



CENTURY PREFERRED DIRECT PPO
Effective January 1, 2010

For help or questions call 1-866-508-0618

with \$10 Generic/\$25 Listed Brand/\$40 Non-Listed Brand Copay Prescription Drug Plan with \$2000 Annual Max

	Option One - \$250/\$500				Option Two \$1500/\$3000			
	Single		Two -		Single		Two -	
	Male	Female	Person	Family	Male	Female	Person	Family
<19	\$234.29	\$332.18	\$606.36	\$1,032.70	\$195.83	\$277.66	\$506.84	\$863.22
19-24	\$234.29	\$332.18	\$606.36	\$1,032.70	\$195.83	\$277.66	\$506.84	\$863.22
25-29	\$234.29	\$332.18	\$606.36	\$1,032.70	\$195.83	\$277.66	\$506.84	\$863.22
30-34	\$312.23	\$382.28	\$616.57	\$1,169.10	\$260.99	\$319.54	\$515.37	\$977.22
35-39	\$312.23	\$382.28	\$616.57	\$1,169.10	\$260.99	\$319.54	\$515.37	\$977.22
40-44	\$403.16	\$421.26	\$684.77	\$1,252.15	\$337.00	\$352.12	\$572.37	\$1,046.65
45-49	\$466.72	\$472.75	\$770.13	\$1,309.67	\$390.12	\$395.17	\$643.73	\$1,094.73
50-54	\$635.13	\$653.22	\$1,114.36	\$1,549.54	\$530.89	\$546.02	\$931.48	\$1,295.22
55-59	\$830.44	\$824.87	\$1,455.35	\$1,876.14	\$694.14	\$689.49	\$1,216.49	\$1,568.22
60-64	\$1,115.75	\$984.92	\$1,846.45	\$2,212.02	\$932.63	\$823.28	\$1,543.41	\$1,848.98
65+	\$1,079.56	\$956.63	\$1,828.35	\$2,100.20	\$902.38	\$799.63	\$1,528.29	\$1,755.52

Includes \$2,000
Prescription Coverage

FOR RENEWALS ONLY. NOT OPEN TO NEW MEMBERS

	Option Three - \$5000/\$10000				Option Four - \$10000/\$20000				\$500 Deductible			
	Single		Two -		Single		Two -		Single		Two -	
	Male	Female	Person	Family	Male	Female	Person	Family	Male	Female	Person	Family
<19	\$122.19	\$173.24	\$316.26	\$538.62	\$103.47	\$146.71	\$267.81	\$456.10	\$223.89	\$317.44	\$579.46	\$986.90
19-24	\$122.19	\$173.24	\$316.26	\$538.62	\$103.47	\$146.71	\$267.81	\$456.10	\$223.89	\$317.44	\$579.46	\$986.90
25-29	\$122.19	\$173.24	\$316.26	\$538.62	\$103.47	\$146.71	\$267.81	\$456.10	\$223.89	\$317.44	\$579.46	\$986.90
30-34	\$162.85	\$199.38	\$321.57	\$609.76	\$137.90	\$168.84	\$272.31	\$516.34	\$298.37	\$365.32	\$589.21	\$1,117.24
35-39	\$162.85	\$199.38	\$321.57	\$609.76	\$137.90	\$168.84	\$272.31	\$516.34	\$298.37	\$365.32	\$589.21	\$1,117.24
40-44	\$210.28	\$219.72	\$357.15	\$653.07	\$178.07	\$186.05	\$302.43	\$553.02	\$385.28	\$402.56	\$654.39	\$1,196.61
45-49	\$243.42	\$246.57	\$401.67	\$683.09	\$206.13	\$208.80	\$340.13	\$578.44	\$446.02	\$451.77	\$735.95	\$1,251.59
50-54	\$331.25	\$340.70	\$581.22	\$808.18	\$280.51	\$288.51	\$492.18	\$684.37	\$606.95	\$624.24	\$1,064.94	\$1,480.80
55-59	\$433.12	\$430.23	\$759.05	\$978.52	\$366.77	\$364.32	\$642.76	\$828.62	\$793.60	\$788.29	\$1,390.79	\$1,792.90
60-64	\$581.93	\$513.70	\$963.03	\$1,153.72	\$492.79	\$435.00	\$815.51	\$976.97	\$1,066.25	\$941.22	\$1,764.53	\$2,113.90
65+	\$563.06	\$498.95	\$953.61	\$1,095.40	\$476.80	\$422.51	\$807.51	\$927.58	\$1,031.68	\$914.19	\$1,747.25	\$2,007.04

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CENTURY PREFERRED DIRECT PPO
Effective January 1, 2010

