EXCLUSIVE PROVIDER ORGANIZATION (EPO) PLANS

DEFINITION

An EPO plan is a form of managed care in which a network of medical care providers has entered into agreements with an insurer to provide health insurance to its members. These plans are designed to provide its members with affordable medical care since costs are controlled by restricting one's care to providers within the network.

EPO plans are similar to Health Maintenance Organization (HMOs) plans as they require members to see physicians within the network and do not reimburse members if they go out-of-network. The main difference between EPOs and HMOs is that EPO providers are paid only for services provided while HMO providers receive monthly payments, making premiums for EPO plans less expensive than for HMOs. EPO plans are similar to Preferred Provider Organization (PPO) plans in terms of structure as they cover in-network medical services, but EPO members cannot file claims for visits and services provided by out-of-network providers.

HOW THEY WORK

Each member selects a primary care physician (PCP) who will handle medical issues, and they will also provide referrals for specialists. All referrals, prescriptions and other services must first be approved by the EPO in order to be covered.

The costs for these plans are generated from premiums, copayments, and deductibles.

EPO insurance carriers are able to negotiate lower rates with health care providers than other types of plans since EPO members are restricted to in-network doctors only.

ADVANTAGES

- For members that are healthy and requiring mostly routine care, these plans provide great care at lower costs than most other managed care programs.
- In the event of a dispute, the insurance company can act as a mediator between the members and the medical service providers.

DISADVANTAGE

- Since their network of physicians is usually smaller than HMOs, this can restrict the member's options and they may end up having to see an out-of-network provider and paying this out-of-pocket.