



HMO Benefit Overview

CESA # 3 INSURANCE PURCHASING COOPERATIVE
HMO1-1

Annual Deductible	\$2,000/\$4,000 (Single/Family)
Coinsurance	0% Coinsurance
Annual Maximum Out of Pocket	\$3,000/\$6,000 (Single/Family)
Lifetime Maximum	Unlimited
Annual Maximum for Essential Benefits	Unlimited
Preventive Services	Unlimited
Dependent Age	26/26
Physician Services	
Office Visit	Subject to Deductible and Coinsurance
Chiropractor Visits	Subject to Deductible and Coinsurance
Hearing Examination	Subject to Deductible and Coinsurance
Podiatry Services	Subject to Deductible and Coinsurance
Vision Services	Subject to Deductible and Coinsurance
Weight Loss/Nutritional Counseling	Subject to Deductible and Coinsurance
Hospital Services	
General Inpatient	Subject to Deductible and Coinsurance
Delivery & Newborn Charges	Subject to Deductible and Coinsurance
Outpatient Services	Subject to Deductible and Coinsurance
Emergency Services	
Emergency Room	\$100 Copayment
Urgent Care	\$25 Copayment
Ambulance	Subject to Deductible and Coinsurance
Pharmacy Benefits	
Tier 1/Tier 2/Tier 3	\$5/\$20/\$40 Copay
Value Tier	\$0 Rx Outcomes
Max Out-of-Pocket (Single/Family)	\$2,000/\$4,000
Behavioral Health	
Inpatient	Subject to Deductible and Coinsurance
Transitional	Subject to Deductible and Coinsurance
Outpatient	
Psychiatrist or Psychologist	Subject to Deductible and Coinsurance
Other Mental Health Professional	Subject to Deductible and Coinsurance
Diagnostic Services	
Lab	Subject to Deductible and Coinsurance
X-Ray	Subject to Deductible and Coinsurance
MRI/MRA Scan	Subject to Deductible and Coinsurance
PET Scan	Subject to Deductible and Coinsurance
CAT Scan	Subject to Deductible and Coinsurance
Other Services	
Anesthesia for Dental	Subject to Deductible and Coinsurance
Autism Spectrum Disorder	See Specific Benefit Category for Applicable Coverage
Durable Medical Equipment	Subject to Deductible and Coinsurance
Home Health Care Services	Subject to Deductible and Coinsurance
Hospice Services	Subject to Deductible and Coinsurance
Kidney Disease Treatment	See Specific Benefit Category for Applicable Coverage
Oral Surgery	100% Coverage
Skilled Nursing Care Facility	Subject to Deductible and Coinsurance
Therapy Services	Subject to Deductible and Coinsurance
TMJ Benefits	Subject to Deductible and Coinsurance

This Benefits Summary is intended to highlight the benefits provided in policy listed above. Please see your policy, including the Certificate of Coverage and Schedule of Benefits (SOB), for limitations and exclusions.