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Century Preferred
$20/$100/$75/$50
Benefits at a Glance for RS4 Teachers

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

	In Network *You pay:*	**Out-of-Network** *You pay:*
Office Visit (**OV**) Copayment	$20	Deductible & Coinsurance
Hospital (**HSP**) Copayment	$100	Deductible & Coinsurance
Urgent Care (**UR**) Copayment	$25	Not covered
Emergency Room (**ER**) Copayment – *waived if admitted*	$75	$75
Outpatient Surgery (**OS**) Copayment	$50	Deductible & Coinsurance
Annual Deductible (*individual/2-member family/3+ member family*)	Not applicable	$200/$400/$500
Coinsurance		20% after deductible up to
Cost Share Maximum (*individual/2-member family/3+ member family*)		$700/$1400/$1750
Lifetime Maximum	Unlimited	$1,000,000

PREVENTIVE CARE

Well child care*	No Copayment	Deductible & Coinsurance
Periodic, routine health examinations*	No Copayment	
Routine eye exams – *one exam every calendar year (superseded by the vision rider)*	No Copayment	
Routine OB/GYN visits – *one exam per year*	No Copayment	
Mammography*	No Charge	
Hearing screening – *covered once per calendar year*	$20 Copayment	

MEDICAL CARE

Primary care office visits	$20 Copayment	Deductible & Coinsurance
Specialist consultations	$20 Copayment	
OB/GYN care	$20 Copayment	
Maternity care – *initial visit subject to copayment, no charge thereafter*	$20 Copayment	
Laboratory	No charge	
X-ray and Diagnostic Testing	No charge	
Allergy Services *Office visits/testing* *Injections—80 visits in 3 years*	 $20 Copayment No charge	

HOSPITAL CARE – *Prior authorization required.*

Semi-private room	$100 Copayment	Deductible & Coinsurance
Maternity and newborn care	$100 Copayment	
Skilled nursing facility – *up to 120 days per calendar year*	$100 Copayment	
Rehabilitative services – *up to 60 days per person per calendar year*	$100 Copayment	
Outpatient surgery – *in a hospital or surgi-center*	$50 Copayment	

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EMERGENCY CARE

Walk-in centers	$20 Copayment	Deductible & Coinsurance
Urgent care – *at participating centers only*	$25 Copayment	Not covered
Emergency care – *copayment waived if admitted*	$75 Copayment	ER Copayment
Ambulance – *air and land are unlimited*	No charge	No charge

OTHER HEALTH CARE

Outpatient rehabilitative services *50 visit maximum for PT, OT, ST and Chiro. per year. Excess covered as out of network.*	$20 Copayment	Deductible & Coinsurance
Prosthetic devices	No charge	
Durable medical equipment	No charge	
Foot Orthotics	Covered	Deductible & Coinsurance

MENTAL HEALTH/SUBSTANCE ABUSE CARE

Inpatient	$100 Copayment	Deductible & Coinsurance
Outpatient/office visits	OV Copayment	

*** Schedule of health examinations:**
0 to 5 mo 6 exams 1 every month
6 mo to 11 mo 3 exams 1 every other month
12 mo to 23 mo 4 exams 1 every 3 months
24 mo to 35 mo 2 exams 1 every 6 months
36 mo to 21 years -1 exam a year
1 exam every 3 years from 22 through 29years
1 exam every 2 years from 30 through 49years
1 exam annually from 50 years and older

***Mammography:**
1 baseline age 35 – 39 years
1 screening per year age 40+
Additional exams when medically necessary

Note: In situations where the member is responsible for obtaining the necessary prior authorization and fails to do so, benefits may be reduced or denied.

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 Certificate/Evidence 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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CENTURY PREFERRED
MANAGED RX, 3 TIER
Benefits at a Glance for RSD4 Teachers

$5 COPAYMENT GENERIC DRUGS
$20 COPAYMENT LISTED BRAND-NAME DRUGS
$35 COPAYMENT NON-LISTED BRAND-NAME DRUGS
$2,000 Annual Maximum

How To Use 3-Tier Managed Rx

3-Tier Managed Rx has three different levels (or "tiers") of copayments, depending on the type of prescription drug you purchase (see the chart below for details). Your copayments will be lower when you use generic or brand-name medications that are on our list of preferred prescription drugs. The medications on this list are selected for their quality, safety and cost-effectiveness. You'll still have coverage brand-name drugs that are not on the list, but your copayment will be higher.

