

**Independent Health
Quarter 1 Rates 2017**

	Standard Platinum	FlexFit Platinum	iDirect Platinum	Choice Plus Platinum
In Network				
H.S.A. Eligible	Non-Qualified	Non-Qualified	Non-Qualified	Non-Qualified
Deductible (single/family)	\$0	\$0	\$1,000/\$2,000 true family	Network A: \$0 Network B: \$1,000/\$2,000 true family
Coinsurance	0%	0%	0%	Network A: 0% Network B: 40%
Out-of-Pocket Maximum (single/family)	\$2,000/\$4,000 embedded	\$5,000/\$10,000 embedded	\$1,000/\$2,000 true family	Network A: \$5,000/\$10,000 embedded Network B: \$6,450/\$12,900 embedded
Out-of-Network				
Deductible (single/family)	\$2,000/\$4,000 embedded	\$2,000/\$4,000 true family	\$2,000/\$4,000 true family	\$2,000/\$4,000 true family
Coinsurance	Deductible then 40%	Deductible then 40%	Deductible then 40%	Deductible then 40%
Out-of-Pocket Maximum (single/family)	\$6,750/\$13,500 embedded	\$6,750/\$13,500 embedded	\$6,750/\$13,500 true family	\$6,750/\$13,500 embedded
Medical Services				
Primary Office Visits	\$15	\$10	Deductible then \$0	Network A: \$10 Network B: Deductible then 40%
Specialist Office Visits	\$35	\$30	Deductible then \$0	Network A: \$30 Network B: Deductible then 40%
Laboratory	\$35	\$10	Deductible then \$0	Network A: \$0 Network B: Deductible then 40%
Advance Radiology	\$35	\$75	Deductible then \$0	Network A: \$75 Network B: Deductible then 40%
Hospital Care				
Inpatient Hospital	\$500	\$500	Deductible then \$0	Network A: \$500 Network B: Deductible then 40%
Outpatient Surgery Facility	\$100	\$150	Deductible then \$0	Network A: \$150 Network B: Deductible then 40%
Emergency Room	\$100	\$150	Deductible then \$0	\$150
Urgent Care	\$55	\$75	Deductible then \$0	Network A: \$75 Network B: Deductible then 40%
Prescription Drugs				
Pharmacy	\$10/\$30/\$60	\$4/\$30/\$100	Deductible then \$0	\$4/\$30/\$100
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
Rates				
Single	\$555.41	\$550.49	\$513.68	\$528.45
Employee & Child(ren)	\$944.20	\$935.83	\$873.26	\$898.37
Employee & Spouse	\$1,110.82	\$1,100.98	\$1,027.36	\$1,056.90
Family	\$1,582.92	\$1,568.90	\$1,463.99	\$1,506.08

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For a complete benefits summary please contact 716 362 7386.

