

**Century Preferred Comp**  
**\$200 / \$400 / \$600 Annual Deductible**  
*Benefits at a Glance Stamford BOE Teachers grp 005*

**Century Preferred Comp is a preferred provider organization (PPO) plan.**

	<b>In Network You pay:</b>	<b>Out-of-Network You pay:</b>
Annual Deductible ( <i>individual/2-member family/3+ member family</i> )	\$200 / \$400 / \$600	
Coinsurance	20% after deductible up to	30% after deductible up to
Coinsurance Maximum ( <i>individual/2-member family/3+ member family</i> )	\$1,000 / \$2,000 / \$3,000	
Lifetime Maximum	Unlimited	\$1,000,000

	<b>In Network After Annual Deductible You pay:</b>	<b>Out-of-Network After Annual Deductible You pay:</b>
<b>PREVENTIVE CARE</b>		
Well child care*	20%	30%
Periodic, routine health examinations*	20%	30%
Routine eye exams – <i>one exam every 2 years</i>	20%	30%
Routine OB/GYN visits – <i>one exam per year</i>	20%	30%
Mammography*	20%	30%
Hearing screening – <i>covered once every two years</i>	20%	30%

	<b>In Network After Annual Deductible You pay:</b>	<b>Out-of-Network After Annual Deductible You pay:</b>
<b>MEDICAL CARE</b>		
Primary care office visits	20%	30%
Specialist consultations	20%	30%
OB/GYN care	20%	30%
Maternity care – <i>initial visit subject to copayment, no charge thereafter</i>	20%	30%
Laboratory	20%	30%
X-ray and Diagnostic Testing	20%	30%
Allergy Services		
<i>Office visits/testing</i>	20%	30%
<i>Injections—80 visits in 3 years</i>	20%	30%

**HOSPITAL CARE – Prior authorization required.**

	<b>In Network After Annual Deductible You pay:</b>	<b>Out-of-Network After Annual Deductible You pay:</b>
Semi-private room	20%	30%
Maternity and newborn care	20%	30%
Skilled nursing facility – <i>up to 120 days per calendar year</i>	20%	30%
Rehabilitative services – <i>up to 60 days per person per calendar year</i>	20%	30%
Outpatient surgery – <i>in a hospital or surgi-center</i>	20%	30%

<b>EMERGENCY CARE</b>	<b>In Network After Annual Deductible You pay:</b>	<b>Out-of-Network After Annual Deductible You pay:</b>
Walk-in centers	20%	30%
Urgent care – <i>at participating centers only</i>	20%	Not covered
Emergency care – <i>copayment waived if admitted</i>	20%	20%
Ambulance – <i>air subject to maximum per trip</i>	20%	20%

<b>OTHER HEALTH CARE</b>		
Outpatient rehabilitative services <i>50 visit maximum for PT, OT, ST and Chiro. per year</i>	20%	30%
Prosthetic devices	20%	30%
Durable medical equipment	20%	30%

<b>MENTAL HEALTH/SUBSTANCE ABUSE CARE</b>		
Inpatient	20%	30%
Outpatient/office visits	20%	30%

**\* Schedule of health examinations:**

1 exam annually regardless of age

**\*Mammography:**

1 baseline screening age 35-39

1 screening per year age 40+

Additional exams when medically necessary

**Note:** In situations where the member is responsible for obtaining the necessary prior authorization and fails to do so, benefits may be reduced or denied.

Please refer to the *SpecialOffers@Anthem* brochure in your enrollment kit for information on the discounts we offer on health-related products and services.

*This does not constitute your health plan or insurance policy. It is only a general description of the plan. The following are examples of services NOT covered by your Century Preferred Health Plan. Please refer to your Certificate/Evidence of Coverage/Summary Booklet for more details: Cosmetic surgeries and services; custodial care; genetic testing; hearing aids; refractive eye surgery; services and supplies related to, as well as the performance of, sex change operations; surgical and non-surgical services related to TMJ syndrome; travel expenses; vision therapy; services rendered prior to your contract effective date or rendered after your contract termination date; and workers' compensation.*

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