Talk to your provider about using generic drugs or listed brand-name drugs. It's a simple way to save out-of-pocket expenses.

Copayments and Day Supplies

- You will be responsible for **one** copayment when purchasing a **30-day supply** of prescription drugs from a retail pharmacy.
- You'll be responsible for the following:

Option 2. Two copayments when purchasing a **30-day to 90-day supply** of maintenance drugs through the voluntary mail-service program (see chart for details).

Generic Drugs Have the Lowest Copayment

		Your copayment:
Tier 1: Generic drugs	The term "generic" refers to a prescription drug that is not protected by a trademark. It is required to meet the same bioequivalency test as the original brand-name drug. Tier 1 copayment applies.	$5
Tier 2: Listed brand-name drugs	The term "listed brand-name" refers to a brand-name prescription drug that is on Anthem Blue Cross and Blue Shield's list of preferred prescription drugs. Tier 2 copayment applies.	$20
Tier 3: Non-listed brand-name drugs	The term "non-listed brand-name" refers to a brand-name prescription drug that is not on Anthem Blue Cross and Blue Shield's list of preferred prescription drugs. Tier 3 copayment applies.	$35
Mail Service	Two copayments per 30-90 day supply	$10 tier 1 $40 tier 2 $70 Tier 3
Annual Maximum	Per member per calendar year	$2,000

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Generic Substitution

Prescriptions will be filled with the generic equivalent when there is one available. Exception: If your doctor indicates "Dispense as Written." In this case you will receive the brand-name drug—and you will be responsible for the applicable listed brand or non-listed brand copayment. NOTE: If your doctor does *not* indicate "Dispense as Written," you will be responsible for the applicable listed brand or non-listed brand-name copayment as well as the difference in cost between the generic and listed brand or non-listed brand name drug.

Voluntary Mail-Service Program

Anthem Rx, our voluntary mail-service drug program, can save you time and expense if you regularly take one or more types of maintenance drugs. You can order up to a **90-day supply** of these medications and have them delivered directly to your home.

Two mail-service copayments will apply as follows: When Rx drugs are dispensed for 30-90 days 2 copays are taken.

National Pharmacy Network

Members also have access to a network of more than 53,000 retail pharmacies throughout the country. Members may call 1-888-207-4214, or go to www.anthemprescription.com, to locate a participating pharmacy when traveling outside the state.

Non-Participating Pharmacies

Members who fill prescriptions at a non-participating pharmacy are responsible for payment at the time the prescription is filled. Members must submit claims to Anthem Blue Cross and Blue Shield for reimbursement, and payment will be sent to the member. Members who use non-participating pharmacies will pay 20% of the in-network allowance, plus the difference between Anthem Blue Cross and Blue Shield's payment and the pharmacist's actual charge.

Limits and Exclusions

Benefits are limited to no more than a **30-day supply** for covered drugs purchased at a retail pharmacy, and no more than a **90-day supply** for covered drugs purchased by mail service. All prescriptions are subject to the quantity limitations imposed by state and federal statutes.

Benefits for prescription birth control and Sexual Dysfunction medications are optional for groups such as yours. Check with your benefits administrator to find out whether or not you have such benefits.

This is not a legal contract. It is only a general description of the Managed Rx, 3 Tier version. Please consult the Evidence of Coverage or prescription drug rider for a complete description of benefits and exclusions applicable to your coverage.

Your Dental Coverage

According to the Surgeon General, good oral health is essential to your overall health and well-being.[1] That's why we offer Full Dental, an easy-to-use dental plan that provides the coverage you need to maintain good health.

Full Dental gives you the choice of using network and non-network dental providers. If you choose network providers, you can save money since Anthem Dental contracts with them to provide quality care at affordable costs. Plus, network dentists file claims on your behalf, so you don't have to spend time dealing with paperwork hassles. If you choose to see out-of-network providers, that's okay, but your out-of-pocket costs will be higher.

