Therapy® B&YOND

Insurance Reference for Parents and Caregivers

What is Health Insurance?

We want to help parents and caregivers

At Therapy and Beyond, we want to make it easier to understand how to use your health insurance to pay for ABA therapy for your child. We understand navigating health insurance coverage can be confusing and we hope this guide can be a useful tool for parents and caregivers.

What does health insurance do?

Health insurance is designed to help you and your family cover the cost of your medical expenses if you get sick, injured, or have an ongoing medical condition, just like auto insurance covers your car if you get into an accident. Health insurance includes several different terms we'll go over: monthly premium, deductible, coinsurance, copayment and out-of-pocket maximum.

Here's an example

Consider this example as we learn more about these health insurance terms in the next pages.

- $500 monthly premium
- $30,000 medical bill
- $3,000 deductible
- 20% coinsurance
- $50 copayment
- $5,000 out-of-pocket maximum

Out-of-Pocket Expenses

Let’s learn more about health insurance terms

What is a premium?

A premium is the specific amount you are responsible for paying each month whether or not you use any medical services. This amount has to be paid each month, or your insurance could get canceled - similar to not paying your cable bill. You can also look at it like a piggy bank - you chip in every month, even if you don’t need it, and that money is there when you do need it! Life happens, and that’s when insurance really comes in handy!

In addition to the monthly premium, your plan will likely have you pay a portion of your medical expenses using your own money. These out-of-pocket costs may include a deductible, copayment, and/or coinsurance.

Section Highlights

Premium

Deductible

Copayment

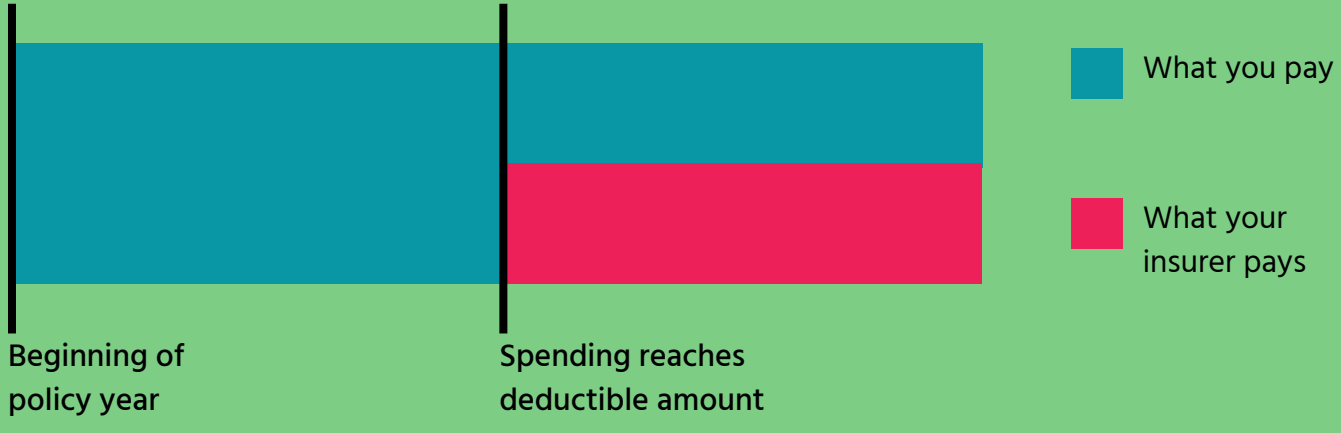
Coinsurance

Out-of-Pocket Maximum

What is a deductible?

A deductible is the amount of money you pay for your health care expenses before your health insurance starts covering some of your costs. In the previous example, your deductible is $3,000, and your health insurance will not pay any of your health care costs until you have paid your entire deductible. So, if you have a $30,000 medical bill, you'll be required to pay your $3,000 deductible. The remaining $27,000 will be split between you and your health insurance provider. Once the insurance company is paying part of the costs, your portion is called the copay, if it is a flat dollar amount. It is called coinsurance if it is a percentage.

