Using Your Insurance for Open-Ended or Specialized Mental Health Services

Check with the policy holder (usually your parent or care-giver) and/or your insurance company for specific details about your coverage. The customer service number for your insurance company is typically listed on the back side of your insurance card.

Here are some important points to consider:

- Check to see whether your coverage uses provider networks. Typically, patients are required to pay more out-of-pocket costs when visiting an out-of-network provider. Call your insurance company or visit the insurance company’s website for a list of in-network providers.
- Ask about copayments. A copay is a charge that your insurance company requires you to pay out of pocket for a specific service. For instance, you may have a $20 copay for each office visit.
- Ask about your deductible. A deductible is the amount that you must pay out-of-pocket before your health insurance makes any payments. Depending on your deductible, for instance, you may have to pay $500 or even $5,000 out-of-pocket before your insurance company will begin making payments on claims. As a result of the parity law, your deductible should apply to both mental and physical health coverage. Some insurance plans do not have a deductible to meet in order to cover mental health services.
- Talk to potential providers. When you are considering scheduling an appointment with a mental health provider, ask if they accept your insurance. Also ask whether they will bill your insurance company directly and you just provide a copayment, or if you have to pay in full and then submit the claim to your insurance company for reimbursement. If your provider does not accept insurance, ask about their payment policy.

Adapted from: American Psychological Association (http://www.apa.org/helpcenter/parity-guide.aspx)