

INDEPENDENT HEALTH'S

2017 Small Group Portfolio

SECOND QUARTER (Q2)



Helping to keep your business healthy by keeping your employees healthy.

Independent Health offers your small business a wide variety of benefits and resources that make it easier for your employees to live a healthy lifestyle. Inside, you'll find our 2017 plan options – each one paired with a wellness benefit, along with a wide range of tools and resources that only Independent Health can offer to help your employees get and stay healthy.

WE'RE HERE WHEN YOU NEED US

Whether it's finding the right health plan, identifying solutions, or getting an answer to your questions, Independent Health will be there when you need us.

Call our RedShirtsSM today at **1-800-453-1910** or your broker coordinator at **(716) 250-7174**, or visit us online at **RedShirtTreatment.com**.

It's all part of the RedShirt[®] Treatment.



2017 Small Group Plans



PLATINUM LEVEL

	Standard Platinum	FlexFit Platinum	iDirect Platinum	Choice Plus Platinum	Passport Plan Platinum
IN-NETWORK (IN)					
Deductible (All plans on this chart accumulate as a true family deductible except standard plans)	\$0	\$0	\$1,000/\$2,000	A: \$0 B: \$1,000/\$2,000	\$0
Coinsurance	0%	0%	0%	A: 0% B: 40%	0%
Out-of-Pocket Maximum (All plans on this chart accumulate as embedded, except iDirect Gold HSAQ & iDirect Platinum)	\$2,000/\$4,000	\$5,000/\$10,000	\$1,000/\$2,000	A: \$5,000/\$10,000 B: \$6,450/\$12,900	\$5,000/\$10,000
OUT-OF-NETWORK (OON)*					
Deductible (All plans on this chart accumulate as a true family deductible except standard plans)	\$2,000/\$4,000	\$2,000/\$4,000	\$2,000/\$4,000	\$2,000/\$4,000	\$2,000/\$4,000
Coinsurance	Deductible then 40%	Deductible then 40%	Deductible then 40%	Deductible then 40%	Deductible then 40%
Out-of-Pocket Maximum (All plans on this chart accumulate as embedded, except iDirect Gold HSAQ & iDirect Platinum)	\$6,750/\$13,500	\$6,750/\$13,500	\$6,750/\$13,500	\$6,750/\$13,500	\$6,750/\$13,500
MEDICAL SERVICES					
Primary Care/Specialist Office Visit	\$15/\$35	\$10/\$30	Deductible then \$0	A: \$10/\$30 B: Deductible then 40%	\$30/\$50
Telemedicine (participating Teladoc® providers only)	\$10	\$10	Deductible then \$0	\$10	\$10
HOSPITAL CARE					
Inpatient Hospital Services (per admission)	\$500	\$500	Deductible then \$0	A: \$500 B: Deductible then 40%	\$500
Outpatient Facility Fee	\$100	\$150	Deductible then \$0	A: \$150 B: Deductible then 40%	\$150
Emergency Room Services	\$100	\$150	Deductible then \$0	\$150	\$150
Urgent Care	\$55	\$75	Deductible then \$0	A: \$75 B: Deductible then 40%	\$75
PRESCRIPTION DRUGS					
Pharmacy	\$10/\$30/\$60	\$4/\$30/\$100	Deductible then \$0	\$4/\$30/\$100	\$4/\$30/50%
PRODUCT DETAILS					
Wellness Benefits	Choice of Health Extras™ or Nutrition Benefit	Choice of Health Extras or Nutrition Benefit	Choice of Health Extras or Nutrition Benefit	Choice of Health Extras or Nutrition Benefit	NY Standard Gym Benefit
Network	IHC	IHC	IHC	Choice Plus High-Performing	IHC & First Health National
HSA-Qualified Plan	No	No	No	No	No
RATES (Q2)					
Employee Rate	\$563.74	\$558.75	\$521.39	\$536.38	\$1,055.47
Employee and Child(ren) Rate	\$958.36	\$949.88	\$886.36	\$911.85	\$1,794.30
Employee and Spouse Rate	\$1,127.48	\$1,117.50	\$1,042.78	\$1,072.76	\$2,110.94
Family Rate	\$1,606.66	\$1,592.44	\$1,485.96	\$1,528.68	\$3,008.09