**Independent Health
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	Standard Gold	iDirect Gold HSAQ	iDirect Gold Copay	iDirect Gold Copay HSAQ	Max Gold	Choice Plus Gold
In Network						
H.S.A. Eligible	Non-Qualified	Qualified	Non-Qualified	Qualified	Non-Qualified	Non-Qualified
Deductible (single/family)	\$600/\$1,200 embedded	\$2,100/\$4,200 true family	\$750/\$1,500 true family	\$1,400/\$2,800 true family	\$1,000/\$2,000 true family	Network A: \$750/\$1,500 true family Network B: \$2,000/\$4,000 true family
Coinsurance	0%	0%	0%	0%	20%	Network A: 0% Network B: 50%
Out-of-Pocket Maximum (single/family)	\$4,000/\$8,000 embedded	\$2,100/\$4,200 fully family	\$6,350/\$12,700 embedded	\$6,000/\$12,000 embedded	\$6,350/\$12,700 embedded	Network A: \$6,350/\$12,700 embedded Network B: \$6,850/\$13,700 embedded
Out-of-Network						
Deductible (single/family)	\$2,500/\$5,000 embedded	\$2,500/\$5,000 true family	\$2,500/\$5,000 true family	\$2,500/\$5,000 true family	\$2,500/\$5,000 true family	\$2,500/\$5,000 true family
Coinsurance	Deductible then 40%	Deductible then 40%	Deductible then 40%	Deductible then 40%	Deductible then 40%	Deductible then 50%
Out-of-Pocket Maximum (single/family)	\$10,000/\$20,000 embedded	\$10,000/\$20,000 true family	\$10,000/\$20,000 embedded	\$10,000/\$20,000 embedded	\$10,000/\$20,000 embedded	\$10,000/\$20,000 embedded
Medical Services						
Primary Office Visits	Deductible then \$25	Deductible then \$0	\$15	Deductible then \$15	\$15	Network A: \$15 Network B: Deductible then 50%
Specialist Office Visits	Deductible then \$40	Deductible then \$0	\$45	Deductible then \$40	\$40	Network A: \$45 Network B: Deductible then 50%
Laboratory	Deductible then \$40	Deductible then \$0	Deductible then \$25	Deductible then \$15	Deductible then 20%	Network A: Deductible then \$25 Network B: Deductible then 50%
Advance Radiology	Deductible then \$40	Deductible then \$0	Deductible then \$100	Deductible then \$75	Deductible then 20%	Network A: Deductible then \$100 Network B: Deductible then 50%
Hospital Care						
Inpatient Hospital	Deductible then \$1000	Deductible then \$0	Deductible then \$1,000	Deductible then \$500	Deductible then 20%	Network A: Deductible then \$1,000 Network B: Deductible then 50%
Outpatient Surgery Facility	Deductible then \$100	Deductible then \$0	Deductible then \$150	Deductible then \$100	Deductible then 20%	Network A: Deductible then \$150 Network B: Deductible then 50%
Emergency Room	Deductible then \$150	Deductible then \$0	\$150	Deductible then \$100	Deductible then 20%	\$150
Urgent Care	Deductible then \$60	Deductible then \$0	\$75	Deductible then \$75	\$75	Network A: \$75 Network B: Deductible then 50%
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%	\$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	Choice of Health Extras or Nutrition Benefit AND Wearable Wireless Activity Tracker Reimbursement	Choice of Health Extras OR Nutrition Benefit
Rates						
Single	\$487.29	\$435.24	\$486.66	\$435.05	\$468.89	\$457.69
Employee & Child(ren)	\$828.39	\$739.91	\$827.32	\$739.59	\$797.11	\$778.07
Employee & Spouse	\$974.58	\$870.48	\$973.32	\$870.10	\$937.78	\$915.38
Family	\$1,388.78	\$1,240.43	\$1,386.98	\$1,239.89	\$1,336.34	\$1,304.42

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**Independent Health
Quarter 1 Rates 2017**

