



A Consumer Guide to Understanding Health Plan Networks

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Many people are now shopping for health insurance.

In 2014, the new **health insurance marketplaces** were launched. These are also known as health insurance exchanges. They were brought about by what people refer to as the **Affordable Care Act**, Healthcare Reform, or Obamacare. This law has enabled many consumers to have health insurance for the first time.

Each consumer has different needs and circumstances. The new health insurance marketplace offers consumers many different and affordable health plans to choose from. When you select a health insurance plan, there are a number of things you should know about the plan's **provider network**.

In the preparation of this guide, the AHIP Foundation obtained input from health plan representatives, consumer group representatives, health literacy experts, and health policy experts. The Foundation appreciates their thoughtful input and guidance.

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8 Steps You Can Take to Understand Your Health Plan's Provider Network

1 Find out if your doctors are in the plan's network. 

2  Know your plan's policies on how to access covered treatments that are not available from a provider within the plan's network.

3 Know your plan's policies on continuing care with a provider who is no longer in the network. 

4  Know your health plan's cost-sharing requirements and how they may differ when using in-network versus out-of-network providers.

5 Know when seeking care out-of-network, your doctor or hospital may charge you more than your plan will pay. 

6  Ask your primary care doctor to recommend in-network providers for you and your family, if you need specialty care.

7 When undergoing treatment in a hospital or other facility, ask to have services performed by in-network providers. 

8  Call your plan's member services center if you have any questions or concerns.

Click the number to learn more about a topic.

A provider network is a set of doctors, hospitals, and other health care providers like nurse practitioners, therapists, and other clinicians that are part of your health insurance plan. Understanding your plan's provider network will help you:

- Save money
- Avoid unexpected costs
- Get better care
- Be more satisfied with the care you receive

There are a number of basic steps that you can take to understand your plan's provider network.

Find out if your doctors are in the plan's network. *(For more information on this topic, see page 13 of this guide.)*



Before you enroll in coverage, check that doctors you typically see or hospitals you typically use are in the plan's network.

If you are already enrolled in coverage and are referred to a specialist, you should also check to see if your specialist is in the network.

You can find information about who is in the network by contacting your health plan's member services department (phone numbers are usually on your insurance card) or by searching the plan's online **provider directory**.

You can also call the doctor or specialist directly to confirm if they participate in your plan.

 Know your plan's policies regarding how to access covered treatments that are not available from a provider within the plan's network. *(For more information on this topic, see page 12 of this guide.)*

Your health plan can provide you with detailed information on how to request **out-of-network** care in the instances where a covered service is not available from an **in-network** provider.

Know your plan's policies on continuing care with a provider who is no longer in the network. *(For more information on this topic, see page 15 of this guide.)*



Your health plan can provide you with detailed information on its policies for minimizing any disruption in your care if you are pregnant or are undergoing a course of treatment for a chronic or serious condition and your provider leaves the network. These policies are usually referred to as **continuity of care** policies.



Know your health plan's cost sharing requirements and how they may differ when using in-network versus out-of-network providers. *(For more information on this topic, see page 9 of this guide.)*

You can find detailed **cost-sharing** information by looking at your plan's membership materials.

You can also contact your health plan's member services department to get this information.

Know when seeking care out-of-network, know that your doctor or hospital may charge you more than your plan will pay.

(For more information on this topic, see page 11 of this guide.)



If your **out-of-network** doctor or hospital charges more than what your plan pays, you will be responsible for the difference between what the doctor or hospital charges and what the plan pays.

When you go out-of-network, ask your doctor or hospital for an estimate of the cost of treatment and what you will have to pay.



Ask your primary care doctor to recommend in-network providers for you and your family, if you need specialty care.

(For more information on this topic, see page 9 of this guide.)

Don't be reluctant to ask your doctor to recommend **in-network** providers only.

If you have any questions about whether a specialist is in your network, check with the specialist directly and verify with your health plan.

When undergoing treatment in a hospital or other facility, ask to have services performed by in-network providers.

(For more information on this topic, see page 14 of this guide.)



This may not be possible in an emergency situation, but for procedures you are scheduling in advance, ask if doctors you will be seeing in the hospital are in your health plan's **provider network**.

You can find out by asking the doctor or specialist who will be providing your care.

Or, you can ask to talk with someone in the hospital's enrollment or billing office to help you find out this information.

You can also contact your plan's membership department.



