

TRADITIONAL PREFERRED PROVIDER ORGANIZATION (PPO) PLAN

WHAT IS A PPO MEDICAL PLAN?

A PPO, or Preferred Provider Organization, is a type of medical plan where employees pay for covered services based on a deductible, copay and coinsurance structure.

The PPO plan gives members flexibility when choosing doctors, hospitals, and other health care providers. PPO plans have a network of preferred providers who have agreed to offer services at negotiated rates, which generally helps members pay less when they use in-network care.

HOW A PPO PLAN WORKS

- **You pay a deductible, copay or coinsurance for covered services.** How you pay for services is outlined in your plan document.
- **Preventive care is covered at no cost.** Services such as certain annual checkups, screenings, and immunizations may be covered at no cost when received from in-network providers.
- **You pay a copay to visit your primary care provider or specialist.** Doctor visits have a copay; however, any additional services may be subject to additional costs.

BENEFITS OF A PPO

- **Lower upfront costs.** Many covered services have a flat copay and do not require the deductible to be met.
- **Lower deductible.** The deductible on a traditional PPO plan is lower than that of a High-Deductible Health Plan (HDHP)
- **Provider flexibility:** Members can choose from a broad network of participating doctors, hospitals, and specialists.

- **No referral requirement:** Members typically do not need a referral from a primary care provider to see a specialist.

THINGS TO CONSIDER BEFORE CHOOSING A PPO

- **Higher premiums:** PPO plans have higher per-paycheck costs than High-Deductible Health Plans (HDHP).
- **Provider network matters:** Using in-network providers helps lower costs and ensures expenses count toward the deductible and out-of-pocket maximum.
- **Understand how the plan pays:** Review the deductible, copays, coinsurance, and out-of-pocket maximum before enrolling.