

BENEFIT	Anthem Century Preferred \$25 Plan RSD # 14 - Teachers & Retired Teachers	ConnectiCare Flex POS \$25 Plan RSD # 14 - Teachers & Retired Teachers
<b>Costshares</b>	In-Network services subject to copays Out-of-Network services subject to deductible and coinsurance  \$25 office visit copay \$25 Emergency Room/\$25 Urgent Care Facility \$200 Outpat Surg Facility / \$200 per Admit 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  \$25 office visit copay \$25 Emergency Room/\$25 Urgent Care Facility \$200 Outpat Surg Facility / \$200 per Admit 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
<b>Preventive Care</b> 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
<b>Medical Services</b>		
Medical Office Visit	\$25 Copay	\$25 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	\$25 Copay No charge 80 visits in 3 year calendar period	\$25 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	\$25 Copay	\$25 Copay
Outpatient MH	\$25 Copay Unlimited visit maximum per calendar year	\$25 Copay Unlimited visit maximum per calendar year

<b>Emergency Care</b> Emergency Room	\$25 copay ( waived if admitted )	\$25 copay ( waived if admitted )
Urgent Care	\$25 copay	\$25 copay
Ambulance	No charge	No charge
<b>Inpatient Hospital</b> General/Medical/Surgical/Maternity (Semi-Private)	<b>Note: All hospital admissions require pre-cert</b> \$200 per admission	<b>Note: All hospital admissions require pre-cert</b> \$200 per admission
Ancillary Services (Medication, Supplies)	Covered	Covered
Psychiatric	\$200 per admission Unlimited day maximum per calendar year	\$200 per admission Unlimited day maximum per calendar year
Substance Abuse/ Detox	\$200 per admission Unlimited day maximum per calendar year	\$200 per admission Unlimited day maximum per calendar year
Skilled Nursing Facility	\$200 per admission Covered up to 120 days	\$200 per admission Covered up to 120 days
Hospice	No charge 60 days per calendar year	No charge 60 days per calendar year
<b>Outpatient Hospital</b> Outpatient Surgery Facility Charges	\$200 Copay	\$200 Copay
Diagnostic Lab & X-ray	No charge	No charge
Pre-Admission Testing	Covered	Covered
<b>Other Services</b> 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