

**City of Waterbury
Benefit Comparison - FIREFIGHTERS**

	Century Preferred Plan A		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
	Copay - \$10 Home &Office Office Visit Maximum - Unlimited \$0 Copay Per Inpatient Admission	Deductible: \$200 Ind./\$400 2 Person/ \$500 Family Coinsurance - 80% to \$2,000 Ind./\$4,000 2 Person/\$5000 Fam. Cost Share Max: \$600 Ind./\$1,200 2 Person/\$1500 Family Out of network reimbursement is based on MAA	No Copay - Preventive Office Visits \$5 Copay Primary Care Office Visits \$10 Copay Specialist Office Visits	Deductible: \$250 Ind./\$750 Fam. Coinsurance 80% to \$6,250 Ind./\$18,750 Fam. CostShare Max: \$1,500 Ind./\$4,500 Fam. Out of network reimbursement is based on MAA	Copay - Preventive Office Visits \$0 Copay - Primary Care \$5 Specialist Office Visits \$10 Copay
	In-Network Lifetime Maximum - Unlimited	Lifetime Maximum - Unlimited	Lifetime Maximum - Unlimited	Lifetime Maximum -\$1,000,000	Lifetime Maximum - Unlimited
PREVENTIVE CARE					
Pediatric	No Copay - Covered according to age based schedule Six exams - Birth to one year Six exams - 1 through 5 years One exam every two years - 6 years through 10 years One exam every year - 11 through 21 years	20% after deductible Covered according to age based schedule	No Copay - Covered according to age based schedule Six exams - Birth to one year Six exams - 1 through 5 years One exam every two years - 6 years through 10 years One exam every year - 11 through 21 years	Not Covered	No Copay - Covered according to age based schedule Six exams - Birth to one year Six exams - 1 through 5 years One exam every two years - 6 years through 10 years One exam every year - 11 through 21 years
Adult	No Copay - Covered according to age based schedule One exam evry 5 years - 22 through 29 years One exam every 3 years - 30 through 39 years One exam every 2 years - 40 through 49 years One exam every year - 50 and older	20% after deductible Covered according to age based schedule	No Copay - Covered according to age based schedule One exam evry 5 years - 22 through 29 years One exam every 3 years - 30 through 39 years One exam every 2 years - 40 through 49 years One exam every year - 50 and older	Not Covered	No Copay - Covered according to age based schedule 1 exam every 5 years from 22 through 29 years 1 exam every 3 years from 30 through 39 years 1 exam every 2 years from 40 through 49 years 1 exam annually from 50 years and older
Gynecological Exams	No copay - One routine exam per year.	20% after deductible One routine exam per year	No Copay - 1 routine exam per year	20% after deductible One routine exam per year	No Copay 1 routine exam per year
Mammographic Services	No Copay Age 35 to 39 - 1 baseline mammography Age 40 to 49 - every 2 years Age 50 and over - once per calendar year In addition - as medically necessary	20% after deductible Covered according to age based schedule	No Copay Age 35 to 39 - 1 baseline mammography Age 40 to 49 - every 2 years Age 50 and over - once per calendar year In addition - as medically necessary	20% after deductible Covered according to age-based schedule	No Copay Age 35 to 39 - 1 baseline mammography Age 40 to 49 - every 2 years Age 50 and over - once per calendar year In addition - as medically necessary
Vision	No copay - One exam every two years	20% 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	\$10 Copay Primary Care \$10 Copay Specialist	20% after deductible 20% after deductible	\$5 Copay Primary Care \$10 Copay Specialist	20% after deductible 20% after deductible	\$5 Copay Primary Care \$10 Copay Specialist
PT/OT Speech/Chiro	No Copay 50 combined treatments Treatment Plan required for PT/OT/Chiro	20% after deductible 50 Combined Treatments Treatment Plan Required	\$10 Copay Subject to medical necessity Prior Auth. Required for PT/OT/Chiro	20% after deductible Subject to medical necessity Prior Auth. Required for PT/OT/Chiro	\$10 Copay Subject to medical necessity Prior Auth Required for PT/OT/Chiro
Allergy Services	\$10 Copay for office visits and testing. No copay for injections Treatment Plan Required	20% after deductible Treatment Plan Required	\$10 Copay for Office Visits No copay for injections 60 treatments in 2 years	20% after deductible 60 treatments in 2 years	\$10 Copay for Office Visits No copay for injections 60 treatments in 2 years
Diagnostic Lab & X-ray	Covered	20% after deductible	Covered	20% after deductible	Covered
Inpatient Medical Services	Covered	20% after deductible	Covered	20% after deductible	Covered
Surgery Fees	Covered	20% after deductible	Covered	20% after deductible	Covered
Office Surgery	Covered	20% after deductible	Covered	20% after deductible	Covered
Mental Health & Substance Abuse					
Inpatient Hospital Psychiatric	\$0 Per Admission	20% after deductible	\$0 Per Admission	20% after deductible	\$0 Per Admission
Outpatient MH	\$10 Per Visit	20% after deductible	\$10 Per Visit	20% after deductible	\$10 Copay
Inpatient Substance Abuse	\$0 Per Admission	20% after deductible	\$0 Per Admission	20% after deductible	\$0 Per Admission
Outpatient MH Substance Abuse	\$10 Per Visit	20% after deductible	\$10 Per Visit	20% after deductible	\$10 Copay

