

CONNECTICUT
INSURANCE
DEPARTMENT

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CONSUMER TOOLKIT

**Navigating Behavioral Health & Substance
Abuse Care with Your Insurance Plan**

What consumers need to know about seeking
approval for behavioral health services.

 **860.297.3900**

www.ct.gov/cid

Connecticut Insurance Department

This consumer toolkit is your guide to helping you make informed healthcare choices. Inside you'll find a glossary of health insurance terms and helpful information to ensure you ask the right questions to your insurer and provider, getting the approved care you need through your health plan.



Research First

Contact your insurer for assistance in choosing the right provider.

In-network providers offer pre-negotiated rates for optimal cost savings.

Discover the benefits of selecting an in-network provider in this toolkit.



Know Your Plan

Check to see what kinds of care are covered under your plan and if you have coverage for out-of-network providers.

Check to see what kinds of care need pre-authorization. Your health insurer may want to approve certain kinds of care ahead of time.



Pre-Authorization for Services

Your health insurer may require confirmation from your doctor regarding the medical necessity of the requested care.

This Toolkit provides valuable insights on navigating the pre-authorization process for services.



Out-of-Pocket Expenses

Typically, you pay a portion of the cost of care out of your own pocket. Opting for an out-of-network provider often results in higher costs for you.

The Toolkit will help you compare the cost of care for both in-network and out-of-network providers.



Informed Decisions

The Connecticut Insurance Department wants you to have the facts and information you need before you make choices on behavioral health and substance abuse care.



Tips for Consumers

- Consult your provider for treatment recommendations and, if necessary, seek referrals to relevant service providers.
- Contact your health insurer to find available behavioral health and substance abuse providers.
- Opt for in-network providers. It costs less and they will also initiate the pre-authorization process for you.
- Have services approved in advance.



Note: Self-insured plans and out-of-state health plans are not regulated by the Connecticut Insurance Department. If you have a large employer plan or an out-of-state plan, please consult your employer for plan-specific details.

Terminology Glossary

Allowed Amount: Maximum amount a plan will pay for a covered health care service.

Balance Billing: Amount that a provider bills you for the difference between the provider's charge and the allowed amount.

Coinsurance: Percentage of the cost that you pay for a covered health care service, after you've paid your deductible.

Copayment: Fixed amount you pay for a covered health care service, in some cases after you've paid your deductible.

Cost Sharing: Your out-of-pocket expenses for covered services. This includes deductibles, coinsurance, copayments, and similar charges.

Deductible: Amount you pay for covered health care services before your health plan begins to pay.

Medically Necessary: Health care services or supplies needed to diagnose or treat an illness, injury, condition, disease, or its symptoms and that meet accepted standards of medicine.

Pre-Authorization: A decision by your health insurer that a health care service, treatment plan, prescription drug or durable medical equipment is medically necessary. Your plan may require pre-authorization for certain services before you receive them.



Research First

Consider using in-network providers whenever possible. Utilizing in-network providers gives you greater protection under your health plan.

In-Network Advantages

- In-network facilities are contracted with the health insurer to provide approved services under your plan.
- In-network providers are required to process the insurance paperwork for pre-authorizations and submit claims for you to the health plan.
- In-network providers are prohibited from billing for any charges other than your copayments, deductibles, or coinsurance under the plan.
- In-network providers agree to accept pre-negotiated rates from the health insurer.

Choosing a Facility

- Discuss treatment options with your health insurer and treating provider. Ask them for a list of in-network facilities in your area.
- If using an out-of-network facility, ask for their help in obtaining your health insurer's approval prior to treatment. You may also ask for assistance in submitting claims and filing appeals with your health insurer.



What is an In-Network Provider?

In-network providers have agreed to a reimbursement rate with the health insurer. In-network providers cannot bill you for more than this rate except for your copayment, deductible, or, coinsurance amounts.

What is an Out-of-Network Provider?

