2020 Individual Products

PLATINUM LEVEL

Niagara River Region Chamber
of Commerce
895 Center Street
Lewiston, New York 14092
(716) 754-9500
suzanne@niagarariverregion.com

	Standard Platinum	FlexFit Platinum	Choice Plus Platinum[2]
IN-NETWORK (IN)			
Deductible	$0	$0	A: $0 **B: $1,500/$3,000 (T)**
Coinsurance	0%	0%	A: 0% B: Deductible then 50%
Out-of-Pocket Maximum	$2,000/$4,000 (E)	**$5,250/$10,500 (E)**	**A: $5,250/$10,500 (E)** **B: $5,250/$10,500 (E)**
OUT-OF-NETWORK (OON)[5]			
Deductible	**$5,000/$10,000 (E)**	$5,000/$10,000 (T)	$5,000/$10,000 (T)
Coinsurance	Deductible then 50%	Deductible then 50%	Deductible then 50%
Out-of-Pocket Maximum	Unlimited	Unlimited	Unlimited
MEDICAL SERVICES			
Primary Care	$15	**$10**	A: $10 B: Deductible then 50%
Specialist Office Visit	$35	**$40**	**A: $40** B: Deductible then 50%
Telemedicine including Mental Health and Substance Use Disorder (participating Teladoc® providers only)	$0	$0	$0
Urgent Care	$55	$75	A: $75 B: Deductible then 50%
Emergency Room Services	$100	$150	A: $150 B: $150
Outpatient Procedures Performed in an Ambulatory Surgery Center	$100	**$50**	A: $50 B: Deductible then 50%
Outpatient Procedures Performed in a Hospital	$100	**$75**	A: $75 B: Deductible then 50%
Inpatient Hospital Services (per admission)	$500	$500	A: $500 B: Deductible then 50%
Lab	$35	**$10**	**A: $10** B: Deductible then 50%
X-Ray	$35	**$40**	**A: $40** B: Deductible then 50%
Routine / Refractive Exam	$40	$40	A: $40 B: Not Applicable
PRESCRIPTION DRUGS			
Pharmacy[4]	$10/$30/$60	**$5**/**$30**/50%	**$5**/$30/50%
PRODUCT DETAILS			
Wellness Benefits	Health Extras℠ or Nutrition	Health Extras℠ or Nutrition	Health Extras℠ or Nutrition
Network	IHC	IHC	Choice Plus
RATES			
Individual Rate	$853.73	$787.77	$750.20
Individual and Child(ren) Rate	$1,440.84	$1,328.71	$1,264.84
Individual and Spouse Rate	$1,692.46	$1,560.54	$1,485.40
Family Rate	$2,405.38	$2,217.39	$2,110.32

**The above rates include $15 monthly billing fee

2020 Individual Products

GOLD LEVEL

GOLD LEVEL PLANS CONTINUED ON NEXT PAGE »

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	Standard Gold	iDirect Gold Copay
IN-NETWORK (IN)		
Deductible	$600/$1,200 (E)	**$1,250/$2,500 (T)**
Coinsurance	0%	0%
Out-of-Pocket Maximum	$4,000/$8,000 (E)	**$6,750/$13,500 (E)**
OUT-OF-NETWORK (OON)[5]		
Deductible	$5,000/$10,000 (E)	$5,000/$10,000 (T)
Coinsurance	Deductible then 50%	Deductible then 50%
Out-of-Pocket Maximum	Unlimited	Unlimited
MEDICAL SERVICES		
Primary Care	Deductible then $25	**$20**
Specialist Office Visit	Deductible then $40	**Deductible then $50**
Telemedicine including Mental Health and Substance Use Disorder (participating Teladoc® providers only)	$0	$0
Urgent Care	Deductible then $60	$75
Emergency Room Services	Deductible then $150	**$150**
Outpatient Procedures Performed in an Ambulatory Surgery Center	Deductible then $100	**Deductible then $50**
Outpatient Procedures Performed in a Hospital	Deductible then $100	**Deductible then $75**
Inpatient Hospital Services (per admission)	Deductible then $1,000	Deductible then $1,000
Lab	Deductible then $40	**Deductible then $20**
X-Ray	Deductible then $40	**Deductible then $50**
Routine / Refractive Exam	$40	$40
PRESCRIPTION DRUGS		
Pharmacy[4]	$10/$35/$70	$10/**$40**/50%
PRODUCT DETAILS		
Wellness Benefits	Health Extras℠ or Nutrition	Health Extras℠ or Nutrition
Network	IHC	IHC
RATES		
Individual Rate	$707.24	$659.87
Individual and Child(ren) Rate	$1,191.81	$1,111.28
Individual and Spouse Rate	$1,399.48	$1,304.74
Family Rate	$1987.88	$1,852.88

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2020 Individual Products

GOLD LEVEL

(CONTINUED)

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	NEW! Max Gold	Choice Plus Gold[2]
IN-NETWORK (IN)		
Deductible	$1,500/$3,000 (T)	**A: $1,250/$2,500 (T)** **B: $2,750/$5,500 (T)**
Coinsurance	0%	A: 0% B: Deductible then 50%
Out-of-Pocket Maximum	$6,750/$13,500 (E)	**A: $6,750/$13,500 (E)** **B: $6,750/$13,500 (E)**
OUT-OF-NETWORK (OON)[5]		
Deductible	$5,000/$10,000 (T)	$5,000/$10,000 (T)
Coinsurance	Deductible then 50%	Deductible then 50%
Out-of-Pocket Maximum	Unlimited	Unlimited
MEDICAL SERVICES		
Primary Care	$20	**A: $20** B: Deductible then 50%
Specialist Office Visit	Deductible then $50	Deductible then **A: $50** B: 50%
Telemedicine including Mental Health and Substance Use Disorder (participating Teladoc® providers only)	$0	$0
Urgent Care	$75	A: $75 B: Deductible then 50%
Emergency Room Services	$150	**A: $150 B: $150**
Outpatient Procedures Performed in an Ambulatory Surgery Center	Deductible then $50	Deductible then **A: $50** B: 50%
Outpatient Procedures Performed in a Hospital	Deductible then $75	Deductible then **A: $75** B: 50%
Inpatient Hospital Services (per admission)	Deductible then $1,000	Deductible then A: $1,000 B: 50%
Lab	Deductible then $20	Deductible then **A: $20** B: 50%
X-Ray	Deductible then $50	Deductible then **A: $50** B: 50%
Routine / Refractive Exam	$40	A: $40 B: Not Applicable
PRESCRIPTION DRUGS		
Pharmacy[4]	$10/Deductible then $40/ Deductible then 50%	$10/**$40**/50%
PRODUCT DETAILS		
Wellness Benefits	Health Extras℠ or Nutrition w/ Activity Tracker[3]	Health Extras℠ or Nutrition
Network	IHC	Choice Plus
RATES		
Individual Rate	$652.81	$621.81
Individual and Child(ren) Rate	$1,099.28	$1,046.58
Individual and Spouse Rate	$1,290.62	$1,228.62
Family Rate	$1,832.76	$1,743.41

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2020 Individual Products

SILVER LEVEL

SILVER LEVEL PLANS CONTINUED ON NEXT PAGE »