* OON coverage only applies to non-participating providers outside the 8 counties of WNY
IHC: Independent Health Corporation

2017 Small Group Plans



GOLD LEVEL

	Standard Gold	iDirect Gold HSAQ	iDirect Gold Copay	iDirect Gold Copay HSAQ	Max Gold
IN-NETWORK (IN)					
Deductible (All plans on this chart accumulate as a true family deductible except standard plans)	\$600/\$1,200	\$2,100/\$4,200	\$750/\$1,500	\$1,400/\$2,800	\$1,000/\$2,000
Coinsurance	0%	0%	0%	0%	20%
Out-of-Pocket Maximum (All plans on this chart accumulate as embedded, except iDirect Gold HSAQ & iDirect Platinum)	\$4,000/\$8,000	\$2,100/\$4,200	\$6,350/\$12,700	\$6,000/\$12,000	\$6,350/\$12,700
OUT-OF-NETWORK (OON)*					
Deductible (All plans on this chart accumulate as a true family deductible except standard plans)	\$2,500/\$5,000	\$2,500/\$5,000	\$2,500/\$5,000	\$2,500/\$5,000	\$2,500/\$5,000
Coinsurance	Deductible then 40%	Deductible then 40%	Deductible then 40%	Deductible then 40%	Deductible then 40%
Out-of-Pocket Maximum (All plans on this chart accumulate as embedded, except iDirect Gold HSAQ & iDirect Platinum)	\$10,000/\$20,000	\$10,000/\$20,000	\$10,000/\$20,000	\$10,000/\$20,000	\$10,000/\$20,000
MEDICAL SERVICES					
Primary Care/Specialist Office Visit	Deductible then \$25/\$40	Deductible then \$0	\$15/\$45	Deductible then \$15/\$40	\$15/\$40
Telemedicine (participating Teladoc® providers only)	\$10	Deductible then \$0	\$10	Deductible then \$10	\$10
HOSPITAL CARE					
Inpatient Hospital Services (per admission)	Deductible then \$1,000	Deductible then \$0	Deductible then \$1,000	Deductible then \$500	Deductible then 20%
Outpatient Facility Fee	Deductible then \$100	Deductible then \$0	Deductible then \$150	Deductible then \$100	Deductible then 20%
Emergency Room Services	Deductible then \$150	Deductible then \$0	\$150	Deductible then \$100	Deductible then 20%
Urgent Care	Deductible then \$60	Deductible then \$0	\$75	Deductible then \$75	\$75
PRESCRIPTION DRUGS					
Pharmacy	\$10/\$35/\$70	Deductible then \$0	\$4/\$30/50%	Deductible then \$4/\$30/50%	Tier 1: \$4 (not subject to deductible) Tier 2: Deductible then \$45 Tier 3: Deductible then 50%
PRODUCT DETAILS					
Wellness Benefits	Choice of Health Extras or Nutrition Benefit	Choice of Health Extras or Nutrition Benefit	Choice of Health Extras or Nutrition Benefit	Choice of Health Extras or Nutrition Benefit	Choice of Health Extras or Nutrition Benefit AND Wearable Wireless Activity Tracker Reimbursement
Network	IHC	IHC	IHC	IHC	IHC
HSA-Qualified Plan	No	Yes	No	Yes	No
RATES (Q2)					
Employee Rate	\$494.60	\$441.77	\$493.96	\$441.58	\$475.91
Employee and Child(ren) Rate	\$840.82	\$751.01	\$839.73	\$750.69	\$809.05
Employee and Spouse Rate	\$989.20	\$883.54	\$987.92	\$883.16	\$951.82
Family Rate	\$1,409.61	\$1,259.04	\$1,407.79	\$1,258.50	\$1,356.34

* OON coverage only applies to non-participating providers outside the 8 counties of WNY
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2017 Small Group Plans



GOLD LEVEL (CONTINUED)

