Anthem

Century Preferred
$15/$250/$50$100

July 1, 2010

Benefits at a Glance for Town of Madison Police Active PPO FD 601/605/608/609

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

	In Network *You pay:*	**Out-of-Network** *You pay:*
Office Visit (**OV**) Copayment	$15	Deductible & Coinsurance
Hospital (**HSP**) Copayment	$250	Deductible & Coinsurancee
Urgent Care (**UR**) Copayment	$25	Not covered
Emergency Room (**ER**) Copayment – *waived if admitted*	$50	$50
Outpatient Surgery (**OS**) Copayment	$100	Deductible & Coinsurance
Annual Deductible (*individual/2-member family/3+ member family*)	Not applicable	$400/$800/$1200
Coinsurance		30% after deductible up to
Cost Share Maximum (*individual/2-member family/3+ member family*)		$2,400/$4,800/$7,200
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 2 years*	NO Copayment	
Routine OB/GYN visits – *one exam per year*	NO Copayment	
Mammography*	No Charge	
Hearing screening – *covered once every two years*	NO Copayment	

MEDICAL CARE

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

HOSPITAL CARE – *Prior authorization required.*

Semi-private room	HSP Copayment	Deductible & Coinsurance
Maternity and newborn care	HSP Copayment	
Skilled nursing facility – *up to 120 days per calendar year*	HSP Copayment	
Rehabilitative services – *up to 60 days per person per calendar year*	No charge	
Outpatient surgery – *in a hospital or surgi-center*	OS Copayment	

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EMERGENCY CARE

Walk-in centers	OV Copayment	Deductible & Coinsurance
Urgent care – *at participating centers only*	UR Copayment	Not covered
Emergency care – *copayment waived if admitted*	ER 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*	NO Copayment	Deductible & Coinsurance
Prosthetic devices - Unlimited	No charge	
Durable medical equipment- Unlimited	No charge	

MENTAL HEALTH/SUBSTANCE ABUSE CARE

Inpatient	HSP Copayment	Deductible & Coinsurance
Outpatient/office visits	OV Copayment	

*** Schedule of health examinations:**
6 exams birth to 1 year
6 exams 1 through 5 years
1 exam every 2 years from 6 through 10 years
1 exam every year from 11 through 21 years
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

***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.

Please refer to the *SpecialOffers@Anthem* brochure in your enrollment kit for information on the discounts we offer on health-related products and services.

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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BlueCare HMO
$20/$500/$100/$100

Benefits at a Glance for Town of Madison Police Active HMO FD 600/602/603/607 *July 1, 2010*

BlueCare is a health maintenance organization (HMO) plan that features a primary care physician (PCP) who works with you to coordinate your health care. PCP referrals are not required to receive care from a specialist provider.

	In-Network *You pay:*
Office Visit (**OV**) Copayment	$20 per visit
Specialist Visit (**SV**) Copayment	$30per visit
Hospital (**HSP**) Copayment	$500 per visit
Urgent Care (**UR**) Copayment	$50
Emergency Room (**ER**) Copayment – *waived if admitted*	$100
Outpatient Surgery (**OS**) Copayment	$100

PREVENTIVE CARE

Well child care	NO Copayment
Periodic, routine health examinations*	NO Copayment
Routine eye exams – *one exam every 2 years*	NO Copayment
Routine OB/GYN visits – *one exam per year*	NO Copayment
Mammography*	No charge
Hearing screening – *as part of the preventive exam*	NO Copayment

MEDICAL CARE

Primary care office visits	OV Copayment
Specialist consultations	SV Copayment
OB/GYN care	SV Copayment
Maternity care – *initial visit subject to copayment, no charge thereafter*	SV Copayment
Laboratory	No charge
X-ray and Diagnostic Testing	No charge
Allergy Services *Office visits/testing* *Injections—60 visits in 2 years*	 SV Copayment No charge

HOSPITAL CARE – *Prior authorization required.*

Semi-private room	HSP Copayment
Maternity and newborn care	HSP Copayment
Skilled nursing facility – *up to 90 days per calendar year*	HSP Copayment
Rehabilitative services – *up to 60 days per person per calendar year*	NO Charge
Outpatient surgery – *in a hospital or surgi-center*	OS Copayment

EMERGENCY CARE

Walk-in centers	OV Copayment
Urgent care – *at participating centers only*	UR Copayment
Emergency care – *copayment waived if admitted*	ER Copayment
Ambulance – *air and land are unlimited*	No charge

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OTHER HEALTH CARE

Outpatient rehabilitative services *Unlimited visit maximum for PT, OT, ST and Chiro. per year subject to medical necessity*	NO Copayment
Prosthetic devices - limited to certain items $1,000 calendar year maximum	20%
Durable medical equipment - limited to certain items $1,000 calendar year maximum	20%

MENTAL HEALTH/SUBSTANCE ABUSE CARE

Inpatient	HSP Copayment
Outpatient/office visits	SV Copayment

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