INDEPENDENT HEALTH'S

2020 Small Group Portfolio

FOURTH QUARTER (Q4)

Meet your RedShirt Team with over 83 years of combined experience with Independent Health (L-R): **Carly** (5 years), **Angelo** (13 years), **Tracy** (19 years), **Brian** (9 years), **Kari** (26 years), **Gina** (11 years).

New Products, Lower Rates, Same Great Team.

At Independent Health, we're more than just a health plan. We're a team of RedShirts℠ focused on giving our members the support they need to make the right choices to get and stay healthy. Call your experienced Independent Health account manager today to learn more about our lower rates for 2020 and new innovative plan designs.

New for 2020:

- **Activate Gold** – fully covers initial $750 (single)/$1,500 (family) of medical/pharmacy expenses
- **Passport Plan Local** – access care locally or nationally for the same low copay/coinsurance

Independent Health®

2020 Small Group Plans

PLATINUM LEVEL

Independent Health

	FlexFit Platinum	Choice Plus Platinum[3]	iShare Platinum	NEW! Passport Plan Local Platinum[5]
IN-NETWORK (IN)				
First Dollar Coverage	N/A	N/A	N/A	N/A
Deductible	$0	A: $0 B: $1,500/$3,000 (T)	$0	$0
Coinsurance	0%	A: 0% B: Deductible then 50%	20%	0%
Out-of-Pocket Max.	$5,250/ $10,500 (E)	A: $5,250/$10,500 (E) **B: $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)	$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	$10	A: $10 B: Deductible then 50%	20%	$10
Specialist Office Visit	$40	A: $40 B: Deductible then 50%	20%	$40
Telemedicine including Mental Health and Substance Use Disorder (participating Teladoc® providers only)	$0	$0	$0	$0
Urgent Care	$75	A: $75 B: Deductible then 50%	20%	$75
Emergency Room Services	$150	A: $150 B: $150	20%	$150
Outpatient Procedures Performed in an Ambulatory Surgery Center	**$50**	A: $50 B: Deductible then 50%	20%	$50
Outpatient Procedures Performed in a Hospital	**$75**	A: $75 B: Deductible then 50%	20%	$75
Inpatient Hospital Services (per admission)	$500	A: $500 B: Deductible then 50%	20%	$500
PRESCRIPTION DRUGS				
Pharmacy[2]	$5/$30/50%	$5/$30/50%	**20%**/20%/**50%**	$5/$30/50%
PRODUCT DETAILS				
Wellness Benefits	Health Extras℠ or Nutrition	Health Extras℠ or Nutrition	Health Extras℠ or Nutrition	Health Extras℠ or Nutrition
Network	IHC	Choice Plus	IHC	IHC + First Health Nationally
Q4 RATES				
Employee Rate	$666.09	$632.16	$634.09	$688.42
Employee and Child(ren) Rate	$1,132.35	$1,074.67	$1,077.95	$1,170.31
Employee and Spouse Rate	$1,332.18	$1,264.32	$1,268.18	$1,376.84
Family Rate	$1,898.36	$1,801.66	$1,807.16	$1,962.00

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. National plans available upon request.
6. Wearable Wireless Activity Tracker Reimbursement – Get 50% off the cost; up to $50 each for you and your covered spouse or domestic partner, if applicable.

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

Bolded items indicate updated changes since the 2019 plan year.

2020 Small Group Plans

GOLD LEVEL

GOLD LEVEL PLANS CONTINUED ON NEXT PAGE »

