UNDERSTANDING INSURANCE

ABOUT NEABPD
WHO WE ARE

National Education Alliance for Borderline Personality Disorder is a charitable organization dedicated to improving the quality of life of people with Borderline Personality Disorder by providing education, raising public awareness, decreasing stigma, and promoting research.

ABOUT THIS BROCHURE

This brochure is intended to help families understand their insurance benefits.

It includes a list of common terms used by insurance companies, how to learn more about your benefits, how to predict what you will be billed for, and more!

TERMINOLOGY

Common insurance terms defined, so you understand what you’re looking at

SCRIPTING

Step-by-step guide for contacting your insurance

PREPARATION

Feel more confident making treatment decisions

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NATIONAL EDUCATION ALLIANCE FOR BORDERLINE PERSONALITY DISORDER
WWW.NEABPD.ORG
# UNDERSTANDING INSURANCE

## TERMINOLOGY

### ALLOWED AMOUNT

This is the maximum that a provider can charge for a given service, based on their agreement with your insurance provider. This number depends on your location, your provider's level of education, and any special agreements the provider may have made with your insurance company.

### CLAIMS, DENIAL, AND APPROVAL

A claim is a document that you or your provider send to your insurer. The claim document lets the insurer know who you are, who your provider was, what service they provided (and for how long), what diagnosis they were treating with that service, and what day the service took place.

If a claim is **approved** and you have not yet met your deductible, you have to pay your provider directly, but the money you pay counts towards your deductible. If a claim is approved and you have already met your deductible (or the deductible does not apply), the insurance will pay the provider directly, minus any copay or percentage that is your responsibility. Any amount you pay will count towards your out-of-pocket max.

If your claim is **denied**, you may still have to pay the provider directly, but the money you spend will not count towards your deductible or your out-of-pocket max.

### COINSURANCE

Coinsurance is the percentage that your insurance company pays once you have met your deductible. You are responsible for the remainder until you have met your out-of-pocket max.

### COPAY

A copay is a flat fee that you pay for certain types of services, and insurance pays the rest. For example, some plans have a $50 copay for regular office visits, and $75 for specialist visits.

If your plan has copays like this, it will usually list them on the insurance card itself.

### CPT CODE

A numeric code that represents the type of service provided, and how long that service lasted. Providers and insurers use CPT codes for billing purposes, rather than typing out a detailed description of every service provided each time you meet. For example, 90837 is a psychotherapy session lasting at least 53 minutes.

### DEDUCTIBLE

Your deductible is a predetermined amount of money that you have to spend on healthcare in a given plan year before the insurance will pay for services. Deductibles are usually large round numbers, like $1,500 or $3,000. All of your in-network spending should count towards the deductible, if the claims are approved.
"DEDUCTIBLE APPLIES" VS. "DEDUCTIBLE DOES NOT APPLY."
Certain visits are always covered by insurance, even if you have not met your deductible yet. For example, annual wellness screenings are typically covered in full. If the deductible applies, it means you will have to pay the provider directly in full until you have met your deductible, and then the insurance will begin to cover a portion. If the deductible does not apply, your insurance will pay for a portion (or all) of the service right away.

DIAGNOSTIC CODE
Every diagnosis has a code, just like every provider has an NPI and every service has a CPT code. Insurers require that any claim or superbill includes a diagnostic code that justifies the service provided. For example, someone must have a mental health diagnosis in order to be covered for a psychotherapy service.

IN-NETWORK (INN) VS. OUT-OF-NETWORK (OON)
An insurance company's "network" is comprised of providers who have signed an agreement with the insurance company. Providers who have signed this agreement are considered "in-network." Providers who are not "in-network" with your insurance company are considered "out-of-network."
Some plans include both INN benefits and OON benefits, meaning you can still be reimbursed for care given by an OON provider. Other health insurance plans only have INN benefits.
If your plan has OON benefits, be aware that they are usually separate from INN benefits. The money you spend in-network does not apply to your out-of-network deductible, and vice versa.

LEVEL OF CARE
This term refers to how much care is needed to sustain or improve someone's health. In the mental health field, the most common levels of care are:
Outpatient: you visit the provider's office less than twice a week
Intensive Outpatient (IOP): usually 3+ days a week for a few hours a day
Partial Hospitalization (PHP): 5 days a week but the patient continues to live at home
Inpatient: short-term hospitalization for a mental health crisis. Inpatient units are monitored by staff 24/7, typically locked, and may include patients who are there involuntarily. Inpatient hospitalization can last as short as one night, or up to a few months, depending on what state you live in and what services are available
Residential: long-term treatment where the patient lives in a facility. Residential facilities do not have the same level of monitoring/security as inpatient, and are not equipped to handle acute crises.

