

In-Network vs. Out-of-Network Care

Know Before You Go

You've probably seen the terms "in-network" and "out-of-network" on your insurer's website and in your plan description. But, what do these terms mean? And how do they affect how much you have to pay for your care?

Your plan contracts with a wide range of doctors, as well as specialists, hospitals, labs, radiology facilities and pharmacies. These are the providers in your "network." Each of these providers has agreed to accept your plan's contracted rate as payment in full for services.

That contracted rate includes both your insurer's share of the cost, and your share. Your share may be in the form of a co-payment, deductible or co-insurance. For instance, your insurer's contracted rate for a primary care visit might be \$120. If you have a \$20 co-payment for primary care visits, you will pay \$20 when you see a doctor in your network. Your insurer will pick up the remaining \$100.

If you go outside your network, it's a different story. You will likely pay more if you go "out-of-network" for your care. That's because:

- Providers outside your network have not agreed to any set rate with your insurer, and may charge more.
- Your plan may require higher co-pays, deductibles and co-insurance for out-of-network care. So, if you normally have to pay 20% of the cost of the service in-network, you may have to pay 30% out-of-network. Often, you'll have to pay that PLUS any difference between your insurer's allowed amount and what the provider charges.
- Your plan may not cover out-of-network care at all, leaving you to pay the full cost yourself.

Your costs for out-of-network care also depend on your type of plan:

- In a Health Maintenance Organization, or HMO, or Exclusive Provider Network, or EPO, you generally have to pay the full cost of any out-of-network care, except for emergencies.
- In a Preferred Provider Organization (PPO) or Point-of-Service (POS) plan, you will usually have to pay:
 - A higher deductible than in-network and or a higher co-pay
 - PLUS a higher percentage co-insurance, which is a percentage of the "allowed amount"
 - PLUS, the full difference between the allowed amount and your provider's actual rate, which could be much higher



These costs can add up quickly, even for routine care. If you have a serious illness, it can mean tens of thousands of dollars more. So, when you need care, it's important to find out if all of your providers are in your plan's network.

In-Network and Out-of-Network Costs in Action: An 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 \times 80\% = \400 | $\$500 \times 80\% = \400 |
| You Pay | \$10 (1%) | \$10 (1%) | $\$500 \times 20\% = \100 (10%) | $\$500 \times 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 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, you may want more options than are available in your network. Sometimes that means using a hospital that does not participate in your plan, or a specialist who is not a part of your network.



Also, patients often go out-of-network by accident. There are two common reasons:

- Your primary care physician refers you to a specialist – who's not in your network.

Don't assume that your PCP 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).

- You have surgery at an in-network hospital – and then get a bill.

While your hospital may participate in your health plan, some providers at that hospital, like anesthesiologists or radiologists, might not. If you have a serious illness, many providers will be involved in your treatment. Inpatient surgery will require a surgeon, an operating room, anesthesia, medication, the hospital room and board and more. All of these will have separate charges, and all will contract separately with insurers.

Before you schedule your procedure, 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.

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