Independent Health

HealthEquity

	NEW! Activate Gold	Standard Healthy NY Gold[4]	iDirect Gold Copay	iDirect Gold Copay HSAQ	Max Gold
IN-NETWORK (IN)					
First Dollar Coverage	$750/$1,500	N/A	N/A	N/A	N/A
Deductible	$1,500/ $3,000 (E)	$600/ $1,200 (E)	$1,250/ $2,500 (T)	**$1,400/ $2,800 (T)**	**$1,500/ $3,000 (T)**
Coinsurance	25% Coinsurance after first dollar and deductible	0%	0%	0%	0%
Out-of-Pocket Max.	$6,750/ $13,500 (E)	$4,000/ $8,000 (E)	**$6,750/ $13,500 (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)	$5,000/ $10,000 (T)
Coinsurance	Deductible then 50%	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)	$10,000/ $20,000 (E)
MEDICAL SERVICES					
Primary Care Office Visit	$20 Copayment after first dollar and deductible	Deductible then $25	$20	**Deductible then $20**	**$20**
Specialist Office Visit	$50 Copayment after first dollar and deductible	Deductible then $40	**Deductible then $50**	**Deductible then $50**	**Deductible then $50**
Telemedicine including Mental Health and Substance Use Disorder (participating Teladoc® providers only)	$0	$0	$0	Deductible then $0	$0
Urgent Care	$75 Copayment after first dollar and deductible	Deductible then $60	$75	Deductible then $75	$75
Emergency Room Services	25% Coinsurance after first dollar and deductible	Deductible then $150	$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 $50**	**Deductible then $50**	**Deductible then $50**
Outpatient Procedures Performed in a Hospital	25% Coinsurance after first dollar and deductible	Deductible then $100	**Deductible then $75**	**Deductible then $75**	**Deductible then $75**
Inpatient Hospital Services (per admission)	25% Coinsurance after first dollar and deductible	Deductible then $1,000	Deductible then $1,000	**Deductible then $1,000**	**Deductible then $1,000**
PRESCRIPTION DRUGS					
Pharmacy[2]	$10/25%/50% after first dollar and deductible	$10/$35/$70	$10/**$40**/50%	Deductible then **$10/$40**/50%	$10/ **Deductible then $40**/ Deductible then 50%
PRODUCT DETAILS					
Wellness Benefits	Health Extras℠ or Nutrition	Health Extras℠ or Nutrition	Health Extras℠ or Nutrition	Health Extras℠ or Nutrition	Health Extras℠ or Nutrition w/ Activity Tracker[6]
Network	IHC	IHC	IHC	IHC	IHC
Q4 RATES					
Employee Rate	$551.90	$513.82	$578.05	$549.37	$561.41
Employee and Child(ren) Rate	$938.23	$873.49	$982.69	$933.93	$954.40
Employee and Spouse Rate	$1,103.80	$1,027.64	$1,156.10	$1,098.74	$1,122.82
Family Rate	$1,572.92	$1,464.39	$1,647.44	$1,565.70	$1,600.02

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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. National plans available upon request.
6. Wearable Wireless Activity Tracker Reimbursement – Get 50% off the cost; up to $50 each for you and your covered spouse or domestic partner, if applicable.

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2020 Small Group Plans

GOLD LEVEL

(CONTINUED)

Independent Health

	iDirect Gold Coinsurance HSAQ	Choice Plus Gold[3]	iShare Gold	NEW! Passport Plan Local Gold HSAQ[5]
	HealthEquity			HealthEquity
IN-NETWORK (IN)				
First Dollar Coverage	N/A	N/A	N/A	N/A
Deductible	**$1,400/ $2,800 (T)**	**A: $1,250/$2,500 (T) B: $2,750/$5,500 (T)**	$0	$1,400/ $2,800 (T)
Coinsurance	Deductible then 20%	A: 0% B: Deductible then 50%	40%	Deductible then 20%
Out-of-Pocket Max.	**$6,750/ $13,500 (E)**	**A: $6,750/$13,500 (E) B: $6,750/$13,500 (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 20%	A: $20 B: Deductible then 50%	40%	Deductible then 20%
Specialist Office Visit	Deductible then 20%	Deductible then **A: $50** B: 50%	40%	Deductible then 20%
Telemedicine including Mental Health and Substance Use Disorder (participating Teladoc® providers only)	Deductible then $0	$0	$0	Deductible then $0
Urgent Care	Deductible then 20%	A: $75 B: Deductible then 50%	40%	Deductible then 20%
Emergency Room Services	Deductible then 20%	A: $150 B: $150	40%	Deductible then 20%
Outpatient Procedures Performed in an Ambulatory Surgery Center	Deductible then 20%	Deductible then **A: $50** B: 50%	40%	Deductible then 20%
Outpatient Procedures Performed in a Hospital	Deductible then 20%	Deductible then **A: $75** B: 50%	40%	Deductible then 20%
Inpatient Hospital Services (per admission)	Deductible then 20%	Deductible then A: $1,000 B: 50%	40%	Deductible then 20%
PRESCRIPTION DRUGS				
Pharmacy[2]	Deductible then 20%/20%/**50%**	$10/**$40**/50%	**40%**/40%/**50%**	Deductible then 20%/20%/50%
PRODUCT DETAILS				
Wellness Benefits	Health Extras℠ or Nutrition	Health Extras℠ or Nutrition	Health Extras℠ or Nutrition	Health Extras℠ or Nutrition
Network	IHC	Choice Plus	IHC	IHC + First Health Nationally
Q4 RATES				
Employee Rate	$532.09	$551.54	$551.34	$549.11
Employee and Child(ren) Rate	$904.55	$937.62	$937.28	$933.49
Employee and Spouse Rate	$1,064.18	$1,103.08	$1,102.68	$1,098.22
Family Rate	$1,516.46	$1,571.89	$1,571.32	$1,564.96

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2020 Small Group Plans

SILVER LEVEL

SILVER LEVEL PLANS CONTINUED ON NEXT PAGE »

Independent Health

HealthEquity | HealthEquity

	Standard Silver	iDirect Silver Copay	iDirect Silver Copay HSAQ	iDirect Silver Coinsurance HSAQ
IN-NETWORK (IN)				
First Dollar Coverage	N/A	N/A	N/A	N/A
Deductible	**$1,300/ $2,600 (E)**	$2,250/ $4,500 (T)	$2,250/ $4,500 (T)	$3,000/ $6,000 (T)
Coinsurance	0%	0%	0%	Deductible then 20%
Out-of-Pocket Max.	**$7,900/ $15,800 (E)**	$7,550/ $15,100 (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 (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 $30	Deductible then $35	Deductible then $35	Deductible then 20%
Specialist Office Visit	Deductible then $50	Deductible then $60	Deductible then $60	Deductible then 20%
Telemedicine including Mental Health and Substance Use Disorder (participating Teladoc® providers only)	$0	$0	Deductible then $0	Deductible then $0
Urgent Care	Deductible then $70	**$75**	Deductible then $75	Deductible then 20%
Emergency Room Services	Deductible then $250	Deductible then $250	Deductible then $250	Deductible then 20%
Outpatient Procedures Performed in an Ambulatory Surgery Center	**Deductible then $150**	Deductible then $175	Deductible then $175	Deductible then 20%
Outpatient Procedures Performed in a Hospital	**Deductible then $150**	Deductible then $200	Deductible then $200	Deductible then 20%
Inpatient Hospital Services (per admission)	Deductible then $1,500	Deductible then $1,000	Deductible then $1,000	Deductible then 20%
PRESCRIPTION DRUGS				
Pharmacy[2]	$10/$35/$70	**$15**/$50/50%	Deductible then $15/$50/50%	Deductible then **20%**/**20%**/50%
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
Q4 RATES				
Employee Rate	$539.92	$502.37	$490.87	$467.15
Employee and Child(ren) Rate	$917.86	$854.03	$834.48	$794.16
Employee and Spouse Rate	$1,079.84	$1,004.74	$981.74	$934.30
Family Rate	$1,538.77	$1,431.75	$1,398.98	$1,331.38

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5. Members must reside in the 8 counties of WNY. National plans available upon request.
6. Wearable Wireless Activity Tracker Reimbursement – Get 50% off the cost; up to $50 each for you and your covered spouse or domestic partner, if applicable.

