

BENEFIT	Anthem Century Preferred \$30 Plan RSD # 14 - Administrarors & IA	ConnectiCare Flex POS \$30 Plan RSD # 14 - Administrarors & IA
Costshares	In-Network services subject to copays Out-of-Network services subject to deductible and coinsurance \$30 office visit copay \$100 Emergency Room/\$50 Urgent Care Facility \$250 Outpat Surg Facility / \$400 Inpat Hosp Out of Pocket Maximum: \$6,600/\$13,200 Out of Network Calendar Year Deductible \$200/\$400/\$500 Coinsurance 80%/20% Calendar Year Out of Pocket Maximum-\$400/\$800/\$1,000 Lifetime Maximum- Unlimited	In-Network services subject to copays Out-of-Network services subject to deductible and coinsurance \$30 office visit copay \$100 Emergency Room/\$50 Urgent Care Facility \$250 Outpat Surg Facility / \$400 Inpat Hosp Out of Pocket Maximum: \$6,600/\$13,200 Out of Network Calendar Year Deductible \$200/\$400/\$500 Coinsurance 80%/20% Calendar Year Out of Pocket Maximum-\$400/\$800/\$1,000 Lifetime Maximum- Unlimited
Preventive Care Pediatric	No charge 7 exams from birth to 1 year of age 7 exams from 1 to 5 years of age 1 exam every calendar year 5 to 22 years of age	No charge No age or frequency based schedule required
Adult	No charge 1 exam per calendar year 22 years of age and older	No charge No age or frequency based schedule required
Vision	No charge 1 vision exam and refraction every calendar year	No charge 1 vision exam and refraction every calendar year
Hearing	No charge 1 hearing screening every calendar year	No charge 1 hearing screening every calendar year
Gynecological	No charge	No charge
Immunizations & Vaccinations (includes those for travel)	No charge	No charge
Medical Services		
Medical Office Visit	\$30 Copay	\$30 Copay
Outpatient PT/OT/ST/Chiro	No charge 50 combined visits per calendar year	No charge 50 combined visits per calendar year
Allergy Testing Injections	\$30 Copay No charge 80 visits in 3 year calendar period	\$30 Copay No charge 80 visits in 3 year calendar period
Diagnostic Lab & X-ray	No charge	No charge
High Cost Diagnostic Test	No charge	No charge
Office Surgery	\$30 Copay	\$30 Copay
Outpatient MH	\$30 Copay Unlimited visit maximum per calendar year	\$30 Copay Unlimited visit maximum per calendar year

Emergency Care Emergency Room	\$100 copay (waived if admitted)	\$100 copay (waived if admitted)
Urgent Care	\$50 copay	\$50 copay
Ambulance	No charge	No charge
Inpatient Hospital General/Medical/Surgical/Maternity (Semi-Private)	Note: All hospital admissions require pre-cert \$400 per admission	Note: All hospital admissions require pre-cert \$400 per admission
Ancillary Services (Medication, Supplies)	Covered	Covered
Psychiatric	\$400 per admission Unlimited day maximum per calendar year	\$400 per admission Unlimited day maximum per calendar year
Substance Abuse/ Detox	\$400 per admission Unlimited day maximum per calendar year	\$400 per admission Unlimited day maximum per calendar year
Skilled Nursing Facility	\$400 per admission Covered up to 120 days	\$400 per admission Covered up to 120 days
Hospice	No charge 60 days per calendar year	No charge 60 days per calendar year
Outpatient Hospital Outpatient Surgery Facility Charges	\$250 Copay	\$250 Copay
Diagnostic Lab & X-ray	No charge	No charge
Pre-Admission Testing	Covered	Covered
Other Services Durable Medical Equipment	No charge Unlimited maximum per calendar year	No charge Unlimited maximum per calendar year
Prescription Drugs	Retail: \$5 Generic / \$25 Brand / \$40 Non Preferred Brand Mail Order: \$10 Generic / \$50 Brand / \$80 Non Preferred Brand Unlimited 30 Days Retail, 100 Days Mail Order	Retail: \$5 Generic / \$25 Brand / \$40 Non Preferred Brand Mail Order: \$10 Generic / \$50 Brand / \$80 Non Preferred Brand Unlimited 30 Days Retail, 100 Days Mail Order
Infertility	Place of Service Copay Applies Unlimited	Place of Service Copay Applies Unlimited