



In Network vs Out of Network – What is the Difference?

In regards to your insurance, you have probably heard the terms “**in-network**” and “**out-of-network**” care thrown around quite a bit by your provider. But what do these terms actually mean, and more importantly what do they mean for you?

Depending on the coverage you have purchased or that was set up by your employer, your plan has established deals with a wide range of dentists and specialists. These are the health care providers that your insurance company considers in your “network.” This means that each of these health care providers is in agreement with your insurance company to accept your plan’s contracted rate as payment for their full services. This contracted rate that was negotiated by your insurance company includes both your insurer’s share of the cost, and the part that you will be responsible for paying. The part that you are responsible for paying may be in the form of a co-payment, co-insurance or deductible. For example, if your insurer’s contracted rate for a dentist visit might be \$120. If you have a \$20 co-payment for regular dental check ups, you will pay \$20 when you see a dentist that is in your network. Your insurer will then be responsible for paying the remaining \$100.

However, if you decide or are forced to go “out-of-network” for dental care, you will most likely not have such a low co-pay. The cost of your care out of network will end up being a lot more of out-of-pocket costs to you. This is because any health care providers outside of your network have not agreed to a contracted rate with your insurance company, and can therefore charge more for the care that they give you. Depending on your plan, you may be required to cover higher co-pays or deductibles for out-of-network care. If you would normally have to pay 20% of the cost of the service for in-network dentists, you may be looking at paying 30% or more to see a dentist out-of-network. Be aware that it is also a possibility that your plan may not cover out-of-network care costs at all, and you would have to pay the full cost of care completely out-of-pocket.

It is important to understand the differences between in-network and out-of-network providers before choosing which dentist is right for you. Check with your insurance company to see which providers in your area are in your plan’s network.

Everyone uses different criteria to select a new dentist or dental specialist. But, is the insurance company’s network part of your list? You may wonder “how does it impact me and why should I even care?” Well, unless money grows on trees at your house, paying attention to whether or not your healthcare providers are in your insurance company’s network is a good idea and an excellent way to save, or at the very least avoid paying more than what’s necessary. While in-network and out-of-network terminology sounds confusing, this guide will help you to understand the impact of your insurance company’s network.

What is a Network?

Your insurer has identified a group of providers who are “in-network” and has contracted with these providers on your behalf to get services at “discounted” rates. The primary advantage of using an in-network provider is that you receive this negotiated or discounted rate for their services, and your insurance generally picks up a larger portion of the bill than with an out-of-network provider. For an example of how the network may affect your pocketbook, see the next page.

A Simple Example

A visit to an in-network physician may charge \$100 for an office visit. Your insurance company has contracted with them to discount this visit to \$60. If your insurance company covers 80% of the cost, the patient responsibility would be \$12. Compare with an out-of-network physician that also charges \$100 for the visit. Without the negotiated rate from your insurance company, your cost will remain \$100. For out-of-network providers and care, your insurance may only cover 60% of the contracted fee of \$60, making your patient responsibility \$64. Even if they did cover 80% of the contracted fee, you would still pay \$52. Big difference!

A More Detailed Example

Let's look at an example. Say you visit a provider who usually charges \$1,000 for a service. But, that provider is in your plan's network. That means they have agreed to accept your insurer's contracted rate – say, \$500 – rather than the amount they normally charge. How much will you have to pay?

	HMO In-Network	POS In-Network	EPO In-Network	PPO In-Network
Provider's Usual Charge	\$1,000	\$1,000	\$1,000	\$1,000
Your Plan's Contracted Rate	\$500	\$500	\$500	\$500
Your Cost Sharing	\$10 co-pay	\$10 co-pay	20% co-insurance	20% co-insurance
Your Plan pays	\$500 - \$10 = \$490	\$500 - \$10 = \$490	\$500 x 80% = \$400	\$500 x 80% = \$400
You pay	\$10 (1%)	\$10 (1%)	\$500 x 20% = \$100 (10%)	\$500 x 20% = \$100 (10%)

Now, let's say you visit a provider outside your network for the same service. The provider still charges \$1,000 – and this time, they do not have any agreement with your insurer to accept a lower rate.

