Understanding Your Out-of-Network (OON) Mental Health Benefits

As a private pay practice, I do not bill insurance directly. However, for those with **Out-of-Network (OON) benefits**, you can often get a large portion of your session fees reimbursed. This guide provides the essential steps and questions to maximize your benefits.

The Financial Process: A 4-Step Guide

1. **You Pay for the Session**
   You pay the full fee for each session at the time of service.

2. **You Receive a Superbill**
   I provide you with a detailed monthly "Superbill" containing all necessary claim codes (CPT, NPI, Tax ID).

3. **You Submit the Claim**
   You send the Superbill directly to your insurance company (usually via their online portal) to file your claim.

4. **You Get Reimbursed**
   Your insurer processes the claim and mails a reimbursement check directly to you based on your plan's coverage.

What Does "Out-of-Network" (OON) Mean?

When a provider is "out-of-network," it means they have not signed a contract with the insurance company. **PPO** and **POS** plans often include OON benefits, allowing you the flexibility to choose a specialized provider that best meets your needs. Reimbursement is typically a percentage of the "**allowed amount**" after you meet your deductible.

Hypothetical Reimbursement Example

This chart breaks down a hypothetical scenario to clarify how your final out-of-pocket cost is calculated.

Scenario Assumptions

Metric	Value
Your Session Fee	**$200.00**
Insurer's "Allowed Amount" (Rate they will pay on)	$150.00
Your Plan Coverage (Coinsurance)	80%
Your Reimbursement Calculation:	
$150.00 (Allowed Amount) × 80% (Coverage)	**$120.00**

Your Final Session Cost:
$80
($200 Fee - $120 Reimbursement)

Key Questions to Ask Your Insurer

Call the "Member Services" or "Behavioral Health" number on your card and use these questions to gather the exact financial details of your plan.

? "Do I have out-of-network mental health benefits?"

- *Key:* If the answer is no, you cannot be reimbursed.

? "What is my out-of-network deductible, and how much have I met?"

- *Key:* This is the amount you must pay out-of-pocket before your plan coverage begins.

? "What percentage of the 'allowed amount' does my plan cover?"

- *Key:* This percentage (e.g., 60%, 80%) is what they will reimburse you for each claim.

? "What is the 'allowed amount' for CPT codes 90834 and 90837?"

- *Key:* This rate is the maximum fee they base their reimbursement percentage on. (90834 = 45min, 90837 = 60min).

? "Is there a limit on the number of sessions allowed per year?"

- *Key:* Check for an annual cap on covered visits.

? "Do I need a referral or any prior authorization (pre-certification)?"

- *Key:* Some plans require this paperwork before your first session can be covered.

A Final Important Note: I encourage you to verify your benefits directly with your insurer. Understanding your benefits upfront ensures there are no surprises and allows you to budget confidently for the valuable therapeutic work.