	Choice Plus Gold	NY PA Gold	Passport Plan Gold
IN-NETWORK (IN)			
Deductible (All plans on this chart accumulate as a true family deductible except standard plans)	A: \$750/\$1,500 B: \$2,000/\$4,000	\$1,000/\$2,000	\$1,000/\$2,000
Coinsurance	A: 0% B: 50%	20%	20%
Out-of-Pocket Maximum (All plans on this chart accumulate as embedded, except iDirect Gold HSAQ & iDirect Platinum)	A: \$6,350/\$12,700 B: \$6,850/\$13,700	\$5,400/\$10,800	\$5,400/\$10,800
OUT-OF-NETWORK (OON)*			
Deductible (All plans on this chart accumulate as a true family deductible except standard plans)	\$2,500/\$5,000	\$2,500/\$5,000	\$2,500/\$5,000
Coinsurance	Deductible then 50%	Deductible then 40%	Deductible then 40%
Out-of-Pocket Maximum (All plans on this chart accumulate as embedded, except iDirect Gold HSAQ & iDirect Platinum)	\$10,000/ \$20,000	\$10,000/ \$20,000	\$10,000/ \$20,000
MEDICAL SERVICES			
Primary Care/Specialist Office Visit	A: \$15/\$45 B: Deductible then 50%	20%/Deductible then 20%	20%/Deductible then 20%
Telemedicine (participating Teladoc® providers only)	\$10	\$10	\$10
HOSPITAL CARE			
Inpatient Hospital Services (per admission)	Deductible then: A: \$1,000 B: 50%	Deductible then 20%	Deductible then 20%
Outpatient Facility Fee	Deductible then: A: \$150 B: 50%	Deductible then 20%	Deductible then 20%
Emergency Room Services	\$150	Deductible then 20%	Deductible then 20%
Urgent Care	A: \$75 B: Deductible then 50%	Deductible then 20%	Deductible then 20%
PRESCRIPTION DRUGS			
Pharmacy	\$4/\$30/50%	\$4/\$30/50%	\$4/\$30/50%
PRODUCT DETAILS			
Wellness Benefits	Choice of Health Extras or Nutrition Benefit	Choice of Health Extras or Nutrition Benefit	NY Standard Gym Benefit
Network	Choice Plus High-Performing	First Health NY PA	IHC & First Health National
HSA-Qualified Plan	No	No	No
RATES (Q2)			
Employee Rate	\$464.56	\$497.97	\$840.38
Employee and Child(ren) Rate	\$789.75	\$846.55	\$1,428.65
Employee and Spouse Rate	\$929.12	\$995.94	\$1,680.76
Family Rate	\$1,324.00	\$1,419.21	\$2,395.08

