Guide to Understanding Your Out of Network Health Insurance Benefits

Most health insurance companies contract with different medical & behavioral health providers in the community to create a network of preferred or covered providers. Depending on your insurance plan and its policies and regulations (each one is different and it can change from plan year to plan year), you may have what are called “out-of-network benefits” or coverage. This means that if you want to see a provider that is not in your insurance company’s network, there is still partial or total coverage available.

Because each health insurance plan is different, the best way to determine if you have out-of-network benefits is to call and speak with a benefits representative at your insurance company directly. The insurance company is also known as the “carrier.” The representative you speak with should be able to explain the details of your plan, as well as provide you with necessary instructions to use your benefits.

Below are steps to take in order to understand how to utilize your out-of-network behavioral health benefits. I encourage you to have something to write with and on, during your conversation. Documenting the date, representative’s name/ID# and call confirmation number (if possible) will also be helpful in case you need a follow up phone conversation or ever appeal or challenge a claim.

STEP 1

Sometimes there are different carriers for behavioral health and medical care existing under one insurance plan. For example Blue Cross Blue Shield could manage your medical benefits while Magellan Behavioral Health could oversee your behavioral or mental health benefits. Refer to the back of your insurance card to obtain the name and number of your behavioral health carrier. You will find contact information on your card. Please keep in mind that you may have to call to confirm the carrier if your insurance card does not show it.

STEP 2

Ask the benefit’s representative to explain what your out-of-network benefits are. Is there a deductible, or is there an annual visit maximum amount? They may ask for information about my location, what my discipline is and other identifying information (like my tax id and national provider identification number). They may also need to clarify your indicative data (name, address, plan number) for security reasons, so keep your card near you.

STEP 3

Ask the representative to confirm the requirements to use out-of-network benefits. For example, I require payment in full at the time of service. Your insurance company may direct you to submit payment to me, and then submit a completed Health Insurance Claim Form to the insurance company. In this case, you would receive the reimbursement check directly. It’s also important to confirm the processing time once a claim form or invoice is submitted, so you can plan accordingly. If your plan is a HMO (Health Maintenance Organization) they may have more in-depth requirements to go outside of the network, and want to pay me directly. Again, each plan is different. Take detailed notes, don’t hesitate to ask clarifying questions, and feel free to contact me for any help along the way.

Once you understand your benefit options and how to use them, we will have a conversation so that I can help you meet all the requirements. I’m happy to help you navigate through this fairly simple process, so let me know if questions arise.