Worksheet: Seeking Mental Health Services in the community with your insurance

What is your insurance plan? _____

Do you have a copy of your card*? Yes/no *If not how do I get one

What is the member/customer service number for your insurance? _____

Questions to ask when calling customer service:

What is your copay for outpatient mental health services? _____ Primary Care/Specialist

What is your deductible? _____ Individual/Family

Does the deductible apply to outpatient mental health services? Yes/no

Has your deductible been met for the year? If not, how much is left before it is met? _____

Is there a co insurance? If so, how much? _____

Are you covered for services in Colorado? _____

Does your plan cover out of network

Script for contacting a therapist:

My name is _____.

I am a CU Boulder _____*(undergraduate/graduate)* student.

I am looking for a therapist who I can see _____*(frequency)* that I can access using my private insurance _____(*name of insurance plan including PPO or HMO)*.

I need support surrounding _____ *(diagnosis, description of symptoms)*.

I am available to schedule for my appointments on _____*(days available)* between _____ *(hours available).*

I hope to begin seeing a local therapist within the next _____ *(provide a time frame)*.

The best way to reach me is _____ *(provide email and/or phone number)*.

Definitions: Insurance terms

Coinsurance - In property insurance, requires the policyholder to carry insurance equal to a specified percentage of the value of property to receive full payment on a loss. For health insurance, it is a percentage of each claim above the deductible paid by the policyholder. For a 20% health insurance coinsurance clause, the policyholder pays for the deductible plus 20% of his covered losses. After paying 80% of losses up to a specified ceiling, the insurer starts paying 100% of losses.

Copayment - A predetermined, flat fee an individual pays for health-care services, in addition to what insurance covers. For example, some HMOs require a $10 copayment for each office visit, regardless of the type or level of services provided during the visit. Copayments are not usually specified by percentages.

Deductible - Amount of loss that the insured pays before the insurance kicks in.

Drug formulary—a list of prescription medications covered by your plan.

Exclusive provider organization (EPO) plan - A more restrictive type of preferred provider organization plan under which employees must use providers from the specified network of physicians and hospitals to receive coverage; there is no coverage for care received from a non-network provider except in an emergency situation.

Explanation of Benefits (EOB): A statement sent from the health insurance company to a member listing services that were billed by a healthcare provider, how those charges were processed, and the total amount of patient responsibility for the claim.

Flexible spending accounts or arrangements (FSA) - Accounts offered and administered by employers that provide a way for employees to set aside, out of their paycheck, pretax dollars to pay for the employee's share of insurance premiums or medical expenses not covered by the employer's health plan. The employer may also make contributions to a FSA. Typically, benefits or cash must be used within the given benefit year or the employee loses the money. Flexible spending accounts can also be provided to cover childcare expenses, but those accounts must be established separately from medical FSAs.

Health maintenance organization (HMO)
A health care financing and delivery system that provides comprehensive health care services for enrollees in a particular geographic area. HMOs require the use of specific, in-network plan providers.

In-network provider—a health care professional, hospital, or pharmacy that is part of a health plan's network of preferred providers. You will generally pay less for services received from in-network providers because they have negotiated a discount for their services in exchange for the insurance company sending more patients their way.

Out-of-network provider—a health care professional, hospital, or pharmacy that is not part of a health plan's network of preferred providers. You will generally pay more for services received from out-of-network providers.

Preferred provider organization (PPO)—a health insurance plan that offers greater freedom of choice than HMO (health maintenance organization) plans. Members of PPOs are free to receive care from both in-network or out-of-network (non-preferred) providers, but will receive the highest level of benefits when they use providers inside the network.