Out-of-Network Benefits Guide

Step-by-Step Guide to Verifying Out-of-Network Benefits for Therapy

Verifying your out-of-network benefits before starting therapy ensures you understand your coverage and financial responsibilities. Here's a detailed guide to help you verify out-of-network benefits for therapy:

Step 1: Review Your Insurance Plan Documents

- **Access Your Insurance Plan Summary**:
  - Find your plan's **Summary of Benefits and Coverage (SBC)** through your insurance portal or HR department. This document outlines your insurance plan's coverage, including out-of-network benefits.
- **Look for Out-of-Network Coverage**:
  - Check if your plan offers out-of-network benefits. Some plans, like HMOs or EPOs, may not cover out-of-network care except for emergencies. See below for further details on choosing a plan with the best out-of-network benefit options.
  - Confirm the **reimbursement percentage** (e.g., 50%, 70%) for out-of-network services.
- **Identify Deductibles and Out-of-Pocket Maximums**:
  - Review if your plan has a **separate out-of-network deductible**. You must meet this deductible before the plan starts reimbursing any therapy costs.
  - Check the **out-of-pocket maximum** for out-of-network care to know the limit on how much you'll pay in a year.

Step 2: Contact Your Insurance Company

- **Call Customer Service**:
  - Call the number on the back of your insurance card and ask to speak to a representative about your out-of-network benefits for mental health or therapy services. Use the following CPT (Procedure Codes) when verifying benefits: 90791 and 90837.
- **Ask for Details on Out-of-Network Therapy Coverage**:
  - Request information on:
    - **Coinsurance**: The percentage of costs the insurance will cover for out-of-network therapy after you meet the deductible.
    - **Out-of-Network Deductible**: How much you need to pay out-of-pocket before the insurance starts covering therapy.

        - **Usual, Customary, and Reasonable (UCR) Rates**: Find out how the insurance calculates reimbursement based on UCR rates in your area. Some plans reimburse a percentage of UCR fees, which may be lower than the therapist's actual charge.
- **Pre-Authorization Requirements**:
    - Ask if you need **pre-authorization** for out-of-network therapy services. Failing to get pre-authorization can result in claim denials.

Step 3: Verify Specific Reimbursement Rates

- **Check for Reimbursement Limits**:
    - Some insurance companies cap how much they will reimburse per therapy session. For example, if your therapist charges $200 per session and your plan reimburses 70% based on a UCR rate of $150, you'll only be reimbursed $105.
- **Ask About Maximum Number of Sessions**:
    - Confirm if there is a limit to how many therapy sessions are covered annually for out-of-network providers.
    - Some plans may have caps like 20 sessions per year or require ongoing pre-approval for additional sessions.

Step 4: Ask About Filing Claims for Out-of-Network Therapy

- **Understand the Claims Process**:
    - Since out-of-network providers typically don't file claims on your behalf, you will need to submit them manually. Confirm the procedure with your insurance company.
- **Gather Necessary Documentation**:
    - Ask the insurance company what documentation is required to file a claim for therapy reimbursement. Typically, you will need:
        - A **superbill** from your therapist (an itemized receipt listing the therapy services, cost, and provider details).
        - **Diagnosis codes** (CPT or ICD codes) that justify the need for therapy.
- **Time Limits for Submitting Claims**:
    - Verify any deadlines for submitting claims to ensure you don't miss reimbursement opportunities.

Step 5: Estimate Your Costs and Reimbursement

- **Calculate Potential Reimbursement**:
    - After understanding the **coinsurance rate**, **UCR rates**, and **deductible**, you can estimate how much you will be reimbursed.
    - Example:
        - Therapist charge: $200/session
        - UCR rate: $150
        - Plan reimbursement: 70% of UCR rate = $105
        - You pay: $200 (upfront) – $105 (reimbursement) = $95 per session.
- **Factor in the Deductible**:
    - If you haven't met your out-of-network deductible, you'll need to pay the full cost of therapy sessions until you reach it.

- Example: If your out-of-network deductible is $1,000, you must pay $1,000 in therapy fees before the insurance begins reimbursing.

