

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 Out-of-Network services - No Coverage unless emergency
	No Copay - Preventive Office Visits \$20 Copay Primary Care Office Visits \$20 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 \$20 Copay Primary Care Office Visits \$20 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 \$10 Copay Primary Care Office Visits \$20 Copay Specialist Office Visits
	In-Network Lifetime Maximum - Unlimited	Lifetime Maximum - Unlimited	Lifetime Maximum - Unlimited	Lifetime Maximum - Unlimited	Lifetime Maximum - Unlimited
PREVENTIVE CARE					
Pediatric	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
Adult	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
Gynecological Exams	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.
Mammographic Services	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 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
Vision	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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MEDICAL SERVICES					
Medical Office Visit	\$20 Copay Primary Care \$20 Copay Specialist	30% after deductible 30% after deductible	\$20 Copay Primary Care \$20 Copay Specialist	30% after deductible 30% after deductible	\$10 Copay Primary Care \$20 Copay Specialist
PT/OT Speech/Chiro	\$20 Copay 50 combined treatments	30% after deductible 50 Combined Treatments	\$20 Copay Subject to medical necessity	30% after deductible Subject to medical necessity	\$20 Copay Subject to medical necessity
Allergy Services	\$20 Copay for office visits and testing. No copay for injections 80 treatments in 3 years	30% after deductible	\$20 Copay for Office Visits No copay for injections 60 treatments in 2 years	30% after deductible 60 treatments in 2 years	\$20 Copay for Office Visits No copay for injections 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					
<i>Prior Auth. Required</i>					
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 Waived if admitted	\$75 Copay Waived if admitted	\$75 Copay Waived if admitted	\$75 Copay Waived if admitted	\$50 Copay 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					
Medical/Surgical	NOTE: Pre-Cert Required \$200 Copay	NOTE: Pre-Cert. Required 30 days/benefit period at 30% after deductible	NOTE: Pre-Cert. Required \$200 Copay	NOTE: Pre-Cert. Required 30% after deductible	NOTE: Pre-Cert. Required \$200 Copay
Maternity (Semi-Private)					
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 Covered up to 120 days per calendar year	20 % After Deductible Covered up to 120 days per calendar year	\$200 Copay Covered up to 90 consecutive days	30% after deductible Covered up to 90 consecutive days	\$200 Copay Covered up to 90 days per calendar year
Hospice	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
Durable Medical Equipment	Covered	30% After Deductible	Covered	Not Covered	Covered
Dependent Eligibility	Child to age 26		Child to age 26		Child to age 26
PHARMACY BENEFIT					
	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