

2019 BCBS of WNY Benefit Comparison for Individuals

	BCBS of WNY Platinum Standard	BCBS of WNY Gold Standard	BCBS of WNY Silver Standard	BCBS of WNY Bronze Standard
In Network:				
Annual Deductible	\$0	\$600 Single / \$1,200 Family	\$1,700 Single / \$3,400 Family	\$4,000 Single / \$8,000 Family
Coinsurance	0%	0%	0%	\$0
Annual Out of Pocket Max	\$2,000 Single / \$4,000 Family	\$4,000 Single / \$8,000 Family	\$7,500 Single / \$15,000 Family	\$7,600 Single / \$15,200 Family
PCP Office Visit	\$15 Copay	Deductible then \$25 Copay	Deductible then \$30 Copay	Deductible then 50% Coinsurance
Specialist Visit	\$35 Copay	Deductible then \$40 Copay	Deductible then \$50 Copay	Deductible then 50% Coinsurance
Sick Child Visit	\$15 Copay	Deductible then \$25 Copay	Deductible then \$30 Copay	Deductible then 50% Coinsurance
Radiology	\$35 Copay	Deductible then \$40 Copay	Deductible then \$50 Copay	Deductible then 50% Coinsurance
Laboratory	\$35 Copay	Deductible then \$40 Copay	Deductible then \$50 Copay	Deductible then 50% Coinsurance
Hospital Inpatient	\$500 Copay	Deductible then \$1000 Copay	Deductible then \$1,500 Copay	Deductible then 50% Coinsurance
Outpatient Surgery	\$100 Copay	Deductible then \$100 Copay	Deductible then \$100 Copay	Deductible then 50% Coinsurance
Outpatient OT/PT/ST	\$25 Copay	Deductible then \$30 Copay	Deductible then \$30 Copay	Deductible then 50% Coinsurance
Emergency Room Care	\$100 Copay	Deductible then \$150 Copay	Deductible then \$250 Copay	Deductible then 50% Coinsurance
Ambulance	\$100 Copay	Deductible then \$150 Copay	Deductible then \$150 Copay	Deductible then 50% Coinsurance
Urgent Care	\$55 Copay	Deductible then \$60 Copay	Deductible then \$70 Copay	Deductible then 50% Coinsurance
Maternity Care				
Outpatient Mental Health	\$15 Copay	Deductible then \$25 Copay	Deductible then \$30 Copay	Deductible then 50% Coinsurance
Chiropractor	\$35 Copay	Deductible then \$40 Copay	Deductible then \$50 Copay	Deductible then 50% Coinsurance
Diabetic Supplies	\$15 Copay	Deductible then \$25 Copay	Deductible then \$30 Copay	Deductible then 50% Coinsurance
Prescription Coverage	Not Subject to Deductible Tier 1 \$10 Tier 2 \$30 Tier 3 \$60	Not Subject to Deductible Tier 1 \$10 Tier 2 \$35 Tier 3 \$70	Not Subject to Deductible Tier 1 \$10 Tier 2 \$35 Tier 3 \$70	After Deductible Tier 1 \$10 Tier 2 \$35 Tier 3 \$70
Out-of-Network:				
Deductible	\$5,000 Single / \$10,000 Family	\$5,000 Single / \$10,000 Family	\$5,000 Single / \$10,000 Family	\$5,000 Single / \$10,000 Family
Coinsurance	50%	50%	50%	50%
Annual Out of Pocket Max	\$10,000 Single / \$20,000 Family	\$10,000 Single / \$20,000 Family	\$10,000 Single / \$20,000 Family	\$10,000 Single / \$20,000 Family
Extra Benefits	\$250 Wellness Card	\$250 Wellness Card	\$250 Wellness Card	\$250 Wellness Card
Rates	Option 1	Option 2	Option 3	Option 4
Single	\$860.80	\$705.52	\$544.80	\$403.15
Subscriber and Spouse	\$1,721.59	\$1,411.04	\$1,089.60	\$806.30
Subscriber and Child(ren)	\$1,463.35	\$1,199.38	\$926.16	\$685.36
Family	\$2,453.27	\$2,010.73	\$1,552.69	\$1,148.97

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2019 BCBS of WNY Benefit Comparison for Individuals

