



Illinois Insurance Facts

Health Maintenance Organizations (HMOs)

Illinois Department of Insurance

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How Does an HMO Work?

HMO plans are very different from traditional health insurance plans. HMOs work on the premise that you can avoid future medical problems by "maintaining" your health now. HMOs usually offer you broader coverages and lower out-of-pocket expenses than traditional insurance, but you must use the HMO's health care providers.

- An HMO may operate only in certain counties and zip codes called a "**service area.**" It is important that you live within your HMO's service area since you must travel there for all medical treatment. If you live elsewhere, but work within an HMO service area, you may still be able to join, depending on how the HMO defines service area.

If you travel a lot, are outside the HMO service area for long periods of time, or have a child attending college outside the service area, an HMO may not be the best choice for you. Most HMOs only provide coverage for emergency treatment if you are outside the service area.

- In an HMO, you must get all medical care from their **network** of health care **providers** (doctors, hospitals and pharmacies). If you want to use the doctor, hospital or pharmacy of your choice, an HMO is probably not for you.
- Most HMOs require you to choose a **Primary Care Physician (PCP)** to manage all your health care needs. In such situations, you must always contact your PCP first. If your PCP decides you need services from a specialist, he or she will refer you to another provider in the HMO network. If the HMO network doesn't include a specialist qualified to treat your condition, your PCP must give you a referral to a provider outside the network.
- Female enrollees may also choose a **Woman's Principal Health Care Provider (WPHCP)** in addition to their PCP. The WPHCP is an obstetrician, gynecologist or a physician specializing in family practice, is a contracted provider within the HMO's network and may act as your PCP. If you do not choose to use a woman's principal health care provider as your PCP, you can visit your WPHCP without a referral from your PCP, but your HMO can require that your PCP and your WPHCP have a referral arrangement with each other.

What is an Evidence of Coverage?

HMOs issue an "**evidence of coverage**" that explains the services, benefits, exclusions and limitations of your coverage. HMOs must provide "basic health care services" such as hospitalization, preventive medicine, office visits, maternity care, diagnostic services and treatments for emergency medical situations, mental health care and substance abuse. It is **very** important to read and understand your evidence of coverage before you seek care. Here are some of the items included in an evidence of coverage:

- **Emergency Room Care** — Explains guidelines you must follow in emergency situations, both inside and outside the HMO service area. If you don't follow those guidelines, you may have to pay the cost of emergency care.

To qualify as a medical emergency, there must be acute symptoms of sufficient severity that you, as a prudent layperson with average knowledge, could reasonably expect that:

- your health is in serious jeopardy;
- you have serious impairment to bodily function;
- you have serious dysfunction of any bodily organ or part.

In emergency situations, use the nearest hospital emergency room. Emergency services may be received from a plan or non-plan provider, including the physician and hospital, without prior authorization from your PCP.

- **Urgent Care** — Some HMOs cover urgent care services for members who travel outside the service area. If you travel a lot, choose an HMO that provides this coverage.
- **Care Received Outside the HMO Service Area** — If you are outside the HMO service area and need medical care that is not urgent in nature, you must call your PCP first.

What are Some Advantages to Joining an HMO?

- **Less paperwork** — There are no claim forms to complete.
- **Fewer expenses** — Your only expenses are your monthly premiums, copayments and/or coinsurance. An HMO copayment is a fixed dollar amount you pay each time you see a physician or buy a prescription. HMO copayments usually cost less than traditional health insurance deductibles and copayments. An HMO coinsurance is a percent of the cost of the health care service.
- **Broader coverages** — HMOs cover a broad range of services including preventive health services, maternity and, well-baby care. The HMO cannot exclude preexisting conditions but you may be charged a higher copayment for those conditions. In addition, there are no lifetime maximum dollar limits on your coverage, although there may be other limits on your coverage. Many HMOs also provide supplemental services, such as vision care, prescription drugs, and durable medical equipment.

