BENEFIT	Anthem Lumenos HDHP $2250/$4500 RSD # 14 - Teachers and Administrators	ConnectiCare Flex POS HDHP $2250/$4500 RSD # 14 - Teachers and Administrators
Costshares	No Office Visit Maximum **In-Network services subject to Deductible** Deductible $2,250/$4,500 (shared with Out-of-Network) Preventive Care not subject to Deductible Member's Coinsurance after Deductible 0% Out of Pocket Maximum - $4,000/$6,850 **Out-of-Network services subject to deductible and coinsurance** Deductible $2,250/$4,500 (shared with In-Network) Coinsurance 80%/20% Out of Pocket Maximum-$6,000/$12,000 Lifetime Maximum- Unlimited	No Office Visit Maximum **In-Network services subject to Deductible** Deductible $2,250/$4,500 (shared with Out-of-Network) Preventive Care not subject to Deductible Member's Coinsurance after Deductible 0% Out of Pocket Maximum - $4,000/$6,850 **Out-of-Network services subject to deductible and coinsurance** Deductible $2,250/$4,500 (shared with In-Network) Coinsurance 80%/20% Out of Pocket Maximum-$6,000/$12,000 Lifetime Maximum- Unlimited
Preventive Care Pediatric	**100%; no deductible** No frequency or age restrictions	**100%; no deductible** No frequency or age restrictions
Adult	**100%; no deductible** No frequency or age restrictions	**100%; no deductible** No frequency or age restrictions
Vision	**100%; no deductible** 1 exam per year	**100%; no deductible** 1 exam per year
Hearing	**100%; no deductible** 1 screening per year	**100%; no deductible** 1 exam per year
Gynecological	**100%; no deductible**	**100%; no deductible**
Immunizations & Vaccinations	**100%; no deductible** (those for travel - no charge after plan deductible)	**100%; no deductible** (those for travel - no charge after plan deductible)
Medical Services Medical Office Visit	$10 Copay after plan deductible	$10 Copay after plan deductible
Outpatient PT/OT/Chiro/ Speech	**No charge after plan deductible** 50 combined visits per calendar year	**No charge after plan deductible** 50 combined visits per calendar year
Allergy Testing Injections	$10 Copay after plan deductible No charge after plan deductible	$10 Copay after plan deductible No charge after plan deductible
Diagnostic Lab & X-ray	**No charge after plan deductible**	**No charge after plan deductible**
Office Surgery	**No charge after plan deductible**	**No charge after plan deductible**
Outpatient MH	**No charge after plan deductible** Unlimited visits combined maximum per calendar year	**No charge after plan deductible** Unlimited visits combined maximum per calendar year

Emergency Care Emergency Room	**$25 copay after deductible**	**$25 copay after deductible**
Urgent Care	**No charge after plan deductible**	**No charge after plan deductible**
Ambulance	**No charge after plan deductible**	**No charge after plan deductible**
Inpatient Hospital	**Note: All hospital admissions require pre-cert**	**Note: All hospital admissions require pre-cert**
General/Medical/Surgical/Maternity (Semi-Private)	**No charge after plan deductible**	**No charge after plan deductible**
Ancillary Services (Medication, Supplies)	**No charge after plan deductible**	**No charge after plan deductible**
Psychiatric	**No charge after plan deductible** Unlimited days combined maximum per calendar year	**No charge after plan deductible** Unlimited days combined maximum per calendar year
Substance Abuse/ Detox	**No charge after plan deductible** Unlimited days combined maximum per calendar year	**No charge after plan deductible** Unlimited days combined maximum per calendar year
Skilled Nursing Facility	**No charge after plan deductible** Covered up to 120 days per calendar year	**No charge after plan deductible** Covered up to 120 days per calendar year
Hospice	**No charge after plan deductible**	**No charge after plan deductible**
Outpatient Hospital Outpatient Surgery Facility Charges	**No charge after plan deductible**	**No charge after plan deductible**
Diagnostic Lab & X-ray	**No charge after plan deductible**	**No charge after plan deductible**
Pre-Admission Testing	**Subject to Deductible & Coinsurance**	**Subject to Deductible & Coinsurance**
Other Services Durable Medical Equipment	**No charge after plan deductible** Unlimited maximum per calendar year	**No charge after plan deductible** Unlimited maximum per calendar year
Prescription Drugs	Retail: $5 Generic / $20 Brand / $35 Non Preferred Brand Mail Order: $5 Generic / $40 Brand / $70 Non Preferred Brand 30 Days Retail, 90 Days Mail Order	Retail: $5 Generic / $20 Brand / $35 Non Preferred Brand Mail Order: $5 Generic / $40 Brand / $70 Non Preferred Brand 30 Days Retail, 90 Days Mail Order
Infertility	**No charge after plan deductible** Unlimited	**No charge after plan deductible** Unlimited