Century Preferred Plan & High Deductible Health Plan Comparison

Anthem	Century Preferred Plan		High Deductible Health Plan with HSA	
	In-Network Member Pays	**Out-of-Network Member Pays**	**In-Network Member Pays**	**Out-of-Network Member Pays**
Cost Share Provisions				
Office Visit (OV) Copayment	$15 per visit	Deductible & Coinsurance	0% after deductible	20% after deductible
Specialist Visit (SV) Copayment	$15 per visit	Deductible & Coinsurance	0% after deductible	20% after deductible
Hospital (HSP) Copayment	$250 per admission	Deductible & Coinsurance	0% after deductible	20% after deductible
Urgent Care (UR) Copayment	$15	Not Covered	0% after deductible	20% after deductible
Emergency Room (ER) Copayment – waived if admitted	$100	$100	0% after deductible	20% after deductible
Outpatient Surgery (OS) Copayment	$200	Deductible & Coinsurance	0% after deductible	20% after deductible
Ambulatory Surgery (ASC) Copayment	$200	Deductible & Coinsurance	0% after deductible	20% after deductible
Calendar Year Deductible (*individual/2-member family/3+ member family*)	Not Applicable	$400/$800/$1,200	Plan Year Deductible $2,000 Individual/$4,000 Family. Combined Deductible for Medical and Prescription. Combined with Out of Network.	
Coinsurance		30% after deductible up to	0% after deductible	20% after deductible
Coinsurance Maximum (*individual/2-member family/3+ member family*)		$2,000/$4,000/$6,000	NA	NA
Cost Share Maximum *(individual/2-member family/3+member family)*	$6,600/$13,200/$13,200	$2,400/$4,800/$7,200	Plan Year Cost Share $3,000 Individual/$6,000 Family	Plan Year Cost Share $4,000 Individual/$8,000 Family
Lifetime Maximum	Unlimited	Unlimited	Unlimited	Unlimited
Preventive Care				
Well child care	No Charge	Deductible & Coinsurance	No Charge - Deductible waived	20% after deductible
Periodic, routine health examinations	No Charge		No Charge - Deductible waived	
Routine OB/GYN visits	No Charge		No Charge - Deductible waived	

Anthem	Century Preferred Plan		High Deductible Health Plan with HSA	
	In-Network Member Pays	**Out-of-Network Member Pays**	**In-Network Member Pays**	**Out-of-Network Member Pays**
Mammography	No Charge		No Charge - Deductible waived	
Hearing screening	No Charge		No Charge - Deductible waived	
Medical Care				
Office visits *Primary Care* *Specialist*	OV Copayment	Deductible & Coinsurance	0% after deductible	20% after deductible
Outpatient mental health & substance abuse	OV Copayment		0% after deductible	20% after deductible
OB/GYN care	OV Copayment		0% after deductible	20% after deductible
Surgical fees of a Physician or Surgeon	No Copayment		0% after deductible	20% after deductible
Maternity care – *initial visit subject to copayment, no charge thereafter*	OV Copayment		0% after deductible	20% after deductible
Diagnostic lab - In an outpatient hospital setting - In an office or reference laboratory	 No Copayment No Charge		0% after deductible	20% after deductible
Diagnostic x-ray	No Copayment		0% after deductible	20% after deductible
High-cost outpatient diagnostic – *prior authorization required*	No Copayment		0% after deductible	20% after deductible
Allergy services *Office visits/testing* *Injections—80 visits in 3 years*	 OV Copayment No Copayment		0% after deductible	20% after deductible
Hospital Care – Prior Authorization required				
Semi-private room *(General/Medical/Surgical/Maternity)*	HSP Copayment	Deductible & Coinsurance	0% after deductible	20% after deductible
Inpatient mental health & substance abuse	HSP Copayment		0% after deductible	20% after deductible
Skilled nursing facility – *up to 120 days per calendar year*	HSP Copayment		0% after deductible	20% after deductible
Rehabilitative services – *up to 60 days per person per calendar year*	No Charge		0% after deductible	20% after deductible
Outpatient surgery – *in a hospital*	OS Copayment		0% after deductible	20% after deductible
Ambulatory surgery – *in other than a hospital setting*	ASC Copayment		0% after deductible	20% after deductible

Anthem	Century Preferred Plan		High Deductible Health Plan with HSA	
	In-Network Member Pays	**Out-of-Network Member Pays**	**In-Network Member Pays**	**Out-of-Network Member Pays**
Emergency Care				
Walk-in centers	OV Copayment	Deductible & Coinsurance	0% after deductible	20% after deductible
Urgent care – *at participating centers only*	UR Copayment	Not Covered	0% after deductible	20% after deductible
Emergency care – *copayment waived if admitted*	ER Copayment	ER Copayment	0% after deductible	0% after deductible
Ambulance	No Charge	No Charge	0% after deductible	0% after deductible
Other Healthcare				
Outpatient rehabilitative services - 5*0 combined visit maximum for PT, OT, ST and Chiro calendar year.*	No Copayment	Deductible & Coinsurance	0% after deductible	20% after deductible
Durable medical equipment / Prosthetic devices *Unlimited maximum per calendar year*	No Copayment	Deductible & Coinsurance	0% after deductible	20% after deductible
Infertility services – *Some restrictions may apply*	Applicable Copayment	Deductible & Coinsurance	0% after deductible	20% after deductible
Home health care	No Copayment	$50 Deductible & 20 % Coinsurance	0% after deductible	20% after deductible
Prescription				
Retail – up to 30-day supply	Tier 1: $5 Tier 2: $10 Tier 3: $20	Not covered	After plan deductible: Tier 1: $5 Tier 2: $20 Tier3: $40 Tier 4: 20% to $200	20% after deductible
Mail Order – up to 90-day supply	2 x Retail Copay	Not covered	After plan deductible: 2 x Retail Copay for Tiers 1-3	20% after deductible
Maximum	Unlimited	NA	Unlimited	Unlimited

Preventive Care Schedules	
Mammography ♦ 1 baseline screening, ages 35 – 39 ♦ 1 screening per year, ages 40+ Additional exams when medically necessary	**Mammography** ♦ 1 baseline screening, ages 35 – 39 ♦ 1 screening per year, ages 40+ Additional exams when medically necessary

Vision Exams: 1 exam every 2 calendar years	***Vision Exams:*** 1 exam every 2 calendar years
Hearing Exams: 1 exam every 2 calendar years	***Hearing Exams:*** 1 exam every 2 calendar years