In Network:	BCBS of WNY / Erie & Niagara Counties Only (Kaleida Health Facilities)		BCBS of WNY / Erie & Niagara Counties Only (Catholic Health Facilities)	
	Platinum Ind Align (Optimum)	Platinum Ind Align (Flexible)	Platinum Ind Focus (Optimum)	Platinum Ind Focus (Flexible)
Annual Deductible	\$0	\$4,000 Single / \$8,000 Family	\$0	\$4,000 Single / \$8,000 Family
Coinsurance	NA	50%	NA	50%
Annual Out of Pocket Max	\$7,900 Single / \$15,800 Family		\$7,900 Single / \$15,800 Family	
PCP Office Visit	\$10 Copay	Deductible then 50%	\$10 Copay	Deductible then 50%
Specialist Visit	\$20 Copay	Deductible then 50%	\$20 Copay	Deductible then 50%
Sick Child Visit	\$10 Copay	Deductible then 50%	\$10 Copay	Deductible then 50%
Radiology	\$20 Copay	Deductible then 50%	\$20 Copay	Deductible then 50%
Laboratory	\$20 Copay	Deductible then 50%	\$20 Copay	Deductible then 50%
Hospital Inpatient	\$500 Copay	Deductible then 50%	\$500 Copay	Deductible then 50%
Outpatient Surgery	\$100 Copay	Deductible then 50%	\$100 Copay	Deductible then 50%
Outpatient OT/PT/ST	\$10 Copay	Deductible then 50%	\$10 Copay	Deductible then 50%
Emergency Room Care	\$250 Copay	\$250 Copay	\$250 Copay	\$250 Copay
Ambulance	\$250 Copay	\$250 Copay	\$250 Copay	\$250 Copay
Urgent Care	\$40 Copay	\$40 Copay	\$40 Copay	\$40 Copay
Maternity Care				
Outpatient Mental Health	\$20 Copay	Deductible then 50%	\$20 Copay	Deductible then 50%
Chiropractor	\$20 Copay	Deductible then 50%	\$20 Copay	Deductible then 50%
Diabetic Supplies	\$10 Copay	Deductible then 50%	\$10 Copay	Deductible then 50%
Prescription Coverage	Not subject to deductible Tier 1 \$5 Tier 2 \$30 Tier 3 50%		Not subject to deductible Tier 1 \$5 Tier 2 \$30 Tier 3 50%	
Out-of-Network: Deductible	\$4,000 Single / \$8,000 Family		\$4,000 Single / \$8,000 Family	
Coinsurance	50%		50%	
Annual Out of Pocket Max	\$10,000 Single / \$20,000 Family		\$10,000 Single / \$20,000 Family	
Extra Benefits	\$250 Wellness Card		\$250 Wellness Card	
Rates	Option 1		Option 2	
Single	\$781.86		\$781.86	
Subscriber and Spouse	\$1,563.71		\$1,563.71	
Subscriber and Child(ren)	\$1,329.16		\$1,329.16	
Family	\$2,228.29		\$2,228.29	

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2019 BCBS of WNY Benefit Comparison for Individuals

In Network:	BCBS of WNY / Erie & Niagara Counties Only (Kaleida Health Facilities)		BCBS of WNY / Erie & Niagara Counties Only (Catholic Health Facilities)	
	Gold Ind Align (Optimum)	Gold Ind Align (Flexible)	Gold Ind Focus (Optimum)	Gold Ind Focus (Flexible)
Annual Deductible	\$500 Single / \$1,000 Family	\$4,000 Single / \$8,000 Family	\$500 Single / \$1,000 Family	\$4,000 Single / \$8,000 Family
Coinsurance	NA	50%	NA	50%
Annual Out of Pocket Max	\$7,900 Single / \$15,800 Family		\$7,900 Single / \$15,800 Family	
PCP Office Visit	Deductible then \$20 Copay	Deductible then 50% Coinsurance	Deductible then \$20 Copay	Deductible then 50% Coinsurance
Specialist Visit	Deductible then \$40 Copay	Deductible then 50% Coinsurance	Deductible then \$40 Copay	Deductible then 50% Coinsurance
Sick Child Visit	Deductible then \$20 Copay	Deductible then 50% Coinsurance	Deductible then \$20 Copay	Deductible then 50% Coinsurance
Radiology	Deductible then \$40 Copay	Deductible then 50% Coinsurance	Deductible then \$40 Copay	Deductible then 50% Coinsurance
Laboratory	Deductible then \$40 Copay	Deductible then 50% Coinsurance	Deductible then \$40 Copay	Deductible then 50% Coinsurance
Hospital Inpatient	Deductible then \$1000 Copay	Deductible then 50% Coinsurance	Deductible then \$1000 Copay	Deductible then 50% Coinsurance
Outpatient Surgery	Deductible then \$150 Copay	Deductible then 50% Coinsurance	Deductible then \$150 Copay	Deductible then 50% Coinsurance
Outpatient OT/PT/ST	Deductible then \$20 Copay	Deductible then 50% Coinsurance	Deductible then \$20 Copay	Deductible then 50% Coinsurance
Emergency Room Care	Deductible then \$300 Copay	Deductible then \$300 Copay	Deductible then \$300 Copay	Deductible then \$300 Copay
Ambulance	Deductible then \$150 Copay	Deductible then \$150 Copay	Deductible then \$150 Copay	Deductible then \$150 Copay
Urgent Care	Deductible then \$50 Copay	Deductible then \$50 Copay	Deductible then \$50 Copay	Deductible then \$50 Copay
Maternity Care				
Outpatient Mental Health	Deductible then \$40 Copay	Deductible then 50% Coinsurance	Deductible then \$40 Copay	Deductible then 50% Coinsurance
Chiropractor	Deductible then \$40 Copay	Deductible then 50% Coinsurance	Deductible then \$40 Copay	Deductible then 50% Coinsurance
Diabetic Supplies	Deductible then \$20 Copay	Deductible then 50% Coinsurance	Deductible then \$20 Copay	Deductible then 50% Coinsurance
Prescription Coverage	Not subject to deductible Tier 1 \$10 Tier 2 \$40 Tier 3 50%		Not subject to deductible Tier 1 \$5 Tier 2 \$40 Tier 3 50%	
Out-of-Network: Deductible	\$4,000 Single / \$8,000 Family		\$4,000 Single / \$8,000 Family	
Out-of-Network: Coinsurance	50%		50%	
Out-of-Network: Annual Out of Pocket Max	\$10,000 Single / \$20,000 Family		\$10,000 Single / \$20,000 Family	
Extra Benefits	\$250 Wellness Card		\$250 Wellness Card	
Rates	Option 3		Option 4	
Single	\$645.73		\$645.73	
Subscriber and Spouse	\$1,291.46		\$1,291.46	
Subscriber and Child(ren)	\$1,097.74		\$1,097.74	
Family	\$1,840.33		\$1,840.33	

