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.

^ Vision benefits administered by EyeMed®

**For a complete Summary of Benefits, please visit** www.amherst.org/policy-options

*No Application Fee required/$25 administration fee per monthly or quarterly billing is included

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

Hearing aids
Single purchase every 3 years

Updated: 1/22/2020

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

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

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