

How to Determine Your Insurance Benefits

Note: Make sure you have your insurance card, date of birth, and home address and date of birth of the policy holder (the policy holder is who the plan is through, so if you are covered under a guardian, parent, or yourself) available before making the call.

Step 1: Call the behavioral health/mental health phone number that is listed on the back of the card.

- If this is not available, you'll call the customer service/member services number.
- Select the option for members.
- When prompted, select the option for benefits (You may also be asked to say what you're calling about; if this is the case, just say "benefits").
- Once the computer stops giving you general information (typically when your plan became effective and the type of plan that you are signed up for) ask for customer service.

Step 2: Once you are speaking to a customer service representative...

- Make sure you write down the name of the person with whom you are speaking and the date of your call.
- Tell the person that you are looking for outpatient mental health benefits (you can specify in office therapy, telehealth visit, or psychiatry).
- Ask them for in-network and out-of-network benefits:
 - In-network benefits are applied to services billed by an in-network provider, or a practitioner who has a contract set up with the insurance company. You are typically responsible for a copay or coinsurance, then the insurance covers the rest. This is usually your most affordable option. The insurance company can help you find someone in-network, or you can ask the therapist directly if they have a contract with your insurance company.
 - Out-of-network benefits are applied to services billed by a practitioner who does not have a contract with your insurance company. While this allows you to see any therapist you choose, you often are required to pay more. Typically, the insurance assesses a deductible and coinsurance (see below), and you may be responsible for paying the difference between the therapist's out-of-pocket rate and the insurance's "reasonable and customary rate" (for example, if the therapist charges \$100 per session and the insurance only pays \$50, you will be responsible for the remaining \$50). In most cases, you pay the therapist at the time of your appointment, then the therapist will give you a receipt to submit to your insurance company. The insurance company will process your claim and will reimburse you directly.
- Other questions that are important:
 - Is there a visit limit?
 - Is there a different rate for telehealth visits (online) vs in person visits?
 - Do you need to get a referral from your primary doctor?
 - Do you need a prior authorization to start meeting with a therapist?
 - Do you have Employee Assistance Program (EAP) benefits?
 - Does the plan run on a calendar year or a contract year?
 - Do you have a deductible and/or out of pocket maximum and how much has been met so far?

Step 3: Before completing your call, ask the representative for a reference number (this will help if you need to contact the insurance company later) with additional questions.

What is a deductible? This means that you are responsible for the contracted rate that has been negotiated between the therapist and the insurance company. Once your deductible is met, then you are responsible for a coinsurance amount, which is a percentage of the contracted amount. For example, if your deductible is \$500, the contracted amount is \$100, and the coinsurance amount is 10%, you will be responsible for \$100 per session until the deductible is met, then will be charged \$10 per session until your plan starts over at the end of the year.