BlueCross BlueShield of Western New York

Amherst Chamber of Commerce
Medical Rates for Individuals
January 1, 2021 - December 31, 2021*

BCBS Individual Market: January 1, 2021 - December 31, 2021

	PLATINUM NEW		GOLD NEW		SILVER NEW		BRONZE NEW	
	BlueCross BlueShield Platinum Standard	BlueCross BlueShield Platinum POS Plus	BlueCross BlueShield Gold Standard	BlueCross BlueShield Gold POS 200	BlueCross BlueShield Silver Standard	BlueCross BlueShield Silver POS 7000	BlueCross BlueShield Bronze Standard	BlueCross BlueShield Bronze POS 8000
In-Network								
Deductible	$0	$0	$600/$1,200 embedded	$800/$1600 embedded	$1,300/$2,600 embedded	$2,500/$5,000 true family	$4,700/$9,400 embedded	$8,000/$16,000 embedded
Out of Pocket Maximum	$2,000/$4,000 embedded	$6000/$12,000 embedded	$4,000/$8,000 embedded	$8,150/$16,300 embedded	$8500/$17,000 embedded	$6,000/$12,000 embedded	$8,550/$17,100 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 embedded	$5,000/$10,000 embedded	$5,000/$10,000 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 with copay before deductible, $50/$75 after deductible	
PCP/Specialist	$15/$35	$10/$20	$25/$40 after deductible	$20/$40 after deductible	$30/$50 after deductible	$30/$50 after deductible		50% 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								
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	$1,000 after deductible	$750 after deductible	$1,500 after deductible	$1,000 after deductible	50% after deductible	50% 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	$300/$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
Telemedicine	$0	$0	$0 after deductible	$0 not subject to deductible	$0 after deductible	$0 after deductible	$0 not subject to deductible	$0 not subject to deductible
Diabetic Services: Drugs/supplies**	$15	$10	$25 after deductible	$20 after deductible	$30 after deductible	$30 after deductible	$50 after deductible	50% after deductible
Vision Pediatric Annual Exam (Routine)	$15	$0	$25 after deductible	$0 not subject to deductible	$30 after deductible	$0 not subject to deductible	50% after deductible	$0 not subject to deductible
Vision Adult Discount Program ^	Blue Discount	Affinity Plus	Blue Discount	Affinity Plus	Blue Discount	Affinity Plus	Blue Discount	Affinity Plus
Health & Wellness Benefit	$250 Wellness Card	$250 Wellness Card	$250 Wellness Card	$250 Wellness Card	$250 Wellness Card	$250 Wellness Card	$250 Wellness Card	$250 Wellness Card
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	$ 860.98	$ 2,532.94	$797.47	$2,342.41	$705.51	$2,066.53	$658.97	$1,926.91	$558.18	$1,624.54	$521.24	$1,513.72	$417.72	$1,203.16	$391.84	$1,125.52
Employee/Child(ren)	$ 1,446.17	$ 4,288.51	$1,338.20	$3,964.60	$1,181.87	$3,495.61	$1,102.75	$3,258.25	$931.41	$2,744.23	$868.61	$2,555.83	$692.62	$2,027.86	$648.63	$1,895.89
Two Person	$ 1,696.96	$ 5,040.88	$1,569.94	$4,659.82	$1,386.02	$4,108.06	$1,292.94	$3,828.82	$1,091.36	$3,224.08	$1,017.48	$3,002.44	$810.44	$2,381.32	$758.68	$2,226.04
Family	$ 2,407.54	$ 7,172.62	$2,226.54	$6,629.62	$1,964.45	$5,843.35	$1,831.81	$5,445.43	$1,544.56	$4,583.68	$1,439.28	$4,267.84	$1,144.25	$3,382.75	$1,070.49	$3,161.47

* Select preventive drugs are at $0 cost share.
** Insulin is subject to deductible and copay but capped at $100 for a 30-day supply.
^ Vision benefits administered by Davis Vision.
For a complete Summary of Benefits and Coverage (SBC), 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: 10/30/2020

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

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