

## 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
<b>COSTSHARES</b>	Member Pays		Member Pays		
	<b>In-Network services subject to copays</b>	<b>Out of Network services subject to deductible and coinsurance</b>	<b>In-Network services subject to copays</b>	<b>Out of Network services subject to deductible and coinsurance</b>	<b>In-Network services subject to copays Out-of-Network services - No Coverage unless emergency</b>
	No Copay - Preventive Office Visits \$25 Copay Primary Care Office Visits \$25 Copay Specialist Office Visits	Deductible: \$400 Ind./\$800 2 Person/ \$1,200 Family Coinsurance - 70% to \$4,000 Ind./\$8,000 2 Person/\$12,000 Fam. Cost Share Max: \$1,600 Ind./\$3,200 2 Person/\$4,800 Family Out of network reimbursement is based on MAA	No Copay - Preventive Office Visits \$25 Copay Primary Care Office Visits \$25 Copay Specialist Office Visits	Deductible: \$400 Ind./\$800 2 Person/ \$1,200 Family Coinsurance - 70% to \$4,000 Ind./\$8,000 2 Person/\$12,000 Fam. Cost Share Max: \$1,600 Ind./\$3,200 2 Person/\$4,800 Family Out of network reimbursement is based on MAA	No Copay - Preventive Office Visits \$15 Copay Primary Care Office Visits \$25 Copay Specialist Office Visits
	In-Network Lifetime Maximum - Unlimited	Lifetime Maximum - Unlimited	Lifetime Maximum - Unlimited	Lifetime Maximum - Unlimited	Lifetime Maximum - Unlimited
<b>PREVENTIVE CARE</b>					
<b>Pediatric</b>	No Copay - Covered according to HCR age based schedule  7 exams, birth to age 1 7 exams, ages 1 -5 1 exams every year age 5 - 22	30% after deductible Covered according to HCR age based schedule	No Copay - Covered according to HCR age based schedule  7 exams, birth to age 1 7 exams, ages 1 -5 1 exams every year age 5 - 22	Not Covered	No Copay - Covered according to HCR age based schedule  7 exams, birth to age 1 7 exams, ages 1 -5 1 exams every year age 5 - 22
<b>Adult</b>	No Copay - Covered according to HCR age based schedule  One exam every year - 22 and older	30% after deductible Covered according to HCR age based schedule	No Copay - Covered according to HCR age based schedule  One exam every year - 22 and older	Not Covered	No Copay - Covered according to HCR age based schedule  One exam every year - 22 and older
<b>Gynecological Exams</b>	No Copay - One routine exam per year.	30% after deductible One routine exam per year	No Copay - One routine exam per year.	30% after deductible One routine exam per year	No Copay - One routine exam per year.
<b>Mammographic Services</b>	No Copay Age 35 to 39 - 1 baseline mammography Age 40 and over - once per calendar year  In addition - as medically necessary	30% after deductible Covered according to age based schedule	No Copay Age 35 to 39 - 1 baseline mammography Age 40 and over - once per calendar year  In addition - as medically necessary	30% after deductible Covered according to HCR age-based schedule	No Copay Age 35 to 39 - 1 baseline mammography Age 40 and over - once per calendar year  In addition - as medically necessary
<b>Vision</b>	No Copay - One exam every two years	30% after deductible Covered every two years	No Copay - One exam every two years	Not Covered	No Copay - One exam every two years

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<b>MEDICAL SERVICES</b>					
<b>Medical Office Visit</b>	\$25 Copay Primary Care \$25 Copay Specialist	30% after deductible 30% after deductible	\$25 Copay Primary Care \$25 Copay Specialist	30% after deductible 30% after deductible	\$15 Copay Primary Care \$25 Copay Specialist
<b>PT/OT Speech/Chiro</b>	\$25 Copay 50 combined treatments	30% after deductible 50 Combined Treatments	\$25 Copay Subject to medical necessity	30% after deductible Subject to medical necessity	\$25 Copay Subject to medical necessity
<b>Allergy Services</b>	\$25 Copay for office visits and testing. No copay for injections 80 treatments in 3 years	30% after deductible	\$25 Copay for Office Visits No copay for injections 60 treatments in 2 years	30% after deductible 60 treatments in 2 years	\$25 Copay for Office Visits No copay for injections 60 treatments in 2 years
<b>Diagnostic Lab &amp; X-ray</b>	Covered	30% after deductible	Covered	30% after deductible	Covered
<b>Inpatient Medical Services</b>	Covered	30% after deductible	Covered	30% after deductible	Covered
<b>Surgery Fees</b>	Covered	30% after deductible	Covered	30% after deductible	Covered
<b>Office Surgery</b>	Covered	30% after deductible	Covered	30% after deductible	Covered
<b>Mental Health &amp; Substance Abuse</b>					
<i>Prior Auth. Required</i>					
<b>Inpatient Hospital Psychiatric</b>	\$300 Copay	30% after deductible	\$300 Copay	30% after deductible	\$300 Copay
<b>Outpatient MH</b>	\$25 Copay	30% after deductible	\$25 Copay	30% after deductible	\$25 Copay
<b>Inpatient Substance Abuse</b>	\$300 Copay	30% after deductible	\$300 Copay	30% after deductible	\$300 Copay
<b>Outpatient MH Substance Abuse</b>	\$25 Copay	30% after deductible	\$25 Copay	30% after deductible	\$25 Copay

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<b>EMERGENCY SERVICES</b>					
<b>Emergency Room</b>	\$100 Copay Waived if admitted	\$100 Copay Waived if admitted	\$100 Copay Waived if admitted	\$100 Copay Waived if admitted	\$100 Copay Waived if admitted
<b>Urgent Care</b>	\$100 Copay	30% after deductible	\$100 Copay	Not Covered	\$100 Copay
<b>Walk-in Center</b>	\$25 Copay	30% after deductible	\$25 Copay	30% after deductible	\$15 copay
<b>Ambulance</b>	Covered	Covered	Covered	Covered	Covered
<b>INPATIENT HOSPITAL</b>	<b>NOTE: Pre-Cert Required</b>	<b>NOTE: Pre-Cert. Required</b>	<b>NOTE: Pre-Cert. Required</b>	<b>NOTE: Pre-Cert. Required</b>	<b>NOTE: Pre-Cert. Required</b>
<b>Medical/Surgical</b>	\$300 Copay	30 days/benefit period at 30% after deductible	\$300 Copay	30% after deductible	\$300 Copay
<b>Maternity (Semi-Private)</b>					
<b>Ancillary Services (Medication, Supplies)</b>	Covered	30% after deductible	Covered	30% after deductible	Covered
<b>OUTPATIENT HOSPITAL</b>					
<b>Outpatient Surgery Facility Charges</b>	\$200 Copay	30% after deductible	\$200 Copay	30% after deductible	\$200 Copay
<b>Diagnostic Lab &amp; X-ray</b>	Covered	30% after deductible	Covered	30% after deductible	Covered
<b>Pre-Admission Testing</b>	Covered	30% after deductible	Covered	30% after deductible	Covered
<b>OTHER SERVICES</b>					
<b>Infertility Services</b>	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
<b>Skilled Nursing Facility</b>	\$300 Copay Covered up to 120 days per calendar year	20 % After Deductible Covered up to 120 days per calendar year	\$300 Copay Covered up to 90 consecutive days	30% after deductible Covered up to 90 consecutive days	\$300 Copay Covered up to 90 days per calendar year
<b>Hospice</b>	Covered Covered up to 60 days per calendar year	30% After Deductible Covered up to 60 days per calendar year	Covered Covered up to 60 days per calendar year	30% after deductible Covered up to 60 days per calendar year	Covered Covered up to 60 days per calendar year
<b>Durable Medical Equipment</b>	Covered	30% After Deductible	Covered	Not Covered	Covered
<b>Dependent Eligibility</b>	Child to age 26		Child to age 26		Child to age 26
<b>PHARMACY BENEFIT</b>					
	Not Applicable	After Medco Benefit; Regular Plan Provisions Apply Deductible: \$400 ind/\$800 2 person/\$1,200 Family  Plan Pays 70% after deductible to \$4,000 ind; \$8,000 2person/\$12,000 Family Employee pays 30% Up to Out of Pocket Maximum of \$1,600 ind; \$3,200 2 person/\$4,800 family 100% after maximum reached  Subject to plan Lifetime Maximum - Unlimited	Not Applicable	Not Applicable	Not Applicable