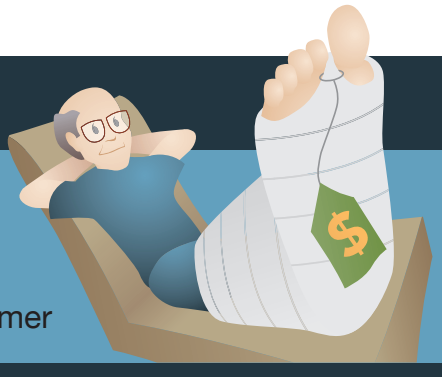

Insurance Coverage

Everything You Need to Know to Become a Smarter Healthcare Consumer

Understand In-Network vs. Out-of-Network

In-Network and Out-of-Network

Everyone uses different criteria to select a new doctor. 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.

Understanding How In-Network vs. Out-of-Network May Affect Your Pocketbook

An 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 50%, making your patient responsibility $50.

Understanding the Math

In-Network		Out-of-Network	
Charge	**$100**	Charge	**$100**
Network Discount	- **$40**	Network Discount	- **$0**
	= **$60**		= **$100**
Insurance coverage @ 80%	- **$48**	Insurance coverage @ 50%	- **$50**
Patient Responsibility	= **$12**	Patient Responsibility	= **$50**

I Went to an In-Network Provider. Why Weren't All of my Services Covered?

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.

What to Do.

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.

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 physician for a checkup and have lab work done. The lab company may be out-of-network. Another fairly common example is that the hospital where a surgery is performed may be in-network but the anesthesiologist is out-of-network.

What to Do.

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.

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.

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. 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.

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 contact 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 capitated 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.

Notes: