



**Independent Health**

**Amherst Chamber of Commerce  
Medical Rates for Individuals  
January 1, 2018 - December 31, 2018**  
No Application Fee Required

Plans are designed based on 4 metal levels that match the percentage of costs covered.  
Generally, as the metal level goes down, the monthly premium goes down while out-of-pocket cost share goes up.

**PLATINUM 90%**  
costs covered by your premium  
(10% out-of-pocket costs)

**GOLD 80%**  
costs covered by your premium  
(20% out-of-pocket costs)

**Silver 70%**  
costs covered by your premium  
(30% out-of-pocket costs)

**Bronze 60%**  
costs covered by your premium  
(40% out-of-pocket costs)



	PLATINUM		GOLD				SILVER				BRONZE				CATASTROPHIC							
	Standard Platinum	Flexfit Platinum	Standard Gold	iDirect Gold Copay	Choice Plus Gold <sup>5</sup>	Standard Silver	iDirect Silver Copay HSAQ	Choice Plus Silver Copay HSAQ <sup>5</sup>	Standard Bronze	iDirect Bronze HSAQ	Standard Catastrophic <sup>1</sup>											
<b>In-Network</b>					A: Catholic Medical Partners B: IH's Full Provider Network			A: Catholic Medical Partners B: IH's Full Provider Network			<b>Must be under age 30</b>											
Deductible <sup>2</sup>	\$0	\$0	\$600/\$1,200	\$1,000/\$2,000	A: \$1,000/\$2,000 B: \$2,000/\$4,000	\$2,000/\$4,000	\$2,000/\$4,000	A: \$2,100/\$4,200 B: \$3,425/\$6,850	\$4,000/\$8,000	\$4,425/\$8,850	\$7,350/\$14,700											
Coinsurance	N/A	N/A	N/A	N/A	A: \$0 B: 50%	N/A	N/A	A: \$0 B: 50%	50%	50%	N/A											
Out of Pocket Maximum <sup>2</sup>	\$2,000/\$4,000	\$6,500/\$13,000	\$4,000/\$8,000	\$7,350/\$14,700	A: \$7,350/\$14,700 B: \$7,350/\$14,700	\$6,750/\$13,500	\$6,550/\$13,100	A: \$6,550/\$13,100 B: \$6,550/\$13,100	\$7,150/\$14,300	\$6,550/\$13,100	\$7,350/\$14,700											
<b>Out-of-Network</b>																						
Deductible <sup>2</sup>	\$2,000/\$4,000	\$2,000/\$4,000	\$2,500/\$5,000	\$2,500/\$5,000	\$2,500/\$5,000	\$3,000/\$6,000	\$3,000/\$6,000	\$5,000/\$10,000	\$5,000/\$10,000	\$5,000/\$10,000	N/A											
Coinsurance	40% after deductible	40% after deductible	40% after deductible	40% after deductible	50% after deductible	40% after deductible	40% after deductible	50% after deductible	50% after deductible	50% after deductible	100%											
Out of Pocket Maximum <sup>2</sup>	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	N/A											
<b>Medical Services</b>																						
Primary Care Office Visit	\$15	\$15	\$25 after deductible	\$15	A: \$15 B: 50% after deductible	\$30 after deductible	\$35 after deductible	A: \$35 after deductible B: 50% after deductible	50% after deductible	50% after deductible	\$0 after deductible 3 visits											
Specialist Office Visit	\$35	\$30	\$40 after deductible	\$45	A: \$45 B: 50% after deductible	\$50 after deductible	\$60 after deductible	A: \$60 after deductible B: 50% after deductible	50% after deductible	50% after deductible	\$0 after deductible											
Telemedicine (participating Teladoc® providers only)	\$0	\$0	\$0	\$0	A: \$0 B: N/A	\$0	\$0 after deductible	A: \$0 after deductible B: N/A	\$0 after deductible	\$0 after deductible	\$0 after deductible											
Inpatient Hospital Services (per admission)	\$500 copay/admission	\$500 copay/admission	\$1,000 copay/admission after deductible	\$1,000 copay/admission after deductible	A: \$1,000 copay/admission after deductible B: 50% coinsurance after ded	\$1,500 copay/admission after deductible	\$1,000 copay/admission after deductible	A: \$1,000 copay/admission after deductible B: 50% coinsurance after ded	50% after deductible	50% after deductible	\$0 after deductible											