In this case, your insurer will base their share of the cost on the allowed amount for that service. This is the most money that they consider to be a fair and reasonable cost, based on what other providers in the area charge. It is not necessarily the same as your plan's contracted rate. In this case, let's say the allowed amount is \$800.

So, what does that mean for you?

	HMO Out-of-Network	POS Out-of-Network	EPO Out-of-Network	PPO Out-of-Network
Provider's Charge	\$1,000	\$1,000	\$1,000	\$1,000
Your Plan's Allowed Amount	\$0	\$800	\$0	\$800
Your Cost Sharing	100%	30% of the allowed amount PLUS the difference between the allowed amount and provider's charge	100%	30% of the allowed amount PLUS the difference between the allowed amount and provider's charge
Your Plan pays	\$0	70% of \$800 = \$560	\$0	70% of \$800 = \$560
You Pay	\$1,000 (100%)	30% of \$800 = \$240 PLUS \$1,000 - \$800 = \$200	\$1,000 (100%)	30% of \$800 = \$240 PLUS \$1,000 - \$800 = \$200
Your Total Cost	\$1,000 (100%)	\$440 (44%)	\$1,000 (100%)	\$440 (44%)

Going out-of-network for this sample service could cost you hundreds of dollars more.

Your plan's actual provisions may be different from those we have used in the examples. Be sure to check your plan booklet, your insurer's website, or call your insurer so you can be sure you understand how your plan works.

Why Weren't All of My Services Covered at an In-Network Provider?

Remember, just because a provider is in-network, it does NOT mean all the healthcare services and treatments you receive will be covered. Using an in-network provider simply means that when you receive services from the provider, your insurance will get you the negotiated rate for the services. They will then provide you with the coverage outlined in your policy. Insurance plans can be confusing, so make sure to check your insurance policy (you should receive a booklet that outlines the scope of your coverage) when you have questions about your coverage.

Issue 1: Are They In or Are They Out? How Do I Find Out Who's In-Network? Doctors frequently move in- and out-of-network. The day the network book is printed or the website is updated, it's out of date. Doctors have been added. Doctors have failed to renew their contract or opted out of a network. Basically, the information is out of date and until you check with the

provider, you really don't know.

Issue 2: The Out-of-Network Service Provided through an In-Network Provider

It's possible to go to an in-network provider and receive services from a provider who is out-of-network. A common example might be that you go to a dentist for a checkup and have a biopsy done. The lab that processes the biopsy may be out-of-network.

Issue 3: I Want to Use an Out-of-Network Provider

As we've discussed, going to an out-of-network provider tends to be more expensive, but it happens. Sometimes you can't help being out-of-network – if you're out of town or your current insurance plan has a limited network.

What to Do If You Must See an Out-of-Network Provider.

Be up front with the provider. Tell them you know they are out-of-network and that you would like to receive the in-network negotiated rate if possible.

Check with your provider when you schedule a visit or before you receive services (when you check in for the appointment). They will need to know your insurance, possibly your group number as well as your "network." All of this information should be on your insurance card.

Awareness that this could happen is the first step to prevention. When you are verifying an appointment of this nature, be sure to ask network questions. If you specifically asked and were not told ahead of time that you were receiving services from an out-of-network provider, the out-of-network provider may be more likely to provide in-network pricing. Contact your insurance company and make them aware of the situation and enlist their help in sorting out what an in-network price should have been. They will have leverage with the providers that you may not.

Get that from them in advance and in writing to save yourself countless hours of headache and expense later. Also, be aware that your payments may not be applied to your deductible. Once you've met your deductible, out-of-network expenses may be your responsibility to pay either in full or a substantially larger portion. It's a good idea to check with your insurance carrier to make sure you understand your plan specifics. Being aware of the potential exposure and knowing the appropriate questions to ask will help you to navigate the system.

Why Go Out-of-Network?

