



The Ins and Outs of Seeking Out-of-Network Care

What Does it Mean to go “Out-of-Network?”

Most insurance plans have a list of preferred providers that they have selected to give you care.

Going out-of-network means you're visiting a provider not preferred by your plan, and who does not have an agreement in place with your insurance company for payment terms.

Depending on your insurance plan, this could result in higher costs, or no coverage at all from your insurance provider.



Some types of health plans, like HMOs or EPOs, do not reimburse out-of-network providers at all. This means that if you have one of these plans, you could be responsible for the full amount charged by your doctor if you choose to go out-of-network for care.

Understanding Your Plan Type Helps you Know Your Out-of-Network Options

HMO: Health Maintenance Organization - HMO plans require you to choose a primary care physician who serves as a centralized person who can refer you to specialized providers for your care. Your doctor will refer you to providers within your network. HMO plans usually only pay for providers that are in network, and have limited or no benefits for out-of-network providers.

PPO: Preferred Provider Organizations - These plans maintain a network of providers, but will still cover out-of-network care, typically with a higher cost to you. However, you do not need a referral to visit any specialist under this plan, whether in network or out-of-network.

EPO: Exclusive Provider Organization - EPO plans do not require you to choose a primary care physician or obtain a referral to see a specialist, but often have a very limited network of providers that you can visit. Most often, there are no benefits for services from out-of-network providers.

POS: Point of Service - These plans resemble HMOs but are less restrictive because you can get coverage for out-of-network care in certain defined circumstances. POS plans usually define the circumstances when out-of-network care is covered. Like HMOs, most POS plans require you to get a referral from your primary care physician beforehand.

Sometimes Visiting an Out-Of-Network Provider is Your Best Option

When Emergencies Happen

In a true emergency situation, you must go to the hospital or urgent care facility that is closest to you. Most plans will make an exception for out-of-network care in the case of a true emergency. It's important that you or a loved one contact your insurance company as soon as possible in the event of an emergency and inform them that you had to seek out-of-network care. Keep in mind that the insurance company will usually have strict guidelines as to what's considered a true emergency.

No Local Providers Available

If you live in a rural area and there is no in-network specialist close by, you may need to utilize an out-of-network doctor. Contact your insurance company if this is the case and they may be able to negotiate with a non-participating doctor for your care, but will expect you to provide documentation that no network provider exists. If so, many health plans will then cover the cost of the visit at the same in-network rate you normally have.

Non-Emergency Care While Out-Of-Town

If you need medical care while away from home, you may have to visit a doctor not connected with your plan. If it's not an emergency, it's a good idea to call your health plan first to find out if there are any in-network doctors in the area. Sometimes insurers will handle your visit to a non-participating provider as if it were in network if the situation warrants.

Continued Specialist Care

If you have a rare or complex condition, specialists can be limited even within your network. Sometimes your current specialist exits your insurance network in the midst of your treatment. You may choose to continue that care out-of-network with the knowledge that your costs will increase. Depending on your plan, you may have the option to appeal for continued in-network coverage, even if only for a period of time or a set number of visits to finish treatment.



The amount you owe is \$2,900 more out-of-network!

! Here's an example of how the same plan may pay for in-network versus out-of-network care	In-Network Benefits	Out-Of-Network Benefits
	Plan pays 80%, you pay 20%	Plan pays 50%, you pay 50%
	Provider's normal retail charge	\$5,000
	Amount allowed by health plan <small>(maximum amount the health plan will consider for the services)</small>	\$3,000
Your cost amount after insurance, owed to the provider	You pay 20% of allowed charge 20% of \$3,000 = \$600	You pay 50% of allowed amount plus the difference between the provider's original amount and allowed amount $\begin{array}{r} (50\% \text{ of } \$3,000) \\ + (\$5,000 - \$3,000) \\ = \$3,500 \end{array}$