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2017 Small Group Plans



SILVER LEVEL

	Standard Silver	iDirect Silver Copay	iDirect Silver Copay HSAQ	iDirect Silver Coinsurance HSAQ	Max Silver
IN-NETWORK (IN)					
Deductible (All plans on this chart accumulate as a true family deductible except standard plans)	\$2,000/\$4,000	\$1,700/\$3,400	\$1,750/\$3,500	\$2,000/\$4,000	\$2,350/\$4,700
Coinsurance	0%	0%	0%	20%	0%
Out-of-Pocket Maximum (All plans on this chart accumulate as embedded, except iDirect Gold HSAQ & iDirect Platinum)	\$6,750/\$13,500	\$7,100/\$14,200	\$6,550/\$13,100	\$6,200/\$12,400	\$7,100/\$14,200
OUT-OF-NETWORK (OON)*					
Deductible (All plans on this chart accumulate as a true family deductible except standard plans)	\$3,000/\$6,000	\$3,000/\$6,000	\$3,000/\$6,000	\$3,000/\$6,000	\$3,000/\$6,000
Coinsurance	Deductible then 40%	Deductible then 40%	Deductible then 40%	Deductible then 40%	Deductible then 40%
Out-of-Pocket Maximum (All plans on this chart accumulate as embedded, except iDirect Gold HSAQ & iDirect Platinum)	\$10,000/\$20,000	\$10,000/\$20,000	\$10,000/\$20,000	\$10,000/\$20,000	\$10,000/\$20,000
MEDICAL SERVICES					
Primary Care/Specialist Office Visit	Deductible then \$30/\$50	Deductible then \$30/\$50	Deductible then \$35/\$60	Deductible then 20%	\$35/Deductible then \$50
Telemedicine (participating Teladoc® providers only)	\$10	\$10	Deductible then \$10	Deductible then \$10	\$10
HOSPITAL CARE					
Inpatient Hospital Services (per admission)	Deductible then \$1,500	Deductible then \$1,000	Deductible then \$1,000	Deductible then 20%	Deductible then \$1,000
Outpatient Facility Fee	Deductible then \$100	Deductible then \$150	Deductible then \$200	Deductible then 20%	Deductible then \$200
Emergency Room Services	Deductible then \$250	Deductible then \$200	Deductible then \$250	Deductible then 20%	Deductible then \$225
Urgent Care	Deductible then \$70	Deductible then \$75	Deductible then \$75	Deductible then 20%	\$50
PRESCRIPTION DRUGS					
Pharmacy	\$10/\$35/\$70	\$10/\$50/50%	Deductible then \$10/\$50/50%	Deductible then \$4/\$30/50%	Tier 1: \$10 (not subject to deductible) Tier 2: Deductible then \$50 Tier 3: Deductible then 50%
PRODUCT DETAILS					
Wellness Benefits	Choice of Health Extras or Nutrition Benefit	Choice of Health Extras or Nutrition Benefit	Choice of Health Extras or Nutrition Benefit	Choice of Health Extras or Nutrition Benefit	Choice of Health Extras or Nutrition Benefit AND Wearable Wireless Activity Tracker Reimbursement
Network	IHC	IHC	IHC	IHC	IHC
HSA-Qualified Plan	No	No	Yes	Yes	No
RATES (Q2)					
Employee Rate	\$430.79	\$429.83	\$398.71	\$392.92	\$422.96
Employee and Child(ren) Rate	\$732.34	\$730.71	\$677.81	\$667.96	\$719.03
Employee and Spouse Rate	\$861.58	\$859.66	\$797.42	\$785.84	\$845.92
Family Rate	\$1,227.75	\$1,225.02	\$1,136.32	\$1,119.82	\$1,205.44

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2017 Small Group Plans



SILVER LEVEL (CONTINUED)

IN-NETWORK (IN)	
Deductible	(All plans on this chart accumulate as a true family deductible except standard plans)
Coinsurance	
Out-of-Pocket Maximum	(All plans on this chart accumulate as embedded, except iDirect Gold HSAQ & iDirect Platinum)
OUT-OF-NETWORK (OON)*	
Deductible	(All plans on this chart accumulate as a true family deductible except standard plans)
Coinsurance	
Out-of-Pocket Maximum	(All plans on this chart accumulate as embedded, except iDirect Gold HSAQ & iDirect Platinum)
MEDICAL SERVICES	
Primary Care/Specialist Office Visit	
Telemedicine (participating Teladoc® providers only)	
HOSPITAL CARE	
Inpatient Hospital Services (per admission)	
Outpatient Facility Fee	
Emergency Room Services	
Urgent Care	
PRESCRIPTION DRUGS	
Pharmacy	
PRODUCT DETAILS	
Wellness Benefits	
Network	
HSA-Qualified Plan	
RATES (Q2)	
Employee Rate	
Employee and Child(ren) Rate	
Employee and Spouse Rate	
Family Rate	

Choice Plus Silver HSAQ	NY PA Silver HSAQ	Passport Plan Silver HSAQ
A: \$1,750/\$3,500 B: \$3,425/\$6,850	\$2,000/\$4,000	\$2,000/\$4,000
A: 0% B: 50%	20%	20%
A: \$6,550/\$13,100 B: \$6,550/\$13,100	\$6,200/\$12,400	\$6,200/\$12,400
\$5,000/\$10,000	\$3,000/\$6,000	\$3,000/\$6,000
Deductible then 50%	Deductible then 40%	Deductible then 40%
\$10,000/\$20,000	\$10,000/\$20,000	\$10,000/\$20,000
Deductible then: A: \$35/\$60 B: 50%	Deductible then 20%	Deductible then 20%
Deductible then \$10	Deductible then \$10	Deductible then \$10
Deductible then: A: \$1,000 B: 50%	Deductible then 20%	Deductible then 20%
Deductible then: A: \$200 B: 50%	Deductible then 20%	Deductible then 20%
Deductible then \$250	Deductible then 20%	Deductible then 20%
Deductible then: A: \$75 B: 50%	Deductible then 20%	Deductible then 20%
Deductible then \$10/\$50/50%	Deductible then \$4/\$30/50%	Deductible then \$4/\$30/50%
Choice of Health Extras or Nutrition Benefit	Choice of Health Extras or Nutrition Benefit	NY Standard Gym Benefit
Choice Plus High-Performing	IHC & First Health NY PA	IHC & First Health National
Yes	Yes	Yes
\$383.54	\$414.52	\$704.44
\$652.02	\$704.68	\$1,197.55
\$767.08	\$829.04	\$1,408.88
\$1,093.09	\$1,181.38	\$2,007.65

