What does in-network mean?

In-network providers have a negotiated price for services set with your health plan, and your insurer will pay its responsibility according to the plan.

In-network providers have to bill your health plan directly, which means you will only owe your predetermined copay or deductible at the time of care. Your insurance plan will collect any additional coinsurance, the percentage of the bill you are responsible for paying, later.

Insurance plans frequently change provider networks to control costs and provide the best care for members. For instance, a plan might decide not to renew a contract with a particular specialist if they can negotiate better rates with other providers.

Insurance providers should have online search functions — such as a provider directory or a find-a-doctor tool — that make it easy and convenient for members to determine which doctors and facilities are in-network. *It's important to regularly check the network directory to avoid unexpected out-of-network fees if your provider leaves your health plan.*

What does out-of-network mean?

Out-of-network providers do not have a negotiated price for services set with your health plan, and they may or may not be paid for by your plan.

Out-of-network providers can require you to pay your entire bill upfront instead of submitting an insurance claim for you — in this case, you would be responsible for submitting a claim to your insurer for reimbursement. They can also balance-bill you, meaning that they can ask you to pay for any portion of the bill that your insurance plan won't cover.

By looking up in-network providers ahead of time in the network directory, you can avoid receiving unexpectedly high bills for your care.

What's the Difference Between In Network and Out Of Network?

When a doctor, hospital, or other provider accepts your health insurance plan we say they're in network. We also call them participating providers.

When you go to a doctor or provider who doesn't take your insurance plan, we say they're out of network.

The main differences between in-network and out-of-network are the costs and whether your health plan helps pay for the care you get from out-of-network providers.

In-network savings

When a provider joins our network, they agree to accept our allowable amount for their services. For example, a doctor may charge $150 for a service. Our allowable amount is $90. So as a member of our medical plan, you save $60.

You'll see these savings listed as a discount on your claims and explanation of benefits statements.

Doctors or hospitals who are not in-network do not accept our allowable amount. You'll be responsible for paying the difference between the provider's full charge and your health insurance plan's allowable amount. That's called balance billing.

If you have a medical emergency or you can't wait for a doctor's office to open, go to the nearest hospital or urgent care. In or out of network, all health insurance plans help pay for medically necessary emergency and urgent care services.

Before you go to a doctor or hospital, it's always a good idea to call and ask if they take your plan.

To find in-network physicians please follow the instructions on our HR-Benefit webpage

How Do I Get My Insurance to Pay for Out-of-Network Services?

If you used an out-of-network provider, ask if they'll submit a claim on your behalf. If they won't, you will need to complete a claim form and provide an itemized statement or detailed receipt (and supporting documentation) to get reimbursed for amounts you owe out of pocket that are covered by your plan. You may need to work with your provider to get the necessary information to file your claim.