Out-of-network 101

Knowing what's in network—and what's not—can be confusing. With Naviguard, you can get help understanding what out-of-network balance bills are, and get help resolving them.

Finding a UnitedHealthcare network provider

UnitedHealthcare® offers access to a large provider network that includes more than 1.7 million physicians and health care professionals and 7,000 hospitals and care facilities nationwide.[1]

Use the provider search tool on **myuhc.com®** to help locate a quality network doctor, dentist, pharmacy and health care facility. You can:

- Filter results by location, gender, language, specialty, services offered and more
- See provider ratings
- Review cost and care options—specific to your plan—before making an appointment

78%

success rate resolving balance medical bills[2]

How to avoid out-of-network expenses:

It's important to understand how your health plan works. If you choose to see a provider that's not in your network, we recommend getting an estimate of the costs in writing before getting care. If your plan includes some out-of-network benefits, you'll want to know what those are to help you prepare for medical bills.

Understanding the No Surprises Act

What is the No Surprises Act (NSA)?

The No Surprises Act prohibits out-of-network providers from pursuing members directly for balance medical bills in situations where the patient has little or no control over who provides their care. Learn more about the No Surprises Act at naviguard.com/no-surprises-act.

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What does the No Surprises Act (NSA) mean for you?

There are still situations where you will not be protected from the No Surprises Act. In fact, it's estimated that the No Surprises Act only impacts 10% of out-of-network claims.[3]

You cannot be balance billed for:

- Out-of-network emergency and air ambulance services
- Care performed by an out-of-network provider at a network facility

Balance billing may occur for:

- Ground ambulance
- Other out-of-network scenarios (e.g., if you choose to go out-of-network)

Get expert guidance resolving out-of-network expenses

A full 85% of out-of-network claims are for services that are not covered by the No Surprises Act, which is why having an out-of-network program is critical.[3] We understand that out-of-network events happen, and we are here to help. If you do receive an unexpected balance bill, Naviguard will review it to help ensure you've been charged correctly, and negotiate with providers on your behalf for a lower amount—when appropriate. This service is included in your UnitedHealthcare® plan and is available to you at **no additional cost**. We've successfully reviewed and managed tens of thousands of out-of-network bills for UnitedHealthcare members with a 78% success rate resolving balance bills.[2]

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of out-of-network claims are for services that are not covered by the No Surprises Act.[3]

3 Myths to Understand About Out-of-Network Bills:

1. **Myth: I am protected from being balance billed in all situations since the NSA was enacted.**

   False, balance billing may still occur in some situations including ground ambulance, when notice and consent criteria are met and in cases where the member choses to go out-of-network. It is estimated that the No Surprises Act only covers 16% of services which is why having an out-of-network program is critical.[3]

2. **Myth: I should pay my bill after receiving an Explanation of Benefits (EOB) in the mail.**

   Keep in mind an EOB is not a bill, it's a recap of how your insurance company is processing a claim from a provider. You will likely see a bill from your provider soon, and unless they apply additional discounts, the amount listed as "patient responsibility" is what you may be asked to pay. If you receive a balance medical bill in excess of you share of costs (co-insurance, co-pay, and deductible) we highly encourage you to contact Naviguard before you pay the bill. We may be able to work with your provider on your behalf to reduce or eliminate the balance medical bill.

3. **Myth: Out-of-network health care costs cannot be avoided**

   While some out-of-network health care costs cannot be avoid, many of them can. It takes some effort up front to possibly save money down the line. Visit our website to learn about the top out-of-network risks and how to avoid them.

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Common out-of-network health care terms and acronyms

Knowing the meaning behind some health care terms isn't always easy. Don't worry, you're not alone.

Half (51%) of insured adults say they find at least one aspect of how their insurance works at least somewhat difficult to understand.[4]

A quarter of all insured adults say they have difficulty understanding specific terms, such as "deductible," "coinsurance," "prior authorization," or "allowed amount."[4]

Three in ten insured adults say they find it difficult to understand statements explaining whether or how much insurance will pay for care; these statements are called Explanation of Benefits, or EOB.[4]

We've included definitions of some of the most commonly misunderstood words here to help you make informed health care decisions — and help you better understand your bill.

