Health Insurance Networks

The Ins and Outs

Since finding in-network care is so important to the cost of the care you receive, you need to know how to find in-network providers for your specific health plan:

- **You can search the plan's online network directory for the most current listing**
- **Call the Customer Service line for the health plan and verify that both the provider and location where you will be seen are considered in-network for your health plan**
- **Ask your primary care doctor for suggestions**

No matter what the insurance company tells you, verify that the provider is in your specific health plan's network at that location when making an appointment. There are times that a medical practice may be in-network, but the provider is not considered to be in-network at that office location.

Provider Network

The provider network is list of doctors, other healthcare providers, pharmacies and medical facilities that have contracted with a health insurance plan to provide medical care to their members.

Provider networks include different types of healthcare professionals such as doctors, therapists-physical, occupational or speech-psychologists, pharmacies, labs and different types of healthcare facilities including hospitals or urgent care clinics.

In-Network Providers

In-network providers are medical providers who join a health insurance network and accept a discounted price or allowed amount for any service they perform as payment in full. The insurance plan pays their portion of the allowed amount, and the patient pays their share of out-of-pocket expenses including deductible, co-pay or co-insurance as required by their policy. *The remaining balance is forgiven or written off by the provider.*

Think of health insurance networks like membership stores. You pay a yearly membership fee to be able to shop there. You can find products there at discounted rates that aren't available at other stores. You may be able to find the same products at other stores; however, you will likely pay much more because you won't be able to take advantage of the discount you receive by shopping there. The same is true with your in-network healthcare provider. You pay your monthly premium to access the much-lower prices the doctor and insurance company have agreed upon. You might be able to see your same doctor outside of an insurance network; however, you will likely be paying the full retail cost of the services you receive.

***Note:** make sure you are searching the correct provider network for your specific plan!*

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Out-of-Network Provider

A healthcare provider who has **not** negotiated a discount with a specific health insurance plan. Since these healthcare providers have not agreed to accept the health insurance plan's allowed amount as payment in full, the provider is allowed to bill the patient for the difference between what the insurance plan allowed and what was billed by the provider.

Balance Billing

The difference between what the health insurance plan will pay and what was billed by the provider. In most cases, you *are responsible for this difference*.

Unless it is considered a true emergency, insurance coverage will vary by plan type. Health Maintenance Organization (HMO) or Exclusive Provider Organization (EPO) plans limit non-emergency coverage to care from in-network providers. This means that as the patient, you would be responsible for the full amount charged by a medical provider. PPO plans will pay a reduced amount for out-of-network care based on the specific details of the policy.

The Affordable Care Act (ACA) requires health insurers to cover emergency care as if it's in-network, regardless of whether the emergency care is received at an in-network or out-of-network facility. However, the out-of-network emergency room and physicians can still balance bill for any remaining balance. If the health insurance plan determines that it was not an emergency, the visit will not be considered in-network and the patient will be responsible to pay a larger amount for this care.

Case Example

It costs more to go out of network.

A member with a PPO plan sees an out-of-network specialist:

Office Visit (original provider's charge)	$500
Insurance Allowance (the amount the insurer agrees to pay)	$300
Out-of-Network Deductible (amount the patient must pay for going out-of-network)	$150
Balance of Allowed Amount (after the deductible)	$150
Insurance Coverage for Patient (60%)	$90
Provider's Allowed Balance Billing (difference between the original charge and allowed amount, which the patient must pay)	$200
Total Paid by the Insurance Company	$90
Total Paid by the Patient	$410

A member with a HMO plan visited the same specialist:

No coverage for non-emergency care	
Total Paid by the Patient (the full original provider's charge)	$500