Call your plan's member services center if you have any questions or concerns.

Your health plan is committed to ensuring you receive necessary care.

If you have questions about your plan or how the network works, contact your health plan's member services department using the phone number on your insurance card.

Also, contact your plan with other concerns you may have.



What a Provider Network Is

A **provider network** is a set of doctors, hospitals, and other health care providers like nurse practitioners, therapists, and other clinicians that are a part of your health insurance plan. Almost every health plan uses a network.

Providers are part of a plan's network because:

- They have agreed to see patients covered by that insurance
- They have agreed to accept the health plan's **contracted rate**, which helps keep coverage affordable
- They have been selected based on the health plan's requirements to ensure that you receive quality and safe care

Not all doctors and hospitals in a community are part of a plan's provider network. That means it is important for you to know if your doctor or hospital is in the network before signing up for a specific health insurance plan. It also means that you should know your health plan's rules for receiving care by a doctor or at a hospital that is not part of the network, called out-of-network care. Rules for receiving **out-of-network** care are likely to vary between health plans.

Why Health Plans use Provider Networks

To keep costs down.

Provider networks help keep your costs down because health plans can negotiate better prices with the

doctors and hospitals in the network.

Lower prices from network providers means that you pay less in insurance **premiums** and other charges.

Network providers agree not to bill you for more than the amount agreed to between the health plan and the provider (the contracted rate).

To promote quality, efficiency, and safety.

Through the use of provider networks, health plans are able to select doctors and hospitals that meet certain **quality, safety, and efficiency** standards.

This provides you with access to:

- Affordable doctors, hospitals, and other health care services
- Doctors, hospitals, and other health care providers like nurse practitioners, therapists, and other clinicians who have demonstrated their ability to deliver quality and safe care

How a Provider Network Works and How it Affects Your Costs

How a provider network works depends on the type of health plan you choose.

When you shop for a health plan, you might see several different plans offered by the same health insurance

company or by different health insurance companies. Often, the differences between the plans are in how much you will pay when you see a doctor or go to the hospital or whether you are required to have a referral from a primary care physician to see a specialist.

In addition, there may be differences in the size of the **provider network** and whether you are required to use only **in-network** providers or are allowed to go to **out-of-network** providers.

Plans That Provide In-Network Care Only

An **HMO (Health Maintenance Organization)** and an **EPO (Exclusive Provider Organization)** are examples of plan types that usually have more restrictions on whether they will pay for services from out-of-network doctors and hospitals.

The details of how these plans work may vary, but generally:

- **HMOs** and **EPOs** almost always provide covered benefits only through their provider networks. This means they do not pay for care received from out-of-network providers.
- You typically pay a **copayment** when you receive care in-network.
- If you go to a provider outside your provider network, you will have to pay all of the costs for services as though those services were not covered by the plan. You will be billed directly by that out-of-network provider for those services, at whatever rate they charge, unless it is for true emergency care.

Another feature these plans might have for in-network providers is what's called a **tiered network**. A tiered network has different levels of providers that are grouped based on whether they are higher-performing in terms of quality, safety, and **efficiency**, or lower-performing when compared to their peers. Health plans that use tiered networks offer consumers lower **cost-sharing** if they use providers in the higher-performing tier. Consumers who choose to go to a provider in a lower-performing tier will have higher cost-sharing. Consumers still have the choice to go to any provider at any level within the tiered network.

Plans That Provide In-Network and Out-of-Network Care

Plans that offer access to both in-network and out-of-network care include **Preferred Provider Organizations (PPOs)** and **Point-of-Service (POS)** plans.

The details of how these plans work can differ, but some general principles usually apply:

- You have lower cost-sharing requirements when you use care delivered by in-network, preferred providers. Another way of saying this is that you will have lower **out-of-pocket costs** if you choose to go to these providers. This can mean lower costs for things like **coinsurance** and copayments for office visits.
- With these plans you sometimes pay a **deductible** before the plan starts in order to pay some or all of your health care bills, although not all plans require a deductible for all services. After the deductible (if applicable) you usually pay a coinsurance or copayment for services you receive. The plan pays the rest when you use in-network providers.
- If you choose to see a doctor who is out-of-network, you will usually pay more. Additional information about what you will have to pay can be found on [page 11](#).

