**In-network & Out-of-network services**

Insurance companies will only approve your mental health benefit if you have a medical necessity to receive them. They will need to receive information regarding the diagnosis, treatment plan, functioning, and ongoing medical needs of the client throughout your service. You will need to consent to this access if you desire to use your mental health benefits through your insurance company. If I am an in-network provider (preapproved provider on their panel) your insurance, I bill them for the service directly and you pay any applicable deductibles at the time of service. I am also happy to provide you with a "superbill" (just a fancy word for an invoice with medical diagnosis) for you to submit to your insurance company for out-of-network (meaning that I am not a provider on their panel) reimbursement. This process usually is more private and does not require a treatment plan and regular follow up to the insurance about your progress. Depending on your out-of-network insurance coverage and benefits, your sessions may be covered in part or in full. Also, some insurance companies do not reimburse for out-of-network services. It is up to the insurance company to decide what this coverage will look like.

**How to know what is best for you?**

I recommend that you contact your insurance company via the number listed on your insurance card to find out more about your out-of-network/in-network benefits. If I am on their panel as in-network provider, but you do not want to use your insurance benefits for your therapy services, you must sign a waiver of insurance for therapy services with me as your provider in order to begin treatment. You can change this at any time; however, past therapy sessions cannot be reimbursed to you as you waived the use of insurance coverage.

**What to ask your insurance company?**

Here are some questions that may helpful in determining benefits and eligibility:

~Does my health insurance benefit cover individual (or service needed) mental heath therapy?

~If so, is Kathleen Romeiro, LCSW #20129 a provider in-network for this company?

~Do I have a deductible due before coverage begins? If so, how much is it and how much has been applied to it so far this year?

~Do I have a copayment, and if so, what amount is it for the service that I am requesting?

~Is there a limit on the number of sessions that are eligible for coverage in a given year? If so, how many sessions are eligible for coverage?
~How much does my benefit reimburse for out-of-network counseling sessions?
~Where do I send my out-of-network claims to in order to be reimbursed for services that I have paid?

**How do deductibles Work?**
To understand how deductibles work, here is an example of a person named John. John has a $500 deductible. Before John's insurance pays 100% of some services, John will have to pay $500 from his own pocket.
FIRST MEDICAL VISIT: John must pay $100 for x-rays. He still has $400 left in his deductible.
SECOND MEDICAL VISIT: John pays a $20 copay (this doesn't apply to his deductible).
THIRD MEDICAL VISIT: John gets blood taken for tests and pays $125.
FOURTH MEDICAL VISIT: John has an emergency and pays $275 at the ER. DEDUCTIBLE IS NOW ZERO.
When John pays all of his deductible, certain services will now be covered at 100%. For example,
if he has to get another x-ray he would not pay for it.

**How do Out-of-Pocket Maximums Work?**
Each insurance plan has an out-of-pocket maximum—a limit to how much you have to pay for health care in a year. After you reach the maximum, you don't have to pay that part of the costs anymore. The example below can help you understand better.
BEFORE FIRST EXPENSE: At the beginning of the year, John has spent zero towards his $1,000 out-of-pocket maximum.
FIRST MEDICAL VISIT: John must pay $100 for x-rays.
SECOND MEDICAL VISIT: John pays a $20 copay.
THIRD MEDICAL VISIT: John gets blood taken for tests and pays $125.
FOURTH MEDICAL VISIT: John has an emergency and pays $275 at the ER.
FIFTH MEDICAL VISIT: John is admitted to the hospital. His bills total over $10,000, but he only pays $480 of it because he has reached his $1,000 out-of-pocket maximum.