

When Out-of-Network Care Can be Covered In Network

Receiving care from a provider in your health plan's network usually costs you much less than going to an out-of-network provider. (See [In-Network and Out-of-Network Care](#)). But, you may need to go out of network for certain types of care, especially if you or a member of your family has a rare illness, such as a genetic disorder. Suppose no provider in your network has the training or experience to treat it the right way. With prior approval from your insurer, you may be able to receive the care you need out-of-network and still pay only the lower, in-network rate.

Different insurers take different approaches to requests for out-of-network care at in-network rates. You may have to make a formal request to your insurer, sometimes called an "appeal," or send in a request for prior authorization. Information about the process to follow should be available from your insurer's website, plan documents or customer service representative.

Your primary care physician (PCP) or in-network specialist typically send the initial request to the insurer. The insurer may deny your first request. But, usually you have more than one chance to get your case reviewed. You may appeal the decision "internally," which means you can ask the insurer to reconsider your benefits denial. If your request is still denied, federal or state law may require your insurer to allow you to start an "external" appeal. That means you appeal to an independent, outside group.

If your insurer agrees to let you go out of network at the in-network rate, your out-of-network referral will usually be to a specific doctor. But, typically, any doctor managing your care will work with other providers who perform related procedures. The claim from the original doctor will be processed at the in-network rate. But, the claims from the other providers may be processed as out of network and you will have to appeal the insurer's decision. To avoid that, it's best that you work out those details with the insurer in advance.

Your health insurer contracts with doctors, hospitals and other providers who agree to accept the insurer's rate as payment for their services. These are the providers in your "network." Staying in your network usually costs you much less than going to an out-of-network provider, as you benefit from the lower rates your insurer has negotiated with network providers.

Not all plans will cover you if you go out of network. And, when you do go out of network, your share of costs will be higher. Some plans may have higher cost-sharing provisions (deductibles, copays and coinsurance) that apply to out-of-network care. For more information, see [In-Network and Out-of-Network Care](#).

There are many reasons you may choose to go out of network even though it may cost you more. For example, maybe you have been diagnosed with a serious illness such as cancer and the doctor you select is not in your network. Maybe the condition is not serious, but you choose to pay more to see a provider you know or who has been referred to you.

In some instances, however, you may be able to go to an out-of-network provider and still pay in-network prices. Suppose you or a member of your family has a rare, serious sickness or health problem, such as a genetic disorder. Suppose no provider in your network has the training or experience to treat it the right way. In such a special, uncommon circumstance, with prior approval from your insurer, you may be able to go out of network while sharing the costs at the lower in-network rate.

This guide will discuss:

- Situations when you may need care from an out-of-network provider;
- How to research where to go for care;
- How to make the case to your insurer that you need to go out of network and should be covered in network; and
- How to take charge of your care once your insurer has agreed to let you go out of network and pay based on in-network rates.

Situations When You May Need Care from an Out-of-Network Provider

There may be several situations when you may need out-of-network care and can get it at the in-network rate. These situations may depend on your plan, or on the laws in your state. For example:

- You have a rare, serious sickness or health problem, such as a genetic disorder. You may have to leave your network to find a provider who is qualified to treat the rare condition.
- You live in a remote area where the network is not adequate to treat your serious condition.
- You have an emergency, when you need care right away for a serious sickness or injury. You may need to go to the nearest emergency room, even if it is not in your network. (See Emergency Care and Urgent Care.)
- You are already being treated by an in-network doctor for a serious condition. Then, you switch to a new health plan and that doctor is not in the new plan's network. Or your plan stays the same, but the doctor leaves the network. You may be able to keep seeing the doctor at the in-network rate for the duration of the treatment.
- Natural disasters can force you to evacuate to places where you need care outside your network. If the state or federal government declares a state of emergency, you may qualify for in-network rates.
- If your child moves away to college and you want him or her to be able to see doctors close to the college, your plan may offer a guest membership. That would allow your child to be a "guest" of a network of doctors in that area. Similarly, some plans have "travel" networks to cover you when on business trips or vacations.

Many states have laws requiring plans to cover such out-of-network services at in-network rates. If you need to go out of network, check with your insurer and follow the rules that pertain to your state and plan.

