



TOTALLY THERE FOR YOU

321 BENEFIT PLAN SERIES - GRANDFATHERED

SUMMARY OF BENEFITS AND COVERAGE	OPTION A	OPTION B	OPTION C	OPTION D	OPTION E
PHYSICIAN SERVICES / PREVENTIVE SERVICES	MEMBER ONLY PAYS ONE CO-PAY PER OFFICE VISIT				
Primary care office visits	\$5 Co-pay	\$10 Co-pay	\$10 Co-pay	\$15 Co-pay	\$20 Co-pay
Specialist office visits	\$5 Co-pay	\$10 Co-pay	\$10 Co-pay	\$15 Co-pay	\$20 Co-pay
Allergy injections	\$5 Co-pay	\$10 Co-pay	\$10 Co-pay	\$15 Co-pay	\$20 Co-pay
Chiropractic care (20 visits per year)	\$5 Co-pay	\$10 Co-pay	\$10 Co-pay	\$15 Co-pay	\$20 Co-pay
Hearing and vision screening	\$5 Co-pay	\$10 Co-pay	\$10 Co-pay	\$15 Co-pay	\$20 Co-pay
Immunizations (pediatric)	\$5 Co-pay	\$10 Co-pay	\$10 Co-pay	\$15 Co-pay	\$20 Co-pay
Well child care	\$5 Co-pay	\$10 Co-pay	\$10 Co-pay	\$15 Co-pay	\$20 Co-pay
Annual physical exam	\$5 Co-pay	\$10 Co-pay	\$10 Co-pay	\$15 Co-pay	\$20 Co-pay
Annual well woman visit	\$5 Co-pay	\$10 Co-pay	\$10 Co-pay	\$15 Co-pay	\$20 Co-pay
PSA screening	\$5 Co-pay	\$10 Co-pay	\$10 Co-pay	\$15 Co-pay	\$20 Co-pay
Nutritional counseling and education	\$5 Co-pay	\$10 Co-pay	\$10 Co-pay	\$15 Co-pay	\$20 Co-pay
Health education and counseling	\$5 Co-pay	\$10 Co-pay	\$10 Co-pay	\$15 Co-pay	\$20 Co-pay
MATERNITY SERVICES					
Prenatal & postnatal care	\$5 Co-pay (one-time Co-pay)	\$10 Co-pay (one-time Co-pay)	\$10 Co-pay (one-time Co-pay)	\$15 Co-pay (one-time Co-pay)	\$20 Co-pay (one-time Co-pay)
Delivery in hospital	Covered	Covered	Covered	\$250 Coinsurance	\$500 Coinsurance
Well baby care in hospital	Covered	Covered	Covered	Covered	Covered
INPATIENT HOSPITAL SERVICES					
Unlimited days in a semi-private room; surgery, all physicians and other ancillary services; related drug therapy; lab tests and x-rays	Covered	Covered	Covered	\$250 Coinsurance Per Admission	\$500 Coinsurance Per Admission
OUTPATIENT PROCEDURES					
Surgery and all invasive procedures conducted in any outpatient setting, including physicians and other ancillary services; related drugtherapy; lab tests and x-rays	Covered	Covered	Covered	\$100 Coinsurance Per Procedure	\$250 Coinsurance Per Procedure
EMERGENCY MEDICAL SERVICES					
Physician and hospital emergency room services (Co-pay waived if admitted)	\$40 Co-pay	\$40 Co-pay	\$40 Co-pay	\$40 Co-pay	\$40 Co-pay
Ambulance services (when medically necessary)	\$75 Co-pay	\$75 Co-pay	\$75 Co-pay	\$75 Co-pay	\$75 Co-pay
AFTER HOURS MEDICAL SERVICES					
Participating after-hours care centers (Urgent Care)	Covered	Covered	Covered	Covered	Covered
DIAGNOSTIC & THERAPEUTIC SERVICES					
Outpatient lab tests; diagnostic x-rays; and radiation therapy at a hospital	Covered	Covered	Covered	Covered	Covered
Chemotherapy	Covered	Covered	Covered	Covered	Covered
Physical, occupational and speech therapy	Covered	Covered	Covered	Covered	Covered
Non-preventative diagnostics including lab, x-ray, pathology, and special diagnostics in a non-hospital setting	Covered	Covered	Covered	Covered	Covered
Mammograms	Covered	Covered	Covered	Covered	Covered
BEHAVIORAL HEALTH CARE					
Outpatient treatment	Covered	Covered	Covered	Covered	Covered
SUBSTANCE ABUSE TREATMENT					
Outpatient Care	Covered	Covered	Covered	Covered	Covered
Intermediate Care	Covered	Covered	Covered	Covered	Covered
OTHER SERVICES					
Home Health Care (limited to 100 visits/year)	Covered	Covered	Covered	Covered	Covered
Hospice Care	Covered	Covered	Covered	Covered	Covered
DURABLE MEDICAL EQUIPMENT / PROSTHETIC DEVICES					
Covered when medically necessary	Covered	Covered	Covered	Covered	Covered
PRESCRIPTION DRUG SERVICES					