What are Some Disadvantages to Joining an HMO?

- **Limited choice** — In an HMO you are not free to choose any doctor, hospital or pharmacy you want. You must use the HMO network providers. HMO contracts with providers end throughout the year. If your doctor leaves the HMO, you will have to choose a new doctor.
- **Affiliation period** — HMOs may impose an "affiliation period." During this time, you have no benefits, but you also don't have to pay premiums. The maximum affiliation period is two months (or three months for late enrollees).

What Should I Look for in Choosing an HMO?

Most people choose an HMO as an option from an employer group, plan or association to which they belong. However, a few HMOs in Illinois sell directly to individuals. When choosing an HMO, you should look at:

The HMO Itself

- Contact the Division of Insurance to find out if the HMO is licensed in Illinois.
- Contact the Division of Insurance to check the HMO's consumer complaint record.
- Ask your friends or family if they belong to the HMO, and whether they are happy with the services and care provided to them.

The HMO Plan

- Is it affordable? How do the premiums, copayments and coinsurance compare to other HMOs offering similar benefits?
- Do the benefits match your needs? Are any services you need not covered?
- How does the plan treat preexisting medical conditions? (For example, even though an HMO can't exclude a preexisting condition, it can require a higher copayment.)

The HMO Health Providers

- Are the HMO providers familiar to you? Are they conveniently located? Is there a wide choice of physicians, specialists and hospitals?
- Are the HMO providers accepting new patients?
- Is your current doctor or specialist with the HMO? If so, is he or she satisfied with the HMO and planning to continue with the HMO?
- Is it easy to change Primary Care Physicians?

What Happens if I am Sick or Hurt after My Doctor's Office has Closed?

Whenever possible, you must call your PCP before you get medical treatment. Your PCP is required to be available 24 hours a day, seven days a week to help you. If you do not call your PCP first, you may be responsible for paying your medical expenses, except in emergency situations.

What if I Have a Problem with My HMO?

If you have questions about your HMO coverage, call the Customer Service number listed in your evidence of coverage. If you have a problem with a claim or treatment, your evidence of coverage explains how to appeal the decision to your HMO.

If your problem cannot be satisfactorily resolved by your HMO, contact the Department Of Insurance Consumer Services Division at (312) 814-2427 or the Department of Insurance Office of Consumer Health Insurance (OCHI) toll free at (877) 527-9431 or visit our website at <http://insurance.illinois.gov>.

The Managed Care Patients Rights Act

The Managed Care Reform and Patient Rights Act, [215 ILCS 134](#) effective January 1, 2000, requires HMOs to provide more open access to information and services to you, including:

- a description of the HMO service area;
- an explanation of exclusions and limitations;
- an explanation of pre-certification and utilization review requirements;
- an explanation of emergency coverage and requirements that must be met in order to receive reimbursement for emergency services;
- a description of the process for selecting a primary care physician;
- a description of any limitations to access specialty care;
- a description of benefits available for out-of-area care or services;
- an explanation of out-of-pocket expenses;
- a description of the provisions to ensure continuity of care;
- an explanation of the appeals process.

This law required many changes to the way HMOs conduct business in Illinois. This list is only a summary of the law. For further details or questions about the Managed Care Reform and Patient Rights Act, please review the fact sheet at <http://www.idfpr.com/DOI/HealthInsurance/ManagedCareReform.asp> or contact us at one of the numbers below.

For More Information

Call our Consumer Services Section at (312) 814-2427 or our Office of Consumer Health Insurance toll free at (877) 527-9431 or visit us on our website at <http://insurance.illinois.gov>

Related Topics

[HMO Complaint and Disposition Report](#)

[Facts About HIPAA – Preexisting Conditions](#)

[I Want To File A Complaint](#)

[Office of Consumer Health Insurance \(OCHI\)](#)

[Health Insurance Continuation Rights – COBRA](#)

[Health Insurance Continuation Rights – Illinois Law](#)

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