Research: Where to Go for Care

If you have a rare and serious condition, find out where you are most likely to get good treatment results. Go online and learn about what hospitals or experts specialize in this condition. Patient support groups for the condition can be a good place to start. Talk to your primary care physician (PCP) and, if necessary, to the appropriate specialist in your network. Learn as much as you can. Does it appear that you can best be treated by a provider outside your network? Then, before you go out of network, ask your insurer to cover your care at the in-network rate.

Making the Case to Your Insurer

Different insurers take different approaches to requests for out-of-network care at in-network rates. You may have to make an appeal, or a formal request, or send in a request for prior authorization. Information about the process to follow should be on your insurer's website or in documents that describe your health plan's benefits. Your insurer's customer service representative should also be able to inform you about the process.

Your PCP and in-network specialist usually get the process started. They work with each other and submit the request to the insurer. Their supporting documents may include medical review of your diagnosis and the reasons why you need to go out of network. You may include a letter from the doctor from whom you seek treatment, and possibly a letter from a patient advocacy group.

Your request typically will be based on the out-of-network doctor's training and experience, which are important to your care and different from those available in network. Experience can be subjective, with different people measuring it in different ways. The more proof you and your doctors can give, the better. For example, suppose only 200 cases of your condition happen per year in the United States. The specialist in your network may not treat even 1 of those cases per year, but the out-of-network specialist treats 12 cases per year. The 12 cases are treated successfully, with documented good results better than those your in-network specialist can show.

The insurer may deny your first request. But, usually you have more than one chance to get your case reviewed. You may appeal the decision "internally," which means your benefits denial is reconsidered by reviewers for the insurer who were not involved in the initial decision. If your request is still denied after the internal appeals process, federal or state law may require the plan to allow you to start an "external" appeal, which means you send information about your benefits denial to an independent, outside group. Or, your insurer may waive the internal appeals process and let you go straight to an external appeal. For more information, see [If Your Plan Doesn't Pay \(Appealing a Reimbursement Decision\)](#).

If your need for care is urgent, ask for an expedited appeals process. You don't want to delay or miss out on treatment.

Taking Charge of Your Care

Your insurer has agreed to let you go out of network at the in-network rate. But, your work is not done. Usually, your out-of-network referral will be to a specific doctor. Typically, however, any

doctor managing your care will work with other providers who perform related procedures. For example, one may be the radiologist who reviews your ultrasound. Another may be the anesthesiologist who puts you to sleep for surgery. There may be no in-network providers at that facility who can do the work. The claim from the original doctor will be processed at the in-network rate. But, the claims from the other providers may be processed as out of network and you will have to appeal the insurer's decision on each of those claims. That may take time and aggravation, so it's best that you work out those details with the insurer in advance.

Some insurers allow you to have a "global out-of-network referral." This means that any bills from a certain hospital are processed at the in-network rate. If your insurer is not able to do that, request a case manager: one person who is your point of contact. Let the case manager know when you will be going to the hospital, and see if the insurer can put a hold on your claims until they can review all your claims at once.

Make sure you know how long your out-of-network referral is good for. Before it expires, if you still need care, ask your PCP to file another out-of-network referral. Once an out-of-network referral is approved, the insurer will usually continue to honor it.

Your Action Plan: Ask for In-Network Coverage for Your Out-of-Network Care

Do you need to go out of network? If so, follow these steps to request coverage at the in-network rate.

- Do your own research to find out what care you need and from whom.
- Talk to your PCP and to your in-network specialist. Tell them what you have learned in your research. Ask them if they can support you with medical documentation.
- Request that your insurer cover you at the in-network rate before you go out of network. If you wait until afterward, you may face big bills and an even harder challenge.
- If your medical need is urgent, ask for an expedited appeals process.
- If your request is approved, ask for a case manager to handle your out-of-network claims.
- Look at your Explanations of Benefits (EOBs) carefully. Make sure your cost sharing is at the in-network rate, not the out-of-network rate.
- Know how long your out-of-network referral is good for. Make sure it covers follow-up care.
- If your request is denied, talk to your out-of-network doctor. Get an estimate of how much the services are going to cost. Use the FH Medical Cost Lookup tool or the FH Dental Cost Lookup tool to see what those services typically cost in that geographic area. See if you can pay at a discounted rate.

Most important, understand you have choices. Don't feel obligated to use an in-network provider that you feel is unfit for your needs. You are your own best advocate. If your network can't give you the care you need, look for out-of-network solutions—and follow all of the steps listed here to have your insurer cover your care at the in-network rate.