

How do I use my insurance for mental health services?

Health insurance can be overwhelming and confusing for most individuals. It's important to know how to contact your insurance company and what questions to ask so you can fully understand how to use your benefits. Be aware that some insurance companies refer to these benefits as mental health benefits and others refer to them as behavioral health benefits. This document will refer to these benefits as mental health benefits.

Not everyone who has mental health benefits wants to use them. Using your mental health benefits limits your choice of mental health providers because not all providers will be in-network with insurance companies. Also, when you use benefits your mental health provider will have to report a diagnosis code to the insurance company which will stay on your record. For most individuals, this will never be a problem. Others may have work-related or other personal reasons they won't want a diagnosis reported to insurance.

If you have out-of-network mental health benefits and choose to use them, you can see any mental health provider you want. You will have to pay whatever fee they charge out-of-pocket and submit a Superbill, a type of receipt, to your insurance company. The insurance company will either apply a portion of the payment to your deductible (should you have one) or send you reimbursement for a portion of the payment. Typically insurance companies pay lower rates than the individual providers charge so you will not get all of your money back. Using your out-of-network benefits also means that the insurance company will have a diagnosis code on your record.

If you choose to use your insurance either in-network or out-of-network, the insurance company will mail an Explanation of Benefits (EOB) to the policy holder (the policy holder is the family member who carries the insurance). The Explanation of Benefits names the person who used the insurance coverage, names the provider, type of services provided and a diagnosis.

If you do not have any mental health benefits on your insurance policy or you simply don't want to use them, you can see any mental health provider that you want. When scheduling the appointment, you will likely be asked if you have insurance you'd like to use. You can simply reply that you do not have insurance that you would like to use. You will have to pay for services out-of-pocket and insurance will not have any documentation from the mental health provider. Some mental health services are quite pricey. If finances are a concern, you can look for a provider who offers a sliding-scale fee. This means that the provider may ask you some questions about your financial situation and determine if they can charge you a lower fee (called a sliding-scale fee).

The most important thing to remember when calling insurance companies to find out your mental health coverage is to ask as many questions as you need to in order to understand the policy.

To find out about your Mental Health Benefits:

1. Call the customer service number on your insurance card and follow the prompts to get a representative on the phone.
2. Ask the representative: Do I have in-network mental health benefits?
 - a. If the representative explains that you DO have in-network mental health coverage:

- i. Ask the representative to explain what your mental health coverage is and listen for:
 1. If you have a deductible and if mental health benefits apply to the deductible. This will help you figure out if you will have out-of-pocket expenses.
 2. If you will be responsible for a co-pay, specialist co-pay, or co-insurance. Some policies have a flat co-pay. A specialist co-pay is often significantly higher than a regular co-pay. Others will require you to pay a percentage of the amount due to the therapist which is called co-insurance. This means you will likely pay a different amount for different levels of licensure for clinicians (i.e. you will likely pay more for a Licensed Psychologist than you would for a Licensed Professional Counselor).
 3. You can ask for a list of in-network mental health providers in your area, OR when you are ready to search for a provider you can refer to one of the online search engines making sure you enter the insurance company that you use (i.e. www.psychologytoday.com).
- b. If the representative explains that you DO NOT have mental/behavioral health coverage:
 - i. Ask the representative if you have out-of-network mental health benefits.
 1. If you do, ask the representative if these benefits apply to any deductible you may have. If it does, you may have to pay a higher rate until your deductible is met.
 2. Ask how you submit for reimbursement. You will need to submit receipts if you have a deductible or if you don't. If you do have a deductible, every time you submit a receipt it will apply to your deductible.

Once you have received the answers to these questions, you can start looking for a mental health provider.

1. If you do have in-network mental health benefits and want to use them, refer to one of the search engines to find an in-network clinician. Then you can start calling or e-mailing clinicians to find a good fit.
2. If you DO NOT have in-network benefits and you DO have out-of-network benefits, you can see any clinician you choose and pay out-of-pocket.
 - c. When you use your out-of-network benefits, make sure the clinician knows that you are using your out-of-network benefits.
 - d. After you pay the clinician, he/she will be able to provide you with a Superbill. A Superbill is a fancy receipt that insurance companies use. It will contain a diagnosis code and a CPT code.
 - e. Submit the Superbill to your insurance as instructed.
 - f. Wait for reimbursement.