Allowed amount

Also known as eligible expense, payment allowance, negotiated rate and allowable charge, it's the maximum amount on which payment is based for covered health care services. If your provider charges more than the allowed amount, you may have to pay the difference. (See balance billing.)

Appeal

A formal request to review an action when you are not satisfied with a decision made by your health plan.

Balance billing

When a provider bills you for the difference between their 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. A network provider may not balance bill you for covered services.

Charged amount

The amount of money you are asked to pay a doctor or other health care provider for a benefit or service you've received.

Claim

A request for a benefit (including reimbursement of a health care expense) made by you or your health care provider to your health insurer or plan for items or services you think are covered.

Coinsurance

Your share of the costs of a covered health care service, calculated as a percentage of the allowed amount for the service. You generally pay coinsurance plus any deductibles you owe. For example: If the health insurance or plan's allowed amount for an office visit is $100 and you've met your deductible, your coinsurance payment of 20% would be $20. The health insurance or plan pays the rest of the allowed amount.

Copay

A dollar amount that you pay to the doctor at your visit.

Deductible

The amount of eligible expense a covered person must pay out-of-pocket (per plan year) before the plan will pay.

Explanation of Benefits (EOB)

A statement from your health plan detailing what costs it will cover for medical care, prescriptions and other medical products you've received.

Maximum out-of-network costs

The limit on total member copayments, deductibles and coinsurance under a benefit contract.

For more common health care terms and acronyms, visit justplainclear.com

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Network

A system of contracted physicians, hospitals and ancillary providers that provides health care to members.

Network provider

Also known as preferred provider and participating provider, it's a provider who has contracted with the health plan to deliver medical services to covered individuals. The provider may be a physician, health care provider, pharmacy, hospital or other facility.

No Surprises Act (NSA)

The No Surprises Act prohibits out-of-network providers from pursuing members directly for balance medical bills in situations where the patient has little or no control over who provides their care. This includes all emergency services (except ground ambulances), or when an out-of-network provider is involved in their care while they are at a network facility.

Out-of-network (OON)

Coverage for treatment by a non-contracted provider. Typically, it requires payment of a deductible and higher copayments and coinsurance than for treatment from a contracted provider. Some health plans do not offer benefits for out-of-network treatment, except in emergencies.

Out-of-pocket maximum

Also known as out-of-pocket threshold, it's the most you could pay during a coverage period (usually one year) for your share of the costs of covered services. After you meet this limit, the plan usually pays 100% of the allowed amount. This limit helps you plan for health care costs—and never includes your premium, balance-billed charges or health care your health insurance or plan doesn't cover. Some health insurance or plans don't count all of your copays, deductibles, coinsurance payments, out-of-network payments or other expenses toward this limit.

Patient responsibility

The amount of money the patient must pay for health care services.

Payer

The organization that pays for the costs of health care services. A payer may be a private insurance company, the government or an employer's self-funded plan.

Premium

The amount that must be paid for your health insurance or plan. You and/or your employer usually pay it monthly, quarterly or yearly.

Provider

A physician, health care professional, hospital or other health care facility that's licensed, certified or accredited as required by state law. Providers can be medical, holistic health professionals, behavioral health professionals or other appropriately trained individuals.

We're here for you

Naviguard is available at no additional cost to you as part of your benefits package.

Learn more

For additional details and resources on out-of-network medical billing, visit naviguard.com/resources

[1] UnitedHealthcare internal analysis, data ending Q2, 2023.

[2] Naviguard data Jan. 1, 2021– July 31, 2023 based on 2021–2023 data for claims on which Naviguard was engaged. Negotiation success rate is based on member-choice, member-initiated claims negotiated to less than billed charges. Negotiation success rate may vary and is not a guarantee of future results.

[3] Based on UnitedHealthcare commercial claims data in 2022

[4] Kaiser Family Foundation, KFF Survey of Consumer Experiences with Health Insurance, 7/25/2023.

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