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	Standard Silver	iDirect Silver Copay HSAQ
IN-NETWORK (IN)		
Deductible	**$1,300/$2,600 (E)**	**$2,250/$4,500 (T)**
Coinsurance	0%	0%
Out-of-Pocket Maximum	**$7,900/$15,800 (E)**	**$6,750/$13,500 (E)**
OUT-OF-NETWORK (OON)[5]		
Deductible	$5,000/$10,000 (E)	$5,000/$10,000 (T)
Coinsurance	Deductible then 50%	Deductible then 50%
Out-of-Pocket Maximum	Unlimited	Unlimited
MEDICAL SERVICES		
Primary Care	Deductible then $30	Deductible then $35
Specialist Office Visit	Deductible then $50	Deductible then $60
Telemedicine including Mental Health and Substance Use Disorder (participating Teladoc® providers only)	$0	Deductible then $0
Urgent Care	Deductible then $70	Deductible then $75
Emergency Room Services	Deductible then $250	Deductible then $250
Outpatient Procedures Performed in an Ambulatory Surgery Center	**Deductible then $150**	**Deductible then $50**
Outpatient Procedures Performed in a Hospital	**Deductible then $150**	**Deductible then $75**
Inpatient Hospital Services (per admission)	Deductible then $1,500	Deductible then $1,000
Lab	Deductible then $50	**Deductible then $35**
X-Ray	Deductible then $50	Deductible then $60
Routine / Refractive Exam	$40	$40
PRESCRIPTION DRUGS		
Pharmacy[4]	$10/$35/$70	Deductible then **$15**/$50/50%
PRODUCT DETAILS		
Wellness Benefits	Health Extras℠ or Nutrition	Health Extras℠ or Nutrition
Network	IHC	IHC
RATES		
Individual Rate	$589.46	$542.37
Individual and Child(ren) Rate	$991.58	$911.53
Individual and Spouse Rate	$1,163.92	$1,069.74
Family Rate	$1,652.21	$1,518.00

**The above rates include $15 monthly billing fee

2020 Individual Products

SILVER LEVEL

(CONTINUED)

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	Max Silver	Choice Plus Silver Copay HSAQ[2]
IN-NETWORK (IN)		
Deductible	**$2,800/$5,600 (T)**	**A: $2,250/$4,500 (E)** **B: $3,750/$7,500 (E)**
Coinsurance	0%	A: 0% B: Deductible then 50%
Out-of-Pocket Maximum	**$7,550/$15,100 (E)**	**A: $6,750/$13,500 (E)** **B: $6,750/$13,500 (E)**
OUT-OF-NETWORK (OON)[5]		
Deductible	$5,000/$10,000 (T)	$5,000/$10,000 (E)
Coinsurance	Deductible then 50%	Deductible then 50%
Out-of-Pocket Maximum	Unlimited	Unlimited
MEDICAL SERVICES		
Primary Care	$35	Deductible then A: $35 B: 50%
Specialist Office Visit	**Deductible then $60**	Deductible then A: $60 B: 50%
Telemedicine including Mental Health and Substance Use Disorder (participating Teladoc® providers only)	$0	Deductible then $0
Urgent Care	**$75**	Deductible then A: $75 B: 50%
Emergency Room Services	**Deductible then $250**	**Deductible then** **A: $250 B: $250**
Outpatient Procedures Performed in an Ambulatory Surgery Center	**Deductible then $50**	Deductible then **A: $50** B: 50%
Outpatient Procedures Performed in a Hospital	**Deductible then $75**	Deductible then **A: $75** B: 50%
Inpatient Hospital Services (per admission)	Deductible then $1,000	Deductible then A: $1,000 B: 50%
Lab	Deductible then $35	Deductible then **A: $35** B: 50%
X-Ray	**Deductible then $60**	Deductible then A: $60 B: 50%
Routine / Refractive Exam	$40	A: $40 B: Not Applicable
PRESCRIPTION DRUGS		
Pharmacy[4]	**$15**/Deductible then $50/ Deductible then 50%	Deductible then **$15**/$50/50%
PRODUCT DETAILS		
Wellness Benefits	Health Extras℠ or Nutrition w/ Activity Tracker[3]	Health Extras℠ or Nutrition
Network	IHC	Choice Plus
RATES		
Individual Rate	$544.29	$518.57
Individual and Child(ren) Rate	$914.79	$871.07
Individual and Spouse Rate	$1,073.58	$1,022.14
Family Rate	$1,523.48	$1,450.17

**The above rates include $15 monthly billing fee

2020 Individual Products

BRONZE LEVEL

Niagara River Region Chamber of Commerce
895 Center Street
Lewiston, New York 14092
(716) 754-9500
suzanne@niagarariverregion.com

	Standard Bronze	iDirect Bronze Coinsurance HSAQ
IN-NETWORK (IN)		
Deductible	**$4,425/$8,850 (E)**	**$5,150/$10,300 (E)**
Coinsurance	Deductible then 50%	Deductible then 50%
Out-of-Pocket Maximum	**$8,150/$16,300 (E)**	**$6,750/$13,500 (E)**
OUT-OF-NETWORK (OON)[5]		
Deductible	$5,000/$10,000 (E)	**$7,500/$15,000 (E)**
Coinsurance	Deductible then 50%	Deductible then 50%
Out-of-Pocket Maximum	Unlimited	Unlimited
MEDICAL SERVICES		
Primary Care	**Deductible then 50% after 3 visits for Primary Care Allowance**	Deductible then 50%
Specialist Office Visit	Deductible then 50%	Deductible then 50%
Telemedicine including Mental Health and Substance Use Disorder (participating Teladoc® providers only)	$0	Deductible then $0
Urgent Care	Deductible then 50%	Deductible then 50%
Emergency Room Services	Deductible then 50%	Deductible then 50%
Outpatient Procedures Performed in an Ambulatory Surgery Center	Deductible then 50%	Deductible then 50%
Outpatient Procedures Performed in a Hospital	Deductible then 50%	Deductible then 50%
Inpatient Hospital Services (per admission)	Deductible then 50%	Deductible then 50%
Lab	Deductible then 50%	Deductible then 50%
X-Ray	Deductible then 50%	Deductible then 50%
Routine / Refractive Exam	$40	$40
PRESCRIPTION DRUGS		
Pharmacy[4]	Deductible then $10/$35/$70	Deductible then 50%
PRODUCT DETAILS		
Wellness Benefits	Health Extras℠ or Nutrition	Health Extras℠ or Nutrition
Network	IHC	IHC
RATES		
Individual Rate	$457.35	$422.56
Individual and Child(ren) Rate	$767.00	$707.85
Individual and Spouse Rate	$899.70	$830.12
Family Rate	$1,275.70	$1,176.55

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2020 Individual Products

CATASTROPHIC

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	Standard Catastrophic[1]
IN-NETWORK (IN)	
Deductible	**$8,150/$16,300 (E)**
Coinsurance	0%
Out-of-Pocket Maximum	**$8,150/$16,300 (E)**
OUT-OF-NETWORK (OON)[5]	
Deductible	Non-Participating Provider services are not covered except as required for Emergency Care and Urgent Care
Coinsurance	Non-Participating Provider services are not covered and you pay the full cost
Out-of-Pocket Maximum	Not Applicable
MEDICAL SERVICES	
Primary Care	Deductible then $0 after 3 visits for Primary Care Allowance
Specialist Office Visit	Deductible then $0
Telemedicine including Mental Health and Substance Use Disorder (participating Teladoc® providers only)	$0
Urgent Care	Deductible then $0
Emergency Room Services	Deductible then $0
Outpatient Procedures Performed in an Ambulatory Surgery Center	Deductible then $0
Outpatient Procedures Performed in a Hospital	Deductible then $0
Inpatient Hospital Services (per admission)	Deductible then $0
Lab	Deductible then $0
X-Ray	Deductible then $0
Routine / Refractive Exam	$40
PRESCRIPTION DRUGS	
Pharmacy[4]	Deductible then $0
PRODUCT DETAILS	
Wellness Benefits	Health Extras℠ or Nutrition
Network	IHC
RATES	
Individual Rate	$294.58
Individual and Child(ren) Rate	$490.29
Individual and Spouse Rate	$574.16
Family Rate	$811.80

**The above rates include $15 monthly billing fee