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EMERGENCY SERVICES					
Emergency Room	No Copay	No Copay	\$50 Copay Waived if admitted	\$50 Copay Waived if admitted	\$50 Copay Waived if admitted
Urgent Care	No Copay at participating facilities.	20% after deductible	\$25 Copay at participating facilities	Not Covered	\$25 Copay at participating facilities
Walk-in Center	\$10 Copay	20% after deductible	\$10 Copay	20% after deductible	\$10 copay
Ambulance Land Max \$500 Air Max \$4,000	Covered to max	Covered to max	Land: \$500 max per trip Air: \$4,000 max trip	Land: \$500 max per trip Air: \$4,000 max per trip	Land: \$500 max per trip Air: \$4,000 max per trip
INPATIENT HOSPITAL	NOTE: Pre-Cert Required	NOTE: Pre-Cert. Required	NOTE: Pre-Cert. Required	NOTE: Pre-Cert. Required	NOTE: Pre-Cert. Required
Medical/Surgical	\$0 Per Admission	30 days/benefit period at 20%	Covered	20% after deductible	Covered
Maternity (Semi-Pr	\$0 Per Admission	20% after deductible			
Ancillary Services (Medication, Supplies)	Covered	20% after deductible	Covered	20% after deductible	Covered
OUTPATIENT HOSPITAL					
Outpatient Surgery	Covered	20% after deductible	Covered	20% after deductible	Covered
Facility Charges					
Diagnostic Lab & X-ray	Covered	20% after deductible	Covered	20% after deductible	Covered
Pre-Admission Testing	Covered	20% after deductible	Covered	20% after deductible	Covered
OTHER SERVICES					
Skilled Nursing Facility	\$0 Per Admission Copay Covered up to 120 days per calendar year	20 % After Deductible Covered up to 120 days per calendar year	\$0 Per Admission Copay Covered up to 90 consecutive days	20% after deductible Covered up to 90 consecutive days	\$0 Per Admission Copay Covered up to 90 days per calendar year
Hospice	Covered - No Copay Covered up to 60 days per calendar year	20% After Deductible Covered up to 60 days per calendar year	Covered - No Copay Covered up to 60 days per calendar year	20% after deductible Covered up to 60 days per calendar year	Covered - No Copay Covered up to 60 days per calendar year
Durable Medical Equipment	Covered	20% 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; 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	Not Applicable	Not Applicable	Not Applicable