community health advocates

Date: _____

Dear Helpline Caller:

Thank you for calling Community Health Advocates (CHA) for help with out-of-network insurance coverage. CHA is a nonprofit dedicated to helping New Yorkers get, keep, and use health insurance.

You recently called us for help because your insurance company out-of-network reimbursement rate is low. First, *you should know that you have the right to file an appeal*. It's not difficult to do. Just follow these simple steps:

1. **Determine how your health plan sets their out of network reimbursement rate**

   Read the attached, *Tips for Determining Your Plan's Out-of-Network Rates* for more help.

2. **Write your appeal letter.**

   Just fill in the enclosed template.

3. **Make a copy for your records**

4. **Send it in to your plan.**

5. **File a complaint with New York State Financial Services at http://www.dfs.ny.gov/consumer/fileacomplaint.htm and New York State Attorney General Office at http://www.ag.ny.gov/health-care/file-a-complaint**

   Send copies of all documents you submitted with your appeal to support your complaint.

Keep a copy of anything you send to the plan, and write down what date you sent it. But you should act quickly because you may have limited time to file your appeal.

If you have any questions, please call our helpline at 888-614-5400. Be sure to say that you've called before so that we can see all the information we have about your case.

Sincerely,

CHA Helpline Team

633 Third Avenue, 10th Floor • New York, NY 10017 • PH 888-614-5400 • FAX 212-614-5378 •
www.communityhealthadvocates.org
Community Health Advocates is a program of the Community Service Society of New York.

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# Tips for Determining Your Plan's Out-of-Network Rates

Insurance plans that have out-of-network coverage may pay less than your doctor bills for a service. Before you dispute the amount your insurance plan paid for your out-of-network care, it is helpful to understand how your plan sets out-of-network reimbursement. Below are some tips for figuring this out.

## 1. Look at your plan documents

Your "Certificate of Coverage," "Contract," or "Summary Plan Description" includes an explanation of how your plan sets payment. Does your plan pay for services that are provided by an out-of-network provider? If so, how do they calculate the amount they will pay? Plans often state that they pay a certain percentage of the rate for out-of-network care. For example, they might pay 80% of the "allowable amount."

## 2. Determine how your plan sets the "Allowable Amount"

There are several possibilities for how the plan determines the "allowable amount."

- Some plans base their allowable amount on the **Medicare Rate**. This means that they base the allowable amount on what Medicare pays for the service.
- Some plans base their allowable amount on a **Usual and Customary Rate**. This means that they base the rate on data about the amount providers in your area charge for the service.
- Some plans base their allowable amount on a **Fee Schedule**. This means that they have their own list of services and what they will pay for each.

## 3. Determine if your plan correctly calculated your reimbursement rate

Once you have figured out how your plan sets the "allowable amount", check to make sure they are doing so correctly for your case.

- If your plan says they use the **Medicare Rate**, you can look up the Medicare rate or Usual and Customary Rate on an online database called Fair Health, located at http://www.fairhealthconsumer.org/.
- If your plan says they use a **Fee Schedule**, you can ask your plan for their Fee Schedule, or for the rate of reimbursement for the services you received.

Then, apply the percentage that your plan says they pay. For example, if your plan says they pay 80% of the allowable amount and that they base the allowable amount on the Usual and Customary Rate, calculate 80% of the Usual and Customary Rate you looked up.

## 4. If your plan paid less than they should have, file an appeal with your plan.

Use the attached letter as a model.

## 5. If you still owe a balance after your plan has paid correctly, negotiate with the provider

Ask the doctor or facility to provide a discount on the balance that you owe.

**Have questions? Contact the Community Health Advocates Helpline at (888)614-5400**

*CHA is a free program that helps New Yorkers get, keep, and use health insurance.*

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**Sample Letter for Out-of-Network Reimbursement Rate Based on the Medicare Rate or Usual and Customary Rate**

[Your Name]
[Your Address]

[Insurance Plan's Address]
[You can find this on your denial notice, in your benefits book, or by calling your plan.]

[Date]

Re: [Name of Person Whose Claim Was Denied]
ID: [Insert Your Health Plan Identification Number]
DOB: [Insert Person Whose Claim Was Denied Date of Birth]
Claim Number: [You can find this on your explanation of benefits or denial letter.]
Date of Service: [This should also be on documents from your plan or your bill.]
Provider: [Name of doctor and/or hospital]

To Whom it May Concern:

I would like to file an appeal on the out-of-network reimbursement rate for medical services described above. Your reimbursement rate is unreasonably low.

According to my policy, out-of-network reimbursement rates are based on the [usual and customary rates or Medicare rates]. Your reimbursement is less than required under my policy.[1]

Based on this information, my out-of-network claims are being under-reimbursed and an increased payment should be granted.

Thank you for your prompt attention to this matter. If you have any questions, please call me at [your phone number].

Sincerely,

[Your Name]

Cc: NYS Attorney General
NYS Department of Financial Services

[1] For any of these services that were provided in the context of an emergency, you must reimburse out-of-network providers the greatest of: (1) your payment level for similar in-network services; (2) your standard formula for non-emergency out-of-network payments; or (3) the Medicare rate. 45 CFR § 147.138(b)(3)(2011).