductible then \$300	Deductible then \$500	Deductible then \$300
Outpatient Procedures Performed in an Ambulatory Surgery Center	40% Coinsurance after first dollar and deductible	Deductible then \$350	Deductible then \$250	Deductible then \$350
Outpatient Procedures Performed in a Hospital	40% Coinsurance after first dollar and deductible	Deductible then \$400	Deductible then \$300	Deductible then \$400
Inpatient Hospital Services (per admission)	40% Coinsurance after first dollar and deductible	Deductible then \$1,500	Deductible then \$1,500	Deductible then \$1,500
PRESCRIPTION DRUGS				
Pharmacy ²	\$15/40%/50% after first dollar and deductible	\$15/\$50/50%	\$15/ \$75 /\$125	Deductible then \$15/\$50/50%
PRODUCT DETAILS				
Wellness Benefits	Health Extras SM or Nutrition	Health Extras SM or Nutrition	Health Extras SM or Nutrition	Health Extras SM or Nutrition
Network	IHC	IHC	IHC	IHC
Q3 RATES				
Employee Rate	\$803.77	\$854.44	\$879.85	\$852.36
Employee & Child(ren) Rate	\$1,366.41	\$1,452.55	\$1,495.75	\$1,449.01
Employee & Spouse Rate	\$1,607.54	\$1,708.88	\$1,759.70	\$1,704.72
Family Rate	\$2,290.74	\$2,435.15	\$2,507.57	\$2,429.23

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

(E) = Embedded Deductible or Out-of-Pocket Maximum
 (T) = True Family (Non Embedded) Deductible or Out-of-Pocket Maximum

Bolded items indicate updated changes since the 2025 plan year.

2026 Small Group Plans



SILVER LEVEL

(CONTINUED)

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
Q3 RATES
Employee Rate
Employee & Child(ren) Rate
Employee & Spouse Rate
Family Rate

NEW! iDirect Silver Copay HSAQ Option 2	iDirect Silver Coinsurance HSAQ	Passport Plan National Silver HSAQ	Passport Plan Local Silver HSAQ ⁴
HealthEquity	HealthEquity	HealthEquity	HealthEquity
N/A	N/A	N/A	N/A
\$4,000/\$8,000 (T)	\$3,500/\$7,000 (T)	\$3,500/\$7,000 (T)	\$3,500/\$7,000 (T)
0%	Deductible then 25%	Deductible then 25%	Deductible then 25%
\$8,300/\$16,600 (E)	\$7,500/\$15,000 (E)	\$7,500/\$15,000 (E)	\$7,500/\$15,000 (E)
\$7,500/\$15,000 (T)	\$7,500/\$15,000 (T)	\$7,500/\$15,000 (T)	\$7,500/\$15,000 (T)
Deductible then 50%	Deductible then 50%	Deductible then 50%	Deductible then 50%
\$15,000/\$30,000 (E)	\$15,000/\$30,000 (E)	\$15,000/\$30,000 (E)	\$15,000/\$30,000 (E)
Deductible then \$35	Deductible then 25%	Deductible then 25%	Deductible then 25%
Deductible then \$65	Deductible then 25%	Deductible then 25%	Deductible then 25%
Deductible then \$0	Deductible then \$0	Deductible then \$0	Deductible then \$0
Deductible then \$75	Deductible then 25%	Deductible then 25%	Deductible then 25%
Deductible then \$300	Deductible then 25%	Deductible then 25%	Deductible then 25%
Deductible then \$350	Deductible then 25%	Deductible then 25%	Deductible then 25%
Deductible then \$400	Deductible then 25%	Deductible then 25%	Deductible then 25%
Deductible then \$1,500	Deductible then 25%	Deductible then 25%	Deductible then 25%
Deductible then \$15/\$50/50%	Deductible then \$15/\$50/50%	Deductible then \$15/\$50/50%	Deductible then \$15/\$50/50%
Health ExtrasSM or Nutrition	Health Extras SM or Nutrition	Health Extras SM	Health Extras SM or Nutrition
IHC	IHC	IHC + United Nationally	IHC + United Nationally
\$777.92	\$796.75	\$1,014.04	\$870.69
\$1,322.46	\$1,354.48	\$1,723.87	\$1,480.17
\$1,555.84	\$1,593.50	\$2,028.08	\$1,741.38
\$2,217.07	\$2,270.74	\$2,890.01	\$2,481.47

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

(E) = Embedded Deductible or Out-of-Pocket Maximum
 (T) = True Family (Non Embedded) Deductible or Out-of-Pocket Maximum

Bolded items indicate updated changes since the 2025 plan year.

2026 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) 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
Q3 RATES
Employee Rate
Employee & Child(ren) Rate
Employee & Spouse Rate
Family Rate

iDirect Bronze Coinsurance HSAQ	iDirect Bronze MV HSAQ	NEW! iDirect Bronze MV
HealthEquity	HealthEquity	
N/A	N/A	N/A
\$6,000/\$12,000 (E)	\$8,450/\$16,900 (E)	\$10,600/\$21,200 (E)
Deductible then 50%	0%	0%
\$7,500/\$15,000 (E)	\$8,450/\$16,900 (E)	\$10,600/\$21,200 (E)
\$12,500/\$25,000 (E)	\$12,500/\$25,000 (E)	\$12,500/\$25,000 (E)
Deductible then 50%	Deductible then 50%	Deductible then 50%
\$25,000/\$50,000 (E)	\$25,000/\$50,000 (E)	\$25,000/\$50,000 (E)
Deductible then 50%	Deductible then \$0	\$30
Deductible then 50%	Deductible then \$0	Deductible then \$0
Deductible then \$0	Deductible then \$0	\$0
Deductible then 50%	Deductible then \$0	Deductible then \$0
Deductible then 50%	Deductible then \$0	Deductible then \$0
Deductible then 50%	Deductible then \$0	Deductible then \$0
Deductible then 50%	Deductible then \$0	Deductible then \$0
Deductible then 50%	Deductible then \$0	Deductible then \$0
Deductible then 50%	Deductible then \$0	Deductible then \$0
Deductible then 50%	Deductible then \$0	Deductible then \$0
Deductible then 50%	Deductible then \$0	Deductible then \$0
Health Extras SM or Nutrition	Health Extras SM or Nutrition	Health ExtrasSM or Nutrition
IHC	IHC	IHC
\$722.59	\$709.41	\$680.60
\$1,228.40	\$1,206.00	\$1,157.02
\$1,445.18	\$1,418.82	\$1,361.20
\$2,059.38	\$2,021.82	\$1,939.71

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

(E) = Embedded Deductible or Out-of-Pocket Maximum
 (T) = True Family (Non Embedded) Deductible or Out-of-Pocket Maximum

Bolded items indicate updated changes since the 2025 plan year.

2026 Small Group Plans



HEALTHY NY

Standard Healthy NY Gold³

IN-NETWORK (IN)	
First Dollar Coverage	N/A
Deductible	\$775/\$1,550 (E)
Coinsurance	0%
Out-of-Pocket Max.	\$10,150/\$20,300 (E)
OUT-OF-NETWORK (OON) ¹	
Deductible	\$7,500/\$15,000 (E)
Coinsurance	Deductible then 50%
Out-of-Pocket Max.	\$15,000/\$30,000 (E)
MEDICAL SERVICES	
Primary Care Office Visit	Deductible then \$25
Specialist Office Visit	Deductible then \$40
Telemedicine – General Medical & Behavioral Health Services (participating Teladoc® providers only) For Dermatology telemedicine refer to the plan's benefit summary	\$0
Urgent Care	Deductible then \$60
Emergency Room Services	Deductible then \$150
Outpatient Procedures Performed in an Ambulatory Surgery Center	Deductible then \$100
Outpatient Procedures Performed in a Hospital	Deductible then \$100
Inpatient Hospital Services (per admission)	Deductible then \$1,000
PRESCRIPTION DRUGS	
Pharmacy ²	\$10/\$35/\$70
PRODUCT DETAILS	
Wellness Benefits	Health Extras SM or Nutrition
Network	IHC
Q3 RATES	
Employee Rate	\$832.68
Employee & Child(ren) Rate	\$1,415.56
Employee & Spouse Rate	\$1,665.36
Family Rate	\$2,373.14

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

(E) = Embedded Deductible or Out-of-Pocket Maximum
 (T) = True Family (Non Embedded) Deductible or Out-of-Pocket Maximum

Bolded items indicate updated changes since the 2025 plan year.

MORE REASONS TO REDSHIRT.

Supporting the health and well-being of your employees means providing the high-quality coverage they need, the leading RedShirt service they deserve and going above and beyond with a wide range of unique health benefits⁵ they want. With convenient access to tools, resources, savings and more, we make achieving better health easier.

\$250 HEALTH EXTRASSM VISA[®]

A debit card to pay for healthy goods and services.



EARN \$1,000 BACK

Nutrition Benefit⁶ pays members back for buying fresh fruits and vegetables.



EARN UP TO \$30 IN REDSHIRT REWARDSSM

Get rewarded⁷ 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!

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.

\$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.



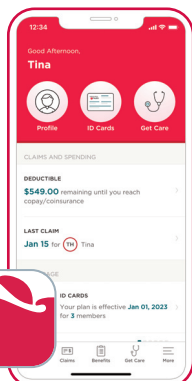
TELEMEDICINE⁵

When members can't reach their primary care physician, Teladoc[®] puts them in touch with a board-certified doctor by phone, mobile app or online video.

PLUS — Vision Discounts with EyeMed providers and 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), e-pay (pay plan bills electronically) and more!

WHERE DEDICATION AND VALUE DRIVE RESULTS.

At Independent Health, our focus is on the personalized, one-on-one attention our members, employers and brokers have come to count on. It starts with an unwavering commitment to doing what's right and working hard to make health care experiences easier through an extensive product portfolio, high-quality coverage and the market-leading RedShirt service you deserve.

9 OUT OF 10
EMPLOYERS
are satisfied with
Independent Health⁸

9 OUT OF 10
MEMBERS
are satisfied and
would re-enroll with
Independent Health⁸

96%
of **EMPLOYERS**
would recommend
Independent Health⁸



THREE YEARS IN A ROW!

Independent Health was rated

5 OUT OF 5

in NCQA's commercial Health Plan Ratings from 2023 to 2025.



RANKED 4 STARS
in the NYS Consumer Rating Guide for **Medicaid** and **Child Health Plus** health plans.



Independent Health's Commercial Employer **NET PROMOTER SCORE (NPS)⁹**

You Deserve the RedShirt Treatment.[®]
Call our RedShirts today at **1-800-453-1910.**
[independenthealth.com](https://www.independenthealth.com)



5. Benefits vary by plan.

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

7. 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.

8. 2024 Consumer and Employer Blinded Stakeholder Studies and 2025 Broker Stakeholder Study.

9. 2024 Independent Health EmployerStakeholder Survey, Large Group NPS.