

Guidelines For Determining Whether Your Insurance Will Cover Mental Health Treatment

Prior to scheduling an appointment with a counselor or psychologist, most consumers who have health insurance need to verify whether they have coverage for mental health services, and if so, what the limits may be to their coverage.

Where to get information about mental health insurance benefits:

- Printed materials such as benefit booklets provided by your insurance company, union, or employer
- Insurance company web sites
- Contact your insurance company directly by phone (a phone number is usually printed on the back of your insurance card)

While a phone call can take more time to complete, this is usually the best way to get detailed information if you are unfamiliar with your insurance coverage, need information about whether you have met any deductibles, or have specific questions about what conditions your insurance may not cover. If you obtain information by phone, be sure to get the name of the person who provided the information, write notes, and confirm your understanding of the benefit before completing the call.

Information that you need to know to fully understand your insurance coverage:

- Does your plan have mental health coverage?
- Does your plan require a referral from your primary care physician, or some other form of preauthorization?
- Are your mental health benefits managed by your insurance company or by a behavioral health management company contracted by your insurance carrier? (If your insurance card lists a phone number to access mental health services, be sure to call that number first.) If your benefit is "managed", this usually means that you will need to obtain preauthorization for services, and that you will need to see a treatment provider who is contracted with the insurance company (or in some instances, a provider who is contracted with the behavioral health management company). Managed care plans almost always require that your treatment provider submit information about your care to a treatment manager designated by the company, and continued treatment beyond the initial authorization is dependent on the approval of the care manager.
- Does your insurance company require that you see one of their contracted providers ("in network" coverage only), or will they cover other providers, as well ("out of network" benefits)? If your insurance has "out of network" coverage, what types of providers do they cover (for example, do they cover licensed counselors, as well as psychologists, and psychiatrists?).
- Most insurance companies expect the consumer to share a portion of the cost for treatment. Ask what your company expects you to pay. Is there a co-payment (a fixed dollar amount for each visit), a coinsurance amount (usually a percentage of the "allowable fee" which often is less than the treatment provider's "usual & customary" fee), or a deductible (amount the consumer pays before the insurance company pays anything)? If you have a deductible, ask for information about how much you still need to pay to meet your deductible amount.
- Is there a limit to the number of sessions covered?
- Does your insurance company exclude any mental health diagnoses or specific types of therapy? If you're unsure about the diagnosis or concerned that the treatment you may need is one excluded by your insurance then you may want to talk with the potential treatment provider about your situation. Please note that insurance companies do sometimes deny coverage for treatment for if they determine that a third party is liable for the condition (e.g. where symptoms are the result of an injury on the job, or the result of a car accident).