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2019 BCBS of WNY Benefit Comparison for Individuals

In Network:	BCBS of WNY / Erie & Niagara Counties Only (Kaleida Health Facilities)		BCBS of WNY / Erie & Niagara Counties Only (Catholic Health Facilities)	
	Silver Ind Align (Optimum)	Silver Ind Align (Flexible)	Silver Ind Focus (Optimum)	Silver Ind Focus (Flexible)
Annual Deductible	\$2,000 Single / \$4,000 Family	\$5,000 Single / \$10,000 Family	\$2,000 Single / \$4,000 Family	\$5,000 Single / \$10,000 Family
Coinsurance	NA	50%	NA	50%
Annual Out of Pocket Max	\$6,100 Single / \$12,200 Family		\$6,100 Single / \$12,200 Family	
PCP Office Visit	Deductible then \$30 Copay	Deductible then 50% Coinsurance	Deductible then \$30 Copay	Deductible then 50% Coinsurance
Specialist Visit	Deductible then \$50 Copay	Deductible then 50% Coinsurance	Deductible then \$50 Copay	Deductible then 50% Coinsurance
Sick Child Visit	Deductible then \$30 Copay	Deductible then 50% Coinsurance	Deductible then \$30 Copay	Deductible then 50% Coinsurance
Radiology	Deductible then \$60 Copay	Deductible then 50% Coinsurance	Deductible then \$60 Copay	Deductible then 50% Coinsurance
Laboratory	Deductible then \$50 Copay	Deductible then 50% Coinsurance	Deductible then \$50 Copay	Deductible then 50% Coinsurance
Hospital Inpatient	Deductible then \$1,000 Copay	Deductible then 50% Coinsurance	Deductible then \$1,000 Copay	Deductible then 50% Coinsurance
Outpatient Surgery	Deductible then \$200 Copay	Deductible then 50% Coinsurance	Deductible then \$200 Copay	Deductible then 50% Coinsurance
Outpatient OT/PT/ST	Deductible then \$30 Copay	Deductible then 50% Coinsurance	Deductible then \$30 Copay	Deductible then 50% Coinsurance
Emergency Room Care	Deductible then \$300 Copay	Deductible then \$300 Copay	Deductible then \$300 Copay	Deductible then \$300 Copay
Ambulance	Deductible then \$300 Copay	Deductible then \$300 Copay	Deductible then \$300 Copay	Deductible then \$300 Copay
Urgent Care	Deductible then \$75 Copay	Deductible then \$75 Copay	Deductible then \$75 Copay	Deductible then \$75 Copay
Maternity Care				
Outpatient Mental Health	Deductible then \$60 Copay	Deductible then 50% Coinsurance	Deductible then \$60 Copay	Deductible then 50% Coinsurance
Chiropractor	Deductible then \$60 Copay	Deductible then 50% Coinsurance	Deductible then \$60 Copay	Deductible then 50% Coinsurance
Diabetic Supplies	Deductible then \$30 Copay	Deductible then 50% Coinsurance	Deductible then \$30 Copay	Deductible then 50% Coinsurance
Prescription Coverage	After Deductible Tier 1 \$10 Tier 2 \$50 Tier 3 50%		After Deductible Tier 1 \$10 Tier 2 \$50 Tier 3 50%	
Out-of-Network: Deductible	\$5,000 Single / \$10,000 Family		\$5,000 Single / \$10,000 Family	
Out-of-Network: Coinsurance	50%		50%	
Out-of-Network: Annual Out of Pocket Max	\$10,000 Single / \$20,000 Family		\$10,000 Single / \$20,000 Family	
Extra Benefits	\$250 Wellness Card / Preventative Drug		\$250 Wellness Card / Preventative Drug	
Rates	Option 5		Option 5	
Single	\$494.24		\$494.24	
Subscriber and Spouse	\$988.48		\$988.48	
Subscriber and Child(ren)	\$840.21		\$840.21	
Family	\$1,408.59		\$1,408.59	

