

## Century Preferred \$15/\$100/\$50/\$0

Century Preferred is a preferred provider organization (PPO) plan.  
Stamford BOE Teachers group 000

<b>COST SHARE PROVISIONS</b>	<b>In-Network Member pays:</b>	<b>Out-of-Network Member pays:</b>
Office Visit ( <b>OV</b> ) Copayment	\$15 per visit	Deductible & Coinsurance
Hospital ( <b>HSP</b> ) Copayment	\$100 per admission	Deductible & Coinsurance
Urgent Care ( <b>UR</b> ) Copayment	\$10	Not covered
Emergency Room ( <b>ER</b> ) Copayment – <i>waived if admitted</i>	\$50	\$50
Outpatient Surgery ( <b>OS</b> ) Copayment	\$0	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
<b>PREVENTIVE CARE</b>		
Well child care	OV Copayment	Deductible & Coinsurance
Periodic, routine health examinations	OV Copayment	
Routine eye exams	OV Copayment	
Routine OB/GYN visits	OV Copayment	
Mammography	No Charge	
Hearing screening	OV Copayment	
<b>MEDICAL CARE</b>		
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	
High-Cost Outpatient Diagnostic – <i>prior authorization required</i>	No charge	
Allergy Services <i>Office visits/testing</i> <i>Injections—80 visits in 3 years</i> <i>Acupuncture</i>	OV Copayment \$15 Copayment \$15 Copayment	
<b>HOSPITAL CARE – Prior authorization required</b>		
Semi-private room ( <i>General/Medical/Surgical/Maternity</i> )	HSP Copayment	Deductible & Coinsurance
Inpatient Mental Health & Substance Abuse	HSP Copayment	
Skilled nursing facility – <i>up to 120 days per calendar year</i>	HSP Copayment	
Rehabilitative services – <i>up to 60 days per person per calendar year</i>	HSP Copayment	
Outpatient surgery – <i>in a hospital or surgi-center</i>	No Copayment	
<b>EMERGENCY CARE</b>		
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
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**OTHER HEALTH CARE**

Outpatient rehabilitative services <i>Unlimited visits per member, per calendar year</i>	OV Co-payment	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.