Medical only - No Drug Benefit

	Option One - \$250/\$500				Option Two \$1500/\$3000			
	Single		Two -		Single		Two -	
	Male	Female	Person	Family	Male	Female	Person	Family
<19	\$198.93	\$282.05	\$514.84	\$876.84	\$160.47	\$227.53	\$415.32	\$707.36
19-24	\$198.93	\$282.05	\$514.84	\$876.84	\$160.47	\$227.53	\$415.32	\$707.36
25-29	\$198.93	\$282.05	\$514.84	\$876.84	\$160.47	\$227.53	\$415.32	\$707.36
30-34	\$265.11	\$324.58	\$523.51	\$992.65	\$213.87	\$261.84	\$422.31	\$800.77
35-39	\$265.11	\$324.58	\$523.51	\$992.65	\$213.87	\$261.84	\$422.31	\$800.77
40-44	\$342.31	\$357.68	\$581.42	\$1,063.17	\$276.15	\$288.54	\$469.02	\$857.67
45-49	\$396.28	\$401.40	\$653.90	\$1,112.00	\$319.68	\$323.82	\$527.50	\$897.06
50-54	\$539.27	\$554.63	\$946.17	\$1,315.67	\$435.03	\$447.43	\$763.29	\$1,061.35
55-59	\$705.10	\$700.37	\$1,235.70	\$1,592.98	\$568.80	\$564.99	\$996.84	\$1,285.06
60-64	\$947.35	\$836.27	\$1,567.77	\$1,878.16	\$764.23	\$674.63	\$1,264.73	\$1,515.12
65+	\$916.62	\$812.25	\$1,552.40	\$1,783.22	\$739.44	\$655.25	\$1,252.34	\$1,438.54

No Prescription Drug Coverage

FOR RENEWALS ONLY. NOT OPEN TO NEW MEMBERS.

	Option Three - \$5000/\$10000				Option Four - \$10000/\$20000				\$500 Deductible			
	Single		Two -		Single		Two -		Single		Two -	
	Male	Female	Person	Family	Male	Female	Person	Family	Male	Female	Person	Family
<19	\$86.83	\$123.11	\$224.74	\$382.76	\$68.11	\$96.58	\$176.29	\$300.24	\$188.53	\$267.31	\$487.94	\$831.04
19-24	\$86.83	\$123.11	\$224.74	\$382.76	\$68.11	\$96.58	\$176.29	\$300.24	\$188.53	\$267.31	\$487.94	\$831.04
25-29	\$86.83	\$123.11	\$224.74	\$382.76	\$68.11	\$96.58	\$176.29	\$300.24	\$188.53	\$267.31	\$487.94	\$831.04
30-34	\$115.73	\$141.68	\$228.51	\$433.31	\$90.78	\$111.14	\$179.25	\$339.89	\$251.25	\$307.62	\$496.15	\$940.79
35-39	\$115.73	\$141.68	\$228.51	\$433.31	\$90.78	\$111.14	\$179.25	\$339.89	\$251.25	\$307.62	\$496.15	\$940.79
40-44	\$149.43	\$156.14	\$253.80	\$464.09	\$117.22	\$122.47	\$199.08	\$364.04	\$324.43	\$338.98	\$551.04	\$1,007.63
45-49	\$172.98	\$175.22	\$285.44	\$485.42	\$135.69	\$137.45	\$223.90	\$380.77	\$375.58	\$380.42	\$619.72	\$1,053.92
50-54	\$235.39	\$242.11	\$413.03	\$574.31	\$184.65	\$189.92	\$323.99	\$450.50	\$511.09	\$525.65	\$896.75	\$1,246.93
55-59	\$307.78	\$305.73	\$539.40	\$695.36	\$241.43	\$239.82	\$423.11	\$545.46	\$668.26	\$663.79	\$1,171.14	\$1,509.74
60-64	\$413.53	\$365.05	\$684.35	\$819.86	\$324.39	\$286.35	\$536.83	\$643.11	\$897.85	\$792.57	\$1,485.85	\$1,780.04
65+	\$400.12	\$354.57	\$677.66	\$778.42	\$313.86	\$278.13	\$531.56	\$610.60	\$868.74	\$769.81	\$1,471.30	\$1,690.06

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Century Preferred Direct (PPO)

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This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. Upon enrollment, it is therefore important that you **READ YOUR POLICY CAREFULLY**.

Major Medical Expense Coverage – Policies of this category are designed to provide, to persons insured, coverage for major hospital, medical, and surgical expenses incurred as a result of a covered accident or sickness. Coverage is provided for daily hospital room and board, miscellaneous hospital services, surgical services, anesthesia services, in-hospital medical services, and out-of-hospital care, subject to any deductibles, copayment provisions, or other limitations which may be set forth in the policy.

