Questions to Ask Your Insurance Plan Before You Go Out-of-Network

1. Are my doctors/dentists members of the plan's network? How can I look up doctors/dentists who participate in the network? Can I get a list of doctors/dentists in my area?

2. How is out-of-network care reimbursed by my plan? Does my plan base reimbursement on "usual, customary and reasonable" (UCR) charges, Medicare fees or some other formula?

3. What are the rules for accessing care outside my plan's network? For example, how will I know if a service or test needs to be pre-authorized? Is there a phone number that I need to call?

4. What services and tests are covered by my plan? Will they be covered if performed by an out-of-network provider? What services or tests are excluded?

5. What is your definition of screening tests? Do I have to pay a co-pay or meet a deductible to have a screening test as recommended by my doctor?

6. What happens if my in-network provider sends lab tests to an out-of-network laboratory? Would I be responsible for additional costs? If so, how can I guard against this additional expense?

7. Is there a deductible? Do both in-network and out-of-network services count towards the same deductible? Do pharmacy services and laboratory services count towards the same deductible?

8. How can I appeal a decision about a claim?

9. How can I confirm that all providers who will provide care during a procedure, surgery or hospitalization (e.g., anesthesiologist, radiologist, pathologist) participate in my plan's network?

10. How does the plan cover emergency services from a non-network provider? How does the plan define "emergency" services? If I am brought by ambulance to a non-participating Emergency Room, am I financially responsible for a decision that was not in my control?

Make a note of the date and the name of the person you speak with

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