Town of Glastonbury Non Affiliate Active
Firm # 000591-030/031
Century Preferred (PPO) $20/$100/$100/$100
Benefits at a Glance

	In Network *You pay:*	**Out-of-Network** *You pay:*
Office Visit Copayment	**$20**	**Deductible & Coinsurance**
Specialist Visit Copayment	**$25**	**Deductible & Coinsurance**
Hospital Copayment	**$100 per day $500 Maximum per Calendar Year**	**Deductible & Coinsurance**
Urgent Care Copayment	**$25**	**Not covered**
Emergency Room Copayment	**$100**	**$100**
Outpatient Surgery Copayment	**$100**	**Deductible & Coinsurance**
Annual Deductible (*individual/2-member family/3+ member family*)	**Not applicable**	**$200/$400/$500**
Coinsurance		**20% after deductible up to**
Coinsurance Maximum (*individual/2-member family/3+ member family*) *The in-network cost share maximum includes the in-network deductible, in-network coinsurance and in-network medical copayments.*	**$6,850/$13,700/ $13,700**	**$1,000.$2,000/$2,500**
Lifetime Maximum	**Unlimited**	**Unlimited**

PREVENTIVE CARE

Well child care	**No Charge**	**Deductible & Coinsurance**
Periodic, routine health examinations	**No Charge**	
Routine eye exams – ***one exam every 2 years***	**No Charge**	
Routine OB/GYN visits – ***one exam per year***	**No Charge**	
Mammography ***1 baseline age 35 – 39 years 1 screening per year age 40+ Additional exams when medically necessary***	**No Charge**	
Hearing screening – ***covered once every two years***	**SV Copayment**	

MEDICAL CARE

Primary care office visits	**OV Copayment**	**Deductible & Coinsurance**
Specialist consultations	**SV Copayment**	
OB/GYN care	**SV Copayment**	
Maternity care – ***initial visit subject to copayment, no charge thereafter***	**SV Copayment**	
Laboratory	**No Charge**	
X-ray and Diagnostic Testing	**No Charge**	
Allergy Services ***Office visits/testing*** ***Injections—80 visits in 3 years***	**SV Copayment No Charge**	

HOSPITAL CARE – ***Prior authorization required.***

Semi-private room	**HSP Copayment**	**Deductible & Coinsurance**
Maternity and newborn care	**HSP Copayment**	
Skilled nursing facility – ***up to 120 days per calendar year***	**HSP Copayment**	
Rehabilitative services – ***up to 60 days per person per calendar year***	**NO Copayment**	
Outpatient surgery – ***in a hospital or surgi-center***	**OS Copayment**	

EMERGENCY CARE

Walk-in centers	**OV Copayment**	**Deductible & Coinsurance**
Urgent care – ***at participating centers only***	**UR Copayment**	**Not covered**
Emergency care	**ER Copayment**	**ER Copayment**
Ambulance	**No Charge**	**No charge**

OTHER HEALTH CARE

Outpatient rehabilitative services ***50 visit maximum for PT, OT, ST and Chiro per year***	**No Charge**	**Deductible & Coinsurance**
Prosthetic devices -unlimited	**No charge**	
Durable medical equipment - unlimited	**No charge**	

MENTAL HEALTH/SUBSTANCE ABUSE CARE

Inpatient	**HSP Copayment**	**Deductible & Coinsurance**
Outpatient/office visits	**OV Copayment**	

PREVENTIVE CARE SCHEDULES

Well Child Care (including immunizations)
- 7 exams, birth to age 1
- 7 exams, ages 1 - 5
- 1 exam every year age 5-22
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Adult Exams
- 1 exam every year, ages 22+

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

Vision Exams: 1 exam every 2 years

Hearing Exams: 1 exam ever year

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.
- 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 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.