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EDUCATION SOLUTIONS

In-Network Providers vs. Out-of-Network Providers

This is a brief outline to help you understand the important differences between using an In-Network Provider vs. an Out-of-Network Provider for medical services covered under your cultural exchange or language travel insurance plan.

First, let's understand the language. They all have the same meaning within each category:

IN

- **In-Network Providers**
- **Preferred Providers**
- **Preferred Provider Organization (PPO) Providers**

OUT

- **Out-of-Network Providers**
- **Non-Preferred Providers**
- **Non-PPO Providers**

What is a network?

A network is a group of providers with a contractual agreement with a Preferred Provider Organization (PPO). It has many thousands of providers all over the United States, such as physicians, hospitals, labs, urgent care centers, pharmacies, etc.

What makes the providers different?

In-Network Providers have agreed to charge lower, negotiated rates for services. This is called the allowed amount or preferred allowance.

For example, if the provider's standard charge is $150 and the insurance company's allowed amount is $100, the provider will apply the discount and deduct the remaining $50 balance from your bill. (Note: some plans call for a copay for in-network use.)

Out-of-Network Providers have **not** agreed to any negotiated rates for services. You'll pay more to see an Out-of-Network Provider because their charges are not discounted and the provider will bill you for the difference, also known as "balance billing."

What is balance billing?

Balance billing is when an Out-of-Network Provider bills you for the difference between their standard charge and the insurance company's allowed amount.

For example, if the provider's standard charge is $150 and the allowed amount is $100, the provider will bill **you** for the remaining $50 balance. An In-Network Provider may **not** balance bill you for covered services.

What does "Covered as any Other Medical Condition" mean?

When you see this listed in a plan summary (or a certificate issued by the insurance company) it is because it is language required by the state Department of Insurance. It simply means, "the same" as the benefit already listed within the plan summary.

For example, the plan summary lists a $100 deductible and 100% coverage at the top. The individually listed benefits below for physician's visits, hospital, surgery, etc. are "the same" and will read, Covered as any Other Medical Condition.