Health Savings Account (HSA)-compatible products are shaded. This product is intended to be federally tax qualified. Approval by the Insurance Department does not guarantee tax qualification. Please seek the counsel of a tax advisor. This policy has not been submitted for approval by the IRS.

A Brief Description of Benefits

Covered Service	In-Network Services (*Out-of-Network Services)						
	Individual Deductible**	\$250	\$1,500	\$5,000	\$10,000	\$1,250	\$2,500
Family Deductible**	\$500	\$3,000	\$10,000	\$20,000	\$2,500	\$5,000	\$8,000
Member In-Network Coinsurance (Member Out-of-Network Coinsurance)	20% (40%)	N/A (20%)	N/A (20%)	N/A (20%)	N/A (20%)	N/A (20%)	N/A (20%)
Member Cost-Share Maximum							
Individual	\$1,500	\$3,000	\$10,000	\$15,000	\$2,500	\$5,000	\$5,000
Family	\$3,000	\$6,000	\$20,000	\$30,000	\$5,000	\$10,000	\$10,000
Lifetime Maximum	\$5,000,000						
Daily Hospital Room and Board							
All Inpatient Admissions	Deductible and In-Network Coinsurance (Deductible and Out-of-Network Coinsurance)						
Inpatient Hospital Services In a Hospital or Residential Treatment Center for Mental Health Care	Deductible and In-Network Coinsurance (Deductible and Out-of-Network Coinsurance)						
Inpatient Rehabilitation Treatment for Substance Abuse Care In a Hospital or Substance Abuse Treatment Facility	Deductible and In-Network Coinsurance (Deductible and Out-of-Network Coinsurance)						
Skilled Nursing Facility up to 120 days per Calendar Year	Deductible and In-Network Coinsurance (Deductible and Out-of-Network Coinsurance)						
Specialty Hospital 60 days per Member per Calendar Year <i>for other than Mental Health and Substance Abuse services only.</i>	Deductible and In-Network Coinsurance (Deductible and Out-of-Network Coinsurance)						
Miscellaneous Hospital Services							
Emergency Room Treatment	Deductible and In-Network Coinsurance (Paid as In-Network Service)						
Urgent Care Services	Deductible and In-Network Coinsurance (Paid as In-Network Service)						

*Out-of-Network Services are noted in parentheses.

**HSA Individual Member: The Deductible must be satisfied before any Covered Services will be paid by the Plan. HSA Family: The Family Deductible must be satisfied by either one Member or all Members collectively before any Covered Services will be paid by the Plan.

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Covered Service	In-Network Services (*Out-of-Network Services)	
Surgical Services		
Outpatient surgery In a licensed ambulatory surgical center (including colonoscopy)	Deductible and In-Network Coinsurance (Deductible and Out-of-Network Coinsurance)	
Medical Office Visit	Deductible and In-Network Coinsurance (Deductible and Out-of-Network Coinsurance)	
Anesthesia Services		
Anesthesia, anesthesia supplies and services	Included in Hospital Services (Included in Hospital Services)	
In-Hospital Medical Services		
Inpatient hospital/inpatient facility visits during a covered Admission	Included in Medical Services (Included in Medical Services)	
Services of a Physician or Surgeon <i>other than a medical office visit</i>	Deductible and In-Network Coinsurance (Deductible and Out-of-Network Coinsurance)	
Out-of-Hospital Care		
Well Child Care 6 exams from birth to 1 year of age 6 exams 1 through 5 years of age 1 exam every 2 Calendar Years 6 through 10 years of age 1 exam every Calendar Year 11 through 21 years of age	Deductible and In-Network Coinsurance (Deductible and Out-of-Network Coinsurance)	No charge In-Network (Deductible and Out-of-Network Coinsurance)
Adult Physical Examinations 1 exam every 5 Calendar Years 22 through 29 years of age 1 exam every 3 Calendar Years 30 through 39 years of age 1 exam every 2 Calendar Years 40 through 49 years of age 1 exam per Calendar Year 50 years of age and older		
Routine gynecological visit 1 visit per Calendar Year including pap smear		
Mammography One baseline screening for female 35 through 39 years of age One screening mammogram every Calendar Year for female 40 and older Note: or more frequently if recommended		
Other Benefits		
Immunizations and Vaccinations includes those needed for travel	Deductible and In-Network Coinsurance (Deductible and Out-of-Network Coinsurance)	No charge In-Network (Deductible and Out-of-Network Coinsurance)
Hearing Exams 1 hearing exam every 2 Calendar Years		
Diagnostic Services	Deductible and In-Network Coinsurance (Deductible and Out-of-Network Coinsurance)	
Infertility Services Office Visit Outpatient Hospital Inpatient Hospital	Deductible and In-Network Coinsurance (Deductible and Out-of-Network Coinsurance)	
Infertility drugs (with infertility diagnosis) The maximum supply of a drug for which Benefits will be provided when dispensed under any one prescription is a 30 day supply or 100 unit dose, whichever is greater.	Deductible and Out-of-Network Coinsurance (Deductible and Out-of-Network Coinsurance)	
Outpatient Rehabilitation Services Restorative physical, occupational, speech therapy (maximum combined 30 visits per calendar year) Chiropractic therapy (maximum 20 visits per calendar year)	Deductible and In-Network Coinsurance (Deductible and Out-of-Network Coinsurance) Deductible and In-Network Coinsurance (Deductible and Out-of-Network Coinsurance)	
Other Therapy Services Outpatient cardiac rehabilitation therapy for up to 36 visits per cardiac episode	Deductible and In-Network Coinsurance (Deductible and Out-of-Network Coinsurance)	