	Standard Silver	iDirect Silver Copay	iDirect Silver Copay HSAQ	iDirect Silver Coinsurance HSAQ	Max Silver	Choice Plus Silver HSAQ
In Network						
H.S.A. Eligible	Non-Qualified	Non-Qualified	Qualified	Qualified	Non-Qualified	Qualified
Deductible (single/family)	\$2,000/\$4,000 embedded	\$1,700/\$3,400 true family	\$1,750/\$3,500 true family	\$2,000/\$4,000 true family	\$2,350/\$4,700 true family	Network A: \$1,750/\$3,500 true family Network B: \$3,425/\$6,850 true family
Coinsurance	0%	0%	0%	20%	0%	Network A: 0% Network B: 50%
Out-of-Pocket Maximum (single/family)	\$6,750/\$13,500 embedded	\$7,100/\$14,200 embedded	\$6,550/\$13,100 embedded	\$6,200/\$12,400 embedded	\$7,100/\$14,200 embedded	Network A: \$6,550/\$13,100 embedded Network B: \$6,550/\$13,100 embedded
Out-of-Network						
Deductible (single/family)	\$3,000/\$6,000 embedded	\$3,000/\$6,000 true family	\$3,000/\$6,000 true family	\$3,000/\$6,000 true family	\$3,000/\$6,000 true family	\$5,000/\$10,000 true family
Coinsurance	Deductible then 40%	Deductible then 40%	Deductible then 40%	Deductible then 40%	Deductible then 40%	Deductible then 50%
Out-of-Pocket Maximum (single/family)	\$10,000/\$20,000 embedded	\$10,000/\$20,000 embedded	\$10,000/\$20,000 embedded	\$10,000/\$20,000 embedded	\$10,000/\$20,000 embedded	\$10,000/\$20,000 embedded
Medical Services						
Primary Office Visits	Deductible then \$30	Deductible then \$30	Deductible then \$35	Deductible then 20%	\$35	Network A: Deductible then \$35 Network B: Deductible then 50%
Specialist Office Visits	Deductible then \$50	Deductible then \$50	Deductible then \$60	Deductible then 20%	Deductible then \$50	Network A: Deductible then \$60 Network B: Deductible then 50%
Laboratory	Deductible then \$50	Deductible then \$30	Deductible then \$40	Deductible then 20%	Deductible then \$35	Network A: Deductible then \$40 Network B: Deductible then 50%
Advanced Radiology	Deductible then \$50	Deductible then \$100	Deductible then \$150	Deductible then 20%	Deductible then \$150	Network A: Deductible then \$150 Network B: Deductible then 50%
Hospital Care						
Inpatient Hospital	Deductible then \$1,500	Deductible then \$1000	Deductible then \$1000	Deductible then 20%	Deductible then \$1,000	Network A: Deductible then \$1,000 Network B: Deductible then 50%
Outpatient Surgery Facility	Deductible then \$100	Deductible then \$150	Deductible then \$200	Deductible then 20%	Deductible then \$200	Network A: Deductible then \$200 Network B: Deductible then 50%
Emergency Room	Deductible then \$250	Deductible then \$200	Deductible then \$250	Deductible then 20%	Deductible then \$225	Deductible then \$250
Urgent Care	Deductible then \$70	Deductible then \$75	Deductible then \$75	Deductible then 20%	\$50	Network A: Deductible then \$75 Network B: Deductible then 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%	Deductible then \$10/\$50/50%
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	Choice of Health Extras or Nutrition Benefit
Rates						
Single	\$424.43	\$423.49	\$392.82	\$387.11	\$416.71	\$377.87
Employee & Child(ren)	\$721.53	\$719.93	\$667.79	\$658.09	\$708.41	\$642.38
Employee & Spouse	\$848.86	\$846.98	\$785.64	\$774.22	\$833.42	\$755.74
Family	\$1,209.63	\$1,206.95	\$1,119.54	\$1,103.26	\$1,187.62	\$1,076.93

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**Independent Health
Quarter 1 Rates 2017**

	Standard Bronze	iDirect Bronze HSAQ	iDirect Bronze MV HSAQ (NEW)
In Network			
H.S.A. Eligible	Non- Qualified	Qualified	Qualified
Deductible (single/family)	\$4,000/\$8,000 embedded	\$4,425/\$8,850 true family	\$6,550/\$13,100 true family
Coinsurance	50%	50%	0%
Out-of-Pocket Maximum (single/family)	\$7,150/\$14,300 embedded	\$6,550/\$13,100 embedded	\$6,550/\$13,100 embedded
Out-of-Network			
Deductible (single/family)	\$5,000/\$10,000 embedded	\$5,000/\$10,000 true family	\$6,550/\$13,100 true family
Coinsurance	Deductible then 50%	Deductible then 50%	Deductible then 50%
Out-of-Pocket Maximum (single/family)	\$10,000/\$20,000 embedded	\$10,000/\$20,000 embedded	\$10,000/\$20,000 embedded
Medical Services			
Primary Office Visits	Deductible then 50%	Deductible then 50%	Deductible then \$0
Specialist Office Visits	Deductible then 50%	Deductible then 50%	Deductible then \$0
Laboratory	Deductible then 50%	Deductible then 50%	Deductible then \$0
Advance Radiology	Deductible then 50%	Deductible then 50%	Deductible then \$0
Hospital Care			
Inpatient Hospital	Deductible then 50%	Deductible then 50%	Deductible then \$0
Outpatient Surgery Facility	Deductible then 50%	Deductible then 50%	Deductible then \$0
Emergency Room	Deductible then 50%	Deductible then 50%	Deductible then \$0
Urgent Care	Deductible then 50%	Deductible then 50%	Deductible then \$0
Prescription Drugs			
Pharmacy	Deductible then \$10/\$35/\$70	Deductible then 50% on all tiers	Deductible then \$0 on all tiers
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
Rates			
Single	\$331.94	\$328.11	\$311.19
Employee & Child(ren)	\$564.30	\$557.79	\$529.02
Employee & Spouse	\$663.88	\$656.22	\$622.38
Family	\$946.03	\$935.11	\$886.89

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**Independent Health
Quarter 1 Rates 2017**