So, why would you go out of network? There are some very good reasons. If you or a loved one is facing a serious illness (oral cancer or facial trauma), you may want more options than are available in your network. Sometimes that means using an oral and maxillofacial surgeon that does not participate in your plan, or a specialist who is not a part of your network.

Patients often go out-of-network by accident. Most commonly, the primary care dentist refers you to a specialist – who's not in your network. Don't assume that your dentist knows the details of your plan. If you need a referral, remind your doctor what insurance coverage you have, and ask him or her to refer you to a specialist in that plan. When you call to make an appointment with that provider, ask the office staff to confirm that the doctor is in your network. You can also call your insurer or visit their website to find a doctor in your network. Make sure you are choosing from the provider

directory for your type of plan (many insurers offer HMO, PPO, EPO and POS options which may have different networks). Before you schedule your consultation or treatment, ask if all the providers are in your network.

What about Emergencies?

What happens if you suffer a heart attack? Waiting to get care in an emergency is dangerous and can even be life-threatening. So, many plans cover some portion of emergency care no matter where you are, even out of their network area. Once your condition is stable, you will generally be moved to an in-network provider for follow-up care.

But remember, that only applies to real emergencies. You should never go to the emergency room for routine care, like check-ups or vaccinations. Emergency room visits cost more than regular doctor's visits, and insurers often won't pay the same amount if it's not a true emergency. That means you'll be left with a big bill. Plus, you'll get better, more personalized care from your own doctor, and you won't have to wait for hours in the ER.

If you're not sure what constitutes an emergency, or what emergency costs are covered, ask your insurer.

Your Action Plan: Don't Get Surprised by the Bill

There are times when going outside your network for care is simply unavoidable. But, the choice should be up to you, and you should make that choice an informed one.

Follow these tips to help manage your costs:

- Ask your provider to refer you in-network first unless there is a specific reason why you want to go out-of-network.
- Before scheduling an appointment with a new provider, ask if they participate in your plan (and your network through that insurer – PPO, POS, EPO or HMO).
- If you're having a complex procedure, like a surgery, ask your doctor if all your providers participate, from the hospital to the lab to the anesthesiologist. Your doctor may be able to change your care to in-network providers for these services.
- If you choose to go out-of-network, ask the provider's staff how much he or she will charge before your visit. Then, talk to your insurer to find out how much of the cost your plan will cover.
- If the out-of-network provider's charge is higher than your insurer's allowed amount, check our consumer cost lookup to see what providers in your area usually charge.
- And most importantly – remember that you are your own best advocate. Speaking up and asking questions up front will help you avoid being surprised at what you may owe.

Terms To Know

Allowed Amount

Usually refers to the amount of payment a provider has agreed to accept for a service, treatment, or product under the terms of their negotiated contract with the insurance company. This can also refer to the maximum amount the insurance company will “allow” a provider to bill for a service, whether they are in or out-of-network.

Billed or Charged Amount

Is the amount initially billed by a provider for a service, treatment or product.

In-Network

Refers to providers who are contracted with an individual’s insurer to provide services at a pre-determined rate.

Insurance Policy

Is a contract between the insured individual and the insurance company detailing which health and medical services are covered by the insurer and the price for coverage paid by the individual.

Network Discount

Is the amount by which a provider’s bill is adjusted as a result of a negotiated rate covered under a negotiated capitation contract between the provider and the insurer. The network discount term often appears on an Explanation of Benefits, but it does not appear on all since those forms vary by insurer. Insurers use many variations on this term including Adjustment, etc.

Out-of-Network

Refers to providers who are not directly contracted with an individual’s insurer to provide services at a pre-determined rate. Most insurers maintain a capitated contract with the providers commonly used by their insured. Many of these contracts are regionally confined since insurers are authorized on a state by state basis as a result of ERISA.

Patient Responsibility

Is the amount that you owe the provider based on information sent from your provider to your insurance company? This should include any co-payments, deductibles, co-insurance and/or excluded charges.

Pre-Negotiated Discount

Also referred to as network discount, is the amount by which a provider’s bill is adjusted as a result of a negotiated rate agreed upon between the provider and the insurer.