Other Types of Plan Networks

In addition to the types of plans described above, health plans are adding plan options that have more selective provider networks to meet consumer needs. Generally, these networks are smaller because they are limited to a set of doctors and hospitals that meet additional performance standards. These new types of plans also typically have lower costs. These types of plans go by many names such as **custom, high-performance, tailored, select, high-value, and narrow** networks. For some patients, these new types of plans offer just the right mix of access, quality, and affordability. However, other patients may prefer a larger provider network, even if it means paying more.

You can find out more about these types of plans by going to the plan's website or by contacting the plan's member services department.

Examples of the in-network cost sharing you might see for different types of plans are described below:

Examples of Cost-Sharing: In-Network

	HMO In-Network	PPO In-Network
Provider Charge for a Service	\$1,000	\$1,000
Plan Contracted Rate for that Service	\$600	\$600
Your Cost Sharing	\$15 copayment	20% coinsurance (after deductible is met, if applicable)
What Your Plan Pays the Provider	\$585 (\$600-\$15)	\$480 (\$600 x 80%)
What You Pay the Provider/ Your Total Costs	\$15	\$120 (\$600 x 20%) (after deductible is met, if applicable)

Important Note: Because of the **Affordable Care Act**, most plans must cover certain **preventive services** such as immunizations and preventive screening tests at no cost to you, so the **cost-sharing** requirements discussed above would not apply to these preventative services. Also, cost-sharing for any service would not apply if you have met your **out-of-pocket maximum**, described further below.

Out-of-Pocket Maximum: All health plans typically include a limit on your **out-of-pocket costs**. They do this to protect you from very high health care expenses, also known as **catastrophic costs**. This limit is referred to as an out-of-pocket maximum. After you reach that maximum, you no longer pay **copayments**, **coinsurance**, and **deductibles** because the plan will begin to pay 100 percent of the medical expenses. This protection typically applies only to **in-network** care.



What to Know about Out-of-Network Care

Should you decide to receive care from a hospital, doctor, or other clinician who is not part of your health plan's **provider network**, there are a few important things to think about:

- Consider that **out-of-network** care will likely cost you more (except in certain situations like emergencies)
- Consider the qualifications of providers

1 Consider that out-of-network care will likely cost you more:

As described in the previous section, some plans cover no out-of-network care, except in emergencies. In these cases you must pay for the full cost of care.

Other plans may provide some out-of-network benefits. However, your portion of the cost (**cost-sharing**) will be higher for seeing an out-of-network provider compared to what you would pay if you saw an **in-network** provider. It is important that you check with your plan to see what type of out-of-network coverage you have.

There are other important things you need to know about your costs for out-of-network care.

Health plans that do allow out-of-network care set a maximum amount they will pay for a health care procedure received out-of-network, often referred to as the **allowed amount**.

Out-of-network providers may charge you more than

the allowed amount, which is often called the **balance bill** or **balance billing**. You will be responsible for this balance bill. The amount of the balance bill may be acceptable to you, but in other cases you may feel that the costs are too high. Your health plan can help you find an in-network doctor or hospital that can provide your care at a lower cost to you.

It's also important to know that the cost of out-of-network care usually does not count toward the out-of-pocket maximum. Thus, you will have higher expenses overall when you go out-of-network.

Rules for what you will pay for out-of-network care may differ in certain situations

This may include the following types of care:

- Emergency care that is out-of-network
- A specific covered treatment or procedure that needs to be out-of-network

See below for more information

For emergency care that is out-of-network:

Under the **Affordable Care Act**, your health plan **copayments** or **coinsurance** has to be the same for emergency care provided in-network and out-of-network.

Even though this is the case, you may be balance billed by an out-of-network provider for emergency care services. You are responsible for the amount of the balance bill.

For a specific covered treatment or procedure that needs to be out-of-network:

There may be rare instances where your doctor may recommend a specific treatment or procedure that is covered under your plan but is not available from doctors or hospitals in the health plan’s network.

If this happens, you and your doctor can submit a request to your plan – called an **appeal** – for out-of-network care to be covered at an in-network cost-sharing amount.

Your health plan will provide you detailed information about the appeals process. This includes information you need to submit to request an appeal. It also includes supporting information required from the doctor recommending the treatment.

Your health plan will let you know how long it will take to make a decision on the request and any additional steps you need to take.

These appeal decision time frames can be shortened in cases where the regular time frame could jeopardize the patient’s life or health – your plan can explain how this works.

Example: The table below shows the difference in costs for in-network and out-of-network care.

	HMO In-Network	HMO Out-of-Network	PPO In-Network	PPO Out-of-Network
Provider Charge for a Service	\$1,000	\$1,000	\$1,000	\$1,000
Plan Contracted Rate for that Service (in network)	\$600	Not Applicable	\$600	Not Applicable
Plan Allowed Amount for Out-of-Network Care	Not Applicable	\$0	Not Applicable	\$900
Your Cost-Sharing	\$15 copayment	100% of Provider Charge	20% coinsurance (after deductible met, if applicable)	30% of the allowed amount plus the balance bill amount
What Your Plan Pays the Provider	\$585 (\$600-\$15)	\$0	\$480 (\$600 x 80%)	\$630 (\$900 x 70%)
What You Pay the Provider/ Your Total Costs	\$15	\$1,000	\$120 (\$600 x 20%) (after deductible met, if applicable)	(30% of \$900) = \$270 plus (\$1000 - \$900) = \$100 Total = \$370
Difference:	You pay \$1,000 if you go OON versus \$15 for in-network.		You pay \$370 if you go OON versus \$120 for in-network.	

If the appeal is approved, then your requested care provided from an out-of-network provider would be covered at in-network cost-sharing. However, you may be balance billed by the out-of-network provider.

2 Consider the qualifications of providers.

For in-network providers:

Health plans carefully check the qualifications of doctors and other clinicians before they can join the provider network. Health plans recheck the qualifications of in-network doctors and clinicians periodically. Health plans also measure provider performance and require them to make improvements, when needed. This provides important protections for you.

You can find out more information by going to the website of the plan or by contacting the plan’s member services department.

For out-of-network providers:

When you go out-of-network there has not been any review by the health plan of the doctor’s or hospital’s qualifications.



How to Find out Which Doctors are Part of a Health Plan’s Network

Use the health plan provider directory:

Every health plan has a **provider directory**. These provider directories are almost always online, and they usually have the following types of information:

- All of the doctors and hospitals that are part of the network
- Other types of health care providers such as psychologists and chiropractors if they are covered by your health insurance
- The location and phone number of the doctors’ offices
- Areas of specialty
- Languages that a provider speaks

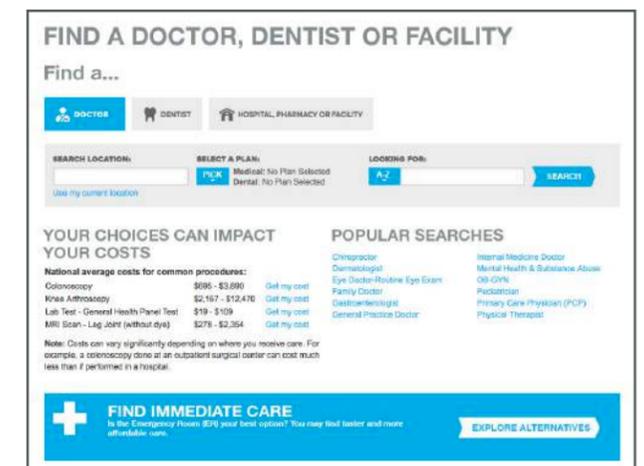
Call the health plan’s member services department:

At times, printed and online provider directories may not always be 100% accurate; you should call the health insurance plan’s member services department to get more current information.

Call the provider’s office to see if there have been changes not reported to the plan:

In addition to checking with your health plan, you should contact your doctor’s office in case there have been recent changes that have not been reported to the health plan. For example, the doctor’s practice may no longer be accepting new patients or may have moved.

Important Note: Up-to-date provider directories depend on providers informing the health plan of any changes. Maintaining up-to-date provider directory information is an important and ongoing task. New doctors, hospitals, and other clinicians may join the **provider network** or others may leave the network during the year. Or, a doctor may no longer be accepting new patients. Although the health plan makes periodic updates to its provider directory, unless the doctor notifies the plan, the online provider directory may not include the most current information.



Important Note: Just because a hospital is **in-network** does not mean all of the doctors at that hospital have agreed to join the network: You may have selected a hospital from a health plan's network to avoid higher **out-of-network cost-sharing**. However, some types of doctors such as emergency care doctors, pathologists, anesthesia doctors, and radiologists may not join the network even though the hospital does. In these cases, you may pay out-of-network rates for the care you receive from these doctors.

