Health Insurance & Mental Health Coverage

What is Health Insurance?

Health Insurance helps you pay for your health care costs and can help protect you from high medical costs. Health Insurance pays some, but not all of your medical costs. The amount paid by your insurance company and the level of coverage offered will depend on the type of health insurance and your specific health plan.

2 Main Types of Health Insurance

The two main types of health insurance are public and private. Public health insurance is provided through the government, like Medicaid & Medicare. Any health coverage that is not received through a government program is considered private health insurance and either provided through an employer or purchased as an individual plan through the marketplace or insurance broker.

Public Health Insurance

- **Medicaid**- federal/state health insurance program for lower-income Americans.
- **CHIP**-(Children's Health Insurance Program) similar to Medicaid and is designed to provide health coverage for people under the age of 18.
- **Medicare**- federal health insurance originally designed for people who are 65 or older but has expanded to included disabled people under 65 & those with special circumstances.

Private Health Insurance

- **Employer-sponsored group plan** The most common way that people get insurance is through a group health plan provided through an employer.
- **Individual health insurance**- Not offered through an employer but may be purchased through an insurance agent, the marketplace or directly through the insurance company.

If you have health insurance, you most likely have a **Managed Care Plan**. Managed Care Plans are health insurance plans that focus on helping to reduce costs for members while improving the quality and outcomes of their care. **The 3 Most Common Types of these Health Plans are:**

1. HMO (Health Maintenance Organization)
2. PPO (Preferred Provider Organization)
3. POS (Point of Service)

HMO

- Must stay In-Network
- Must have a PCP
- Must get a referral to see a specialist
- lower monthly premiums/deductibles

PPO

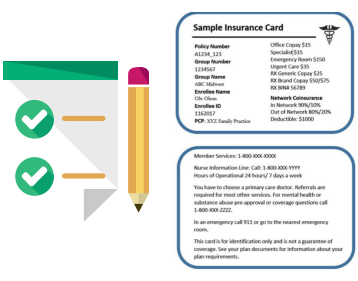
- In-Network & Out-of-Network Benefits
- No need to select a PCP
- No referrals needed
- Higher monthly premiums/deductibles

POS

- In-Network & Out-of-Network Benefits, but OON Benefits may cost more
- Must select a PCP
- No referrals needed
- Higher monthly premiums compared to HMO plans

Understanding Your Mental Health Coverage & Benefits

Most insurance plans provide mental health and substance use disorder benefits. However, the level of coverage offered will vary based on your specific type of health plan. The best way to find out your coverage, what types of services are covered, the amount paid for these services, and any steps you must take to have treatment covered is to review your insurance policy.



Summary of Benefits & Coverage

All health insurance companies are required to provide you with a Summary of Benefits, which is an easy-to-understand summary of benefits and coverage. The SBC provides a snapshot of the plans costs, benefits, covered services and any limits and exceptions on coverage. Insurance companies are required to provide you with a copy of your plans SBC upon enrollment but many insurance companies also make the SBC available online.

Call your Insurance Company

Contact your insurer directly by calling the telephone number on the back of your insurance card.

Reviewing a copy of your Summary of Benefits is a great tool to help you answer general questions about your plans coverage and benefits but contacting your health insurance company and speaking to a customer service agent can help you better understand how your plan will help you pay for services that are specific to your needs.

Understanding the costs associated with your health plan:

- **Premium=** each month, you pay a premium to have health insurance, even if you do not use it.
- **Co-payment=** the dollar amount the patient is expected to pay at the time of service.
- **Deductible=** the amount you have to pay before your health insurance helps pay your bills.
- **Co-Insurance=** After you have met your deductible, the amount that you have to pay is called your co-insurance. This is a percent (%) of the total cost.
- **Out-of-pocket maximum=** the total amount of money you might have to pay in a year if you get all of your care in-network.

Questions to Ask Your Insurance

- Have your insurance card ready. If you don't have your physical insurance card, you may be able to log into your health insurance website to get information needed to access your benefits (such as Member ID number and Customer Service phone number.)
- Look on your insurance card and locate the "member health benefits" phone number or "customer service" phone number.
- Follow the prompts for "members" and select the option for "benefit information" or you may be given the option to speak to a live insurance representative, let them know that you are calling to obtain your "mental health benefits information"

1. What is my deductible for in-network mental health benefits?
2. Do I have out-of-network mental health benefits?
   If so, is there an out-of-network deductible, co-insurance or co-pay?
3. Is there a limit on sessions the plan will cover per year?
   If yes, how many?
4. Do I need any pre-authorization or referral for treatment?
5. Are telehealth services covered?

"The doctor's name I am seeing is John Smith at Coleman Health Services, is he in-network?"

You can ask the representative for a list of in-network providers or if you know the name of the provider you want to receive services from, you can give the representative the name of the provider and they can tell you if the provider is in-network or out-of-network.

To get more detailed coverage information, your insurance representative may ask you for the Clinical Procedure Terminology (CPT) code for the services you plan to receive

Below is a list of our most common services and CPT codes:

90791: Initial Diagnostic Assessment
90834: Individual Psychotherapy (45 min)
90837: Psychotherapy (60 min)
90847: Couples/Family Psychotherapy
90853: Group Psychotherapy

Questions?

Call Us at (330) 677-7971 or Email Us at ClientBilling@ColemanServices.org

Have Questions about your Insurance or Need Help Getting Health Insurance
Call or Email Us
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ClientBilling@ColemanServices.org

Glossary of Key Health Insurance Terms

ESSENTIAL HEALTH BENEFITS:	Health care services that insurances must cover under the Affordable Care Act. Includes outpatient care you get without being admitted to a hospital, emergency services, hospitalization, pregnancy, maternity and newborn care, mental health, prescription drugs, laboratory services and more.
SUMMARY OF BENEFITS & COVERAGE (SBC)	A document that lists the plan's benefits. It may make it easier to compare costs, benefits and coverage between different health plans. **Also known as:** SBCS, benefits summary
Mental Health Parity (Act):	Mental health parity refers to providing the same insurance coverage for mental health treatment as is offered for medical and surgical treatments. The Mental Health Parity Act was passed in 1996, and established parity in lifetime benefit limits and annual limits.
ALLOWED AMOUNT:	The maximum amount an insurance company will pay for a covered health service.
COORDINATION OF BENEFITS (COB):	A provision used to establish the order in which health insurance plans pay claims when more than one plan exists. Determines which insurance is primary and secondary.
CLAIM:	A paper or electronic request by a plan member's health care provider, for the insurance company to pay for medical services
Explanation of Benefits (EOB)	The health insurance company's written explanation of how a medical claim was paid. It contains detailed information about what the company paid and what portion of the costs you are responsible.

COST SHARING:	The general term that refers to the share of costs for services covered by a plan or health insurance that you must pay out of your own pocket (sometimes called "out-of-pocket costs"). Some examples of types of cost sharing include copayments, deductibles, and coinsurance. Other costs, including your premiums, penalties you may have to pay or the cost of care not covered by a plan or policy are usually not considered cost sharing.
PREMIUM:	The amount of money charged by your insurance company for the plan you've chosen. It is usually paid on a monthly basis (aka monthly premium)
COPAY:	A fixed amount you pay for a health care service, usually when you receive the service. The amount can vary by the type of service.
DEDUCTIBLE:	The amount you pay for health care services before your insurance begins to pay.
DEPENDENT:	Any individual, either a spouse or child, that is covered by the primary insured member's plan.
OUT-OF-POCKET MAXIMUMS:	A predetermined amount of money you will have to pay during a policy period (usually a year) for health care services. Once you've reached your out-of-pocket maximum, your plan begins to pay 100 percent of the allowed amount for covered services.
IN-NETWORK PROVIDER:	A healthcare provider who is part of a plan's network
OUT-OF-NETWORK PROVIDER:	A healthcare provider who is **not** part of a plan's network. Costs associated with out-of-network providers may be higher or not covered by your plan. Consult your plan for more information.
SPECIALIST:	A physician specialist focusing on a specific area of medicine or a group of patients to diagnose, manage, prevent or treat certain types of symptoms and conditions. A **non-physician specialist** is a provider who has special training in a specific area of health care.

GUARANTOR:	Individual responsible for any medical expenses incurred on the patient's behalf. This may be the patient's parents, legal guardian, or the patient if over 18 or if emancipated.
MINORS:	A person who has not reached the age of adulthood. In most states, a person reaches adulthood and acquires all of the rights and responsibilities of an adult when he or she turns 18 and completes high school (either by graduating or dropping out). Minors (unless emancipated) are not financially responsible for medical debts
NON-COVERED CHARGES:	Charges for health care services your plan does not cover
MEDICAL NECESSITY"	Services, supplies or prescription drugs that are needed to diagnose or treat a medical condition. Also, an insurer must decide if this care is:
SUBSCRIBER:	The policyholder who pays for a specific insurance plan. If you have insurance is through your own employer, or it's your own plan that you directly pay, then you are the subscriber.
SUBSIDY:	Government financial assistance that helps you pay for insurance purchased on the marketplace.
THIRD PARTY LIABILITY (TPL):	Third parties that may be liable to pay for services include private health insurance, Medicare, employer-sponsored health insurance, settlements from a liability insurer, workers' compensation, longterm care insurance, and other State and Federal programs (unless specifically excluded by Federal statute).
MARKETPLACE:	Internet resource where individuals, families, and small businesses can: learn about their health coverage options; compare commercial health insurance plans based on costs, benefits, and other important features; choose a plan; and enroll in coverage. A key component of the Affordable Care Act.