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2018 Plan Summaries for Participating/Network Providers See the Choices Book and/or Summary Plan Description for Nonparticipating Provider Information			
Plan Name	**Empire Plan (001) Choice Book Pages 18-27**	**BCBS of WNY (067) Choice Book Pages 30-31**	**Independent Health (059) Choice Book Pages 40-41**
Annual Out-of-Pocket Maximum (In-Network Benefits Only)	Individual coverage: $2,550 for the Prescription Drug Program. $4,800 shared maximum for the Hospital, Medical/Surgical and Mental Health Substance Abuse Programs. Family coverage: $5,100 for the Prescription Drug Program. $9,600 shared maximum for the Hospital, Medical/Surgical and Mental Health Substance Abuse Programs.	Individual: $3,000 per year Family: $6,000 per year	Individual: $4,000 per year Family: $8,000 per year
Benefits			
Office Visits	$20 per visit	$20 per visit	$20 per visit
Annual Adult Routine Physicals	No copayment	No copayment	No copayment
Well Child Care	No copayment	No copayment	No copayment
Specialty Office Visits	$20 per visit	$20 per visit	$20 per visit
Diagnostic/Therapeutic Services			
Radiology	$20 per visit	$20 per visit	$20 per visit
Lab Tests	$20 per visit	No copayment	$10 per visit
Pathology	$20 per visit	No copayment	$10 per visit
EKG/EEG	$20 per visit	$20 per visit	$20 per visit
Radiation	No copayment	$20 per visit	$20 per visit
Chemotherapy	No copayment	$20 per visit	$20 per visit
Dialysis	No copayment		

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Women's Health Care/OB GYN (Preventative)			
Pap Tests	No copayment	No copayment	No copayment
Mammograms	No copayment (routine only)	No copayment (routine only)	No copayment
Pre and Postnatal visits	$20 per visit	$20 for initial visit only, then no copayment	No copayment
Screenings and Maternity-Related Lab Tests	$20 per visit		
Bone Density Tests	$20 per visit	No copayment	No copayment
Breastfeeding Services & Equipment	No copayment for pre/postnatal counseling and equipment purchase from a participating provider; one double-electric breast pump per birth		
Family Planning Services	$20 per visit	$20 per visit	$20 per visit
Infertility Services	$20 per visit, no copayment at designated Centers of Excellence	$20 per visit, coverage is provided to diagnose and treat fertility. Applicable copayments apply.	
Physician's Office	$20 per visit		$20 per visit
Outpatient Surgery Facility	$30 or $40 per visit		$100 per visit
Contraceptive Drugs and Devices	No copayment for certain FDA-approved oral contraception methods (including outpatient surgical implantation) and counseling.	No copayment for contraceptive drugs and devices unless a generic equivalent is available, would be subject to a Tier 2 or 3 copayment	Copayment applies only for select Tier 3 oral contraceptive drugs and devices
Inpatient Surgery			
Inpatient Hospital Surgery	No copayment	No copayment	No copayment

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Outpatient Surgery			
Hospital	$40 or $60 per visit	$100 per visit	$100 per visit
Physician's Services	$20 per visit	$20 per visit	$20 per visit
Outpatient Surgery Facility	$40 or $60 per visit	$100 per visit	$100 per visit
Emergency Room (waived if admitted)	$60 or $70 per visit	$100 per visit	$100 per visit
Urgent Care	$20 per visit; $30 or $40 if owned by hospital	$35 per visit, only covered in the eight-county service area of Western New York	$35 per visit, within the service area.
Ambulance	$35 per trip	$100 per trip	$100 per trip
Mental Health Benefits			
Mental Health Practitioner Services	$20 per visit	$20 per visit	$20 per visit
Inpatient Mental Health	No copayment	No copayment	No copayment
Outpatient Drug/Alcohol Rehab	$20 per visit	$20 per visit	$20 per visit
Inpatient Drug/Alcohol Rehab	No copayment	No copayment	No copayment
Rehabilitative Care, Physical, Speech and Occupational Therapy			
Inpatient Care Maximum 45 Days	No copayment	No copayment	No copayment
Outpatient Care Maximum 20 Visits Combined per Year	$20 per visit	$20 per visit	$20 per visit
Medical Supplies			
Durable Medical Equipment	No copayment	50% coinsurance	50% coinsurance
Prosthetics	No copayment	20% coinsurance	No copayment
Orthotic Devices	No copayment	20% coinsurance	No copayment (excludes shoe inserts)
Diabetic Supplies	No copayment	$20 per item	$20 per item
Insulin and Oral Agents	Covered under prescription drug program subject to drug copayment	$20 per item	$20 per item or applicable pharmacy copayment, whichever is less

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Diabetic Shoes	$500 annual maximum benefit	Not covered	No copayment, one pair per year when medically necessary
Prescription Drugs			
Prescription Drugs	$5 Level 1, $25 Level 2, $45 Level 3	$5 Tier 1, $30 Tier 2, $60 Tier 3	$5 Tier 1, $30 Tier 2, $60 Tier 3
Specialty Drugs	Available through mail order at applicable copayment	Available through mail order at applicable copayment	Require prior approval and subject to applicable copayment
Additional Benefits			
Hospice	No copayment, no limit	No copayment, max 210 days per year	No copayment, no limit
Skilled Nursing Facility	Up to 365 benefit days, no copayment	50 day max- No copayment	45 day max- No copayment
Dental	Not covered	Not covered	$50 per cleaning and 20% discount at select providers (preventative only)
Vision	Not covered	Discounts available. Please call 1-888-497-7491 for information.	$10 per visit once every 12 months (routine only)
Hearing Aids	Up to $1,500 per aid per year every 4 years (every 2 years for children) if medically necessary.	Discounts available. Please call 1-888-497-7491 for information.	Discounts available at select locations

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Out of Area	Benefits are the same wherever you are and based on whether or not you treat with a participating provider .See Choices Book or Summary Plan Description for detailed information.	Worldwide coverage for emergency care available through BlueCard Program. Away From Home Care (AFHC) allows you to obtain coverage thorugh a nearby Blue HMO when you are away from home and our service area.	While traveling outside the service area, members may be covered for emergency and urgent care situations only; may require prior approval from carrier.
Home Health Care			40 visits max, $20 per visit
Eyeglasses			$50 for single vision lenses, frams; 40% off retail price
Urgent Care in Service Area for After Hours Care			$35 per visit
Wellness Services		$300 Wellness Card allowance for use at participating providers	$275 allowance for use at a participating facility

DISCLAIMER: This summary is meant to provide a general outline of the main provisions of each health care option. Details of these programs are contained in the information packages provided by each provider. If there is a difference between the summary and the documents or contract, the documents and contracts will govern in every instance. Other HMO plans are available to employees who live outside the eight (8) counties of Western New York. Please see the NYSHIP Choice Book for these plans.