- For example, this can be a problem if you need surgery and think everything is in-network but find out later that part of your care, such as anesthesia, was out-of-network.
- For example, you are scheduled for surgery at an in-network hospital. Before the surgery, your doctor orders x-rays, however, the radiologist who reads the x-rays does not have a contract with your health plan, even though they work in the in-network hospital. As a result, you may get a separate bill from the radiologist. If your health plan provides coverage for the specific x-ray ordered, some of the radiologist's bill may be paid for by the plan, but anything over the plan's allowed amount can be balance billed by the out-of-network radiologist and you will be responsible for those charges.
- **Best advice:** If you are going to the hospital for an elective procedure, ask ahead of time if all your doctors are a part of the network.

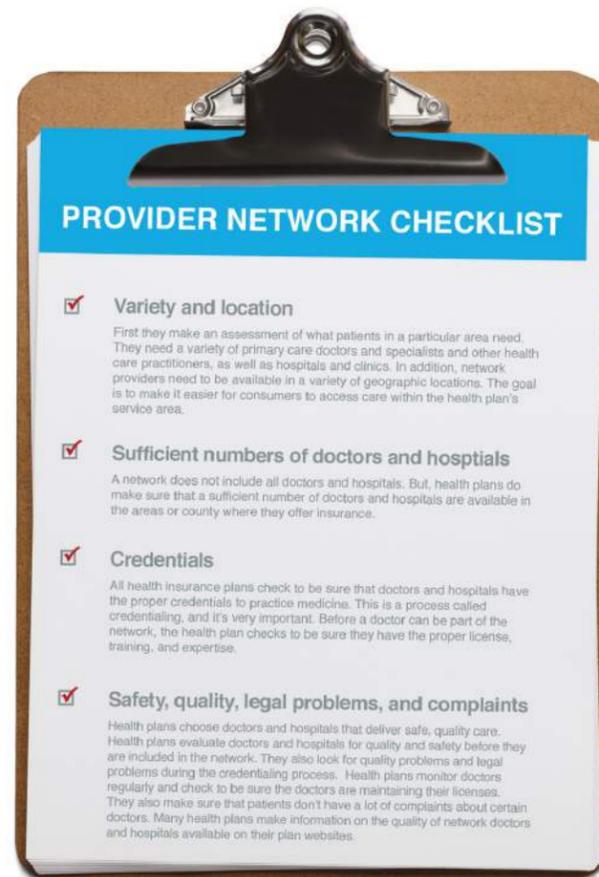
How Health Plans Select Providers for Their Networks

Health plans consider a number of factors when determining which providers to include in their networks.

Health plans aim to build their provider networks by contracting with providers that deliver safe, efficient, quality care that is also affordable. To achieve these goals, they consider a range of factors when creating their networks of providers. More detailed information can be found at your plan's website or by contacting your plan's member services department.

Generally, though, plans look at the following in creating networks:

- **Variety and location:** First they make an assessment of what patients in a particular area need. They need a variety of primary care doctors and specialists and other health care practitioners, as well as hospitals and clinics. In addition, network providers need to be available in a variety of geographic locations. The goal is to make it easier for consumers to access care within the health plan's service area.



- **Sufficient numbers of doctors and hospitals:** A network does not include all doctors and hospitals. But, health plans do make sure that a sufficient number of doctors and hospitals are available in the areas or county where they offer insurance.
- **Credentials:** All health insurance plans check to be sure that doctors and hospitals have the proper credentials to practice medicine. This is a process called **credentialing**, and it's very important. Before a doctor can be part of the network, the health plan checks to be sure they have the proper license, training, and expertise.
- **Safety, quality, legal problems, and complaints:** Health plans choose doctors and hospitals that deliver safe, quality care. Health plans evaluate doctors and hospitals for quality and safety before they are included in the network. They also look for quality problems and legal problems during the credentialing process. Health plans monitor doctors regularly and check to be sure the doctors are maintaining their licenses. They also make sure that patients don't have a lot of complaints about certain doctors. Many health plans make information on the quality of network doctors and hospitals available on their plan websites.

Why all doctors aren't in all health plans

Not all health care providers want to be in the network of every insurance company. And, not all health care providers are willing to meet criteria or negotiate on their prices. So, health insurance plans don't usually have every doctor or hospital in their network. But, they do make sure that enough providers are in the network to deliver the care that patients need.

What Happens When Your Doctor Leaves Your Health Plan's Network

Why a provider may leave

There may be instances when a doctor you are seeing leaves or is no longer part of the plan's network. This can happen for a number of reasons. For example, a doctor may retire or move to a different area, the

plan may choose not to renew a doctor's contract, or the doctor may choose to no longer participate in the network.

What your health plan will do

- **Notify you, if your primary care doctor leaves the network:** Typically, health plans have steps in place to notify you if your primary care doctor is no longer part of the health plan's network. You can go to your plan's website or contact your plan's member services department for more information about how this works.
- **Tell you how to choose another primary care doctor:** Your health plan will let you know how to select another doctor who is part of the network.
- **Notify your primary care doctor, if one of your specialists leaves:** In some plans, the primary care doctor must provide patients with referrals for care from specialists. If you have this type of plan, the health plan may also notify your primary care doctor if you used a particular specialist who is no longer in the plan's network.

This information helps to ensure that your primary care doctor refers you to specialists within the plan's network, so that you and other patients don't incur the higher out-of-pocket costs associated with **out-of-network** care.

- **Your health plan will help ensure continuity of care if you are pregnant or undergoing a course of treatment for a serious or terminal illness.** Health plans have protections in place to help avoid any disruption in your care if you are pregnant or undergoing a course of treatment for a chronic or serious condition, and your provider is no longer in the network. These protections are typically referred to as continuity of care policies.

How continuity of care policies help

They help ensure patients continue to receive care from the same doctor if undergoing a course of treatment, such as radiation or chemotherapy, for a serious or terminal illness.

They also help provide the same continuity of care for women who are pregnant, through post-partum care, if their doctor leaves the network.

How continuity of care policies work

Generally, a health plan's **continuity of care** policy will allow you to continue care with a doctor who is no longer in the network. They will do this for a certain period of time, and at the lower **cost-sharing** rate that applies to providers in the network.

However, sometimes, the doctor may **balance bill** you above your cost-sharing amounts.

Best advice: Talk to your doctor to see if they will charge you any amount above what your plan cost-sharing would be. This is important.

If you continue to see your out-of-network doctor after your continuity of care period ends, you will be responsible for payment at the higher, out-of-network rate (the balance bill), or the entire bill if your plan does not cover out-of-network care.

Your plan can help transition your care to another **in-network** doctor, if necessary, after your continuity of care period ends.

Your health plan can give you more detailed information about how its continuity of care policy works.

How Health Plans Help to Ensure Access to Care

With traditional face-to-face visits

Face-to-face visits between doctors and patients are the main way patients receive health care.

With the use of modern technology

At the same time, access to doctors and other clinicians is being supplemented in new, innovative ways. For example, health plans are increasingly including in their covered benefits, use of modern technology to enable patients to access care “virtually” through:

- The Internet, such as email and Skype
- Video conferencing
- Smartphone applications

With the use of non-traditional sites of care

Many health plans are also using non-traditional sites of care to give patients greater, and more convenient, access to care. They do so by allowing patients to “walk in” to receive basic and preventive services through places such as **retail clinics**.

With the use of other clinicians

More health plans are including other types of clinicians in their networks in addition to doctors. Two groups of providers now often considered part of the team of clinicians responsible for treating patients are:

- nurse practitioners
- physician assistants

With the use of specialized care sites

The use of specialized care sites, often designated as **centers of excellence**, have also helped expand what networks have to offer. It also expands the quality of care patients can have beyond local geographic areas. These are facilities that meet high quality standards and have extensive experience in highly specialized services, such as organ transplants.

Who Makes Sure Health Plan Networks Meet Certain Standards

Health plan networks must meet certain standards. These standards are set by state and federal agencies and private **accreditation** organizations. In addition, health plans evaluate how well they are serving their members.

State Requirements

States typically have a variety of requirements related to the number and type of doctors and hospitals that must be included in plan networks.

These requirements are called “access standards.” They are meant to ensure that you can get in to see a doctor or hospital in a reasonable amount of time.

State insurance departments also monitor the quality of insurance plans, including their networks, and can take away their licenses or fine them for repeated problems.

Some of the areas states look at when assessing health plans' **provider networks** include:

- How well patients are able to access care based on where providers are located
- How long patients have to wait to get appointments
- How well the health plan is serving the needs of patients who require complex care

Federal Requirements

Qualified health plans operating in the new **health insurance marketplaces**, or **health insurance exchanges**, established by the **Affordable Care Act (ACA)**, and plans participating in the Medicare and Medicaid programs must meet certain access requirements set by the federal government.

