KAISER PERMANENTE®

HMO Plus and DHMO Plus
Frequently Asked Questions

WHAT IS HMO PLUS AND DHMO PLUS?

HMO Plus and Deductible HMO Plus (DHMO Plus) offer full HMO coverage through the Kaiser Permanente delivery system, plus some coverage for certain routine out-of-network services - 10 out-of-network medical services (with some limitations) and 5 prescription fills/refills for each member every contract year.

Though members will experience the highest quality care and health outcomes from Kaiser Permanente providers and facilities, this plan allows members to seek certain routine services from any licensed non-participating provider in the United States.

WHAT ARE THE DIFFERENCES BETWEEN HMO PLUS AND DHMO PLUS?

With DHMO Plus, the member is required to satisfy a deductible for in-network services before the Health Plan begins to pay for covered services. There is no additional or separate deductible for the HMO Plus benefits.

WHY DID WE CREATE THESE NEW PRODUCTS?

HMO Plus and DHMO Plus are competitively priced products that give members complete access to our integrated model, while providing some limited external provider choice, all in one plan.

WHAT GROUPS WOULD BENEFIT FROM HMO PLUS?

Kaiser Permanente designed the HMO Plus coverage to appeal to new groups trying to solve for employees with travel needs and new groups with employees who have established relationships with doctors, including those who may want to get another medical opinion outside of Kaiser Permanente. HMO Plus plans will be available in both slice and sole carrier situations.

WHAT ARE THE NETWORK OPTIONS?

These plans can only be paired with the Signature provider network. Members can see any other licensed provider in the U.S. under the HMO Plus (limited out-of-network) coverage on a limited basis.

DO OTHER CARRIERS HAVE SIMILAR PRODUCTS?

No. There are currently no similar products in the market.

ARE THESE PRODUCTS AVAILABLE TO IN AND OUT-OF-AREA MEMBERS?

Members must live or work in the Kaiser Permanente Mid-Atlantic service area.

ARE THESE PRODUCTS HSA-QUALIFIED?

These products are not HSA compatible. They are HRA 213(d), limited-purpose and FSA (Medical and Dependent Care) compatible.

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WHAT PROCESS CAN MEMBERS EXPECT WHEN THEY GO OUTSIDE OF KAISER PERMANENTE FOR SERVICES?

When utilizing out-of-network services, some providers and pharmacies may require payment of the full cost at the point of service and then the member must file a claim for reimbursement from Kaiser Permanente. Some providers may process the claim for the member; it will depend on those providers' respective offices.

ARE REFERRALS OR PRE-AUTHORIZATIONS NEEDED TO USE OUT-OF-NETWORK BENEFITS?

No. HMO Plus and DHMO Plus members can use their out-of-network benefits without a referral or pre-authorization.

WILL MEMBERS BE BALANCE BILLED?

There is the potential, in Washington, DC and Virginia, that members may be balance billed*.

HOW ARE THE OUT-OF-NETWORK VISITS COUNTED?

An out-of-network "visit" is any encounter or service that is rendered out-of-network. For instance, a member who sees a specialist and has lab work done uses two "visits" from the annual limit. Multiple encounters in the same office setting on the same day may count as multiple visits and will accrue towards the annual visit limits.

WHAT HAPPENS IF A MEMBER GOES OVER THEIR VISIT OR RX LIMIT?

Members will either be required to pay out of pocket for any additional out-of-network services or they may obtain all their care in-network for the remainder of the contract year.

HOW WILL MEMBERS KNOW HOW MANY VISITS THEY HAVE USED?

The visit counts will be included on the EOB and members can call the number on their ID card to inquire.

ARE THE 10 VISITS AND 5 PRESCRIPTIONS FOR EACH MEMBER, OR ARE THOSE SHARED WITHIN A FAMILY?

Each individual member with a Plus product will have 10 visits (for certain physician, lab and imaging services) and 5 prescription fills/refills per year.

*Maryland law regulates the payment to non-participating providers and prohibits balance billing by such providers.