A Guide to Understanding Your Out of Network Benefits

This information is typically found in your *Summary of Benefits* (you should have received either a paper or electronic copy of this at time of enrollment). If not, check your insurance company's website. Be sure to search your specific plan information.

Understanding key terms:

Out of network deductible: The amount of money you have to pay before you are eligible for reimbursement. Any money spent at any out of network provider in the calendar year will contribute toward meeting your deductible.

Coinsurance/ Copay: This is the amount of the fee that you will be responsible for once your deductible is met. For example, if your insurance covers 75% of the cost of an out of network visit, you will be responsible for the remaining 25%.

Allowed or Capped Amount: Some insurance companies determine a maximum cost per service that they will cover. If the allowed/ capped amount is less than the service fee, the insurance company will operate as though their capped/allowed amount is the cost of the session, covering the contracted percentage rate of the capped/allowed amount. You are responsible for the copay, and the amount of the session that exceeds the allowed/capped amount.

Sometimes the Summary of Benefits does not include all of the information you need to understand what payment and insurance coverage will look like. You can use the below questions to help guide a conversation with a representative at your insurance company:

- How much of my deductible has been met this year?
- What is my out-of-network deductible for outpatient mental health? *(Outpatient means treatment outside a hospital.)*
- What is my out-of-network coinsurance for outpatient mental health?
- Do I need a referral from an in-network provider to see someone out-of-network?
- How do I submit claim forms for reimbursement? *(Claims are forms that are sent to your insurance company to receive reimbursement for sessions you paid for out of pocket.)*