Qualified health plans in the marketplaces must also meet other requirements, such as being accredited by a recognized accrediting entity (see below) and implementing a quality improvement strategy aimed at improving the care delivered to plan members.

Accreditation Organization Requirements

In the health insurance exchanges and to participate in the Medicare program, health plans are required to go through a special evaluation from what's called an **accreditation** organization. They need to do this in addition to meeting all other state and federal requirements.

In addition, many plans offering insurance coverage outside the health insurance exchanges voluntarily go through accreditation.

Plans must send the accreditation organization data on how many doctors and other clinicians are in the network and the number of patients.

Accreditation organizations also look at the ability of plan members to get appointments, after-hours care, and member services by phone.

If there are problems, the health plans have to track

how long it takes for you and other patients to get an appointment.

Private accreditation standards are updated periodically with input from consumers and other stakeholders.

Health Plans' Own Requirements

Health plans conduct their own assessments of their provider networks. They monitor their provider networks to see if there are enough clinicians based on the needs and preferences of their members. They address any changes that may be needed by adjusting the size or composition of provider networks. In other words, they try to make sure that they have the types and numbers of providers that you and other plan members need in their provider network.

They also assess how well they are responding to patient issues regarding how easy it is to get service and care. They have member services staff to answer questions you may have and a process to follow up on any concerns you may have regarding your access to network providers.

In addition, as mentioned above, many health plans voluntarily undergo accreditation even when they are not required to, resulting in additional evaluation and oversight of their provider networks.

Requirements Related to Patient Complaints

In addition, the federal government, states, and accreditation organizations look to see how many patients file complaints. Health plans are required to investigate complaints and resolve legitimate problems.

Glossary

Accreditation – An evaluation process in which a health plan undergoes an examination of its administrative procedures to determine if it meets standards defined by the accrediting body, including standards related to quality and network adequacy.

Affordable Care Act (ACA) – The health care reform law – the Patient Protection and Affordable Care Act – enacted in March 2010.

Allowed Amount - Maximum amount on which insurance payment is based for covered health care services delivered out-of-network. This may also be called “eligible expense,” “payment allowance,” or “negotiated rate.” If your provider charges more than the allowed amount, you may have to pay the difference (called **balance billing**).

Appeal – A request from a patient and his/her provider to the health plan to review a coverage decision.

Balance Bill or Balance Billing - When a provider bills you for the difference between the provider’s charge and the allowed amount. For example, if the provider’s charge is \$100 and the allowed amount is \$70, the provider may bill you for the remaining \$30. Balance billing could happen when you see an out-of-network provider.

Catastrophic Costs – Refers to very high health care costs or expenditures for an individual or family.

Center of Excellence – A hospital or other facility that specializes in certain illnesses and/or treatments and meets quality and efficiency criteria.

Coinsurance - Your percentage share of the costs of a covered health care service.

Continuity of Care – Policies and protections health plans have in place to help avoid any disruption in care if an individual is undergoing a course of treatment and a provider leaves the network. Such policies help ensure stability in care for those in the middle of a health care episode, such as pregnancy or treatment for a serious illness.

Contracted Rate - The amount that health plans will pay to health care providers in their networks for a particular service.

Copayment - A fixed amount (for example, \$15) you pay for a covered health care service, usually when you get the service. The amount can vary by the type of covered healthcare service.

Cost-Sharing – This represents your overall share of costs. Generally, it is the combination of premiums you pay plus any other copayments or coinsurance or deductibles you are responsible for under the plan.

Credentialing – The process by which health plans collect and review information on the clinical competence of a health care provider and whether the provider meets the health plan’s pre-established criteria for participation in the plan’s network.

Deductible - The amount you are expected to pay for health care services before your health plan begins to pay. For example, if your deductible is \$1,000, your plan won’t pay anything until you’ve met your \$1,000 deductible for covered health care services that are subject to the deductible. The deductible may not apply to all services, for example, preventive services such as blood pressure screening.

Efficiency – The appropriate use of clinical resources as compared to industry standards and the use of resources by provider peers.

Exclusive Provider Organization (EPO) – Similar to an HMO, this type of plan encourages consumers to seek care from in-network providers. Typically, EPOs provide covered benefits exclusively through their provider networks only and consumers are responsible for paying for care from out-of-network providers.

