# City of Waterbury Benefit Comparison

| | Century Preferred Plan Three | | BlueCare POS | | BlueCare POE |
|---|---|---|---|---|---|
| | In Network | Out of Network | In Network | Out of Network | In Network Services Only |
| **COSTSHARES** | | Member Pays | | Member Pays | |
| | **In-Network services subject to copays** | **Out of Network services subject to deductible and coinsurance** | **In-Network services subject to copays** | **Out of Network services subject to deductible and coinsurance** | **In-Network services subject to copays<br>Out-of-Network services - No Coverage unless emergency** |
| | $20 Copay - Preventive Office Visits<br>$20 Copay Primary Care Office Visits<br>$20 Copay Specialist Office Visits | Deductible: $400 Ind./$800 2 Person/ $1,200 Family<br>Coinsurance - 70% to $4,000 Ind./$8,000 2 Person/$12,000 Fam.<br>Cost Share Max: $1,600 Ind./$3,200 2 Person/$4,800 Family<br>Out of network reimbursement is based on MAA | $20 Copay - Preventive Office Visits<br>$20 Copay Primary Care Office Visits<br>$20 Copay Specialist Office Visits | Deductible: $400 Ind./$800 2 Person/ $1,200 Family<br>Coinsurance - 70% to $4,000 Ind./$8,000 2 Person/$12,000 Fam.<br>Cost Share Max: $1,600 Ind./$3,200 2 Person/$4,800 Family<br>Out of network reimbursement is based on MAA | $10 Copay - Preventive Office Visits<br>$10 Copay Primary Care Office Visits<br>$20 Copay Specialist Office Visits |
| | In-Network Lifetime Maximum - Unlimited | Lifetime Maximum - Unlimited | Lifetime Maximum - Unlimited | Lifetime Maximum -$1,000,000 | Lifetime Maximum - Unlimited |
| **PREVENTIVE CARE** | | | | | |
| **Pediatric** | $20 Copay - Covered according to age based schedule<br><br>Six exams - Birth to one year<br>Six exams - 1 through 5 years<br>One exam every two years - 6 years through 10 years<br>One exam every year - 11 through 21 years | 30% after deductible<br>Covered according to age based schedule | $20 Copay - Covered according to age based schedule<br><br>Six exams - Birth to one year<br>Six exams - 1 through 5 years<br>One exam every two years - 6 years through 10 years<br>One exam every year - 11 through 21 years | Not Covered | $10 Copay - Covered according to age based schedule<br><br>Six exams - Birth to one year<br>Six exams - 1 through 5 years<br>One exam every two years - 6 years through 10 years<br>One exam every year - 11 through 21 years |
| **Adult** | $20 Copay - Covered according to age based schedule<br><br>One exam evry 5 years - 22 through 29 years<br>One exam every 3 years - 30 through 39 years<br>One exam every 2 years - 40 through 49 years<br>One exam every year - 50 and older | 30% after deductible<br>Covered according to age based schedule | $20 Copay - Covered according to age based schedule<br><br>One exam evry 5 years - 22 through 29 years<br>One exam every 3 years - 30 through 39 years<br>One exam every 2 years - 40 through 49 years<br>One exam every year - 50 and older | Not Covered | $10 Copay - Covered according to age based schedule<br><br>1 exam every 5 years from 22 through 29 years<br>1 exam every 3 years from 30 through 39 years<br>1 exam every 2 years from 40 through 49 years<br>1 exam annually from 50 years and older |
| **Gynecological Exams** | $20 Copay - One routine exam per year. | 30% after deductible<br>One routine exam per year | $20 Copay - One routine exam per year. | 30% after deductible<br>One routine exam per year | $10 Copay<br>1 routine exam per year |
| **Mammographic Services** | No Copay<br>Age 35 to 39 - 1 baseline mammography<br>Age 40 and over - once per calendar year<br><br>In addition - as medically necessary | 30% after deductible<br>Covered according to age based schedule | No Copay<br>Age 35 to 39 - 1 baseline mammography<br>Age 40 and over - once per calendar year<br><br>In addition - as medically necessary | 30% after deductible<br>Covered according to age-based schedule | No Copay<br>Age 35 to 39 - 1 baseline mammography<br>Age 40 and over - once per calendar year<br><br>In addition - as medically necessary |
| **Vision** | $20 Copay - One exam every two years | 30% after deductible<br>Covered every two years | $20 Copay - One exam every two years | Not Covered | $10 Copay - One exam every two years |

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| **MEDICAL SERVICES** | | | | | |
| **Medical Office Visit** | $20 Copay Primary Care<br>$20 Copay Specialist | 30% after deductible<br>30% after deductible | $20 Copay Primary Care<br>$20 Copay Specialist | 30% after deductible<br>30% after deductible | $10 Copay Primary Care<br>$20 Copay Specialist |
| **PT/OT Speech/Chiro** | $20 Copay<br>50 combined treatments | 30% after deductible<br>50 Combined Treatments | $20 Copay<br>Subject to medical necessity | 30% after deductible<br>Subject to medical necessity | $20 Copay<br>Subject to medical necessity |
| **Allergy Services** | $20 Copay for office visits and testing.<br>No copay for injections<br>80 treatments in 3 years | 30% after deductible | $20 Copay for Office Visits<br>No copay for injections<br>60 treatments in 2 years | 30% after deductible<br>60 treatments in 2 years | $20 Copay for Office Visits<br>No copay for injections<br>60 treatments in 2 years |
| **Diagnostic Lab & X-ray** | Covered | 30% after deductible | Covered | 30% after deductible | Covered |
| **Inpatient Medical Services** | Covered | 30% after deductible | Covered | 30% after deductible | Covered |
| **Surgery Fees** | Covered | 30% after deductible | Covered | 30% after deductible | Covered |
| **Office Surgery** | Covered | 30% after deductible | Covered | 30% after deductible | Covered |
| **Mental Health & Substance Abuse**<br>**Prior Auth. Required** | | | | | |
| **Inpatient Hospital Psychiatric** | $200 Copay | 30% after deductible | $200 Copay | 30% after deductible | $200 Copay |
| **Outpatient MH** | $20 Copay | 30% after deductible | $20 Copay | 30% after deductible | $20 Copay |
| **Inpatient Substance Abuse** | $200 Copay | 30% after deductible | $200 Copay | 30% after deductible | $200 Copay |
| **Outpatient MH Substance Abuse** | $20 Copay | 30% after deductible | $20 Copay | 30% after deductible | $20 Copay |

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| **EMERGENCY SERVICES** | | | | | |
| **Emergency Room** | $75 Copay<br>Waived if admitted | $75 Copay<br>Waived if admitted | $75 Copay<br>Waived if admitted | $75 Copay<br>Waived if admitted | $50 Copay<br>Waived if admitted |
| **Urgent Care** | $75 Copay | 30% after deductible | $75 Copay | Not Covered | $50 Copay |
| **Walk-in Center** | $20 Copay | 30% after deductible | $20 Copay | 30% after deductible | $10 copay |
| **Ambulance** | Covered | Covered | Covered | Covered | Covered |
| **INPATIENT HOSPITAL** | NOTE: Pre-Cert Required | NOTE: Pre-Cert. Required | NOTE: Pre-Cert. Required | NOTE: Pre-Cert. Required | NOTE: Pre-Cert. Required |
| **Medical/Surgical Maternity (Semi-Private)** | $200 Copay | 30 days/benefit period at<br>30% after deductible | $200 Copay | 30% after deductible | $200 Copay |
| **Ancillary Services (Medication, Supplies)** | Covered | 30% after deductible | Covered | 30% after deductible | Covered |
| **OUTPATIENT HOSPITAL** | | | | | |
| **Outpatient Surgery Facility Charges** | $100 Copay | 30% after deductible | $100 Copay | 30% after deductible | $100 Copay |
| **Diagnostic Lab & X-ray** | Covered | 30% after deductible | Covered | 30% after deductible | Covered |
| **Pre-Admission Testing** | Covered | 30% after deductible | Covered | 30% after deductible | Covered |
| **OTHER SERVICES** | | | | | |
| **Infertility Services** | Covered | 30% After Deductible | Phase I: $20 copay, Phase II and III: 50% coinsurance | Not Covered | Phase I: $10 copay, Phase II and III: 50% coinsurance |
| **Skilled Nursing Facility** | $200 Copay<br>Covered up to 120 days per calendar year | 20 % After Deductible<br>Covered up to 120 days per calendar year | $200 Copay<br>Covered up to 90 consecutive days | 30% after deductible<br>Covered up to 90 consecutive days | $200 Copay<br>Covered up to 90 days per calendar year |
| **Hospice** | Covered<br>Covered up to 60 days per calendar year | 30% After Deductible<br>Covered up to 60 days per calendar year | Covered<br>Covered up to 60 days per calendar year | 30% after deductible<br>Covered up to 60 days per calendar year | Covered<br>Covered up to 60 days per calendar year |
| **Durable Medical Equipment** | Covered | 30% After Deductible | Covered | Not Covered | Covered |
| **Dependent Eligibility** | Child to age 25 | | Child to age 25 | | Child to age 25 |
| **PHARMACY BENEFIT** | | | | | |
| | Not Applicable | After Medco Benefit;<br>Regular Plan Provisions Apply<br>Deductible: $400 ind/$800 2 person/$1,200 Family<br><br>Plan Pays 70% after deductible to $4,000 ind;<br>$8,000 2person/$12,000 Family<br>Employee pays 30%<br>Up to<br>Out of Pocket Maximum of $1,600 ind;<br>$3,200 2 person/$4,800 family<br>100% after maximum reached | Not Applicable | Not Applicable | Not Applicable |