Out of network providers have not agreed on a reimbursement rate with the health insurer. They can bill you for the difference between their billed charges and the insurer's allowed amount. This is called balance billing.

Considerations

- Out-of-network providers and facilities may not be willing to request pre-authorization for services or advocate on your behalf.
- Out-of-network providers and facilities are not required to submit claims for you.
- Out-of-network providers and facilities can ask you to personally guarantee payment for service before they treat you as a patient.
- Out-of-network providers and facilities are not limited in what they may charge you. You may be balanced billed for the remaining provider charges after the health insurer pays its portion.



Know Your Plan

Always contact your health insurer to verify your plan's coverage details. You can also refer to your policy or certificate of coverage for more information.

Plan Features

Out-of-Network Provider Costs

Using out-of-network providers results in higher cost shares for services, including copayments, deductibles, and coinsurance. Additionally, you may be billed by the provider for amounts that exceed your plan's allowed limit, which can be significant.

Out-of-Network Providers

Verify your plan's out-of-network benefits. If not available, choose an in-network provider or seek approval for an in-network exception to see an out-of-network provider.

Out-of-Network Requirements

Before choosing an out-of-network facility, contact your health insurer to ensure the facility meets your plan's licensing requirements. Your insurer will gather information about their medical license and treatments they provide.



Pre-Authorization

Pre-Authorization Services

Review your coverage certificate for services that require pre-authorization. If needed, have your provider seek approval from your health insurer.

In-Network Exception

For out-of-network services, request an in-network exception from your insurer. Approved exceptions cover services at in-network cost shares when you have the need for specialty care or no in-network providers are available. Pre-submission may be required by some insurers.

Out-of-Network Pre-Authorizations

When you pre-authorize services using an out-of-network provider, you will be responsible for out-of-network cost shares unless you submit an in-network exception request and are approved by your insurer.



Medical Necessity Approval

Some services require prior authorization from your insurer to ensure they are medically necessary. Contact your insurer or review your policy to verify which services require pre-approval before receiving those services.



Pre-Authorization & Medical Necessity

Pre-authorization is a process to confirm that your health insurer's guidelines for medical necessity are met before getting services. Your treating provider's participation is important.

- Your health insurer may need to discuss your medical records, symptoms, duration, and current management with your provider.
- If your out-of-network provider doesn't help with pre-authorization, you must submit the information to your health insurer.
- Having assistance from a healthcare professional who can provide clinical background and treatment records is crucial to demonstrate medical necessity.

Appealing Medical Necessity Denials

You have the right to appeal if your health insurer denies your services. The denial letter from your insurer provides detailed information on the appeal process, including where to send your appeal request.

- Make sure to carefully read the letter to understand the time limit for filing your appeal. This includes information on how to file an appeal and where the appeal request should be sent.
- If you have exhausted all available appeals with your insurer or have an urgent request, you can seek an independent review through the State of Connecticut External Review Program.
- For questions on filing an appeal or applying for an External Review, contact your health insurer or the Connecticut Insurance Department.





Out-of-Pocket Expenses

Before proceeding with out-of-network services, it is important to understand all your out-of-pocket expenses prior to services being incurred.

- If you choose to use an out-of-network facility, ask your health insurer to determine if the facility meets the licensing requirements for the services you need. If not, the services will not be reimbursable under your plan.
- Ask your health insurer what your out-of-pocket cost shares are when using out-of-network providers. These will include any copayment, deductible, coinsurance, and the billed charges that exceed the allowed amount set by your plan.
- Call your health insurer to be sure that your plan offers the option to use out-of-network providers.
- Be sure to ask the health insurer how they determine the allowed amount paid to out-of-network providers and facilities. Health plans use different methods for setting out-of-network reimbursements. Verify this information ahead of time.
- Be aware that out-of-network charges that exceed the allowed amount set by your health insurer are your responsibility.

For Assistance

Please contact the Insurance Department for any information that you may need so that you have all the facts to make informed healthcare decisions.



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