

2020 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	\$1,300 Single / \$2,600 Family	\$4,425 Single / \$8,850 Family
Coinsurance	0%	0%	0%	\$0
Annual Out of Pocket Max	\$2,000 Single / \$4,000 Family	\$4,000 Single / \$8,000 Family	\$7,900 Single / \$15,800 Family	\$8,150 Single / \$16,300 Family
PCP Office Visit	\$15 Copay	Deductible then \$25 Copay	Deductible then \$30 Copay	First 3 visits covered in full, 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
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	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	\$883.54	\$724.17	\$563.65	\$413.81
Subscriber and Spouse	\$1,767.08	\$1,448.33	\$1,127.30	\$827.61
Subscriber and Child(ren)	\$1,502.02	\$1,231.09	\$958.20	\$703.47
Family	\$2,518.10	\$2,063.87	\$1,606.40	\$1,179.36

2020 BCBS of WNY Benefit Comparison for Individuals

	BCBS of WNY Gold Ind Destination 65 (NEW)	BCBS of WNY Silver Ind Destination 65 (NEW)
In Network:		
Annual Deductible	\$1,400 Single / \$2,800 Family	\$2,500 Single / \$5,000 Family
Coinsurance	0%	0%
Annual Out of Pocket Max	\$5,000 Single / \$10,000 Family	\$6,400 Single / \$12,800 Family
PCP Office Visit	Deductible then \$10 Copay	Deductible then \$15 Copay
Specialist Visit	Deductible then \$35 Copay	Deductible then \$40 Copay
Sick Child Visit	Deductible then \$10 Copay	Deductible then \$15 Copay
Radiology	Deductible then \$100 Copay	Deductible then \$100 Copay
Laboratory	Deductible then \$10 Copay	Deductible then \$10 Copay
Hospital Inpatient	Deductible then \$290 copay per day for 5 days per admission	Deductible then \$360 copay per day for 5 days per admission
Outpatient Surgery	Deductible then \$300 Copay	Deductible then \$450 Copay
Outpatient OT/PT/ST	Deductible then \$10 Copay	Deductible then \$15 Copay
Emergency Room Care	Deductible then \$90 Copay	Deductible then \$90 Copay
Ambulance	Deductible then \$90 Copay	Deductible then \$90 Copay
Urgent Care	Deductible then \$65 Copay	Deductible then \$65 Copay
Outpatient Mental Health	Deductible then \$10 Copay	Deductible then \$15 Copay
Chiropractor	Deductible then \$10 Copay	Deductible then \$15 Copay
Diabetic Supplies	Deductible then \$10 Copay	Deductible then \$15 Copay
Prescription Coverage	After Deductible Tier 1 \$5 Tier 2 \$50 Tier 3 50%	After Deductible Tier 1 \$5 Tier 2 \$50 Tier 3 50%
Out-of-Network:		
Deductible	Not Covered	Not Covered
Coinsurance	Not Covered	Not Covered
Annual Out of Pocket Max	Not Covered	Not Covered
Extra Benefits	\$250 Wellness Card / HSA Eligible	\$250 Wellness Card / HSA Eligible
Rates	Option 1	Option 2
Single	\$617.34	\$480.46
Subscriber and Spouse	\$1,234.67	\$960.92
Subscriber and Child(ren)	\$1,049.47	\$816.79
Family	\$1,759.41	\$1,369.31

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2020 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	\$5,000 Single / \$10,000 Family	\$0	\$5,000 Single / \$10,000 Family
Coinsurance	NA	50%	NA	50%
Annual Out of Pocket Max	\$8,150 Single / \$16,300 Family		\$8,150 Single / \$16,300 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	\$100 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
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 \$20 Tier 3 50%		Not subject to deductible Tier 1 \$5 Tier 2 \$20 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		\$250 Wellness Card	
Rates	Option 1		Option 2	
Single	\$789.26		\$789.26	
Subscriber and Spouse	\$1,578.53		\$1,578.53	
Subscriber and Child(ren)	\$1,341.75		\$1,341.75	
Family	\$2,249.40		\$2,249.40	

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2020 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	\$800 Single / \$1,600 Family	\$5,000 Single / \$10,000 Family	\$800 Single / \$1,600 Family	\$5,000 Single / \$10,000 Family
Coinsurance	NA	50%	NA	50%
Annual Out of Pocket Max	\$8,150 Single / \$16,300 Family		\$8,150 Single / \$16,300 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
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 \$5 Tier 2 \$40 Tier 3 50%		Not subject to deductible Tier 1 \$5 Tier 2 \$40 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		\$250 Wellness Card	
Rates	Option 3		Option 4	
Single	\$650.68		\$650.68	
Subscriber and Spouse	\$1,301.37		\$1,301.37	
Subscriber and Child(ren)	\$1,106.16		\$1,106.16	
Family	\$1,854.44		\$1,854.44	

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2020 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	\$2,500 Single / \$5,000 Family	\$5,000 Single / \$10,000 Family	\$2,500 Single / \$5,000 Family	\$5,000 Single / \$10,000 Family
Coinsurance	NA	50%	NA	50%
Annual Out of Pocket Max	\$6,000 Single / \$12,000 Family		\$6,000 Single / \$12,000 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
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 \$5 Tier 2 \$50 Tier 3 50%		After Deductible Tier 1 \$5 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 / HSA Eligible		\$250 Wellness Card / Preventative Drug / HSA Eligible	
Rates	Option 5		Option 5	
Single	\$492.00		\$492.00	
Subscriber and Spouse	\$984.00		\$984.00	
Subscriber and Child(ren)	\$836.40		\$836.40	
Family	\$1,402.20		\$1,402.20	

* Preventative Drug : Select Preventative Drugs are at \$0 cost-share, not subject to deductible

2020 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	\$8,000 Single / \$16,000 Family	\$8,150 Single / \$16,300 Family	\$8,000 Single / \$16,000 Family	\$8,150 Single / \$16,300 Family
Coinsurance	50%	0% / 50%	50%	0% / 50%
Annual Out of Pocket Max	\$8,150 Single / \$16,300 Family		\$8,150 Single / \$16,300 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
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 \$15 Tier 2 50% Tier 3 50%	
Out-of-Network: Deductible	\$8,150 Single / \$16,300 Family		\$8,150 Single / \$16,300 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 7		Option 8	
Single	\$383.17		\$383.17	
Subscriber and Spouse	\$766.35		\$766.35	
Subscriber and Child(ren)	\$651.39		\$651.39	
Family	\$1,092.04		\$1,092.04	

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