HEALTH INSURANCE NETWORKS
WHAT THE ACRONYMS MEAN

Health Insurance Networks and their acronyms can be very confusing. It is very important that you understand the differences between them. With some of the networks, there is no coverage if you don't stay in their network. The insurance companies are trending toward narrower networks to control costs. This means you may not have the flexibility to see the doctor or hospital of your choice unless you are in the correct network. Make sure that you read the fine print on the Summary of Benefits and Coverage for each plan you're considering before you enroll. That way you'll know for sure what each plan will expect from you, and what you can expect from it. Make sure you research the doctors and hospitals in the network that you are choosing. It is not good enough that your doctor accepts "United Health Care" or whatever company you are dealing with. There are different networks within that company and you need to make sure he is in that specific network. You might want to ask your doctor what specific networks he is in. If you need help looking into these details, call us at 972-771-6043 and we'll help.

Preferred Provider organization (PPO)
A type of health plan that is generally more expensive because it contracts with a broader array of hospitals and doctors to form its provider network. It's the only type of plan that always has some coverage for out-of-network services, if at lower levels than for in-network care. Plan members don't need to select a primary-care physician, and they may go to any health care professional they want without a referral.

Health maintenance organization (HMO)
An insurance plan that usually limits coverage to care from doctors who work for or contract with the HMO. The plans often provide integrated care and focus on prevention and wellness. Except in an emergency, a patient needs a referral from his or her designated primary-care physician, or gatekeeper. The plans generally won't cover out-of-network care except in an emergency.

Exclusive provider organization (EPO)
An insurance plan where services are covered only if patients go to doctors, specialists or hospitals in the plan's network, except in an emergency. The insurer manages the care by requiring prior authorization of drugs and certain services. Plan members, though, do not have to choose a primary-care doctor who provides referrals to specialists, as they must in a health maintenance organization.

Point of service plan (POS)
A plan typically tacked on to a health maintenance organization policy to allow some out-of-network coverage. As with an HMO plan, the patient must choose an in-network primary-care physician who makes referrals to specialists. As is not true of an HMO plan, the specialists may be out of network, though the plan will pay less than it does for in-network care. Definitions may vary by plan provider. Please read the Summary of Benefits. POS plans will have a narrower network than the PPO.

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