Keep in mind that your plan may have a **family deductible** in addition to **individual deductibles** for each family member. Individual deductibles are lower than the family deductible. Once an individual hits their individual deductible, their health insurance plan kicks in just for them. But once the family deductible is met, health insurance kicks in for every member of the family, regardless of whether or not an individual has reached their deductible.



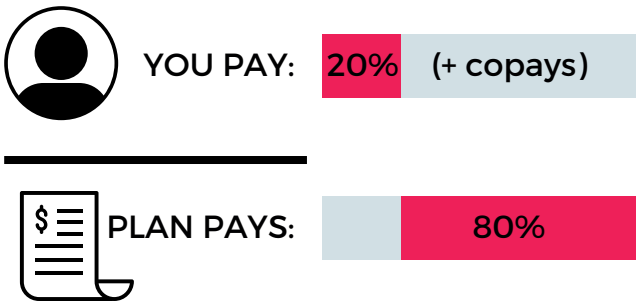
Copayment

A copayment is a flat fee that you pay for a covered service with the insurance company paying the remainder of the cost. This copay can be paid either before or after you've hit your deductible. If your copayment is $50 on a doctor's visit, you could pay $50 for each visit until you reach your out-of-pocket maximum. For example, you may pay $50 for a doctor's visit that would typically cost $150 if you didn't have a copay plan; you pay $50 and your insurance plan will cover the remaining $100. Some plans do not offer copay plans, and instead, all monies paid go towards the annual deductible.

Coinsurance

Coinsurance is a percentage of the cost that you must pay after your deductible is met. In the previous example, your plan has a 20% coinsurance. If your medical expense is $30,000, you would only be responsible for 20% ($6,000) and your insurance would cover the remaining $24,000. This cost sharing ends when you reach your out-of-pocket maximum.

20% Coinsurance



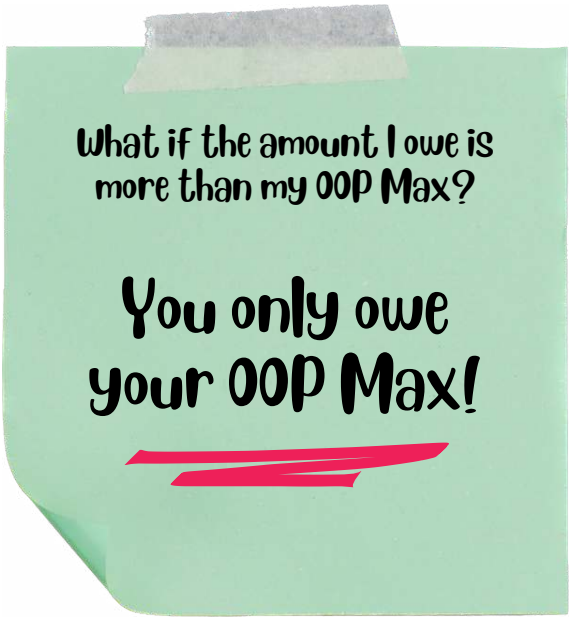
How do I know if I have a copayment or coinsurance?

There are many, many health insurance plans, all of them different. Oftentimes there is copayment and coinsurance information on your health insurance card. You can find other plan information here as well, such as your plan ID and deductible amounts.

If you are still unsure, it would be best to reach out to your health insurance provider to get more information. You can usually find a customer service phone number on your health insurance card, or you can head to your provider's website.

What is an out-of-pocket maximum (OOP Max)?

Unexpected health care costs can add up quickly, but luckily each insurance plan comes with a safety net called the out-of-pocket maximum. This is the most you'll have to pay for in-network services in a plan year. If your medical bill exceeds this amount, your insurance plan will cover 100% for the rest of the year. Deductibles, copayments, and coinsurance go toward your out-of-pocket limit; monthly premiums do not count toward this amount. Remember, your deductible and out-of-pocket maximum resets every year when your policy renews, generally on January 1st.



OOP Max Example

$30,000 medical bill
$3,000 deductible
20% coinsurance
$5,000 out-of-pocket maximum

Let's say you have a medical need that costs $30,000.

You're required to pay your $3,000 deductible.

Your 20% coinsurance on the rest of the costs ($27,000) comes to $5,400. That makes your total cost $8,400.

That's $3,000 (your deductible) plus $5,400 (coinsurance).

But your out-of-pocket maximum is $5,000, which means your insurance company pays all covered costs above $5,000 for this medical expense and any covered care you get for the rest of the year.

Because of this, you only pay $5,000.

ABA Coverage and More

How does this fit into ABA therapy?

In-network vs out-of-network care

A provider network is a list of doctors that are connected to your plan. Insurance companies negotiate discounts with these providers, and they then become in-network. If you choose an in-network provider, discounts get passed down to you. If you choose out-of-network, you could end up paying more, and your out-of-pocket limit does not apply. When a provider says, “Yes, we take your insurance,” this doesn’t necessarily mean they are “in-network.”

HMOs

HMOs are the most restrictive type of insurance and out-of-network providers are not covered. If you have an HMO plan, you’ll be asked to choose a primary care physician (PCP) that is in-network, and this PCP will coordinate all your care.

PPOs

PPOs are the least restrictive. Your insurance will cover you no matter where you go, but you’ll pay more if you go out-of-network. Typically you have the option between choosing to see an in-network doctor at a lower cost or an out-of-network doctor at a higher cost.

Section Highlights

Provider Networks

HMO vs PPO

Referrals

Secondary Coverage

Authorized Hours

Other Important Terms

What is a referral?

Some insurance plans require a referral from your primary care physician (PCP) in order for you to see a specialist, such as an ABA provider or a diagnosing physician (see below). This is different than a diagnosis and is needed before an evaluation can be scheduled.

What is a specialist?

A specialist focuses on a specific area of medicine or a group of patients to diagnose, manage, prevent, or treat certain types of symptoms and conditions. Some examples of a specialist would be a diagnostician, a heart surgeon, a Board Certified Behavior Analyst, etc.

Why is coordination of care important?

Deliberately organizing patient care activities and sharing information among all of the participants concerned with a patient's care helps achieve safer and more effective care. At Therapy and Beyond, COLLABORATION IS KEY to your family's success.

Other Important Terms

What is open enrollment?

open enrollment is a period during which you may freely enroll in or change your health insurance plan. There are also qualifying events in which you can change your insurance plan, such as getting married, having a baby, or losing health coverage elsewhere. Changing your insurance during this time is considered a Special Enrollment Period.

Primary vs Secondary coverage

Primary health insurance is the plan that kicks in first, paying the claim as if it were the only source of health coverage. The secondary insurance plan picks up some (or all) of the costs leftover after the primary plan has paid the claim.

What is a patient responsibility balance?

Any balance due after insurance has covered its portion is the responsbility of the patient.

Other Important Terms

What is a peer review?

A peer review is a review with your insurance company and provider discussing your child's progress and future goals for learning. Peer reviews are important in order to obtain initial treatment or continue treatment.

Can I file an appeal?

Sometimes after a peer review, your ABA treatment or other services may be denied by your insurance provider. If this happens, you can request that the decision in your case be looked at again.

What are authorized hours?

These are the number of hours your insurance provider will authorize for certain services, like ABA therapy. If you disagree with the amount of hours authorized, you may file an appeal.

Understanding Your Insurance Benefits

Our billing team is here to help you with the following:

- Verification of your insurance benefits to determine your actual costs according to your family's insurance policy.
- Provision of a Payment Plan that includes an estimated monthly patient financial responsibility based on the information obtained from your insurance company.
- Processing of claims and direct communication with your insurance provider.

Please Note:
ABA therapy is defined as a medical treatment, and therefore a medical file must be maintained with documented diagnoses and assessment reports. Although initially gathering all the documentation can be tiring, it is required before services can start and will protect you from future coverage and treatment challenges that could arise years later. Even if your child is receiving the treatment as a behavioral intervention, and we are not billing insurance, Therapy and Beyond is a medical practice, and we are required to maintain medical files for all patients.

