**Patient Guide for Insurance Basics: What you Need to Know**

Insurance can be confusing. Please use this guide below as a tool to better understand your insurance plan. \*Verification of benefits/eligibility through your insurance is an estimation. Ultimately, if your insurance company processes a claim differently than what is stated in the verification of benefits, you are still responsible for the invoice. Please check with your insurance company to understand your benefits. \*

1. How do I know if my insurance plan is accepted?
   1. We accept Harvard Pilgrim, Blue Cross Blue Shield, Aetna, Tricare Humana Military, MassHealth (MassHealth Standard, MassHealth CommonHealth, and MassHealth Family Assistance), and United HealthCare ONLY if administered by Harvard Pilgrim.
2. Do you accept out of network insurance plans?
   1. At this time Extra Steps does NOT accept out of network insurance plans.
3. Do you supply super bills?
   1. At this time Extra Steps does NOT give out superbills. We are prohibited from doing so because our NPI number is tied to commercial insurance.
4. How do you determine coverage for my child?
   1. We verify your coverage with your insurance company before your treatment begins. **Please note:** When we verify your insurance coverage, it is only a quote, not a guarantee that your provider will pay. We encourage you to call your insurance company to determine the exact benefits your plan provides. To assure the highest level of coverage, please review any possible limitations and requirements your insurance plan might have. Ultimately, you are responsible for the invoice provided by Extra Steps, which is dictated by your insurance company.
5. What requirements does my insurance require?
   1. You will need to check with your insurance company directly to determine the specifics of your plan, but here are a few common requirements of insurance plans:
   2. Co-pay by the patient at the time of service
   3. Referrals from primary care physician (PCP) at the initial visit
   4. Limits for therapy visits each calendar year
   5. Pre-certifications/Prior Authorization
   6. Deductible and co-insurance obligations
6. What are visit limits?
   1. There are two types of limits:  
      - **Hard Max:** this is a set limit ex 50 per year. You cannot appeal or request more visits once this is exhausted.  
      - **Soft Max:** this is a soft limit. You can apply for more visits once yours are exhausted and most carriers will do a medical necessity review. There is no guarantee they will approve more visits.  
        
      Even if your insurance does not have a visit limit, insurance will still often only pay for 1 hour of each specialty per day, including physical, occupational, and speech therapy.
   2. DIAGNOSIS SPECIFIC Limits: Some states have legislation for a specific diagnosis to offer unlimited visits regardless of your plan. This is typically only for Autism, but it is worth asking your carrier. If this is diagnosis-specific, you will need that specific diagnosis on your prescription if this is the case.  
        
      **Out- of- Pocket Max:** An out-of-pocket maximum is a cap, or limit, on the amount of money you have to pay for covered health care services in a plan year. If you meet that limit, your health plan will pay 100% of all covered health care costs for the rest of the plan year. Some health insurance plans call this an out-of-pocket limit. Please keep in mind though visit limits STILL apply. So if you are out of visits they still will not pay. Out of network carriers will only pay 100% of their reasonable and customary charge and families will be billed the difference. If your insurance will not cover more than 1 hour of each specialty per day, you will still be billed for the additional hour of any specialty even if you have hit your out-of-pocket max.  
        
      **Prior Authorization:** Some plans require prior authorization before they will cover visits. They will often require a copy of your evaluation and care plan and will determine how many visits they deem appropriate during a specific time frame. Often this can cause delays due to the clinical reviewers needing time to review the evaluation.