2018 HEALTH INSURANCE RATES

Grand Island Chamber of Commerce

	BLUE CROSS BLUE SHIELD OF WNY				Independent Health			
	HMO 110 Plus Platinum	Align Blended Silver Optimum Choice	Align Blended Silver Flexible Choice	Healthy Balance POS 8100 Pkg 1 Silver	Flex Fit Platinum	iDirect Silver Copay	iDirect Coinsurance Silver	iDirect Bronze
Single	***$571.87***	***$412.40***	***$412.40***	***$436.77***	***$575.63***	***$442.83***	***$404.80***	***$343.10***
Employee + 1 Adult	***$1,143.74***	***$824.80***	***$824.80***	***$873.54***	***$1,151.26***	***$885.66***	***$809.60***	***$686.20***
Employee + Children	***$972.18***	***$701.08***	***$701.08***	***$742.51***	***$978.57***	***$752.81***	***$688.16***	***$583.27***
Family	***$1,629.83***	***$1,175.35***	***$1,175.35***	***$1,244.80***	***$1,640.55***	***$1,262.07***	***$1,153.68***	***$977.84***
DEDUCTIBLE / COINSURANCE / DEPENDENTS								
Deductible - In Network	$0	$1300/$2600	$3500/$7000	$2000/$4000	N/A	$1700/$3400	$2000/$4000	$4425/$8850
Coinsurance - In Network	0%	25%	50%	20%	Applies Where Indicated	Applies Where Indicated	20%	50%
Deductible - Out of Network	$1500/$3000	$3500/$7000	$3000/$6000	$2000/$4000	$2000/$4000	$3000/$6000	$3000/$6000	$5000/$10000
Coinsurance - Out of Network	40%	50%	50%	40%	40%	40%	40%	50%
Out-of-Pocket Max - In Network	$4000/$8000	$6550/$13100	$6550/$13100	$5500/$11000	$5000/$10000	$7100/$14200	$6200/$12400	$6550/$13100
Out-of-Pocket Max - Out of Network	$4000/$8000	$10000/$20000	$10000/$20000	$10000/$20000	$6750/$13500	$10000/$20000	$10000/$20000	$10000/$20000
PRESCRIPTION DRUG COVERAGES								
Prescription Drug	$5/$30/50%	$5/$30/50% after Deductible met	Not Covered	$5/$30/50% after Deductible met	$4/$30/$100	$10/$50/50%	$4/$30/50% after Deductible met	50% after Deductible met
Mailorder RX - Must be obtained from Walgreens or Wegmans	2.5 copays for 90 days	2.5 copays for 90 days	Not Covered	2.5 copays for 90 days	2.5 copays for a 3 month supply	2.5 copays for a 3 month supply	2.5 copays for a 3 month supply after Deductible met	
PREVENTATIVE SERVICES								
Bone mineral density measurement/test	Covered in full	Covered in full	Covered in full	Covered in full	$0	$0	$0	$0
Cholesterol test (lipid panel)					$0	$0	$0	$0
Colonoscopy and sigmoidoscopy	Covered in full	Covered in full	Covered in full	Covered in full	$0	$0	$0	$0
Contraceptive Drugs, Devices, Counseling					$0	$0	$0	$0
immunizations	Covered in full	Covered in full	Covered in full	Covered in full	$0	$0	$0	$0
Mammograms	Covered in full	Covered in full	Covered in full	Covered in full	$0	$0	$0	$0
Pap smear	Covered in full	Covered in full	Covered in full	Covered in full	$0	$0	$0	$0
Physical exam	Covered in full	Covered in full	Covered in full	Covered in full	$0	$0	$0	$0
Prostate test ("PSA")	Covered in full	Covered in full	Covered in full	Covered in full	$0	$0	$0	$0
Well child visit	Covered in full	Covered in full	Covered in full	Covered in full	$0	$0	$0	$0
Well woman visit	Covered in full	Covered in full	Covered in full	Covered in full	$0	$0	$0	$0
Out-of-Network - cost	40% Coinsurance after Deductible				40% after Deductible met	40% after Deductible met	40% after Deductible met	50% after Deductible met
PHYSICIAN & OTHER SERVICES								
Primary Office Visits	$20	$30 after Deductible met	50% after Deductible met	20% after Deductible met	$10	$30 after Deductible met	20% after Deductible met	50% after Deductible met
Specialist Office Visits	$30	$50 after Deductible met	50% after Deductible met	20% after Deductible met	$30	$50 after Deductible met	20% after Deductible met	50% after Deductible met
Allergy Testing & Treatment	PCP/Specialist Copay	PCP/Specialist Copay after Deductible met	50% after Deductible met	20% after Deductible met	$10/$30	$30/$50 after Deductible met	20% after Deductible met	50% after Deductible met
Outpatient Surgical Procedures (in physician's office)	PCP/Specialist Copay	PCP/Specialist Copay after Deductible met	50% after Deductible met		$30	$50 after Deductible met	20% after Deductible met	50% after Deductible met
Out-of-Network - cost					40% after Deductible met	40% after Deductible met	40% after Deductible met	50% after Deductible met
HOSPITAL SERVICES								
Inpatient Hospital	$500	25% after Deductible met	50% after Deductible met	$750 after Deductible met	$500	$1000 after Deductible met	20% after Deductible met	50% after Deductible met
Inpatient Hospice	$30	25% after Deductible met	50% after Deductible met	20% after Deductible met	$0	$0 after Deductible met	$0 after Deductible met	$0 after Deductible met
Outpatient Hospital	$150	25% after Deductible met	50% after Deductible met	20% after Deductible met	$150	$150 after Deductible met	20% after Deductible met	50% after Deductible met
Outpatient Procedure					$30	$50 after Deductible met	20% after Deductible met	50% after Deductible met
Skilled Nursing Facility	$500	25% after Deductible met	50% after Deductible met	$750 after Deductible met	$500	$1000 after Deductible met	20% after Deductible met	50% after Deductible met
