



HMO Medical FAQs

Q: How does an HMO medical plan work?

An HMO (Health Maintenance Organization) is a network of health providers that offer treatment for participants belonging to the HMO. The focus of care is on wellness, maintenance of care and all types of urgent and ongoing care. Typically, patient's care is directed or pre-approved by a Primary Care Physician (PCP) chosen by the member.

Q: Must I use an HMO provider to receive care?

Yes, there is no out of HMO network care that is covered. All care must be provided by the HMO facility or network of HMO network physicians/providers. If traveling outside the HMO territory, or covering a dependent who resides outside the HMO territory, only emergency care is covered---as defined by the specific HMO.

Q: Do I need a referral from my primary care doctor to see a specialist if I am in an HMO?

Yes, this is often the case. It is best to understand this component prior to enrolling. Make sure you know for the specific HMO you're considering; which primary care doctors are available, whether they are adding new patients, and their rules on how to use a specialist.

Q: What is the cost advantage of an HMO over a PPO (Preferred Provider Organization) medical plan?

Generally, with HMOs, you pay a premium and most care is then provided at little or no cost. Typically, there aren't high deductibles or 20-30% member coinsurance like a PPO. There may, however, be office visit copays, hospital admission copays and sharing of prescription costs. It is always a good idea to review the plan details to best understand all the cost and coverage components of the HMO plan.

Q: Do HMOs provide other benefits?

Refer to your specific plan summaries and details. Often, HMOs include benefits for accidents, wellness/health club discounts, vision, and dental benefits or discounts and other related health coverage.