



**Independent Health**

**Amherst Chamber of Commerce  
Medical Rates for Individuals  
January 1, 2019 - December 31, 2019**

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)



**IHA Individual Market: January 1, 2019 - December 31, 2019**

	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>4</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						Must be under age 30			
Deductible <sup>2</sup>	\$0		\$0		\$600/\$1,200		\$1,000/\$2,000		A: \$1,000/\$2,000 B: \$2,000/\$4,000		\$1,700/\$3,400		\$1,950/\$3,900		A: \$1,900/\$3,800 B: \$3,425/\$6,850		\$4,000/\$8,000		\$5,000/\$10,000		\$7,900/\$15,800			
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		\$6,750/\$13,500		\$4,000/\$8,000		\$7,350/\$14,700		A: \$7,350/\$14,700 B: \$7,350/\$14,700		\$7,500/\$15,000		\$6,550/\$13,100		A: \$6,550/\$13,100 B: \$6,550/\$13,100		\$7,600/\$15,200		\$6,700/\$13,400		\$7,900/\$15,800			
<b>Out-of-Network<sup>5</sup></b>																								
Deductible <sup>2</sup>	\$5,000/\$10,000		\$5,000/\$10,000		\$5,000/\$10,000		\$5,000/\$10,000		\$5,000/\$10,000		\$5,000/\$10,000		\$5,000/\$10,000		\$5,000/\$10,000		\$5,000/\$10,000		\$5,000/\$10,000		N/A			
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		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		\$0 after deductible		\$0			
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		\$0 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: \$200 after deductible B: \$200 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		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		\$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	\$ 880.87	\$ 2,592.61	\$ 838.66	\$ 2,465.98	\$731.91	\$2,145.73	\$702.89	\$2,058.67	\$655.25	\$1,915.75	\$594.08	\$1,732.24	\$551.66	\$1,604.98	\$522.33	\$1,516.99	\$429.03	\$1,237.09	\$423.69	\$1,221.07	\$275.88	\$777.64		
Individual/Child(ren)	\$ 1,479.98	\$ 4,389.94	\$ 1,408.22	\$ 4,174.66	\$1,226.75	\$3,630.25	\$1,177.41	\$3,482.23	\$1,096.43	\$3,239.29	\$992.44	\$2,927.32	\$920.32	\$2,710.96	\$870.46	\$2,561.38	\$711.85	\$2,085.55	\$702.77	\$2,058.31	\$451.50	\$1,304.50		
Individual/Spouse	\$ 1,736.74	\$ 5,160.22	\$ 1,652.32	\$ 4,906.96	\$1,438.82	\$4,266.46	\$1,380.78	\$4,092.34	\$1,285.50	\$3,806.50	\$1,163.16	\$3,439.48	\$1,078.32	\$3,184.96	\$1,019.66	\$3,008.98	\$833.06	\$2,449.18	\$822.38	\$2,417.14	\$526.76	\$1,530.28		
Child Only Rate	\$ 377.62	\$ 1,082.86	N/A	N/A	\$316.25	\$898.75	N/A	N/A	N/A	N/A	\$259.46	\$728.38	N/A	N/A	N/A	N/A	\$191.46	\$524.38	N/A	N/A	N/A	N/A		
Family	\$ 2,464.23	\$ 7,342.69	\$ 2,343.93	\$ 6,981.79	\$2,039.69	\$6,069.07	\$1,956.99	\$5,820.97	\$1,821.21	\$5,413.63	\$1,646.88	\$4,890.64	\$1,525.98	\$4,527.94	\$1,442.39	\$4,277.17	\$1,176.49	\$3,479.47	\$1,161.27	\$3,433.81	\$740.01	\$2,170.03		

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

<sup>4</sup> Offered in Erie & Niagara Counties only.

<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>5</sup> All plans include Out-of-Network Coverage. Please refer to Summary of Benefits & Coverage (SBC) for further details.

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

<sup>6</sup> No Application Fee Required

Updated: 11/1/2018