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2017 Small Group Plans



BRONZE LEVEL

IN-NETWORK (IN)

Deductible (All plans on this chart accumulate as a true family deductible except standard plans)

Coinsurance

Out-of-Pocket Maximum (All plans on this chart accumulate as embedded, except iDirect Gold HSAQ & iDirect Platinum)

OUT-OF-NETWORK (OON)*

Deductible (All plans on this chart accumulate as a true family deductible except standard plans)

Coinsurance

Out-of-Pocket Maximum (All plans on this chart accumulate as embedded, except iDirect Gold HSAQ & iDirect Platinum)

MEDICAL SERVICES

Primary Care/Specialist Office Visit

Telemedicine (participating Teladoc® providers only)

HOSPITAL CARE

Inpatient Hospital Services (per admission)

Outpatient Facility Fee

Emergency Room Services

Urgent Care

PRESCRIPTION DRUGS

Pharmacy

PRODUCT DETAILS

Wellness Benefits

Network

HSA-Qualified Plan

RATES (Q2)

Employee Rate

Employee and Child(ren) Rate

Employee and Spouse Rate

Family Rate

	Standard Bronze	iDirect Bronze HSAQ	iDirect Bronze MV HSAQ (NEW)	Passport Plan Bronze HSAQ
Deductible	\$4,000/\$8,000	\$4,425/\$8,850	\$6,550/\$13,100	\$4,425/\$8,850
Coinsurance	50%	50%	0%	50%
Out-of-Pocket Maximum	\$7,150/\$14,300	\$6,550/\$13,100	\$6,550/\$13,100	\$6,550/\$13,100
Deductible	\$5,000/\$10,000	\$5,000/\$10,000	\$6,550/\$13,100	\$5,000/\$10,000
Coinsurance	Deductible then 50%	Deductible then 50%	Deductible then 50%	Deductible then 50%
Out-of-Pocket Maximum	\$10,000/\$20,000	\$10,000/\$20,000	\$10,000/\$20,000	\$10,000/\$20,000
Primary Care/Specialist Office Visit	Deductible then 50%	Deductible then 50%	Deductible then \$0	Deductible then 50%
Telemedicine	Deductible then \$10	Deductible then \$10	Deductible then \$0	Deductible then \$10
Inpatient Hospital Services	Deductible then 50%	Deductible then 50%	Deductible then \$0	Deductible then 50%
Outpatient Facility Fee	Deductible then 50%	Deductible then 50%	Deductible then \$0	Deductible then 50%
Emergency Room Services	Deductible then 50%	Deductible then 50%	Deductible then \$0	Deductible then 50%
Urgent Care	Deductible then 50%	Deductible then 50%	Deductible then \$0	Deductible then 50%
Pharmacy	Deductible then \$10/\$35/\$70	Deductible then 50% on all tiers	Deductible then \$0 on all tiers	Deductible then 50% on all tiers
Wellness Benefits	Choice of Health Extras or Nutrition Benefit	Choice of Health Extras or Nutrition Benefit	Choice of Health Extras or Nutrition Benefit	NY Standard Gym Benefit
Network	IHC	IHC	IHC	IHC & First Health National
HSA-Qualified Plan	No	Yes	Yes	Yes
Employee Rate	\$336.92	\$333.03	\$315.86	\$587.43
Employee and Child(ren) Rate	\$572.76	\$566.15	\$536.96	\$998.63
Employee and Spouse Rate	\$673.84	\$666.06	\$631.72	\$1,174.86
Family Rate	\$960.22	\$949.14	\$900.20	\$1,674.18

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