NAVIGATING HEALTH INSURANCE

SEARCHING FOR A THERAPIST ON YOUR INSURANCE

1. Please locate your health insurance card. This will identify the insurance and plan you have.

2. Navigate to the home page of your insurance carrier and locate their behavioral health provider directory.

3. You will enter in your preferences in the search box (male, female, type of issue, and/or within what mile radius depending on how far you might be willing to drive.). Remember, the more general your search is the more providers you will find.

4. Alternatively, you can call the number on the back of your insurance card and speak with a representative who can provide you with a list of providers in your geographical region.

Once you have a narrowed down a list of providers:

1. Call the phone number of the provider you are interested in.

2. If you get a voicemail –leave your name, phone number, and let them know you are interested in making an appointment.

3. When you have the opportunity to speak with them, they may ask some of your concerns. Let them know briefly why you are interested in making an appointment (e.g. anxiety, referred/suggested by the counseling center, etc.).

4. Confirm that they take your insurance. If they do not, you can decide if you will want to see them, but you may want to ask them how much they charge per session. If this is not comfortable for you, you can proceed to contact the next provider on your list.

5. If you feel comfortable, you can set up your first appointment.

6. Keep in mind, each counselor works differently. Your first session is an opportunity to ask them questions, as well, so that you feel comfortable. Sometimes you must attend a few sessions before you feel comfortable.

7. Please do follow up to share if you made the connection with an outside referral or not.

NAVIGATING HEALTH INSURANCE

PAYING FOR THERAPY WITH IN-NETWORK INSURANCE BENEFITS

The cost of therapy varies across insurance plans, so the first thing you want to do is contact your insurance company to find out what your plan covers.

1. Locate your health insurance card and call the number on the back.
   Plan for the call to take about 15-30 minutes, and be sure to record the name of who you spoke to. Also, have something to take notes with, and ask the following questions.

2. Does my plan have behavioral health benefits?

3. What services are covered?
   Examples include 30, 45, 50, or 60 minutes sessions, individual therapy, and group therapy.

4. Is there a limit on how many sessions my plan will cover per year? If Yes, How many? What happens if I need more?

5. Do I need a prior authorization or a physician referral for psychotherapy? If yes, how do I request that?

6. What's my deductible for in-network behavioral health benefits?
   A deductible is the amount you have to pay for covered services before your health insurance starts to pay. With a $2,000 deductible, for example, you pay the first $2,000 of covered services yourself. After you pay your deductible, you usually pay only a copayment, or copay, for covered services. Therefore, you also want to ask: How much of my deductible has been met so far?

7. What's my co-pay amount?
   A co-pay is a fixed amount ($20, for example) you pay each session after you've met your deductible.

8. What is the policy year?
   Your financial responsibilities reset each policy year. This means that if you do have a deductible, you will have to meet that deductible again in the next policy year—so if your policy year is January 1 to December 31, and you have a $2000 deductible that you met in September, once January 1 rolls around next year, you will have to pay your $2000 deductible again.

9. Do I have out-of-network mental health benefits?
   If no, then ask the representative you are speaking to for names in-network within your geographical area.
   If yes, you want to ask the additional questions specific to these benefits below.

NAVIGATING HEALTH INSURANCE

PAYING FOR THERAPY WITH OUT-OF-NETWORK BENEFITS

Out-of-network providers do not accept your insurance plan. However, if your plan has out-of-network benefits, you will be able to get a portion of your out-of-pocket expenses reimbursed. It is important to ask all the questions below to understand your financial responsibility if you go to a provider that does not accept your insurance.

1. What are the requirements to use out-of-network benefits? Is prior authorization required? Is a referral required from my primary care physician?

2. What services are covered?
   Examples include 30, 45, 50, or 60 minutes sessions, individual therapy, and group therapy.

3. Is there a limit on how many sessions my plan will cover per year? If Yes, How many? What happens if I need more?

4. Do I have an out-of-network deductible? If yes, what is it? How much of my out-of-network deductible has been met.

5. What is the start date of the calendar year my out-of-network policy is based on?

6. What percentage of services is covered/what is my co-insurance?

7. How much is the insurance company's "usual and customary fee?"
   This is the charges made by your health insurance provider for a given medical service. A charge is considered reasonable, usual and customary if it matches the general prevailing cost of that service within your geographic area, which is calculated by your insurance company.

8. What percentage of the "usual and customary fee" do they cover?

9. How many days do I have to submit my receipt of sessions?
   After your sessions, you will need to submit a receipt and a form designated by your insurance to receive reimbursement. If you do not submit within the period designated, you will not be reimbursed.