Choosing the right health plan can feel like you’re trying to navigate through an alphabet soup, especially when it comes to EPO versus PPO. The two may sound similar, but they are different in their coverage options.

What Is an EPO?
Exclusive Provider Organizations require patients to stay within a set network of providers. In this way, EPO plans are similar to HMO plans. You will be required to pay out-of-network expenses if you receive care at a facility not on the approved list of providers — except in an emergency. However, having this direct network access typically enables patients to get lower premium rates and copayments. An EPO is distinct from an HMO in that it does not require you to obtain referrals from your primary care physician in order to see specialists. Although you have to stay in-network with your EPO, you can self-refer to specialists you want to see.

What Is a PPO?
Preferred Provider Organization plans offer you more flexibility than EPOs by partially covering services provided by out-of-network providers. As with an EPO, PPO patients do not need referrals to visit a specialist. If you go out-of-network, your insurer will cover a portion of your costs, but you’ll still have some out-of-pocket charges to pay. Your charges will likely be higher for out-of-network care, but your care will be partially covered, unlike with an EPO. The flexibility of a PPO comes with a price — patients usually pay higher premiums than with an EPO. Chances are your deductible will also be higher with a PPO.

What's the Biggest Difference Between an EPO and PPO?
The most important difference between an EPO and a PPO is that EPOs cover services only from providers in their network, whereas PPOs cover the services of both in- and out-of-network providers.

Is an EPO or a PPO Best for Your Needs?
If you know that your doctor or hospital is in an EPO plan’s network that you’re considering, an EPO may offer you more affordable premiums and cost sharing (things like deductibles and copays). If you’re willing to do your own research to find the right provider or specialist within a plan, then an EPO might be right for you.

If you’re looking for more flexibility in provider options and see a variety of specialists, or you travel frequently enough that you may receive care out-of-network, it could be worth considering a PPO. If you have doctors that you aren’t willing or able to give up seeing, but they’re not in-network, a PPO will be your best bet.

Why Are In-Network Providers More Affordable?
Your costs will be lower when you go to an in-network doctor because insurance companies contract lower rates with providers who are in their networks. When you go out-of-network, those doctors don’t have contracted rates — thus costing your insurance company, and you, more. “The reason doctors are not in a network is because they want to charge whatever they want, and not be
restricted to what the insurance company is willing to pay them,” says Stacey Weinstein, a full-service independent insurance broker with KGK Agency based in New York.

Here are the three main things to consider before choosing an EPO or PPO plan.

Make Sure Your Doctors Are In-Network
Check whether the doctors you plan to visit or already go to will be included when you’re deciding between an EPO and a PPO, says Martin Rosen, executive vice president at Health Advocate. If you select an EPO, your choice is going to be limited to a specific network of providers.

Balance Cost and Flexibility
Although EPOs may be less expensive for monthly premiums and cost sharing, you’ll face more restrictions in which providers you can see, Rosen says. PPOs may cost more, but you’ll have more flexibility in choosing doctors.

“Any person that uses their health plan a lot needs to not only look at the premiums and deductibles, but should strongly consider the ‘maximum out-of-pocket’ expenses,” Weinstein says. If you’re expecting a lot of expenses in the next year, it’s worth searching for a plan with a lower out-of-pocket maximum, as this could greatly limit what you’ll end up paying in total.

Understand the Fine Print
Both EPOs and PPOs will vary by plan and insurance company, so it’s crucial to examine the fine print.

Deductibles are one aspect that will vary by plan. The deductible is the portion of covered expenses you’ll need to pay before insurance coverage goes into effect each calendar year. Simply put, deductible means the amount you’ll be responsible for before your insurance plan kicks in and starts paying for part or all of your care. Plans will also vary according to coinsurance or copays required in addition to the deductible. Co-pays are set amounts you’ll pay for doctor visits, prescriptions and other services; coinsurance is the percentage you owe after your health insurance pays its portion of the service outside the deductible. You’ll want to also know about each plan’s out-of-pocket maximum, which limits the total amount you'll have to spend on your health care each year.

If you require specific prescription drugs, you’ll also want to find out whether they will be covered under your desired plan. If your prescription isn’t covered, you’ll need to ask your doctor for an alternative drug, or pay for it on your own. With the right research, you may be able to find a different plan that does cover your prescription.