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2019 BCBS of WNY Benefit Comparison for Individuals

In Network:	BCBS of WNY / Erie & Niagara Counties Only (Kaleida Health Facilities)		BCBS of WNY / Erie & Niagara Counties Only (Catholic Health Facilities)	
	Bronze Ind Align (Optimum)	Bronze Ind Align (Flexible)	Bronze Ind Focus (Optimum)	Bronze Ind Focus (Flexible)
Annual Deductible	\$7,500 Single / \$15,000 Family	\$7,900 Single / \$15,800 Family	\$5,500 Single / \$11,000 Family	\$7,150 Single / \$14,300 Family
Coinsurance	50%	50%	NA	50%
Annual Out of Pocket Max	\$7,900 Single / \$15,800 Family		\$7,150 Single / \$14,300 Family	
PCP Office Visit	Deductible then 50%	Deductible then 0% Coinsurance	Deductible then 50%	Deductible then 0% Coinsurance
Specialist Visit	Deductible then 50%	Deductible then 0% Coinsurance	Deductible then 50%	Deductible then 0% Coinsurance
Sick Child Visit	Deductible then 50%	Deductible then 0% Coinsurance	Deductible then 50%	Deductible then 0% Coinsurance
Radiology	Deductible then 50%	Deductible then 0% Coinsurance	Deductible then 50%	Deductible then 0% Coinsurance
Laboratory	Deductible then 50%	Deductible then 0% Coinsurance	Deductible then 50%	Deductible then 0% Coinsurance
Hospital Inpatient	Deductible then 50%	Deductible then 0% Coinsurance	Deductible then 50%	Deductible then 0% Coinsurance
Outpatient Surgery	Deductible then 50%	Deductible then 0% Coinsurance	Deductible then 50%	Deductible then 0% Coinsurance
Outpatient OT/PT/ST	Deductible then 50%	Deductible then 0% Coinsurance	Deductible then 50%	Deductible then 0% Coinsurance
Emergency Room Care	Deductible then 50%	Deductible then 50% Coinsurance	Deductible then 50%	Deductible then 50% Coinsurance
Ambulance	Deductible then 50%	Deductible then 50% Coinsurance	Deductible then 50%	Deductible then 50% Coinsurance
Urgent Care	Deductible then 50%	Deductible then 0% Coinsurance	Deductible then 50%	Deductible then 0% Coinsurance
Maternity Care				
Outpatient Mental Health	Deductible then 50%	Deductible then 0% Coinsurance	Deductible then 50%	Deductible then 0% Coinsurance
Chiropractor	Deductible then 50%	Deductible then 0% Coinsurance	Deductible then 50%	Deductible then 0% Coinsurance
Diabetic Supplies	Deductible then 50%	Deductible then 0% Coinsurance	Deductible then 50%	Deductible then 0% Coinsurance
Prescription Coverage	After Deductible Tier 1 \$15 Tier 2 \$50 Tier 3 50%		After Deductible Tier 1 \$10 Tier 2 50% Tier 3 50%	
Out-of-Network: Deductible	\$7,900 Single / \$15,800 Family		\$7,150 Single / \$14,300 Family	
Out-of-Network: Coinsurance	50%		50%	
Out-of-Network: Annual Out of Pocket Max	\$10,000 Single / \$20,000 Family		\$10,000 Single / \$20,000 Family	
Extra Benefits	\$250 Wellness Card		\$250 Wellness Card	
Rates	Option 7		Option 8	
Single	\$382.68		\$382.68	
Subscriber and Spouse	\$765.35		\$765.35	
Subscriber and Child(ren)	\$650.55		\$650.55	
Family	\$1,090.62		\$1,090.62	

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