Understanding Your Out-of-Network Reimbursement

A guide from [Practice Name] to help you navigate submitting for insurance reimbursement

Because our practice is private-pay, you're paying for services directly and, if your insurance plan includes out-of-network mental health benefits, submitting a document called a superbill to your insurer for possible reimbursement. This process can feel confusing, so here's a plain-language walkthrough of how it works, what affects your reimbursement amount, and what to do if something looks off.

What Is a Superbill?

A superbill is an itemized receipt we provide after each session. It includes your diagnosis code, the procedure code for the service (for example, a 45-minute individual therapy session), the date of service, and the fee charged. It is not a bill from us to your insurer, it's a document you submit yourself, so your insurer can consider reimbursing you directly for care you've already paid for.

How the Reimbursement Process Works

1. Check your out-of-network benefits. Call the member services number on your insurance card and ask specifically about your "out-of-network outpatient mental health" benefit, your out-of-network deductible, and your coinsurance percentage after that deductible is met.
2. Request your superbill. We provide this after each session, or on a schedule you prefer (weekly or monthly), so you can submit as you go rather than all at once.
3. Submit the superbill to your insurer. Most insurers accept these through an online member portal, a mobile app, or by mail. Keep a copy for your own records.
4. Your insurer reviews the claim. They apply your deductible, calculate their "allowed amount" for the service, and issue payment (usually directly to you) for the covered portion.
5. You receive an Explanation of Benefits (EOB). This document shows what was billed, what your insurer allowed, what they paid, and what you're responsible for. It is not a bill, it's a summary of how the claim was processed.

What Affects Your Reimbursement Amount

Several factors determine how much you'll actually get back, and they can vary significantly even between people on the exact same insurance plan:

- Your deductible. Nothing is typically reimbursed until you've met your plan's out-of-network deductible for the year.
- Your insurer's "allowed amount." Insurers set their own benchmark for what a service is "worth," and that benchmark, not our fee, is usually the basis for reimbursement.

- Your coinsurance. After your deductible is met, you're typically reimbursed a percentage (often 50 to 80 percent) of the allowed amount, not the full fee.
- Plan design. Some plans have generous out-of-network mental health benefits; others have very limited ones, even under the same insurance carrier.

A Note on Your Rights Under Federal Law

Federal mental health parity law generally requires insurers to treat out-of-network mental health reimbursement no less favorably than they treat comparable out-of-network medical or surgical care. In practice, this means the way your insurer calculates reimbursement for a therapy session should be consistent with how it calculates reimbursement for other out-of-network specialty care, not stricter or less generous simply because the service is mental health related. This is a general legal protection, not a guarantee of a specific dollar amount, and the details can be complex.

If Your Reimbursement Seems Low or Was Denied

- Re-read your Explanation of Benefits carefully. Denials are sometimes due to a missing code or documentation issue that's easy to correct with a resubmission.
- Call member services and ask directly how the allowed amount was calculated, and whether it's consistent with allowed amounts for comparable out-of-network medical specialists on your plan.
- Ask about your right to appeal. Most plans have a formal appeals process, and persistence sometimes changes the outcome.
- If you believe your plan is treating mental health claims less favorably than medical claims, you can contact the U.S. Department of Labor's Employee Benefits Security Administration, which handles mental health parity complaints for many plans.
- Let us know if this happens. While we can't act as your billing advocate or negotiate with your insurer on your behalf, we're glad to answer questions about your superbill or point you toward additional resources.

Questions?

Reach out to [Practice Name] at [phone/email] any time you have a question about your superbill or the reimbursement process. We want the financial side of your care to feel as clear and manageable as the clinical side.

This handout is for general educational purposes only and is not legal, financial, or insurance advice. Reimbursement amounts, deductibles, and coverage terms are determined by your specific insurance plan; contact your insurer directly for details about your coverage. Consult an attorney for guidance on a specific parity concern.