Health Insurance Networks

The Ins and Outs

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!
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.