BCBS Individual Market: January 1, 2020 - December 31, 2020

BlueCross BlueShield of Western New York

Amherst Chamber of Commerce
Medical Rates for Individuals
January 1, 2020 - December 31, 2020

	PLATINUM				GOLD				SILVER				BRONZE			
	BlueCross BlueShield Platinum Standard		BlueCross BlueShield Platinum Ind align or focus[1+]		BlueCross BlueShield Gold Standard		BlueCross BlueShield Gold Ind align or focus[1+]		BlueCross BlueShield Silver Standard		BlueCross BlueShield Silver Ind align or focus[1+]		BlueCross BlueShield Bronze Standard		BlueCross BlueShield Bronze Ind align or focus[1+]	
In-Network			Optimum Choice	Flexible Choice			Optimum Choice	Flexible Choice			Optimum Choice	Flexible Choice			Optimum Choice	Flexible Choice
Deductible	$0		$0	$5,000/$10,000 embedded	$600/$1,200 embedded		$800/$1,600 embedded	$5,000/$10,000 embedded	$1,300/$2,600 embedded		$2,500/$5,000 true family	$5,000/$10,000 true family	$4,425/$8,850 embedded		$8,000/$16,000 embedded	$8,150/$16,300 embedded
Out of Pocket Maximum	$2,000/$4,000 embedded		$8,150/$16,300 embedded		$4,000/$8,000 embedded		$8,150/$16,300 embedded		$7,900/$15,800 embedded		$6,000/$12,000 embedded		$8,150/$16,300 embedded		$8,150/$16,300 embedded	
Out-Of-Network																
Deductible	$5,000/$10,000 embedded		$5,000/$10,000 embedded		$5,000/$10,000 embedded		$5,000/$10,000 embedded		$5,000/$10,000 embedded		$5,000/$10,000 true family		$5,000/$10,000 embedded		$8,150/$16,300 embedded	
Out of Pocket Maximum	$10,000/$20,000 embedded		$10,000/$20,000 embedded		$10,000/$20,000 embedded		$10,000/$20,000 embedded		$10,000/$20,000 embedded		$10,000/$20,000 embedded		$10,000/$20,000 embedded		$10,000/$20,000 embedded	
Medical Services													3 PCP visits covered in full			
PCP/Specialist	$15/$35		$10/$20	50% after deductible	$25/$40 after deductible		$20/$40 after deductible	50% after deductible	$30/$50 after deductible		$30/$50 after deductible	50% after deductible	50% after deductible		50% after deductible	0% after deductible
Laboratory Services	$35		$20		$40 after deductible		$40 after deductible		$50 after deductible		$50 after deductible		50% after deductible		50% after deductible	
Prescription Drugs			+ $0 Preventive Rx Plan				+ $0 Preventive Rx Plan				+ $0 Preventive Rx Plan					
Tier1/Tier2/Tier3	$10/$30/$60		$5/$20/50%		$10/$35/$70 not subject to deductible		$5/$40/50% not subject to deductible		$10/$35/$70 not subject to deductible		$5/$50/50% * after deductible		$10/$35/$70 after deductible		$15/50%/50% after deductible	
Inpatient/Outpatient Services																
Inpatient Hospital (per admission)	$500		$500	50% after deductible	$1,000 after deductible		$750 after deductible	50 % after deductible	$1,500 after deductible		$1,000 after deductible	50% after deductible	50% after deductible		50% after deductible	0% after deductible
Outpatient Facility Fee	$100		$100		$100 after deductible		$150 after deductible		$150 after deductible		$200 after deductible		50% after deductible		50% after deductible	
Emergency Room/Ambulance	$100		$300		$150 after deductible		$300 after deductible		$250/$150 after deductible		$300 after deductible		50% after deductible		50% after deductible	
Urgent Care	$55		$40		$60 after deductible		$50 after deductible		$70 after deductible		$75 after deductible		50% after deductible		50% after deductible	
Additional Services	Telemedicine hosted by Doctor On Demand®: $0 copay after deductible on HSA-qualified plans and $0 copay not subject to deductible on non-HSA-qualified plans															
Diabetic Services: Drugs/supplies	$15		$10	50% after deductible	$25 after deductible		$20 after deductible	50% after deductible	$30 after deductible		$30 after deductible	50% after deductible	50% after deductible		50% after deductible	0% after deductible
Vision Pediatric Annual Exam (Routine)	$15		$0		$25 after deductible		$0		$30 after deductible		$0		50% after deductible		$0	
Vision Adult Discount Program ^	Standard		Enhanced		Standard		Enhanced		Standard		Enhanced		Standard		Enhanced	
Health & Wellness Benefit	$250 Wellness Card + $25 for health survey		$250 Wellness Card + $25 for health survey		$250 Wellness Card + $25 for health survey		$250 Wellness Card + $25 for health survey		$250 Wellness Card + $25 for health survey		$250 Wellness Card + $25 for health survey		$250 Wellness Card + $25 for health survey		$250 Wellness Card + $25 for health survey	
HSA-Eligible	No		No		No		No		No		✓ HSA Eligible Plan		No		No	
	Monthly	Quarterly	Monthly	Quarterly	Monthly	Quarterly	Monthly	Quarterly	Monthly	Quarterly	Monthly	Quarterly	Monthly	Quarterly	Monthly	Quarterly
Single	$ 908.54	$ 2,675.62	$814.26	$2,392.78	$749.17	$2,197.51	$675.68	$1,977.04	$588.65	$1,715.95	$517.00	$1,501.00	$438.81	$1,266.43	$408.17	$1,174.51
Employee/Child(ren)	$ 1,527.02	$ 4,531.06	$1,366.75	$4,050.25	$1,256.09	$3,718.27	$1,131.16	$3,343.48	$983.20	$2,899.60	$861.40	$2,534.20	$728.47	$2,135.41	$676.39	$1,979.17
Two Person	$ 1,792.08	$ 5,326.24	$1,603.53	$4,760.59	$1,473.33	$4,369.99	$1,326.37	$3,929.11	$1,152.30	$3,406.90	$1,009.00	$2,977.00	$852.61	$2,507.83	$791.35	$2,324.05
Family	$ 2,543.10	$ 7,579.30	$2,274.40	$6,773.20	$2,088.87	$6,216.61	$1,879.44	$5,588.32	$1,631.40	$4,844.20	$1,427.20	$4,231.60	$1,204.36	$3,563.08	$1,117.04	$3,301.12

[1] Align features Kaleida Health facilities; available to residents of Erie & Niagara counties only.

[+] Focus features Catholic Health facilities; available to residents of Erie & Niagara counties only.

* Select preventive drugs are $0 cost-share, not subject to deductible on Silver Ind align & focus plans.

^ Vision benefits administered by EyeMed®

Jpdated: 10/30/2019

Habilitation (PT/OT/ST)
60 combined visits per condition, per plan year

Home health care
40 visits per plan year

Hospice
210 days per plan year, 5 visits per plan year for family bereavement

Hearing aids
Single purchase every 3 years

Rehab, outpatient (PT/OT/ST)
60 combined visits per condition, per plan year

Rehab, inpatient (PT/OT/ST)
60 combined visits, per plan year

Substance abuse, outpatient
Unlimited, 20 visits per plan year for family counseling

Skilled nursing facility
Unlimited, 200 days per yr-Standard plans