

Amherst Chamber of Commerce Medical Rates for Small Group January 1, 2019 - December 31, 2019																													
	PLATINUM						GOLD		SILVER								BRONZE												
	BlueCross BlueShield Platinum HMO 110 Plus		BlueCross BlueShield Platinum PPO 843		Independent Health FlexFit Platinum		Independent Health iDirect Gold Copay HSAQ		BlueCross BlueShield Silver POS 8100		BlueCross BlueShield Silver 7100 align Tiered		Independent Health iDirect Silver Copay		Independent Health iDirect Silver Coinsurance HSAQ		Independent Health Choice Plus Silver HSAQ (Catholic Health facilities)		Independent Health iDirect Bronze HSAQ										
In- Network											(Kaleida Facilities Only)						Network A (Tailored)		Network B (Full)										
Deductible	\$0		\$0		\$0		\$1,500/\$3,000		\$2,900/\$5,800 true family		\$1,700/\$3,400 true family		\$2,250/\$4,500		\$3,000/\$6,000		\$2,600/\$5,200		\$3,750/\$7,500										
Coinsurance	0%		20%		Applies where indicated		Applies where indicated		35% after deductible		0%		Applies where indicated		20% after deductible		Applies where indicated		50% after deductible										
Out of Pocket Maximum	\$4,500/\$9,000 embedded		\$2,000/\$4,000 embedded		\$5,250/\$10,500		\$5,750/\$11,500		\$6,650/\$13,300 embedded		\$6,500/\$13,000 embedded		\$7,550/\$15,100		\$6,650/\$13,300		\$6,650/\$13,300		\$6,650/\$13,300										
Out-Of-Network																													
Deductible	\$5,000/\$10,000 embedded		\$5,000/\$10,000 embedded		\$5,000/\$10,000		\$5,000/\$10,000		\$5,000/\$10,000 true family		\$5,000/\$10,000 true family		\$5,000/\$10,000		\$5,000/\$10,000		\$5,000/\$10,000		\$8,000/\$16,000										
Coinsurance	50% after deductible		50% after deductible		50% after deductible		50% after deductible		50% after deductible		50% after deductible		50% after deductible		50% after deductible		50% after deductible		50% after deductible										
Out of Pocket Maximum	\$10,000/\$20,000 embedded		\$10,000/\$20,000 embedded		\$10,000/\$20,000		\$10,000/\$20,000		\$10,000/\$20,000 embedded		\$10,000/\$20,000 embedded		\$10,000/\$20,000		\$10,000/\$20,000		\$10,000/\$20,000		\$10,000/\$20,000										
Medical Services																													
PCP	\$5		20% after deductible		\$10		\$15 after deductible		35% after deductible		\$25 after deductible		\$35 after deductible		20% after deductible		\$35 after deductible		50% after deductible										
Specialist	\$25		20% after deductible		\$40		\$40 after deductible		35% after deductible		\$50 after deductible		\$60 after deductible		20% after deductible		\$60 after deductible		50% after deductible										
Diagnostic X Ray	\$25		20% after deductible		\$30		\$15 after deductible		35% after deductible		\$50 after deductible		\$60 after deductible		20% after deductible		\$60 after deductible		50% after deductible										
Laboratory Testing	\$0		20% after deductible		\$0		\$0 after deductible		35% after deductible		\$50 after deductible		\$40 after deductible		20% after deductible		\$40 after deductible		50% after deductible										
Chiropractic Services	\$5		20% after deductible		\$40		\$40 after deductible		35% after deductible		\$25 after deductible		\$60 after deductible		20% after deductible		\$60 after deductible		50% after deductible										
Maternity Services: Prenatal/Postnatal Care	\$5		20% after deductible		\$0		\$0 after deductible		35% after deductible		\$25 after deductible		\$0		\$0		\$0		\$0										
Inpatient Maternity	\$500		20% after deductible		\$500		\$500 after deductible		\$1,000 after deductible		\$750 after deductible		\$1,000 after deductible		20% after deductible		30% after deductible^		50% after deductible										
Hospital Services																													
