Using Your Health Insurance for Mental Health Care

It is often helpful to review ‘behavioral health’ benefits (under which outpatient mental health is listed) before moving forward in the care process. Calling the member services phone number on the back of your insurance card and asking the following questions will help you to understand your ‘behavioral health benefits’.

- **Ask to be transferred to the ‘behavioral health department’** as many insurance plans separate physical health and mental health benefits.
- **What is my deductible for behavioral health?** A deductible is the amount of money your plan requires you to pay out of pocket for services before your benefits ‘kick in’.
- **What is my co-pay or co-insurance?** A co-pay is a flat fee per visit, and co-insurance is a percentage of the cost of the total visit. You will pay only your co-pay or co-insurance after you have paid down your deductible.
- **Do I have a session limit?**
- **Do I need a referral from my primary care doctor to see a therapist or psychiatrist?**
- **May I have a list of local ‘in network’ providers emailed to me?** If in network options are not available nearby, most plans offer out of network benefits (typically associated with a higher deductible and higher co-pays or co-insurance see below next steps).

*During the Covid-19 crisis, access to in person therapeutic or psychiatric services may be unavailable. Please ask your insurance carrier if ‘teletherapy’:

- Is covered and if coverage is temporary
- Is covered at the same benefits as in person behavioral health

If it appears that your only option for utilizing your health insurance plan is to access ‘out of network benefits’ the following questions should be asked:

- Can I request an ‘exception’ or ‘appeal’ be made for me due to not having ‘in network’ providers in the area I live?
- Can I qualify for a ‘student rider’ (if you are a student) or ‘temporary residence rider’ allowing me access to providers in the area I live for the cost associated with my in network benefits?

If the answer to the above questions is no, you should ask for the cost of ‘out of network care’ including deductible and co-pay or co-insurance. You will not be offered a list of providers, but can schedule an appointment with the provider of your choice. You can expect to:

- Pay in full and at the time of your visits for each session
- Request invoices from your provider stating that you have paid in full. Clarify with your provider how often you would like to receive these (some clients prefer an invoice per session, some prefer to get an invoice monthly)
- Submit your ‘paid’ invoices to your insurance company’s claims department (address should be listed on your insurance card, but clients should always call the member’s services phone number to confirm)
- Insurance Companies will send reimbursement checks directly to clients for a portion of the session cost (based on what out of network benefits cover)