Determining the Amount Your Health Insurer Requires You to Cover

Health insurance plans vary greatly in the amount of coverage they offer their members. The practitioner you have chosen will verify your coverage is active, but they have limited access to the information you need to determine exactly how much your insurer requires you to pay for each session. Information accessible to us on-line by your health insurer is often inaccurate or impossible to interpret accurately. To ensure you know exactly what your financial responsibility will be, call the "Customer Service" phone number found on the back of your insurance card, Select the automated phone system option for "Eligibility and Benefits".

Provide to the Representative...
Your full name, the I.D. # found on the front of your current insurance card, as well as your Date of Birth.
(If calling on behalf of a child or other family member, provide their information instead).

Inform the Representative...
"I am calling for Out-Patient Mental Health Benefits in an office setting".

Ask the Representative...

1. "Is the practitioner an In or Out-of-Network Provider?" In-Network:* Out-of-Network: _____ _____

   (You will need to provide the name and address of the practitioner you will be seeing).

2. "Do I have an annual deductible I must meet? If "Yes", how much is it per year? "How much has been met to date?" _____ _____

3. "Do I have a Co-Pay? If "Yes, how much is it per visit? $(i.e. $10, 25, $50, etc.) _____

4. "Is there a Co-insurance? If "Yes, how much does insurer cover?% _____ (i.e. 80%) If "Yes, how much is my responsibility?% (i.e. 20%) _____

If you have a deductible, this is the amount you must pay out-of-pocket each year before your insurer will cover any portion of your medical/mental health expenses. The Representative may mention an "Out-of-Pocket Max". If your out-of-pocket expenses reach this amount, your insurer will cover your visits 100% and your financial responsibility should be $0 until the plan renews.

Insurers rarely require a prior authorization, or referral, for mental health services. If you are told you need a prior authorization, ask the Representative to check to see if it is needed for the following three (3) codes: 90791; 90834; 90837. Also, if you are told that you need a referral, ask them to double check whether it is required for mental health services.

These Representatives are there to assist you. Never hesitate to ask them as many questions as necessary to ensure you fully understand your health insurance coverage. Before the end of each call, always ask for a Call Reference # from the Representative and note the person's name, as well as date and time of your phone call.

*If your health insurance is through another BCBS plan other than Horizon BCBS of NJ, ask your provider if they are contracted with Horizon's PPO plans. If they are, they are considered an In-Network Provider for out-of-state BCBS plans as well.

If you have what is known as a "Medicare Advantage Plan" though Aetna, Horizon, United Healthcare, or any other commercial insurer, it is considered primary to the traditional Medicare you have through CMS. Therefore, you should call the phone number found on the back of your Medicare Advantage Plan, instead of Medicare, to obtain "outpatient mental health benefits in an office setting".

Finally, the provider you are working with will file claims on your behalf to your insurer. When the first claim is processed and paid, you should receive a copy of the "Explanation of Benefits" or "EOB" from your insurer. The EOB will reflect how your health insurer processed the claim(s) and indicate any amount or percentage you may be responsible to pay to the provider.