

Amherst Chamber of Commerce - 2012 Medical Rates

Services	BlueCross BlueShield of WNY		Independent Health	Univera Healthcare	
	POS 250D	POS 8100	FlexFit Select	valUcare	valUcare - HDHP
Office Visit	\$25	Deductible then 20%	Active: \$15 (Age 19+) / \$30 (Age 0-18) Family: \$25 (Age 19+) / \$0 (Age 0-18)	Adult: \$30 Children to Age 19: \$0	Deductible then 20%
Specialist	\$40	Deductible then 20%	\$45	\$50	Deductible then 20%
Diagnostic X Ray	20% Coinsurance	Deductible then 20%	\$45	\$50	Deductible then 20%
Laboratory Testing	20% Coinsurance	Deductible then 20%	Covered in Full	Covered in Full	Deductible then 20%
Chiropractic Services	\$40	Deductible then 20%	\$45	\$50	Deductible then 20%
Maternity Services	Covered in Full After \$25 Copay for Initial Visit	Deductible then 20%	Covered in Full After Copay for Initial Visit	Covered in Full	Deductible then 20%
Inpatient Maternity	20% Coinsurance	Deductible then 20%	Active: \$750 Family: \$750 (Age 19+)/\$0 (Age 0-18)	Covered in Full	Deductible then 20%
Hospital Services					
Inpatient Hospital	Deductible then 20%	Deductible then 20%	Active: \$750 Family: \$750 (Age 19+)/\$0 (Age 0-18)	\$500	Deductible then 20%
Outpatient Surgical Procedures	20% Coinsurance	Deductible then 20%	\$150	\$250	Deductible then 20%
Ambulance	Deductible then 20%	Deductible then 20%	\$150	\$250	Deductible then 20%
Emergency Room	Deductible then 20%	Deductible then 20%	\$150	\$250	Deductible then 20%
Urgent Care	20% Coinsurance	Deductible then 20%	\$45	\$50	\$50
Outpatient Mental Health Care					
Outpatient Mental Health Care	\$40 (20 Visits Per Year)	Deductible then 20% (20 Visits Per Year)	Active: \$15 (Age 19+) / \$25 (Age 0-18) Family: \$25 (Age 19+) / \$0 (Age 0-18)	\$50	Deductible then 20%
Durable Medical Supplies	50% Coinsurance	Deductible then 20%	Covered at 50% (\$1,000 Annual Max)	Covered at 50%	Deductible then 20%
Physical, Speech, Occupational Therapy	20% Coinsurance (30 Aggregate Visits)	Deductible then 20% (30 Aggregate Visits)	\$45 (20 Visits Per Yer)	\$50 (45 Visits Per Year)	Deductible then 20% (45 Visits Per Year Combined)
Diabetes Supplies (30 Day Supply)	\$25	Deductible then 20%	Active: \$15 / Family: \$25	\$30	Deductible then 20%
Home Health Care (40 Visits)	\$25	Deductible then 20%	\$45	Covered in Full	Deductible then 20%
Prescription Drugs					
Retail (30 Day Supply)	\$15/\$50/50%	Deductible then \$15/\$50/50%	\$10 Generics	\$5/\$45/\$90 \$0 Generics to Age 19 \$250/\$750 Brand Deductible	\$5/\$35/\$70 \$0 Generics to Age 19
Mail Order (90 Day Supply)	2.5 Copays	Deductible then 2.5 Copays	2.5 Copays	3 Copays	3 Copays
Additional Services					
Vision	Covered in Full (Limited 1 Visit Every 2 Years)	Covered in Full (Limit 1 Visit Every 2 Years)	\$10 - Routine Exam	\$50 - Routine Eye Exam \$60 Annual Material Allowance	Deductible then 20%
Health & Wellness Benefit	Not Covered	Not Covered	\$250 Allowance	Not Covered	Not Covered
Out of Network		Combined In & Out of Network		Combined In & Out-of-Network	
Deductible	\$1,000/\$2,000 - In \$2,000/\$4,000 - Out	\$1,500/\$3,000	\$1,500/\$3,000 - Active \$1,000/\$2,000 Family	\$500/\$1,500	\$1,300/\$2,600
Coinsurance	20% In / 50% Out	0% In / 30% Out	30%	20%	20% In / 40% Out
Out of Pocket Maximum	\$5,000/\$10,000 In \$10,000/\$20,000 Out	\$4,000/\$8,000 In \$10,000/\$20,000 Out	\$5,000/\$10,000	\$1,500/\$4,500	\$3,000/\$6,000
Lifetime Maximum	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited
Quarterly Premium		Quarterly Premium		Quarterly Premium	
Single	\$995.50	\$792.40	\$1,459.66	Small Group: \$1,460.14 Sole Prop: \$1,675.87	Small Group: \$960.55 Sole Prop: \$1,006.63
Family	\$2,597.53	\$2,000.89	\$3,616.18	Small Group: \$3,813.16 Sole Prop: \$4,381.84	Small Group: \$2,511.10 Sole Prop: \$2,872.57