

**CENTURY PREFERRED \$20/\$30/\$250/\$100/\$100 STAMFORD BOE ADM FD 001**

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

<b>COST SHARE PROVISIONS</b>	<b>In-Network Member pays:</b>	<b>Out-of-Network Member pays:</b>
Office Visit (OV) Copayment	\$20 per visit	Deductible & Coinsurance
Office Visit (SV) Copayment	\$30 per visit	
Hospital (HSP) Copayment	\$250 per admission	Deductible & Coinsurance
Urgent Care (UR) Copayment	\$10	Not Covered
Emergency Room (ER) Copayment – <i>waived if admitted</i>	\$100	\$100
Outpatient Surgery (OS) Copayment	\$100	Deductible & Coinsurance
Annual Deductible ( <i>individual/2-member family/3+ member family</i> )	Not Applicable	\$300/\$600/\$800
Coinsurance		20% after deductible up to
Cost Share Maximum ( <i>individual/2-member family/3+member family</i> )		\$1,300/ \$2,600 / \$3,300
Lifetime Maximum	Unlimited	\$1,000,000
<b>PREVENTIVE CARE</b>		
Well child care	OV Copayment	Deductible & Coinsurance
Periodic, routine health examinations	OV Copayment	
Routine eye exams	SV Copayment	
Routine OB/GYN visits	OV Copayment	
Mammography	No Charge	
Hearing screening	SV 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	SV Copayment	
Maternity care – <i>initial visit subject to copayment, no charge thereafter</i>	OV Copayment	
Diagnostic lab and x-ray	No Charge	
<b>High-cost outpatient diagnostic – prior authorization required</b> <i>The following are subject to copay: MRI, MRA, CAT, CTA, PET, SPECT scans</i> <i>Note: \$375 Copayment Maximum per Member per Calendar Year</i>	\$75 Copayment (See note)	
Allergy services <i>Office visits/testing</i> <i>Injections—80 visits in 3 years</i>	SV Copayment NO 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>	OS 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

<b>OTHER HEALTH CARE</b>	<b>In-Network Member pays:</b>	<b>Out-of-Network Member pays:</b>
Outpatient rehabilitative services <i>Unlimited visit maximum for PT, OT and St and Chiro. per year</i>	SV Copayment	Deductible & Coinsurance
Durable medical equipment / Prosthetic devices <i>Unlimited maximum per calendar year</i>	Covered	Deductible & Coinsurance
Infertility services – <i>prior authorization required</i> <i>Some restrictions may apply</i>	Applicable Copayment	Deductible & Coinsurance
Home health care	No Charge	\$50 Deductible & 20 % Coinsurance
Prescription drugs – <i>filled at a pharmacy</i>	Not Covered	Not Covered

**PREVENTIVE CARE SCHEDULES**

**Well Child Care (including immunizations)**

- ◆ 6 exams, birth to age 1
- ◆ 6 exams, ages 1 - 5
- ◆ 1 exam every 2 years, ages 6 - 10
- ◆ 1 exam every year, ages 11 - 21

**Mammography**

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

**Adult Exams**

- ◆ 1 exam every 5 years, ages 22 - 29
- ◆ 1 exam every 3 years, ages 30 - 39
- ◆ 1 exam every 2 years, ages 40 - 49
- ◆ 1 exam every year, ages 50+

**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.*

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