HMO vs. PPO: Choosing the right health plan

Here is some important information that you should consider before you select coverage for you and your family.

Know the differences: HMO and PPO plans

HMO

Choosing a primary care physician (PCP) is one of the keys to using an HMO plan. Except for emergencies and urgent care received outside of their PCP's service area, members of an HMO plan must access **covered services** through a network of physicians and facilities as directed by their PCP. HMO plans may be a good choice and offer a cost-efficient way to maintain your health care if you and your family go to the doctor often. You simply pay a fixed **copayment** each time you visit your PCP.

VS.

PPO

With PPO plans, you may select any physicians and hospitals within the plan's network, as well as outside of the network. Keep in mind that if your doctor (or other provider) is not part of the plan's PPO network, you may have to pay more for each visit.

PPO plans require you to meet an annual **deductible** before your plan coverage begins. Once you meet the deductible, you share a percentage of costs, called **coinsurance**, with your plan. You can see **preferred providers (network providers)** and pay lower coinsurance amounts. Or you can see any **non-preferred providers (non-network providers)** you want and pay more.

Quick health basics

Here are short explanations of some common terms. They can help you better understand the terms included in your enrollment materials. Once you have become a Blue Shield member, please refer to your *Evidence of Coverage* (EOC) for the official definitions of these terms.

Coinsurance: The percentage of the allowable amount or billed charges that you must pay for covered services after meeting any applicable plan deductible.

Copayment: The fixed amount and/or percentage amount you must pay for covered services after meeting any applicable plan deductible.

Copayment/coinsurance maximum: The limit on the amount you must pay in copayments or coinsurance after any applicable deductible has been met for certain covered services during a calendar year. Once the maximum is reached, Blue Shield will pay 100% of the allowable amount for these covered services, up to specified maximums for the rest of the calendar year. Certain PPO plan covered services, such as office visits, generally do not count toward these maximums, and continue to be your responsibility.

Covered services: The medical services and supplies that are covered by the health plan.

Deductible: The initial amount you must pay in a calendar year for particular covered services before Blue Shield pays.

Formulary: A preferred list of drugs which may include generic and brand-name drugs. In certain plans, members pay less for formulary than non-formulary drugs. We also have plans that cover only formulary drugs.

Non-preferred provider (PPO plans only): A provider who is not in the Blue Shield PPO network, also called a non-network provider.

Out-of-pocket maximum: A dollar limit on the total amount that a member has to pay for many covered services in a calendar year, including the copayments, coinsurance, and deductible.

Primary care physician: The network physician who serves as an HMO member's designated primary healthcare provider and provides or coordinates all of the member's care, usually within a medical group. Tandem PPO members are also matched with a PCP to help them navigate their healthcare needs.

Preferred provider (PPO plans only): A provider who is part of the Blue Shield PPO network. Also called a network provider. PPO members pay less when they see preferred providers.