

HMOs vs. PPOs

The two most common health plans available these days are HMOs and PPOs. Both can be affordable, and both can offer access to high-quality care. But they do have their differences.

Both HMOs (Health Management Organizations) and PPOs (Preferred Provider Organizations) are kinds of managed care. That means your costs stay lower — but there will be restrictions on how you receive your care.

What's The Difference Between an HMO and PPO?

HMOs and PPOs differ in two main ways: **cost** and **access**.

With an HMO plan, your costs tend to be much lower and co-payments are low when you visit a doctor or hospital. This means your out-of-pocket expenses are kept at a minimum.

The tradeoff for these low costs is that your HMO plan comes with restrictions on when you can receive care — and who you can receive it from. To receive coverage, you must get care from a doctor on the plan's pre-approved list of healthcare providers. And if you need specialist care, you'll need a referral from your doctor. For some kinds of specialist care, you'll need approval from the plan's management.

PPO plans can be more expensive, but have fewer restrictions. Many PPO plans have a higher deductible. And your PPO plan will have higher monthly premiums.

But with a PPO, you'll be able to see almost any doctor you choose. PPO plans also have pre-approved lists of healthcare providers — but they also provide coverage when you see providers who aren't on that list. When you see a pre-approved doctor, you'll save more money — but you won't be stuck without coverage if you choose to see an "out-of-network" provider. If you chose to see an out-of-network doctor the plan will pay only the agreed upon contracted amount and you the member will be balanced billed.

Should you have additional questions, please contact the medical carriers:

Presbyterian-HMO: (888) 275-7737

BCBS-HMO and PPO: (877) 994-2583