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2020 Small Group Plans

SILVER LEVEL

(CONTINUED)

Independent Health

HealthEquity | HealthEquity | HealthEquity

	Max Silver	iDirect Silver Blended HSAQ	Choice Plus Silver HSAQ[3]	NEW! Passport Plan Local Silver HSAQ[5]
IN-NETWORK (IN)				
First Dollar Coverage	N/A	N/A	N/A	N/A
Deductible	$2,800/ $5,600 (T)	**$3,000/ $6,000 (T)**	**A: $2,250/$4,500 (T)** B: $3,750/$7,500 (T)	$3,000/ $6,000 (T)
Coinsurance	0%	Deductible then 25%	A: 0% B: Deductible then 50%	Deductible then 20%
Out-of-Pocket Max.	**$7,550/ $15,100 (E)**	**$6,750/ $13,500 (E)**	**A: $6,750/$13,500 (E) B: $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	$35	Deductible then $35	Deductible then A: $35 B: 50%	Deductible then 20%
Specialist Office Visit	**Deductible then $60**	**Deductible then $60**	Deductible then A: $60 B: 50%	Deductible then 20%
Telemedicine including Mental Health and Substance Use Disorder (participating Teladoc® providers only)	$0	**Deductible then $0**	Deductible then $0	Deductible then $0
Urgent Care	**$75**	Deductible then $75	Deductible then A: $75 B: 50%	Deductible then 20%
Emergency Room Services	**Deductible then $250**	Deductible then 25%	Deductible then A: $250 B: $250	Deductible then 20%
Outpatient Procedures Performed in an Ambulatory Surgery Center	Deductible then $175	Deductible then 25%	Deductible then A: $175 B: 50%	Deductible then 20%
Outpatient Procedures Performed in a Hospital	Deductible then $200	Deductible then 25%	Deductible then A: $200 B: 50%	Deductible then 20%
Inpatient Hospital Services (per admission)	Deductible then $1,000	Deductible then 25%	Deductible then **A: $1,000** B: 50%	Deductible then 20%
PRESCRIPTION DRUGS				
Pharmacy[2]	**$15**/ Deductible then $50/ Deductible then 50%	Deductible then **$15**/25%/**50%**	Deductible then $15/$50/50%	Deductible then 20%/20%/50%
PRODUCT DETAILS				
Wellness Benefits	Health Extras℠ or Nutrition w/ Activity Tracker[6]	Health Extras℠ or Nutrition	Health Extras℠ or Nutrition	Health Extras℠ or Nutrition
Network	IHC	IHC	Choice Plus	IHC + First Health Nationally
Q4 RATES				
Employee Rate	$498.08	$461.57	$476.06	$482.10
Employee and Child(ren) Rate	$846.74	$784.67	$809.30	$819.57
Employee and Spouse Rate	$996.16	$923.14	$952.12	$964.20
Family Rate	$1,419.53	$1,315.47	$1,356.77	$1,373.99

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2020 Small Group Plans

BRONZE LEVEL

BRONZE LEVEL PLANS CONTINUED ON NEXT PAGE »

Independent Health

HealthEquity | HealthEquity

	Standard Bronze	iDirect Bronze Blended HSAQ	iDirect Bronze Coinsurance HSAQ
IN-NETWORK (IN)			
First Dollar Coverage	N/A	N/A	N/A
Deductible	**$4,425/ $8,850 (E)**	**$4,000/ $8,000 (E)**	$5,150/ $10,300 (E)
Coinsurance	Deductible then 50%	Deductible then 30%	Deductible then 50%
Out-of-Pocket Max.	**$8,150/ $16,300 (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)	**$7,500/ $15,000 (E)**
Coinsurance	Deductible then 50%	Deductible then 50%	Deductible then 50%
Out-of-Pocket Max.	$10,000/ $20,000 (E)	$10,000/ $20,000 (E)	**$15,000/ $30,000 (E)**
MEDICAL SERVICES			
Primary Care Office Visit	**Deductible then 50% after 3 visits for Primary Care Allowance**	**Deductible then $40**	Deductible then 50%
Specialist Office Visit	Deductible then 50%	**Deductible then $60**	Deductible then 50%
Telemedicine including Mental Health and Substance Use Disorder (participating Teladoc® providers only)	$0	Deductible then $0	Deductible then $0
Urgent Care	Deductible then 50%	**Deductible then $75**	Deductible then 50%
Emergency Room Services	Deductible then 50%	Deductible then 30%	Deductible then 50%
Outpatient Procedures Performed in an Ambulatory Surgery Center	Deductible then 50%	Deductible then 30%	Deductible then 50%
Outpatient Procedures Performed in a Hospital	Deductible then 50%	Deductible then 30%	Deductible then 50%
Inpatient Hospital Services (per admission)	Deductible then 50%	Deductible then 30%	Deductible then 50%
PRESCRIPTION DRUGS			
Pharmacy[2]	Deductible then $10/$35/$70	Deductible then **$20**/30%/**50%**	Deductible then 50%
PRODUCT DETAILS			
Wellness Benefits	Health Extras℠ or Nutrition	Health Extras℠ or Nutrition	Health Extras℠ or Nutrition
Network	IHC	IHC	IHC
Q4 RATES			
Employee Rate	$440.02	$440.21	$429.07
Employee and Child(ren) Rate	$748.03	$748.36	$729.42
Employee and Spouse Rate	$880.04	$880.42	$858.14
Family Rate	$1,254.06	$1,254.60	$1,222.85

