

Century Preferred \$10/\$0/\$25/\$0

Century Preferred is a preferred provider organization (PPO) plan.
Stamford BOE Security grp 003

COST SHARE PROVISIONS	In-Network Member pays:	Out-of-Network Member pays:
Office Visit (OV) Copayment	\$10 per visit	Deductible & Coinsurance
Hospital (HSP) Copayment	No charge	Deductible & Coinsurance
Urgent Care (UR) Copayment	\$10	Not covered
Emergency Room (ER) Copayment – <i>waived if admitted</i>	\$25	\$25
Outpatient Surgery (OS) Copayment	No charge	Deductible & Coinsurance
Annual Deductible (<i>individual/2-member family/3+ member family</i>)	Not applicable	\$300/\$600/\$800
Coinsurance		20% after deductible up to
Coinsurance Maximum (<i>individual/2-member family/3+ member family</i>)		20%
Cost Share Maximum (<i>individual/2-member family/3+member family</i>)		\$1,300/\$2,600/\$3,300
Lifetime Maximum	Unlimited	Unlimited
PREVENTIVE CARE		
Well child care	No Copayment	Deductible & Coinsurance
Periodic, routine health examinations	No Copayment	
Routine eye exams	No Copayment	
Routine OB/GYN visits	No Copayment	
Mammography	No Charge	
Hearing screening	No Copayment	
MEDICAL CARE		
Office visits	OV Copayment	Deductible & Coinsurance
Outpatient Mental Health & Substance Abuse - <i>prior authorization required</i>	OV Copayment	
OB/GYN care	OV Copayment	
Maternity care – <i>initial visit subject to copayment, no charge thereafter</i>	OV Copayment	
Diagnostic Lab, X-ray and Testing	No charge	
Acupuncture	OV Copayment	
Allergy Services <i>Office visits/testing</i>	OV Copayment	
<i>Injections—80 visits in 3 years</i>	OV Copayment	
HOSPITAL CARE – Prior authorization required		
Semi-private room (<i>General/Medical/Surgical/Maternity</i>)	No Copayment	Deductible & Coinsurance
Inpatient Mental Health & Substance Abuse	No Copayment	
Skilled nursing facility – <i>up to 120 days per calendar year</i>	No Copayment	
Rehabilitative services – <i>up to 60 days per person per calendar year</i>	No charge	
Outpatient surgery – <i>in a hospital or surgi-center</i>	No Copayment	
EMERGENCY CARE		
Walk-in centers	OV Copayment	Deductible & Coinsurance
Urgent care – <i>at participating centers only</i>	UR Copayment	Not covered
Emergency care – <i>copayment waived if admitted</i>	ER Copayment	ER Copayment
Ambulance	No charge	No charge

OTHER HEALTH CARE

Outpatient rehabilitative services <i>Unlimited maximum per calendar year</i>	OV Copayment	Deductible & Coinsurance
Durable medical equipment / Prosthetic Devices <i>Unlimited maximum per calendar year</i>	No charge	Deductible & Coinsurance
Infertility Services (<i>diagnosis and treatment</i>)	Covered	Deductible & Coinsurance
Home Health Care	No charge	Deductible & Coinsurance

PREVENTIVE CARE SCHEDULES

Well Child Care (including immunizations)

- ◆ 1 exam every year regardless of age

Mammography

- ◆ 1 baseline screening, ages 35-39
- ◆ 1 screening per year, ages 40+
- ◆ Additional exams when medically necessary

Adult Exams

- ◆ 1 exam every year, regardless of age

Vision Exams: 1 exam every calendar year

Hearing Exams: 1 exam every 2 calendar years

OB/GYN Exams: 1 exam per calendar year

Notes To Benefit Descriptions

- ◆ In situations where the member is responsible for obtaining the necessary prior authorization and fails to do so, benefits may be reduced or denied.
- ◆ Inpatient Hospital Per Admission Copay is waived if readmitted within 30 days for same diagnosis. Maximum of 3 copays per person per year.
- ◆ Skilled Nursing Facility Copay is waived if admitted within 3 days of hospital discharge.
- ◆ Home Health Care services are covered when in lieu of hospitalization. Includes infusion (IV) therapy.
- ◆ Members must utilize participating Blue Quality Centers for Transplant hospitals to receive benefits for Human Organ & Tissue Transplant services. This network of the finest medical transplant programs in the nation is available to members who are candidates for an organ or bone marrow transplant. A nurse consultant trained in case management is dedicated to managing members who require organ and/or tissue transplants. Covered services are subject to a lifetime maximum of \$1,000,000.
- ◆ Members are responsible for the balance of charges billed by out-of-network providers after payment for covered services has been made by Anthem Blue Cross and Blue Shield according to the Comprehensive Schedule of Professional Services.

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 Plan. Please refer to your Subscriber Agreement/Certificate 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.

A product of Anthem Blue Cross and Blue Shield serving residents and businesses in the State of Connecticut.