How Do I Know What My Insurance Covers?

Figuring out what your plan covers can be an overwhelming and exhausting process and overall, a lot of work.

Every insurance plan is different.
Here are some ways you can find out what your insurance plan covers:

- If you have access to it, read your insurance manual. There should be a Summary of Benefits section that lists out covered services, costs, etc.
- Visit your health plan’s website. Your mental/behavioral health benefits should be listed under covered benefits on the site. Your insurance card may include the web address. If you do not already have one, you may need to create an online account to view your plan information.
- Call your insurance company’s Member Services number, a toll-free number typically listed on the back of your insurance card. Ask to speak to a customer representative about coverage for mental health services. Ask them to explain your benefits. If you have a diagnostic code, that may help you get accurate information. Diagnosis codes are a combination of numbers and letters typically used by treatment providers and insurance companies to identify covered benefits, claims, and payment. If you have a provider, you can ask them what your diagnosis code is for insurance purposes. Please remember – you are not your diagnosis. There labels are used to help describe, for insurance, and not to define.

Questions to ask when you call for insurance benefits:

- Is mental health a covered benefit?
- Is mental health covered for outpatient and higher levels of care such as Intensive Outpatient, Partial Hospital, Residential, and Inpatient?
- Is there coverage specific for eating disorder treatment?
- Is nutritional counseling covered? (Sometimes, this is referred to as medical nutritional therapy – MNT)
- Are there a limited number of visits covered (for mental health therapy, medical nutrition therapy, inpatient, etc.)?
- What is my copay for (service requested)?
- What is my deductible?
- What is my out-of-pocket max?
- Do I have out-of-network benefits?
- Can you explain to me what my benefits are (for requested service)?
Can you send me a copy of my benefits, and/or can I access it on the insurance website?
Ask for a copy of the guidelines your insurance company uses to determine the level of care (they're required to give it to you).

- You can also call a treatment center or provider and provide your health insurance information. They will reach out to insurance for you and run a “Verification of Benefits” and break down what your benefits look like and what is covered.

What is a Medical Necessity? Is that different from a covered service?

Medical necessity is a term you may come across when seeking mental health and eating disorder treatment. Medical necessity is not the same as a covered medical benefit.

A medical benefit is something that your insurance plan has agreed to cover. Medical necessity is treatment, such as higher levels of care of eating disorder treatment, that your provider feels is necessary for you to receive. Insurance may not agree with what is medically necessary. Insurance companies often deny coverage for medically necessary eating disorder treatment or approve treatment only for a lower level of care.

If your insurance company denies your treatment, you have the right to appeal their decision. If working with a provider, they can help guide you through the appeal process. Your insurance company will also provide you information needed to appeal their decision yourself. Be persistent and advocate for yourself as much as possible.

Denials can be reversed. Do not give up!

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