Anthem

Century Preferred
$25/$150/$50/$75

Benefits at a Glance for Madison BOE Administrators Actives ***Revised for July 1, 2012***
PPO FD 201

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

	In Network *You pay:*	**Out-of-Network** *You pay:*
Office Visit (OV) Copayment	**$25**	**Deductible & Coinsurance**
Hospital (HSP) Copayment	**$150**	**Deductible & Coinsurancee**
Urgent Care (UR) Copayment	**$25**	**Not covered**
Emergency Room (ER) Copayment – *waived if admitted*	**$50**	**$50**
Outpatient Surgery (OS) Copayment	**$75**	**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*)		**$1,000/$2,000/$2,500**
Lifetime Maximum	**Unlimited**	**Unlimited**

PREVENTIVE CARE

Well child care*	**NO Copayment**	**Deductible & Coinsurance**
Periodic, routine health examinations	**NO Copayment**	
Routine eye exams – *one exam every 2 years*	**OV Copayment**	
Routine OB/GYN visits – *one exam per year*	**NO Copayment**	
Mammography	**No Charge**	
Hearing Exams – *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*	**NO 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 Copayment**	
Outpatient surgery – *in a hospital or surgi-center*	**OS Copayment**	

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 – excess covered as out-of-network***	**OV 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:**
Age 0 up to age 1 – 7 visits
Age 1 up to age 5 – 7 visits
Age 5 up to age 12 – 1 every year
Age 12 up to age 22 – 1 every year
Age 23+ - 1 every year

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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REVISED