Employer/Group: CITY OF WATERBURY
Firm Division: 001645212 - CITY OF WATERBURY-TEACHERS

CENTURY PREFERRED,$25.00

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

COST SHARE PROVISIONS	**In Network** ***Member Pays:***	**Out-of-Network** ***Member Pays:***
Office Visit Copayment	$25.00	Deductible & Coinsurance
Specialist Visit Copayment	$25.00	
Hospital Copayment *(per admission)*	$300.00	
Urgent Care Copayment	$100.00	
Outpatient Surgery Copayment	$200.00	
Emergency Room Copayment *(waived if admitted)*	$100.00	$100.00
Annual Deductible *(indiviual/2-member family/3+ member family)*	Does not apply	$400/$800/$1,200
Coinsurance	Does not apply	30 %
Coinsurance Maximum *(indiviual/2-member family/3+ member family)*	Does not apply	$1,200/$2,400/$3,600
Lifetime Maximum	Unlimited	Unlimited

PREVENTIVE CARE

Well child care*	No Copay	Deductible & Coinsurance
Periodic, routine health examinations*	No Copay	Deductible & Coinsurance
Routine eye exams	No Copay	Deductible & Coinsurance
Routine OB/GYN visits	No Copay	
Mammography*	No Copay	
Hearing screening	No Copay	

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MEDICAL CARE **MEDICAL CARE**	**In Network** ***Member Pays:***	**Out-of-Network** ***Member Pays:***
Office visits	$25.00	Deductible & Coinsurance
Office visits - Specialist	$25.00	
Outpatient mental health & substance abuse *(prior authorization may be required)*	Refer to Plan Document	
OB/GYN care	$25.00	
Maternity care *(initial visit subject to copayment, no charge thereafter)*	$25.00	
Diagnostic lab and x-ray	Covered	
High-cost outpatient diagnostic *(prior authorization may be required)* *The following are not subject to copay: MRI, MRA, CAT, CTA, PET, SPECT scans*	No Copay	
Allergy services - Office Visits	$25.00	
Allergy services - Testing	$25.00	
Allergy services - Injections *(80 - Within 3 Years)*	No Copayment	

HOSPITAL CARE - *Prior authorization may be required*

Semi-private room *(General/Medical/Surgical/Maternity)*	$300.00	Deductible & Coinsurance
Inpatient mental health and substance abuse	$300.00	
Skilled nursing facility *(up to 120 days per calendar year)*	$300.00	
Rehabilitative services *(up to 60 days per calendar year)*	No Charge	
Outpatient surgery *(in a hospital or surgi-center)*	$200.00	

EMERGENCY CARE

Walk-in centers	$25.00	Deductible & Coinsurance
Urgent care *(at participating centers only)*	$100.00	Deductible & Coinsurance
Emergency care *(copayment waived if admitted)*	$100.00	$100.00
Ambulance	No Copayment	No Copayment

OTHER HEALTH CARE **OTHER HEALTH CARE**	**In Network** ***Member Pays:***	**Out-of-Network** ***Member Pays:***
Physical, Occupational, Speech and Chiropractic Therapies *(50 - Per Member Per Calendar Year)*	$25.00	Deductible & Coinsurance
Durable Medical Equipment and Prosthetics *(Unlimited maximum per calendar year)*	No Copayment	Deductible & Coinsurance
Infertility Services *(Prior authorization may be required - Some restrictions may apply)*	Refer to Plan Document	Deductible & Coinsurance
Home Health Care	No Copayment	$50.00 Deductible & 20% Coinsurance

*** PREVENTIVE CARE SCHEDULES**

Well Child Care: *(including immunizations)*

-7 exams, birth to age 1
-7 exams, ages 1 thru 5
-1 exam every year, ages 5 thru 12
-1 exam every year, ages 12 thru 22

Adult Exams:

-1 exam annually, ages 22 and over

Mammography: *(additional exams when medically necessary)*

AGE 35-39, 1 BASELINE EXAM;
AGE 40 AND OVER, 1 EVERY YEAR

Vision Exams: ONCE EVERY 2 YEARS
Hearing Exams: ONCE EVERY 2 YEARS
OB/GYN Exams: 1 EXAM PER MEMBER PER CALENDAR YEAR

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Note To Benefit Descriptions:

- In situations where the member is responsible for obtaining the necessary prior authorizations 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.
- 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 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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DENTAL FLEX

Description of Benefits	***You Pay:***
Annual Deductible *(individual/family)*	$50.00/$150.00
Annual Maximum *(per member per calendar year)*	$1,000.00
Lifetime Orthodontic Maximum *(per member)*	Does not Apply

Diagnostic & Preventive Services

- Periodic evaluations	- Fluoride treatments to age 19	No Charge
- Initial evaluation	- X-rays	
- Cleanings, 2 per year	- Emergency Palliative treatment	

Basic Services

- Fillings	- Simple and surgical extractions	No Charge
- Repairing and relining of dentures	- Recement bridge	
- Endodontics including but not limited to root canal therapy		

Major Services

- Space maintainers to age 19	- Crowns	50%, after deductible
- Oral surgery	- Inlays	
- Recement crown	- Onlays	

Accessing Benefits:

Participating Dentists Benefits: When a member receives care from one of our participating Dentists, he or she simply presents his or her identification card showing dental coverage. The dentist bills us directly for all covered services. For dental care provided by a Participating Dentist, we will pay the lesser of Dentist's usual charge or maximum allowable amount as determined by Anthem BCBS. The participating Dentist will accept Anthem BCBS's payment in full and make no additional charge to the member, except as otherwise specified in the member's certificate of coverage.
Non-Participating Dentists Benefits: Anthem BCBS will pay the maximum allowable amount as determined by Anthem BCBS. The member is responsible for any difference between the amount paid by

Anthem BCBS and the fee charged by the Dentist.

Dental claims should be submitted to Anthem BCBS Dental, P.O.Box 547, North Haven CT 06473.

Principle Limitations and Exclusions

Services received from a dental or medical department maintained by an employer, a mutual benefit association, labor union, trustee or other similar person or group; Services for which the member incurs no Dentists' Charge or which are services of a type ordinarily performed by a physician, or charges which would not have been made if insurance was not available; Services with respect to congenital malformations; Services, treatment or supplies furnished by or at the direction of any government, state or political subdivision; Any items not specifically listed in this Policy; Lost or stolen dentures or denture duplication; Gold foil restorations; Temporary services and appliances; such as crown or tooth preparations and temporary fillings, crowns, bridges and dentures; Application of sealants, regardless of reason; Services as determined by the company, that are rendered in a manner contrary to normal dental practice. A complete list of exclusions appears in the Certificate of Coverage.

This is not a legal policy or contract. It is only a general description of your benefits. If there are discrepancies between the Certificate of Coverage and this summary, the Certificate of Coverage shall control.