2021 Small Group Plans

IN-NETWORK	FlexFit Platinum	iDirect Silver Copay	iDirect Silver Coinsurance	iDirect Bronze
Deductible	$0	$2,250/$4,500	$3,000/$6,000	$5,600/$11,200
Coinsurance	0%	0%	20% after deductible	50% after deductible
Out-of-Pocket Max	$5,250/$10,500	$7,550/$15,100	$6,950/$13,900	$6,950/$13,900

OUT-OF-NETWORK				
Deductible	$5,000/$10,000	$5,000/$10,000	$5,000/$10,000	$7,500/$15,000
Coinsurance	20% after deductible	50% after deductible	50% after deductible	50% after deductible
Out-of-Pocket Max	$10,000/$20,000	$10,000/$20,000	$10,000/$20,000	$15,000/$30,000

MEDICAL SERVICES				
Primary Care Office Visits	$10	$35 after deductible	20% after deductible	50%after deductible
Specialist Office Visits	$40	$60 after deductible	20% after deductible	50%after deductible
Telemedicine	$10	$35 after deductible	20% after deductible	50%after deductible
Inpatient Hospital Services	$500	$1,000 Copay after deductible	20% after deductible	50%after deductible
Outpatient Surgery Services	$50	$50 after deductible	20% after deductible	50%after deductible
Out Patient Facility Fee	$75	$175 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	$5/$30/50%	$10/$50/50%	20%/20%/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	$615.10	$468.13	$435.69	$391.26
Employee & Child(ren) Rate	$1045.67	$795.82	$740.67	$665.14
Employee & Spouse Rate	$1230.20	$936.26	$871.38	$782.52
Family Rate	$1753.04	$1334.17	$1241.72	$1115.09