How to Determine Your Out-of-Network Benefits

(Call your insurance company’s customer service number and inquire about the following:)

1. Determine your *out of network deductible*: This is the amount of money you must pay *before* you are eligible for reimbursement.

This amount resets every calendar year.

1. Determine if you have a *coinsurance*: This is the percentage of the service fee that you’re ultimately responsible for paying. For example, if your coinsurance is 25% and your doctor charges $200, you are responsible for $50 and your insurance will send you a check for $150 after the session, once you’ve met your deductible and submitted a claim. (Note: you will need to pay the full $200 directly to your doctor and submit your Superbill to your insurance company for reimbursement.)

1. Determine if your insurance company has an *allowed amount,* which caps the session fee that they will cover. For example, if your insurance has determined $200 is their “allowed amount” per session, at a 25% coinsurance rate ($50), your insurance company will only reimburse you up to $150, no matter what the doctor’s session fees are.

\*It is important to know that submitting claims for out of network benefits is like submitting in network claims in that when you submit claims for out of network benefits you are authorizing your insurance company to have access to your mental health records. In addition, to receive reimbursement for out of network benefits, you will also have to have a diagnosis that the insurance company deems ‘medically necessary.’ For example, most insurance companies do not consider ‘partner relationship’ problems or ‘phase of life’ problems as medically necessary diagnoses but do consider depression and anxiety as medically necessary.

Out of network deductible: \_\_\_\_\_\_\_\_\_\_

Co-insurance percentage: \_\_\_\_\_\_\_\_\_\_

Allowed amount: \_\_\_\_\_\_\_\_\_\_