*Out-of-Network Services are noted in parentheses.

Covered Service	In-Network Services (*Out-of-Network Services)
Radiation therapy Chemotherapy for the treatment of cancer Electroshock Therapy Kidney Dialysis in a Hospital or free-standing dialysis center	Deductible and In-Network Coinsurance (Deductible and Out-of-Network Coinsurance)
Allergy Testing and Treatment Allergy visits/testing Immunotherapy or other therapy treatments to a maximum of 80 visits over a 3 Calendar Year period	Deductible and In-Network Coinsurance (Deductible and Out-of-Network Coinsurance)
Ambulance Services Maximum for land: Paid according to the Department of Public Health Ambulance Service Rate Schedule Maximum for air: Paid according to the Department of Public Health Air Ambulance Service Rate Schedule	Deductible and In-Network Coinsurance (Paid as an In-Network Service)
Outpatient Treatment for Mental Health Care and Substance Abuse Care	Deductible and In-Network Coinsurance (Deductible and Out-of-Network Coinsurance)
Private Duty Nursing Limited to \$15,000 Per Calendar Year	Not applicable (Deductible and Out-of-Network Coinsurance)
Diabetic equipment, drugs and supplies purchased at a Pharmacy that is not a Durable Medical Equipment supplier	Covered according to prescription drug plan
Human Organ and Tissue Transplant Services \$1,000,000 Lifetime Maximum	Deductible and In-Network Coinsurance (Deductible and Out-of-Network Coinsurance)
Home Health Care Nursing and therapeutic services limited to 200 visits Home health aide services limited to 80 visits that are applicable to the 200 visit limit	No cost share (\$50 deductible and 20% coinsurance) <i>For HSA-qualified plan: Deductible and In-Network Coinsurance (Deductible and Out-of-Network Coinsurance)</i> (The deductible for Home Health Care benefits accrues towards the member's annual deductible)
Infusion Therapy Unlimited Lifetime Maximum	Deductible and In-Network Coinsurance (Deductible and Out-of-Network Coinsurance)
Durable Medical Equipment Hearing Aid Coverage available for dependent children age 12 years and under with a maximum of \$1,000 within a two year period.	Deductible and In-Network Coinsurance (Deductible and Out-of-Network Coinsurance)
Ostomy Related Services	Deductible and In-Network Coinsurance (Deductible and Out-of-Network Coinsurance)
Hospice Care (inpatient) 60 days per Calendar Year.	Deductible and In-Network Coinsurance (Deductible and Out-of-Network Coinsurance)
Wig Up to \$350 maximum per member per calendar year	No cost share
Specialized Formula	\$20 copayment
Penalty for Failure to Prior Authorize Elective Hospital Admissions, Partial Hospitalizations or Day/Night Visit Programs or Authorize a Medical Emergency Admission within 2 business days Penalty for Failure to Prior Authorize Covered Services Please note that the combined penalty amount for Facility Benefit and the Admitting Physician Benefit will be no greater than \$500	\$500 Hospital and 25% Physician of Maximum Allowable Amount (MAA) (\$500 Hospital and 25% Physician) (of Maximum Allowable Amount (MAA)) \$500 Hospital and 25% Physician of Maximum Allowable Amount (MAA) (\$500 Hospital and 25% Physician) (of Maximum Allowable Amount (MAA))

*Out-of-Network Services are noted in parentheses.

Note: Services applicable after Deductible and Coinsurance. Member is responsible for the difference between Maximum Allowable Amount (MAA) and total charge.