BENEFIT	Anthem Century Preferred $10 Plan RSD # 14 - Town of Bethlehem	ConnectiCare Flex POS $10 Plan RSD # 14 - Town of Bethlehem
Costshares	In-Network services subject to copays Out-of-Network services subject to deductible and coinsurance $10 office visit copay $25 Emergency Room/$25 Urgent Care Facility $0 Outpat Surg Facility / $0 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 $10 office visit copay $25 Emergency Room/$25 Urgent Care Facility $0 Outpat Surg Facility / $0 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	$10 Copay	$10 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	$10 Copay No charge 80 visits in 3 year calendar period	$10 Copay No charge 80 visits in 3 year calendar period
Diagnostic Lab & X-ray High Cost Diagnostic Test	No charge No charge	No charge No charge
Office Surgery	$10 Copay	$10 Copay
Outpatient MH	$10 Copay Unlimited visit maximum per calendar year	$10 Copay Unlimited visit maximum per calendar year

Emergency Care Emergency Room	$25 copay (waived if admitted)	$25 copay (waived if admitted)
Urgent Care	$25 copay	$25 copay
Ambulance	No charge	No charge
Inpatient Hospital	**Note: All hospital admissions require pre-cert**	**Note: All hospital admissions require pre-cert**
General/Medical/Surgical/Maternity (Semi-Private)	$0 per admission	$0 per admission
Ancillary Services (Medication, Supplies)	Covered	Covered
Psychiatric	$0 per admission Unlimited day maximum per calendar year	$0 per admission Unlimited day maximum per calendar year
Substance Abuse/ Detox	$0 per admission Unlimited day maximum per calendar year	$0 per admission Unlimited day maximum per calendar year
Skilled Nursing Facility	$0 per admission Covered up to 120 days	$0 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	No charge	No charge
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 / $10 Brand / $10 Non Preferred Brand Mail Order: $3 Generic / $3 Brand / $3 Non Preferred Brand Unlimited 100 Days Retail, 100 Days Mail Order	Retail: $5 Generic / $10 Brand / $10 Non Preferred Brand Mail Order: $3 Generic / $3 Brand / $3 Non Preferred Brand Unlimited 100 Days Retail, 100 Days Mail Order
Infertility	Place of Service Copay Applies Unlimited	Place of Service Copay Applies Unlimited