

# Understanding Out-of-Network (OON) Benefits

If your health plan includes out-of-network (OON) benefits, it is important to understand how those benefits work. This guide will help you make informed decisions and understand your rights.

## Using Out-of-Network Benefits

If you choose to access care from a provider who is not in your plan's network, keep the following in mind:

- **You may be responsible for a significant portion of the cost:** Health plans typically reimburse only a portion of the billed charge from an OON provider. You are responsible for paying the difference between your provider's billed charge and the plan's allowed amount.
- **There is no standard method for determining OON payments.** Each health plan determines how it will cover such services. These details are outlined in your Certificate of Coverage (COC), which you can request from your health plan or, if you receive health insurance through your employer, from your benefits manager.
- **You must meet a separate OON deductible:** OON services are subject to a separate deductible, which is often higher than the in-network deductible. Only the plan's allowed amount is applied to your OON deductible.
  - Example: If your provider charges \$1,000 but your plan's allowed amount is \$200, you pay the \$800 difference plus any applicable coinsurance.
- **Coinsurance may also apply:** After you meet your OON deductible, you may be responsible for coinsurance, which is a percentage of the allowed amount. This percentage is outlined in the Schedule of Benefits section of your COC.

- **You can request an OON reimbursement estimate:** Upon request, most New York regulated health plans must provide an approximate dollar amount they will reimburse for a specific OON service. If your request does not include billing codes, the plan may give a range instead of a specific amount.
- **Payment methodologies may change:** Your health plan's approach to determining OON reimbursements may change upon annual renewal of your health insurance policy. It is good practice to review your COC health insurance policy each year to stay informed about updates.

## Filing an Appeal

When your health plan denies a request for care, it must send you a notice call and an Initial Adverse Determination. You or your designee can submit an internal appeal directly to your health plan within 180 days. Be sure to follow the instructions and deadlines outlined in the denial letter.

If your health plan upholds its decision after an internal appeal, it must issue a Final Adverse Determination (FAD). Upon receiving the FAD, you have 120 days to file an external appeal with the New York State Department of Financial Services.

An external appeal is conducted by an independent medical expert who is not affiliated with your health plan. There are fees associated with external appeals:

- Plans may charge \$25 per appeal, max \$75/year (waived for Medicaid, Child Health Plus, Family Health Plus, or financial hardship).
- Providers may be charged \$50 per appeal (refunded if the denial is overturned).



## More Information

To learn more about your rights or to file an appeal, visit [dfs.ny.gov/externalappeal](https://dfs.ny.gov/externalappeal) or scan QR code:

