Health Maintenance Organization (HMO)

HMOs are coordinated care plans. These are similar to other HMO plans for the under-65 market. An HMO has a network of providers that the member will have to stay within in order to get covered services without having to pay extra out of their own pocket. Enrollees usually have to elect a primary care physician that they must see for any initial and ongoing care without a referral. A referral is when the primary care physician refers a patient to see a specialist, or to get a second opinion. In most cases, under an HMO, a member cannot self-refer, and services will not be covered, if they do not go through their primary care provider.

Some services, such as emergency care, are covered out of network, and a plan can offer a point-of-service option, which allows the beneficiary to go outside of the network. Going out of network will require higher cost sharing by the member. However, an HMO cannot have a higher out-of-pocket cost than $6,700.