What is a Payment Plan?

In order to make treatment more affordable, Therapy and Beyond will create a Payment Plan based on the benefit information received from your insurance company. We will spread the amount due over convenient monthly payments.

WHAT BENEFIT INFORMATION DOES THERAPY AND BEYOND RECEIVE FROM THE INSURANCE COMPANY?

We obtain the effective date of the policy, deductible, copay, coinsurance, and out-of-pocket maximum information.

HOW DOES THE INFORMATION FROM THE INSURANCE COMPANY TURN INTO A PAYMENT PLAN?

Based on the services that you select for your child, we will then take the information from your insurance company and create a monthly Payment Plan.

WHAT IS THE DURATION OF THE PAYMENT PLAN?

The Payment Plan is for 12 months or the number of months remaining based on when your child starts services. For example, if your child starts services in April, your Payment Plan will pay for the months your child receives services; April - January. Since our team verifies benefits throughout the month of January, our billing year begins in February and ends on January of the following year.

Example: Your child starts services in April, and there is a $1,000 deductible that your insurance company requires you to pay. For your convenience, a Payment Plan will be created for you for the deductible of $1,000 with a payment due each month from April through January.

WHAT HAPPENS IF SERVICES ARE TERMINATED PRIOR TO DECEMBER?

If the entire $1,000 deductible was applied to our claim by your payer, you will still have a balance due that will need to be paid. For example, if services are terminated at the end of October, there would still be a balance due of $300 (payments for November, December and January).

WHAT HAPPENS TO MY SERVICE DEPOSIT?

If there is still a balance due, as in the example above, we would apply the $250 service deposit to the outstanding balance of $300, which would leave a balance due of $50.

WHAT IF I DON'T HAVE A DEDUCTIBLE BUT A COPAY?

In this case, we would take the number of visits per week and multiply it by the copay amount to create the Payment Plan. If the estimated deductibles for the year are above the out-of-pocket maximum, then the out-of-pocket maximum is used and divided over the number of payments.

Example: John is being seen 5 days per week and has a $25 copay for each visit. The copay totals $125 per week.

WILL MY PAYMENT PLAN REMAIN THE SAME?

This will depend on how your insurance company processes your claims. The Payment Plan is an estimate based on the information received from your insurance company. If the claims are processed differently from the benefit verification information received, your Payment Plan amount can change and may increase or decrease.

Other Payment Questions

We understand payment and insurance can be confusing, so here are a few more common questions we receive. Is there something else you need to know? Contact us at billing@therapyandbeyond.com.

IF MORE THAN ONE FAMILY MEMBER IS COVERED ON MY PLAN, DO MY PAYMENTS AUTOMATICALLY DEFER TO THE FAMILY OOP MAX FOR ABA SERVICES?

Due to the costs of ABA, deferment to the family out-of-pocket maximum is becoming more and more common. Check with your insurance provider for more details.

IS THERE A BENEFIT MAXIMUM FOR ABA, SPEECH, AND/OR OCCUPATIONAL THERAPIES?

This may vary across insurance companies, so it's best to check with your insurance provider. For example, a plan may cover up to $50k of ABA. After insurance has paid that much to the provider, they will no longer cover the service for the year. This can also apply to speech and occupational therapies.

CAN I ESTIMATE HOW MUCH MY PAYMENT WILL BE ANNUALLY?

For a payment estimate, we recommend you use the out-of-pocket maximum amount (individual or family depending), and divide that amount by 12. This will give you an estimate of costs we anticipate for Therapy and Beyond. From there, consider the cost of the monthly premium. If that monthly premium is high to keep the out-of-pocket maximum low, you may encounter a larger financial burden.

IS MY DEDUCTIBLE/COPAY/COINSURANCE INCLUDED IN MY OUT-OF-POCKET MAXIMUM?

In most insurance plans, these are included in your out-of-pocket maximum. We always recommend checking with your insurance provider for specific details.