Inpatient Hospital (per admission)	\$500		20% after deductible		\$500		\$500 after deductible		\$1,000 after deductible		\$750 after deductible		\$1,000 after deductible		20% after deductible		30% after deductible		50% after deductible										
Outpatient Surgery: Hospital/Ambulatory	\$150		20% after deductible		\$150/\$125		\$100/\$75 after deductible		35% after deductible		\$150 after deductible		\$200/\$175 after deductible		20%/20% after deductible		\$200 after deductible		50% after deductible										
Emergency Room	\$150		20% after deductible		\$150		\$100 after deductible		35% after deductible		\$250 after deductible		\$250 after deductible		20% after deductible		\$250 after deductible		50% after deductible										
Telemedicine	\$20		\$40		\$0 ¹		\$0 ¹		\$40		\$40		\$0 ¹		\$0 ¹ after deductible		\$0 after deductible ¹		\$0 after deductible ¹										
Urgent Care	\$40		20% after deductible		\$75		\$75 after deductible		35% after deductible		\$75 after deductible		\$75 after deductible		20% after deductible		\$75 after deductible		50% after deductible										
Prescription Drugs\ Mail Order Available																													
Retail (30 Day Supply)	\$5/\$25/50%		\$10/\$30/50% after deductible		\$5/\$30/50%		\$4/\$30/50% after deductible		\$5/\$30/50% after deductible + \$0 Preventive Rx		\$5/\$30/50% after deductible + \$0 Preventive Rx		\$10/\$50/50%		\$15/\$50/50% after deductible		\$15/\$50/50% after deductible		50% all tiers after deductible										
Additional Services																													
Vision Exam (Routine)	\$0		\$0		\$40		\$40		\$0		\$0		\$40		\$40		\$40		\$40										
Health & Wellness Benefit	\$250 Wellness Card		\$250 Wellness Card		\$250 Wellness Card or Nutrition Benefit		\$250 Wellness Card or Nutrition Benefit		\$250 Wellness Card		\$250 Wellness Card		\$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-Eligible	No		No		No		Yes: HSA Qualified		Yes: HSA Qualified		Yes: HSA Qualified		No		Yes: HSA Qualified		Yes: HSA Qualified		Yes: HSA Qualified										
Rates	Monthly	Quarterly	Monthly	Quarterly	Monthly	Quarterly	Monthly	Quarterly	Monthly	Quarterly	Monthly	Quarterly	Monthly	Quarterly	Monthly	Quarterly	Monthly	Quarterly	Monthly	Quarterly									
Single	\$604.65	\$1,763.95	\$744.54	\$2,183.62	\$663.83	\$1,941.49	\$556.31	\$1,618.93	\$444.19	\$1,282.57	\$450.80	\$1,302.40	\$511.54	\$1,484.62	\$476.12	\$1,378.36	\$460.01	\$1,330.03	\$438.73	\$1,266.19									
Employee/Child(ren)	\$1,010.41	\$2,981.23	\$1,248.22	\$3,694.66	\$1,111.01	\$3,283.03	\$928.23	\$2,734.69	\$737.64	\$2,162.92	\$748.86	\$2,196.58	\$852.12	\$2,506.36	\$791.90	\$2,325.70	\$764.52	\$2,243.56	\$728.34	\$2,135.02									
Two Person	\$1,184.30	\$3,502.90	\$1,464.08	\$4,342.24	\$1,302.66	\$3,857.98	\$1,087.62	\$3,212.86	\$863.39	\$2,540.17	\$876.61	\$2,579.83	\$998.08	\$2,944.24	\$927.24	\$2,731.72	\$895.02	\$2,635.06	\$852.46	\$2,507.38									
Family	\$1,677.01	\$4,981.03	\$2,075.69	\$6,177.07	\$1,845.67	\$5,487.01	\$1,539.23	\$4,567.69	\$1,219.71	\$3,609.13	\$1,238.55	\$3,665.65	\$1,411.64	\$4,184.92	\$1,310.69	\$3,882.07	\$1,264.78	\$3,744.34	\$1,204.13	\$3,562.39									
Pediatric Dental Rate (Per Child)	\$19.55		\$19.55		\$15.43		\$15.43		\$19.55		\$19.55		\$15.43		\$15.43		\$15.43		\$15.43										
Additional plans are available to groups with 2 or more employees										^ See Benefit Summary for more info										Updated: 10/11/2018									
Embedded Deductible: Once any family member has met the individual deductible, subsequent medical costs are covered for that person, even if the family deductible has not been satisfied.																													
True Family Deductible: Any individual within a family can accumulate the entire family deductible.																													
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