Outpatient Surgery Physician Services	\$100	\$0	\$100 after deductible	\$45 after deductible	A: \$45 after deductible B: 50% coinsurance after ded	\$100 after deductible	\$60 after deductible	A: \$0 after deductible B: 50% coinsurance after ded	50% after deductible	50% after deductible	\$0 after deductible											
Outpatient Facility Fee	\$100	\$50	\$100 after deductible	\$150 after deductible	A: \$150 after deductible B: 50% coinsurance	\$100 after deductible	\$200 after deductible	A: \$100 after deductible B: 50% coinsurance after ded	50% after deductible	50% after deductible	\$0 after deductible											
Emergency Room Services	\$100	\$150	\$150 after deductible	\$200	A: \$200 B: \$200	\$250 after deductible	\$250 after deductible	A: \$250 after deductible B: \$250 after deductible	50% after deductible	50% after deductible	\$0 after deductible											
Urgent Care	\$55	\$75	\$60 after deductible	\$75	A: \$75 B: 50% after deductible	\$70 after deductible	\$75 after deductible	A: \$75 after deductible B: 50% after deductible	50% after deductible	50% after deductible	\$0 after deductible											
Pharmacy <sup>3</sup>	\$10/\$30/\$60	\$10/\$50/50%	\$10/\$35/\$70	\$10/\$30/50%	\$10/\$30/50%	\$10/\$35/\$70	\$10/\$50/50% after deductible	\$10/\$50/50% after deductible	\$10/\$35/\$70 after deductible	50% on all tiers after deductible	\$0 on all tiers after deductible											
Health & Wellness Benefit	\$250 Wellness Card or Nutrition Benefit	\$250 Wellness Card or Nutrition Benefit	\$250 Wellness Card or Nutrition Benefit	\$250 Wellness Card or Nutrition Benefit	\$250 Wellness Card or Nutrition Benefit	\$250 Wellness Card or Nutrition Benefit	\$250 Wellness Card or Nutrition Benefit	\$250 Wellness Card or Nutrition Benefit	\$250 Wellness Card or Nutrition Benefit	\$250 Wellness Card or Nutrition Benefit	\$250 Wellness Card or Nutrition Benefit											
HSA-Qualified	No	No	No	No	No	No	HSA-Qualified	HSA-Qualified	No	HSA-Qualified	No											
<b>Monthly/Quarterly Rates</b>	Monthly	Quarterly	Monthly	Quarterly	Monthly	Quarterly	Monthly	Quarterly	Monthly	Quarterly	Monthly	Quarterly	Monthly	Quarterly	Monthly	Quarterly	Monthly	Quarterly	Monthly	Quarterly	Monthly	Quarterly
Individual	\$ 833.15	\$ 2,449.45	\$ 773.02	\$ 2,269.06	\$695.95	\$2,037.85	\$685.78	\$2,007.34	\$633.89	\$1,851.67	\$582.87	\$1,698.61	\$549.83	\$1,599.49	\$509.46	\$1,478.38	\$469.92	\$1,359.76	\$466.28	\$1,348.84	\$285.34	\$806.02
Individual/Child(ren)	\$ 1,398.86	\$ 4,146.58	\$ 1,296.63	\$ 3,839.89	\$1,165.62	\$3,446.86	\$1,148.33	\$3,394.99	\$1,059.77	\$3,129.31	\$973.38	\$2,870.14	\$917.21	\$2,701.63	\$848.58	\$2,495.74	\$781.36	\$2,294.08	\$775.18	\$2,275.54	\$467.58	\$1,352.74
Individual/Spouse	\$ 1,641.30	\$ 4,873.90	\$ 1,521.04	\$ 4,513.12	\$1,366.90	\$4,050.70	\$1,346.56	\$3,989.68	\$1,242.38	\$3,677.14	\$1,140.74	\$3,372.22	\$1,074.66	\$3,173.98	\$993.92	\$2,931.76	\$914.84	\$2,694.52	\$907.56	\$2,672.68	\$545.68	\$1,587.04
Child Only Rate	\$ 357.96	\$ 1,023.88	N/A	N/A	\$301.43	\$854.29	N/A	N/A	N/A	N/A	\$254.84	\$714.52	N/A	N/A	N/A	N/A	\$208.31	\$574.93	N/A	N/A	N/A	N/A
Family	\$ 2,328.23	\$ 6,934.69	\$ 2,156.86	\$ 6,420.58	\$1,937.21	\$5,761.63	\$1,908.22	\$5,674.66	\$1,759.77	\$5,229.31	\$1,614.93	\$4,794.79	\$1,520.77	\$4,512.31	\$1,405.71	\$4,167.13	\$1,293.02	\$3,829.06	\$1,282.65	\$3,797.95	\$766.97	\$2,250.91

<sup>1</sup> Subscriber must be under the age of 30 at the beginning of the plan year or meet federal eligibility requirements.

<sup>2</sup> For Individual & Child(ren), Individual & Spouse, & Family Plans, the deductible and out-of-pocket maximum is two times the individual plan deductible.

<sup>3</sup> All pharmacy copays/coinsurance accumulate to out-of-pocket maximums.

<sup>4</sup> Out-of-Network coverage only applies to non-participating providers outside the 8 counties of WNY.

<sup>5</sup> Offered in Erie & Niagara Counties only.