



HMO, PPO and POS Health Plans

Question:

What is the difference among HMO, PPO, and POS health plans? Which is best for a small business?

Answer:

Choosing a health plan that will work for your business depends on your company's needs and financial situation. Very large companies frequently offer employees a choice of health plans or insurers. Small companies with price restraints typically can afford to offer only one plan.

Health maintenance organization (HMO): This is generally the least expensive group health option, and also the least flexible. In exchange for a monthly premium, you are entitled to doctor visits, preventive care, and medical treatment, all for an additional co-pay of \$5 to \$10 for each appointment. You cannot visit a doctor who's outside the HMO network. Requiring you to visit only doctors who are contracted to provide services allows an HMO to keep its costs down.

An HMO covers prescription drugs. As the employer, you decide what percentage of each prescription will be covered by the HMO, and what the employee pays out-of-pocket. This can range from a single-digit co-pay of \$5 for some drugs, to a co-payment covering almost the entire cost of the drug.

An HMO requires patients to select a "primary care physician," a gatekeeper who takes care of your routine medical needs, such as checkups and basic prescriptions. Your primary care doctor also can refer you to a specialist, who is also within the HMO's network. The only time that an HMO will pay for your medical care without a referral is for emergency-room treatment. By law, an HMO cannot require referrals for emergency care.

Preferred provider organization (PPO): More flexible and with a slightly higher premium than an HMO, a PPO allows you to venture out-of-network at your discretion and does not require a referral from a primary-care physician. However, the \$5 to \$10 co-payment provides you with a financial incentive to stay in the network. Straying from the PPO network means that you pay the cost of your treatment in full, and then submit the bill for reimbursement to the insurance company. A PPO generally reimburses 80 percent of out-of-network costs.

Point-of-service plan (POS): POS plans are almost a hybrid of HMO and PPO plans. Like an HMO, you designate an in-network physician to be your primary care provider. However, like a PPO, a POS plan lets you go out-of-network. But when you go on your own, you'll have to pay most of the cost, unless your primary care physician refers you to an out-of-network doctor. Then, the health plan will pick up the tab.

Please note that this description/explanation is intended only as a guideline.

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