Step 6: Keep Detailed Records of Your Claims

- **Track Your Payments and Reimbursements**:
  - Keep a record of all therapy sessions, receipts, and insurance submissions. This helps you track when you've met your deductible and ensure you receive proper reimbursement.
- **Follow Up on Claim Status**:
  - Monitor your claims to ensure timely reimbursement. If a claim is denied, review the **Explanation of Benefits (EOB)** and contact your insurance company for clarification or file an appeal.

Choosing an Insurance Plan with Out of Network Benefits

Choosing the right insurance plan that includes strong out-of-network benefits can provide flexibility and access to a broader range of healthcare providers. Here's a detailed guide to help you make the best choice during open enrollment:

Step 1: Understand Different Plan Types

- **Preferred Provider Organization (PPO)**:
  - **Best for Out-of-Network Benefits**: PPOs generally offer the most robust out-of-network coverage.
  - **Flexible**: You can see any healthcare provider without a referral.
  - **Higher Premiums**: Expect higher monthly premiums, but with better out-of-network reimbursement.
- **Point of Service (POS)**:
  - **Moderate Flexibility**: POS plans allow you to see out-of-network providers, but only with a referral from your primary care physician (PCP).
  - **Lower Premiums**: Compared to PPOs, POS plans may offer lower premiums, but at the cost of requiring referrals and having stricter network rules.
- **Health Maintenance Organization (HMO) or Exclusive Provider Organization (EPO)**:
  - **Limited Out-of-Network Coverage**: These plans typically don't cover out-of-network care unless it's an emergency.
  - **Lower Costs**: HMOs and EPOs are usually less expensive, but offer little to no out-of-network benefits.

Step 2: Assess Out-of-Network Coverage

- **Reimbursement Levels (Coinsurance)**:
  - PPO and POS plans typically cover 50-80% of out-of-network costs after the deductible is met. Look for plans with higher reimbursement rates (e.g., 70-80%) for out-of-network care.
- **Deductibles**:
  - **Separate Deductibles**: Many plans have a separate out-of-network deductible, which is usually higher than the in-network deductible. Make sure to factor this into your

decision.
    - **Example**: If the in-network deductible is $1,500, the out-of-network deductible might be $3,000 or higher. You must meet this before your insurance begins to cover a portion of out-of-network care.
- **Out-of-Pocket Maximum**:
    - Some plans may have a separate out-of-pocket maximum for out-of-network care, or they may exclude out-of-network expenses from counting toward the overall limit.
    - Ensure the plan's out-of-pocket maximum is reasonable for out-of-network services to protect you from excessive medical bills.

Step 3: Consider Balance Billing and Usual & Customary Rates

- **Balance Billing**:
    - Out-of-network providers can charge more than what your insurance considers "reasonable and customary." The provider may then "balance bill" you for the difference between what the insurance pays and the actual charge.
    - Some insurance plans may offer protections against balance billing, so check for this feature when comparing options.
- **Reasonable & Customary Fees**:
    - Insurance companies reimburse based on what they deem "reasonable and customary" for out-of-network services in your area. If a provider's charges exceed this amount, you may have to pay the difference.
    - Look for plans that define reasonable and customary rates favorably, such as those that reimburse based on a percentage of the provider's actual charges rather than a lower fixed rate.

Step 4: Supplemental Insurance for Out-of-Network Coverage

- **Gap Insurance**:
    - Some employers offer gap insurance plans that help cover the difference between out-of-network charges and what your primary insurance pays. These plans can be a valuable option if you expect to use out-of-network services often.
- **Health Savings Account (HSA)**:
    - If you choose a high-deductible health plan (HDHP) with out-of-network benefits, consider pairing it with an HSA. Contributions are tax-free and can be used to pay out-of-pocket medical expenses, including out-of-network costs.

Step 5: Ask for Real-Life Examples and Support

- **Speak with HR or Benefits Advisors**:
    - During open enrollment, ask your human resources team or insurance representative for examples of how out-of-network claims are processed under different plans.
- **Request Specifics on Reimbursement**:
    - Ask for examples of therapy out-of-network services and how much you would pay under each plan. This can help clarify the potential cost-sharing responsibility.