2024 Small Group Plans

GOLD LEVEL

GOLD LEVEL PLANS CONTINUED ON NEXT PAGE »

Independent Health

	Activate Gold	Standard Healthy NY Gold[4]	iDirect Gold Copay	iDirect Gold Copay Option 2
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)	$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)	**$5,900/$11,800 (E)**	$6,750/$13,500 (E)	**$6,750/$13,500 (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	$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
PRESCRIPTION DRUGS				
Pharmacy[2]	$10/25%/50% after first dollar and deductible	$10/$35/$70	$10/$40/50%	$10/$40/$100
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
Q3 RATES				
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

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

GOLD LEVEL

(CONTINUED)

	iDirect Gold Copay Option 3	iDirect Gold Copay HSAQ	Passport Plan National Gold HSAQ	Passport Plan Local Gold HSAQ[5]
IN-NETWORK (IN)		HealthEquity	HealthEquity	HealthEquity
First Dollar Coverage	N/A	N/A	N/A	N/A
Deductible	$600/$1,200 (T)	**$1,600/$3,200 (T)**	**$1,600/$3,200 (T)**	**$1,600/$3,200 (T)**
Coinsurance	0%	0%	Deductible then 20%	Deductible then 20%
Out-of-Pocket Max.	**$5,900/$11,800 (E)**	$4,500/$9,000 (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)	$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	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%
PRESCRIPTION DRUGS				
Pharmacy[2]	$10/$35/50%	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℠ or Nutrition	Health Extras℠	Health Extras℠ or Nutrition
Network	IHC	IHC	IHC + **United** National	IHC + **United** National
Q3 RATES				
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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