From Cleanings to Root Canals, We've Got You Covered

Full Dental offers the benefits you need to achieve and maintain good oral health. Your plan may include coverage for the following*:

- Regular cleanings
- X-rays
- Denture repair and relining
- Oral evaluations
- Fluoride application to age 19
- Fillings
- Root canals
- Simple Extractions
- Emergency treatment

**For details on your coverage, please refer to your summary of dental benefits.*

Finding a Dentist is Easy

With the majority of Connecticut dental providers participating in the *Full Dental* network, you won't have to go far to find a participating dentist. In fact, you've got your choice of nearly 73,000 providers in our national dental network.

An online list of participating dentists is available at **anthem.com**. While this online directory is updated weekly, please check with your selected dentist to confirm his or her continued participation in the Anthem networks. If you don't have access to the Internet, call the number at the back of this booklet to see if your dentist is part of the network.

[1]Oral Health in America: A REPORT OF THE SURGEON GENERAL, www.nidcr.nih.gov/sgr, OCT. 27, 2000.

FULL DENTAL PLAN

The Full Dental Plan covers diagnostic, preventive and restorative procedures necessary for adequate dental health.

COVERED SERVICES INCLUDE:

- ❑ Oral Examinations 1/36 months
- ❑ Periapical and bitewing x-rays 1/Year
- ❑ Topical fluoride applications for members under age 19- 2/Year
- ❑ Prophylaxis, including cleaning and polishing – 2/Year
- ❑ Relining of dentures
- ❑ Repairs of broken removable dentures
- ❑ Palliative emergency treatment
- ❑ Routine fillings consisting of silver amalgam and tooth color materials; including stainless steel crowns (primary teeth)*
- ❑ Simple extractions **
- ❑ Endodontics-including pulpotomy, direct pulp capping and root canal therapy (excluding restoration)

* Payment for an inlay, onlay or crown will equal the amount payable for a three-surface amalgam filling when the member is not covered by Dental Amendatory Rider A.

** Payment for a surgical extraction or a hemisection with root removal will equal the amount payable for a simple extraction when the member is not covered by the Dental Amendatory Rider A.

ACCESSING BENEFITS:

Participating Dentists Benefits
When a member receives care from one of over 1,800 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 the dentist's usual charge or the Usual, Customary and Reasonable Charge as determined by us. The dentist accepts our reimbursement as full payment and may not bill the member for any additional charges.

Non-Participating Dentists Benefits
For covered dental services provided by a Non-Participating Dentist, in or out of Connecticut, we pay the lesser of the dentist's charge or the applicable allowance for the procedure, as determined by us. The member is responsible for any difference between the amount paid by us and the fee charged by the dentist.

This does not constitute your health plan or insurance policy. It is only a general description for the purposes of this Request for Proposal, of the Anthem Blue Cross Blue Shield Full Dental Plan. Refer to your Master Group Policy or Description of Benefits, on file with your employer, for a complete listing of benefits, maximums, exclusions and limitations.

Dental Amendatory Rider A
Additional Basic Benefits

In addition to the services provided under your dental program, the following additional basic benefits are provided:

- Inlays (not part of bridge)
- Onlays (not part of bridge)
- Crown (not part of bridge)
- Space Maintainers
- Oral surgery consisting of fracture and dislocation treatment, diagnosis and treatment of cyst and abscess, surgical extractions and impaction
- Apicoectomy

The dental services listed above are subject to the following qualifications:

We will pay for individual crowns, inlays and onlays only when amalgam or synthetic fillings would not be satisfactory for the retention of the tooth, as determined by us.

We will not pay for a replacement provided less than five (5) years following a placement or replacement which was covered under this Rider. We will not pay for individual crowns, inlays or onlays placed to alter vertical dimension, for the purpose of precision attachment of dentures, or when they are splinted together for any reason.