MEDICAL NECESSITY
For every treatment or service a provider gives, they must be able to explain why it was medically necessary for that patient. This is often the case for higher levels of care, expensive medications, or long-term treatment. Insurance may deny claims that fall outside of typical patterns of use until the provider appeals on the grounds of medical necessity.
## TERMINOLOGY

| **NPI NUMBER** | All healthcare providers have a National Provider Identification number. Similar to a Social Security Number, the NPI is used to identify providers numerically. Insurers use this number to find your provider in their database. |
| **PLAN YEAR** | Your deductible and other costs are calculated according to your "plan year." Most plan years run from January 1 to December 31, but this is not a guarantee. When the plan year renews, your deductible and out-of-pocket costs refresh as well. |
| **OUT-OF-POCKET MAX** | Out-of-pocket max is the most you can be asked to pay for in-network, approved care during that plan year. |
| **PATIENT ADVOCATE** | Someone whose job is to help you navigate and understand your healthcare. They can act as a "translator" between you and a complicated health system, speaking to providers on your behalf, helping you identify available resources, and/or understand your benefits. Patient advocates are employed at hospitals and insurance companies. |
| **PRIOR AUTHORIZATION** | Some treatments are only covered if the insurance company approves in advance. This process typically involves your provider contacting your insurance to explain why the treatment is medically necessary. If the treatment is provided without this prior authorization, the insurance will not cover it. |
| **SUPERBILL** | A superbill is like a combination between a claim form and a receipt. It is most often used to get reimbursement for out-of-network care. When you see an out-of-network provider, you pay them directly for their services. The provider then gives you a superbill which has all the same information as a claim form, and also confirms you have already paid. You then submit the superbill to your insurance directly (there is usually an option to do this online through the member portal). From there, your insurer will either apply the amount spent to your OON deductible, or provide you with a partial reimbursement. |
FINDING INFORMATION

DISCLAIMER:
These questions listed here are a guideline, but each health insurance plan has its own nuances, and each individual's situation is different. Not every question listed will be relevant to every situation.

WHERE TO GET INFORMATION
Most plans have an online portal. The portal will contain information about what claims have been filed on the patient’s behalf, progress towards deductible, and any other resources available through the insurance plan (such as health coaching, educational pamphlets, or a patient advocate).

The portal should also contain a link to your entire plan details (not just the overview), although that document may be very lengthy and difficult to understand if you do not have a background in medicine.

It is often easier to call your insurance company directly. There should be a “Patient Access” or “Customer Service” number on your insurance card. When you call, make sure you have something to write with handy so you can take down any necessary details.

QUESTIONS YOU MAY WANT TO ASK
What is the deductible for my plan? How much of the deductible has already been met / how much remains?

Do I have out-of-network benefits? If so, what is the deductible? What is the coinsurance once the deductible has been met?

I / my family member has been recommended for a higher level of care (IOP, PHP, etc). Do we need prior authorization for this service? If so, who should my provider contact? Are there any facilities at this level of care near me that are in-network?

What is the copay or coinsurance for this level of care? Does the deductible apply? If the deductible applies, what is the allowed amount for this level of care by this provider / this facility? (This will help you estimate how much you will pay for each office visit or day of treatment until your deductible has been met)

Is there any limit on the number of psychotherapy sessions (or days at a higher level of care) covered by this plan? If so, can this be appealed if the services are still medically necessary? How?

Are psychotherapy sessions limited to a certain duration (i.e. 45 minutes vs 60 minutes)?

I have reached out to the in-network providers in my area and they are not taking new clients / they do not specialize in my diagnosis. I would like to see an out-of-network provider at in-network rates. Is this possible, and if so, what documentation is required and where do I send it?

Always get the call reference number and the name of the person you spoke to before you hang up. This will be helpful in filing an appeal if your claim is denied, or following up on previous calls.
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PLANNING GUIDE

DISCLAIMER:
The number presented here are examples for educational purposes only. Your actual costs will depend on the specifics of your plan, the provider you see, and many other variables. Only your insurance company can verify your plan details.

SAMPLE PLAN DETAILS

In-network deductible: $1,000
Office visit copay: $50
Coinsurance: 90%

Out-of-network deductible: $2,000
Out-of-network coinsurance: 50%

EQUATIONS

Deductible / allowed amount = number of sessions until I meet my deductible.

coinsurance*allowed amount = how much insurance pays after deductible is met

SCENARIO ONE: IN-NETWORK PROVIDER WITH COPAY

1: Find a provider who is in-network. Confirm CPT codes used by provider (if possible)
2: Insurer verifies that the deductible does not apply for those CPT codes, and those are copay visits
3: Insurer verifies you have a standard office visit copay of $50.
4: Every time you visit your provider, you will pay $50. If you reach your out-of-pocket max, you pay $0.

SCENARIO TWO: IN-NETWORK PROVIDER WITH DEDUCTIBLE

1: Find a provider who is in-network. Confirm CPT codes used by provider (if possible)
2: Insurer verifies that deductible does apply for these services.
3: Ask insurer what the allowed amount (or contracted rate) is for [CPT code] billed by [NPI if you have it, or provider name & education level].
4: Insurer verifies the allowed amount for that CPT code is $100.
5: You will pay $100 per visit until you meet the deductible. Remember that all approved in-network spending counts towards the deductible, even if you see multiple providers.
6: In ten sessions (or fewer), you have met your deductible. After that, you pay $10 per session until you reach your out-of-pocket max, and then you pay $0

SCENARIO THREE: OUT-OF-NETWORK PROVIDER

1: Find a provider who is out-of-network. Session rate is $200
2: Insurer verifies out-of-network benefits (with/without) the need for prior authorization.
3: Ask insurer what the allowed amount is for [CPT code] billed by [NPI if you have it, or provider education level].
4: Insurer verifies the allowed amount for that CPT code billed by that provider is $100.
5: You will pay $200 per visit directly to the out-of-network provider.
6: Provider gives you a superbill, which you submit to insurance.
7: Insurance counts $100 (the allowed amount) per session towards your out-of-network deductible. The out-of-network deductible does not include the in-network spending you may have already made.
8: After 20 (or fewer) sessions, you have met your OON deductible. Your insurance will then reimburse you $50 (50% of the $100 allowed amount) per session, and your out of pocket cost will be $150 per session.