BENEFIT	Anthem Century Preferred $20 Plan RSD # 14 - Cafeteria	ConnectiCare Flex POS $20 Plan RSD # 14 - Cafeteria
Costshares	In-Network services subject to copays Out-of-Network services subject to deductible and coinsurance $20 office visit copay $25 Emergency Room/$25 Urgent Care Facility $25 Outpat Surg Facility / $25 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 $20 office visit copay $25 Emergency Room/$25 Urgent Care Facility $25 Outpat Surg Facility / $25 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	$20 Copay	$20 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	$20 Copay No charge 80 visits in 3 year calendar period	$20 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	$20 Copay	$20 Copay
Outpatient MH	$20 Copay Unlimited visit maximum per calendar year	$20 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)	$25 per admission	$25 per admission
Ancillary Services (Medication, Supplies)	Covered	Covered
Psychiatric	$25 per admission Unlimited day maximum per calendar year	$25 per admission Unlimited day maximum per calendar year
Substance Abuse/ Detox	$25 per admission Unlimited day maximum per calendar year	$25 per admission Unlimited day maximum per calendar year
Skilled Nursing Facility	$25 per admission Covered up to 120 days	$25 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	$25 Copay	$25 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 / $20 Brand / $30 Non Preferred Brand Mail Order: $10 Generic / $40 Brand / $60 Non Preferred Brand Unlimited 30 Days Retail, 100 Days Mail Order	Retail: $5 Generic / $20 Brand / $30 Non Preferred Brand Mail Order: $10 Generic / $40 Brand / $60 Non Preferred Brand Unlimited 30 Days Retail, 100 Days Mail Order
Infertility	Place of Service Copay Applies Unlimited	Place of Service Copay Applies Unlimited