ACCESSING BENEFITS:

Participating Dentists Benefits

Anthem Blue Cross and Blue Shield will pay the lesser of 50% of the dentist's usual charge or 50% percent of the Usual, Customary and Reasonable Charge, as determined by us, for the dental services described in this Rider. Dentists who participate in our dental programs agree to accept our allowance as full payment and may not bill the member for any additional charges except for the remaining coinsurance balance.

Non-Participating Dentists Benefits

In the event these services are rendered by a non-participating dentist, we will pay to the member the lesser of 50% of the dentist's charge or 50% of the applicable allowance for the procedure as determined by us. The member is responsible for any difference between the amount paid by us and the fee charged by the dentist.

This does not constitute your health plan or insurance policy. It is only a general description for the purposes of this Request for Proposal, of the Anthem Blue Cross and Blue Shield Dental Amendatory Rider A.

Your Vision Coverage

Recognizing that more than 60 million Americans are in need of vision correction, Anthem offers quality vision coverage at a price you can afford.

Easy-to-manage vision benefits are available through *Anthem Vision*. The plan includes network and non-network benefits, and provides:

- A broad national network of more than 43,000 providers and provider locations including independent practitioners and well-known retailers like LensCrafters®, JC Penney Optical and most Sears Optical, Target® Optical and Pearle Vision® locations.
- Coverage for eye exams, as well as eyeglasses or contacts. Copayments may apply.
- An attractive retail frames allowance, with additional savings, even after your benefits are used up.
- Faster delivery of glasses – from an hour to just a few days, depending on the provider you choose.

Additional Savings on Eyewear

Once you've used up your benefits for eyewear, preferred pricing is available so you can receive up to approximately 40 percent in savings on frames and/or lenses, 10 to 15 percent off contact lenses and 20 percent off non-prescription sunglasses and other eyewear accessories.

Choosing a Provider is Easy

Select from providers in *Anthem Vision's* broad network. An online list of participating vision providers is available at **anthem.com**. While this online directory is updated weekly, please check with your selected vision provider to confirm his or her continued participation in the Anthem networks. If you don't have access to the Internet, call the number at the back of this booklet to see if your provider is part of the network.

Coverage While Traveling

With our broad national network, you may use your *Anthem Vision* benefits at any participating provider throughout the country.

For details on your coverage, please refer to your summary of vision benefits.

VISION CARE PLAN

ANTHEM BLUE CROSS AND BLUE SHIELD'S VISION CARE RIDER OFFERS:

- **Yearly eye examinations for vision corrections**
- **Coverage for prescription lenses (single-vision, bifocals, trifocals), frames, and contact lenses with fitting, adjustment and aftercare for maintenance of comfort and efficiency.**
- **In-plan and out-of-plan coverage.**

ACCESSING BENEFITS:

- **Participating providers will bill Blue Cross and Blue Shield directly. The member pays the provider directly for any charges which exceed the maximum allowance.**
- **Non-participating providers require payment from the member who, in turn, submits the itemized bill to Blue Cross and Blue Shield for reimbursement to the allowable schedule.**

VISION EXAM COVERAGE:

Exam with dilation of pupils (cycloplegia) and post cycloplegic visit if required	**Up to $50 per calendar year**
Exam without cycloplegia	**Up to $50 per calendar year**

OPTICAL SERVICES:

Frames for prescription lenses	**Up to $50 per calendar year**
Single vision lenses	**Up to $60 per calendar year**
Bifocal lenses	**Up to $70per calendar year**
Trifocal lenses	**Up to $90 per calendar year**
Contact lenses when used to correct visual acuity to 20/70 or when medically necessary	**Up to $180 per calendar year Per Member per Eye**
Contact lenses when used for any other reason, equivalent to amount payable for single vision Lenticular Lenses	**Up to $60 per calendar year** **Up to $140.00 per cal. yr**

PRINCIPAL LIMITATIONS & EXCLUSIONS

Services, frames, and lenses required by the employer as a condition of employment. Sunglasses, tinted glasses or industrial glasses unless they are prescription lenses. Contact lenses for cosmetic, convenience or any purpose other than correction of visual acuity to 20/70 or medical necessity as determined by Blue Cross and Blue Shield, will be covered in an amount up to the single prescription lenses indemnity amount subject to the annual maximum.