With open enrollment season upon us, now is your chance to enroll in your health insurance or make a change to your policy for the coming year. If your employer offers only a few health insurance options, then the decision will be relatively straightforward. In many cases, you'll have options from which to choose, and identifying the right plan might be a lot more complicated.

“As Americans we will drive around an extra three miles to save a nickel on gas,” says Martin Rosen, cofounder of health care advocacy and assistance company Health Advocate, a subsidiary of West Corporation. Consumers will do even more to save money on their health insurance costs, which in some cases are so significant that a savings feels like a salary increase.

Here is a convenient explanation of the differences among HMOs, PPOs, and EPOs—along with strategies for choosing an insurance plan that will fit your needs.

HMOs (health maintenance organization): HMOs have a network of doctors and other providers. Typically, an HMO will only cover your medical costs at a participating in-network doctor, hospital, or other provider. You don't have the option to shop around like you’d have with other types of insurance, such as a PPO. However, because of its narrower coverage, an HMO might have lower premiums than other options. Often, HMOs do not have a deductible.

When looking at an HMO, consider the size of its network, says Rosen. “There are some insurance programs in some geographic areas where they have a very robust network,” he says. In these robust plans, insurers have negotiated contracts with a large number of providers, including primary care physicians, specialists, and hospitals. Also consider whether your current doctor or other providers are in-network and whether you need a referral from your primary care doctor for lab work or an appointment with a specialist. Rosen says traditional HMOs often require referrals. “Some HMOs are a little bit more open in allowing you to go to certain providers without a referral,” he explains. “But generally with an HMO, the primary care doctor is referred to as ‘the gatekeeper.'”

PPOs (preferred provider organization): PPOs have an in-network option similar to an HMO, but they also may cover a portion of your costs (or in some cases, all of your costs, if your plan has a deductible that you’ve met) to see an out-of-network provider. However, visiting an out-of-network doctor may subject you to higher copayments or coinsurance. “The PPO model creates a highly incentivized financial program for you to use the in-network providers,” Rosen says.
If you have any chronic health issues that require consults with certain specialists or if you’ve built a rapport with your primary care doctor, the out-of-network option might be important to you. “With the out-of-network option with the PPO, financially you’re paying more money, but you might be able to go to a doctor who’s not in the network,” Rosen says.

EPOs (exclusive provider network): An EPO often has characteristics of both HMOs and PPOs. Like an HMO, an EPO might only cover you to see in-network providers. Unlike most HMOs, however, you may not need a referral to see a specialist. Rosen says some EPOs have very narrow provider networks, which can help keep premiums low. He points to hospital employees who have no copayments, coinsurance, or other costs so long as they use that hospital’s facilities for care as part of their EPO. “Sometimes in those EPOs, [there are] also rules of how and when you can go,” he adds. If having your choice of providers is important to you, check the network to see if your doctors are included before you sign up for an EPO.

Several websites have online or mobile calculators to help estimate your healthcare costs under various health care plans. You can’t necessarily predict every potential medical cost for the coming year, but anticipating what you can and comparing your options will help you choose a suitable health plan for your needs.