2018 Small Group Plans

IN-NETWORK	FlexFit Platinum	iDirect Silver Copay	iDirect Silver Coinsurance	iDirect Bronze
Deductible	$0	$2,000/$4,000	$2,500/$5,000	$4,425/$8,850
Coinsurance	0%	0%	20%	50%
Out-of-Pocket Max	$5,000/$10,000	$7,350/$14,700	$6,650/$13,100	$6,650/$13,100
OUT-OF-NETWORK				
Deductible	$2,000/$4,000	$3,000/$6,000	$3,000/$6,000	$5,000/$10,000
Coinsurance	40% after deductible	40% after deductible	40% after deductible	50% after deductible
Out-of-Pocket Max	$6,750/$13,500	$10,000/$20,000	$10,000/$20,000	$10,000/$20,000
MEDICAL SERVICES				
Primary Care Office Visits	$20	$30 after deductible	20% after deductible	50%after deductible
Specialist Office Visits	$30	$50 after deductible	20% after deductible	50%after deductible
Inpatient Hospital Services	$500 copayment	$1,000 Copay after deductible	20% after deductible	50%after deductible
Outpatient Surgery Services	$0	$50 after deductible	20% after deductible	50%after deductible
Out Patient Facility Fee	$150	$150 after deductible	20% after deductible	50%after deductible
Emergency Room	$150	$200 after deductible	20% after deductible	50%after deductible
Urgent Care	$75	$75 after deductible	20% after deductible	50%after deductible
PRESCRIPTION DRUGS				
Pharmacy	$4/$30/$100	$10/$50/50%	$15/$50/50% after deductible	50% on all tiers after deductible
PRODUCT DETAILS				
Wellness Benefits	Health Extras or Nutrition	Health Extras or Nutrition	Health Extras or Nutrition	Health Extras or Nutrition
RATES				
Employee Rate	$668.91	$493.12	$455.32	$396.28
Employee & Child(ren) Rate	$1,137.15	$838.30	$774.04	$673.68
Employee & Spouse Rate	$1,337.82	$986.24	$910.64	$792.56
Family Rate	$1,906.39	$1,405.39	$1,297.66	$1,129.40