Health Insurance Exchanges – A resource where individuals, families, and small businesses can: learn about their health coverage options; compare health plans based on costs, benefits, and other important features; choose a plan; and enroll in coverage. The health insurance exchanges, also known as the health insurance marketplaces, also provide information on programs that help people with low to moderate income and resources pay for coverage. Visit www.healthcare.gov for more information. See also health insurance marketplaces.

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Health Maintenance Organization (HMO) – A health plan that uses a provider network and encourages consumers to seek care from in-network providers. Typically, HMOs provide covered benefits exclusively through their provider networks and consumers typically pay a copayment when accessing care. Consumers would be responsible for paying for care from out-of-network providers.

High Performance/High Value Provider Network – A relatively new plan offering that gives enrollees access to a network of providers that have shown results in providing high quality, affordable care. High performance or high value networks are typically smaller than other networks with a focus on utilizing a select group of quality providers to deliver care. Other common terms include **custom, tailored, select, or narrow** network plans.

In-Network – Refers to care received from a health care provider that is part of a health plan’s contracted network.

Network Adequacy – The extent to which a network offers the appropriate types and numbers of providers in the appropriate geographic distribution according to the needs of the plan’s members.

Out-of-Network - Refers to care received from a health care provider that is not part of a health plan’s contracted network.

Out-of-Pocket Costs – The patient’s expenses for medical care that are not reimbursed by insurance. Out-of-pocket costs include deductibles, coinsurance, and copayments for covered services plus all costs for services that are not covered. There are separate out-of-pocket costs for individuals and families.

Out-of-Pocket Maximum – The maximum amount you are required to pay out-of-pocket. Health plans typically have a limit on the out-of-pocket costs you are required to pay, after which the plan pays 100% of medical expenses. This protection typically applies only to care received within the health plan’s provider network.

Point-of-Service (POS) – A health plan that includes features of either HMOs or EPOs as well as PPOs. Consumers are encouraged to use in-network providers by having lower copays for such providers. However, members have the choice to go to an out-of-network provider and have higher copayments.

Preferred Providers – Refers to doctors, hospitals, and other clinicians within the health plan’s provider network.

Preferred Provider Organization (PPO) – Health plans that provide enrollees with access to both in-network and out-of-network care. PPOs typically have lower cost-sharing requirements and out-of-pocket costs when enrollees receive care delivered by in-network, preferred providers. PPOs typically have a **deductible** and a **coinsurance** feature, meaning that a consumer must first pay the deductible and then any applicable coinsurance.

Premium - The amount that must be paid for your health insurance plan. Premiums are typically paid monthly. Premiums are in addition to copayments, coinsurance, or deductibles.

Preventive Services – Health care services that are aimed at preventing complications of existing diseases or preventing the occurrence of a disease. The Affordable Care Act requires health plans to cover certain preventive services (e.g. those with a rating of A or B from the U.S. Preventative Services Task Force), including those for adults, women, pregnant women, and children, without an individual having to pay a copayment or coinsurance or meet a deductible. This requirement applies only when these services are delivered by a network provider. For a complete list of preventive services covered under the Affordable Care Act without your having to pay a copayment or coinsurance or meet your deductible when delivered by an in-network provider, see <http://www.hhs.gov/healthcare/facts/factsheets/2010/07/preventive-services-list.html>

Primary Care Provider (PCP) – A physician or other medical professional who serves as a member’s first contact with a plan’s health care system. Also known as a primary care physician, personal care physician, or personal care provider.

Provider Directory – A paper or online resource that lists providers participating in a health plan’s network, often accompanied by additional information on the providers and their practices.

Provider Network – The group of physicians, hospitals, and other medical care professionals that a health plan has contracted with to deliver medical services to its members.

Qualified Health Plan (QHP) – Health plans that are certified by the health insurance marketplace, provide essential health benefits, follow established limits on cost-sharing, and meet other requirements.

Quality – Care that is safe, effective, patient-centered, timely, efficient, and equitable.

Retail Clinic – Walk-in clinics typically located in retail stores or pharmacies and designed to treat uncomplicated minor illnesses and provide preventive health services. Also referred to as minute clinics.

Safety – The prevention of harm to patients and freedom from accidental or preventable injuries produced by medical care.

Service Area – The geographic region served by a health plan or health care provider.

Tiered Network – A provider network that has different levels of providers that are grouped based on whether they are higher-performing in terms of quality, safety, and efficiency, or lower-performing when compared to their peers.



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