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6. Wearable Wireless Activity Tracker Reimbursement – Get 50% off the cost; up to $50 each for you and your covered spouse or domestic partner, if applicable.

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2020 Small Group Plans

BRONZE LEVEL

(CONTINUED)

Independent Health

	HealthEquity		HealthEquity
	iDirect Bronze MV HSAQ	**NEW!** iDirect Bronze MV	**NEW!** Passport Plan Local Bronze HSAQ[5]
IN-NETWORK (IN)			
First Dollar Coverage	N/A	N/A	N/A
Deductible	**$6,750/ $13,500 (E)**	$8,150/ $16,300 (E)	$5,150/ $10,300 (E)
Coinsurance	0%	0%	Deductible then 50%
Out-of-Pocket Max.	**$6,750/ $13,500 (E)**	$8,150/ $16,300 (E)	$6,750/ $13,500 (E)
OUT-OF-NETWORK (OON)[1]			
Deductible	**$7,500/ $15,000 (E)**	$10,000/ $20,000 (E)	$7,500/ $15,000 (E)
Coinsurance	Deductible then 50%	Deductible then 50%	Deductible then 50%
Out-of-Pocket Max.	**$15,000/ $30,000 (E)**	$20,000/ $40,000 (E)	$15,000/ $30,000 (E)
MEDICAL SERVICES			
Primary Care Office Visit	Deductible then $0	Deductible then $0	Deductible then 50%
Specialist Office Visit	Deductible then $0	Deductible then $0	Deductible then 50%
Telemedicine including Mental Health and Substance Use Disorder (participating Teladoc® providers only)	Deductible then $0	$0	Deductible then $0
Urgent Care	Deductible then $0	Deductible then $0	Deductible then 50%
Emergency Room Services	Deductible then $0	Deductible then $0	Deductible then 50%
Outpatient Procedures Performed in an Ambulatory Surgery Center	Deductible then $0	Deductible then $0	Deductible then 50%
Outpatient Procedures Performed in a Hospital	Deductible then $0	Deductible then $0	Deductible then 50%
Inpatient Hospital Services (per admission)	Deductible then $0	Deductible then $0	Deductible then 50%
PRESCRIPTION DRUGS			
Pharmacy[2]	Deductible then $0	Deductible then $0	Deductible then 50%
PRODUCT DETAILS			
Wellness Benefits	Health Extras℠ or Nutrition	Health Extras℠ or Nutrition	Health Extras℠ or Nutrition
Network	IHC	IHC	IHC + First Health Nationally
Q4 RATES			
Employee Rate	$426.38	$405.85	$442.55
Employee and Child(ren) Rate	$724.85	$689.95	$752.34
Employee and Spouse Rate	$852.76	$811.70	$885.10
Family Rate	$1,215.18	$1,156.67	$1,261.27

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. National plans available upon request.
6. Wearable Wireless Activity Tracker Reimbursement – Get 50% off the cost; up to $50 each for you and your covered spouse or domestic partner, if applicable.

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

Bolded items indicate updated changes since the 2019 plan year.

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