Health Maintenance Organization (HMO)

Highlights	
PCP required	✓
Referral required	✓
Copayments/coinsurance	✓
Out-of-network coverage	X
Deductible	X
Tiered plan	X
Authorized benefits	✓
Unauthorized benefits[1]	X

[1]Unauthorized care is limited to emergency services only.

Note: This information is intended to provide an overview of the plan. Providers are reminded to check the member's ID card to verify the plan in which the member is enrolled. Services and subsequent payment are pursuant to the member's benefit plan document. Prior to initiating services, member eligibility and benefits should be verified by logging on to the secure Provider website.

Overview

The HMO plan offers comprehensive coverage for eligible employer groups and non-group subscribers. Each of the HMO plan types requires new members to select a PCP. Until a member selects a PCP, they will only be covered for ER services.

<u>Cost-Share</u>

Cost-share varies by plan design, and is primarily in the form of a copayment.

Note: Coinsurance applies primarily to durable medical equipment, hearing aids, low-protein foods and prosthetics. There is no deductible.

<u>Out-of-Plan Care</u>

Refer to the Authorization Policy and the Use of Out-of-Network Providers Policy for information on referring members to out-of-plan providers.