Out-of-Network - cost					40% after Deductible met	40% after Deductible met	40% after Deductible met	50% after Deductible
MATERNITY SERVICES								
Maternity Services	$20	$30 after Deductible met	50% after Deductible met	20% after Deductible met	$0	$0 after Deductible met	$0 after Deductible met	$0 after Deductible met
In Patient Maternity	$500	30% after Deductible met	50% after Deductible met	$750 after Deductible met	$500	$1000 after Deductible met	20% after Deductible met	50% after Deductible met
Out-of-Network - cost					40% after Deductible met	40% after Deductible met	40% after Deductible met	50% after Deductible met
EMERGENCY & URGENT CARE								
Emergency Room	$100	30% after Deductible met	25% after Deductible met	20% after Deductible met	$150	$200 after Deductible met	20% after Deductible met	50% after Deductible met
Urgent Care	$40	30% after Deductible met	25% after Deductible met	20% after Deductible met	$75	$75 after Deductible met	20% after Deductible met	50% after Deductible met
Ambulance	$100	30% after Deductible met	25% after Deductible met	20% after Deductible met	$150	$200 after Deductible met	20% after Deductible met	50% after Deductible met
DIABETIC SUPPLIES & SERVICES								
Diabetic Medical Supplies	$20	$30 after Deductible met	50% after Deductible met	20% after Deductible met	$10	$30 after Deductible met	20% after Deductible met	50% after Deductible met
Diabetic Equipment	$20	$30 after Deductible met	50% after Deductible met	20% after Deductible met	$10	$30 after Deductible met	20% after Deductible met	50% after Deductible met
Insulin and other Oral Agents	$20	$30 after Deductible met	50% after Deductible met	20% after Deductible met	$10	$30 after Deductible met	20% after Deductible met	50% after Deductible met
Out-of-Network - cost					40% after Deductible met	40% after Deductible met	40% after Deductible met	50% after Deductible met
DIAGNOSTIC TESTING SERVICES								
Laboratory Testing	Covered in full	30% after Deductible met	50% after Deductible met	20% after Deductible met	$10	$30 after Deductible met	20% after Deductible met	50% after Deductible met
EKG					$30	$50 after Deductible met	20% after Deductible met	50% after Deductible met
Routine Radiology	$30	30% after Deductible met	50% after Deductible met	20% after Deductible met	$30	$50 after Deductible met	20% after Deductible met	50% after Deductible met
Advance Radiology					$75	$50 after Deductible met	20% after Deductible met	50% after Deductible met
Out-of-Network - cost					40% after Deductible met	40% after Deductible met	40% after Deductible met	50% after Deductible met
ADDITIONAL SERVICES								
Durable Medical Equipment	50%	30% after Deductible met	50% after Deductible met	20% after Deductible met	50% coinsurance	50% after Deductible met	50% after Deductible met	50% after Deductible met
Mental Health Inpatient	$500	30% after Deductible met	50% after Deductible met	$750 after Deductible met	$500	$1000 after Deductible met	20% after Deductible met	50% after Deductible met
Mental Health Outpatient	$30	Covered in full	50% after Deductible met	20% after Deductible met	$30	$50 after Deductible met	20% after Deductible met	50% after Deductible met
Chiropractic	$20	$50 after Deductible met	50% after Deductible met	20% after Deductible met	$30	$50 after Deductible met	20% after Deductible met	50% after Deductible met
Chemotherapy	$30	30% after Deductible met	50% after Deductible met	20% after Deductible met	$10/$30	$30/$50 after Deductible met	20% after Deductible met	50% after Deductible met
Home Health Care	$30	$50 after Deductible met	50% after Deductible met	20% after Deductible met	$10	$30 after Deductible met	20% after Deductible met	50% after Deductible met
Unique Benefits	$250 wellness card	$250 wellness card	N/A	$250 wellness card	$250 gym/wellness or $500/$1000 purchase of produce	$250 gym/wellness or $500/$1000 purchase of produce	$250 gym/wellness or $500/$1000 purchase of produce	$250 gym/wellness or $500/$1000 purchase of produce
Out-of-Network - cost					40% after Deductible met	40% after Deductible met	40% after Deductible met	50% after Deductible met
VISION SERVICES								
Routine Eye - 1 every 2 yrs.	$30	$50 after Deductible met	50% after Deductible met	20% after Deductible met	$30	$50 after Deductible met	20% after Deductible met	50% after Deductible met
Standard Plastic Lenses	$50 allowance	$50 allowance	$50 allowance	$50 allowance	$50	$50	$50	$50
Eyewear-Frames	40%	40%	40%	40%	40% discount	40% discount	40% discount	40% discount
Conventional Contact Lenses	15%	15%	15%	15%	15% discount	15% discount	15% discount	15% discount
Lasik Eye Surgery	15%off retail or 5% off promotinal price	15%off retail or 5% off promotinal price	15%off retail or 5% off promotinal price	15%off retail or 5% off promotinal price	15% off retail 5% off promotional	15% off retail 5% off promotional	15% off retail 5% off promotional	15% off retail 5% off promotional