	NY / PA Gold	NY / PA Silver HSAQ
In Network		
H.S.A. Eligible	Non-Qualified	Qualified
Deductible (single/family)	\$1,000/\$2,000 true family	\$2,000/\$4,000 true family
Coinsurance	20%	20%
Out-of-Pocket Maximum (single/family)	\$5,400/\$10,800 embedded	\$6,200/\$12,400 embedded
Out-of-Network		
Deductible (single/family)	\$2,500/\$5,000 true family	\$3,000/\$6,000 true family
Coinsurance	Deductible then 40%	Deductible then 40%
Out-of-Pocket Maximum (single/family)	\$10,000/\$20,000 embedded	\$10,000/\$20,000 embedded
Medical Services		
Primary Office Visits	20%	Deductible then 20%
Specialist Office Visits	Deductible then 20%	Deductible then 20%
Laboratory	Deductible then 20%	Deductible then 20%
Advanced Radiology	Deductible then 20%	Deductible then 20%
Hospital Care		
Inpatient Hospital	Deductible then 20%	Deductible then 20%
Outpatient Surgery Facility	Deductible then 20%	Deductible then 20%
Emergency Room	Deductible then 20%	Deductible then 20%
Urgent Care	Deductible then 20%	Deductible then 20%
Prescription Drugs		
Pharmacy	\$4/\$30/50%	Deductible then \$4/\$30/50%
Product Details		
Wellness Benefits	Choice of Health Extras or Nutrition Benefit	Choice of Health Extras or Nutrition Benefit
Rates		
Single	\$490.61	\$408.39
Employee & Child(ren)	\$834.04	\$694.26
Employee & Spouse	\$981.22	\$816.78
Family	\$1,398.24	\$1,163.91

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**Independent Health
Quarter 1 Rates 2017**

	Passport Plan Platinum	Passport Plan Gold	Passport Plan Silver HSAQ	Passport Plan Bronze HSAQ
In Network				
H.S.A. Eligible	Non-Qualified	Non-Qualified	Qualified	Qualified
Deductible (single/family)	\$0	\$1,000/\$2,000 true family	\$2,000/\$4,000 true family	\$4,425/\$8,850 true family
Coinsurance	0%	20%	20%	50%
Out-of-Pocket Maximum (single/family)	\$5,000/\$10,000 embedded	\$5,400/\$10,800 embedded	\$6,200/\$12,400 embedded	\$6,550/\$13,100 embedded
Out-of-Network				
Deductible (single/family)	\$2,000/\$4,000 tue family	\$2,500/\$5,000 true family	\$3,000/\$6,000 true family	\$5,000/\$10,000 true family
Coinsurance	Deductible then 40%	Deductible then 40%	Deductible then 40%	Deductible then 50%
Out-of-Pocket Maximum (single/family)	\$6,750/\$13,500 embedded	\$10,000/\$20,000 embedded	\$10,000/\$20,000 embedded	\$10,000/\$20,000 embedded
Medical Services				
Primary Office Visits	\$30	20%	Deductible then 20%	Deductible then 50%
Specialist Office Visits	\$50	Deductible then 20%	Deductible then 20%	Deductible then 50%
Laboratory	\$10	Deductible then 20%	Deductible then 20%	Deductible then 50%
Advanced Radiology	\$75	Deductible then 20%	Deductible then 20%	Deductible then 50%
Hospital Care				
Inpatient Hospital	\$500	Deductible then 20%	Deductible then 20%	Deductible then 50%
Outpatient Surgery Facility	\$150	Deductible then 20%	Deductible then 20%	Deductible then 50%
Emergency Room	\$150	Deductible then 20%	Deductible then 20%	Deductible then 50%
Urgent Care	\$75	Deductible then 20%	Deductible then 20%	Deductible then 50%
Prescription Drugs				
Pharmacy	\$4/\$30/50%	\$4/\$30/50%	Deductible then \$4/\$30/50%	Deductible then 50% on all tiers
Product Details				
Wellness Benefits	NY Standard Gym Benefit	NY Standard Gym Benefit	NY Standard Gym Benefit	NY Standard Gym Benefit
Rates				
Single	\$1,039.87	\$827.96	\$694.03	\$578.75
Employee & Child(ren)	\$1,767.78	\$1,407.53	\$1,179.85	\$983.88
Employee & Spouse	\$2,079.74	\$1,655.92	\$1,388.06	\$1,157.50
Family	\$2,963.63	\$2,359.69	\$1,977.99	\$1,649.44

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