What is Health Insurance?

Health Insurance helps you pay for and 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 you purchase or 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 and Medicare. Private health insurance, which is common way that people get insurance is provided through an employer but may be purchased as an individual plan through the marketplace or insurance broker.

Public Health Insurance

- Employer-sponsored group plan
- Federal/State health insurance program
- Managed Care Plan
- Health Maintenance Organization (HMO)
- Preferred Provider Organization (PPO)
- Point of Service (POS)

Private Health Insurance

- Individual health insurance
- Individual health insurance—Not offered
- Medicaid
- CHIP

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 list of the plan costs, benefits, covered services and any limits and exceptions. An coverage beneficiaries are required to provide you with a copy of their plan. SBCs exist for Individual plans, however, it’s possible that many insurance companies also online the SBC availability.

Understanding the costs associated with your health plan:

- **Out-of-pocket maximum**: The total amount of money you might have to pay in a year if you go out of your care provider.
- **Premium**: The monthly cost you pay for health insurance. This is the amount you pay for coverage before you use any services.
- **Deductible**: The amount you pay each year before the health plan will start paying for services.
- **Co-insurance**: This is a percent (%) of the total cost. This is the percentage of the total cost that you pay after your deductible is met.
- **Copay**: The fixed dollar amount you pay for each service.

Call Your Insurance Company

Contact your insurance directly by calling the phone number or selecting the option for “benefit information”. If you have a question about your plan’s coverage and benefits, contact your health insurance company and speaking to a customer service agent can help you better understand how your plan will help pay for services that are specific to your needs.

Questions to Ask Your Insurance

1. **What is my deductible for in-network mental health benefits?**
2. **Do I have out-of-network mental health benefits?**
3. **Is there a limit on sessions the plan will cover per year?**
4. **What will out-of-network mental health benefits?**
5. **Have you used your deductible, out-of-pocket maximum, or copay?**
6. **If yes, how many?**
7. **Is there a set of network mental health benefits?**
8. **If so, how do I use network benefits?**
9. **Can I see the same provider for in-network and out-of-network services?**
10. **Can I use my insurance to pay for services provided by a provider who is not in-network?**
11. **Can I use my insurance to pay for services provided by a provider who is not in-network?**
12. **Is there a limit on services that the plan will pay for?**
13. **If yes, how many?**

To get more detailed coverage information, you may also ask your Clinical Psychologist (CPT code 90834) what the services you plan to receive are included in CPT code 90834.


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Glossary of Key Health Insurance Terms

ESSENTIAL HEALTH BENEFITS:
A list of essential health benefits that must be included in any non-grandfathered health plan. These benefits include hospitalization, prescription drugs, mental health and addiction services, among other things. The Affordable Care Act requires insurers to offer plans that cover these benefits, and individuals are encouraged to purchase coverage that includes them.

SUMMARY OF BENEFITS & COVERAGES (SBC):
A document that lists the plan's benefits. It is meant to be easy to compare costs, benefits and coverage between different health plans. State laws may impact the SBC, affecting how it is communicated.

Mental Health Parity (Act):
Mental health parity refers to the equal treatment of mental health and substance use disorders in insurance coverage. It is required under the Affordable Care Act. The treatment of mental illness, but was often ignored, and established parity in behavioral health services 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 there are two or more plans. Determined by primary and secondary.

CLAIM:
A paper or electronic request by a provider for payment of medical services.

Explanations of Benefits (EOB):
The insurance company's written explanation of how a claim was paid. It contains detailed information about what the company paid and what portion of the costs are your responsibility.

COBRA:
A federal law that requires employers to offer health insurance coverage to employees and their families for up to 18 months after a qualified event, such as the employee's or dependent's loss of employment, death, divorce, or retirement.

DEFINABLE:
The amount of money charged by your insurance company for the plan's stop-loss coverage. It is usually paid on a monthly basis (or another billing period).

DEDUCIBLE:
The amount you must pay for health care services before your insurance begins to pay.

DENTAL:
Any individual, either a spouse or child, that is covered by the primary insurance policy.

DRUG COVERAGE MAXIMUM:
A preset amount of money you have to pay for your prescription drugs for a policy year. After you reach this limit, your insurance will pay for the remaining costs. If you have a drug maximum, you will need to keep track of how much you have spent on prescription drugs for the year.

IN-NETWORK PROVIDERS:
A network of providers that you can access with your insurance plan.

OUT-OF-NETWORK PROVIDERS:
A network of providers that you can access with your insurance plan.

PHARMACY:
A pharmacy provider who is associated with your member's network.

PHYSICIAN:
A person who has completed an accredited residency program and is licensed to practice medicine in a specific field.

CONTRIBUTION:
The amount of money that an individual or employer pays towards the cost of health insurance.

MEDICAL INCURRANCE:
Also known as medical loss ratio (MLR) or patient-protection ratio. It is the percentage of premium revenue that is spent on medical care and quality improvement activities. If the MLR is less than 80%, the insurance company must refund the difference to the policyholder.

MEDICAL MALPRACTICE:
Any violation of standard medical care that results in harm to a patient. Medical malpractice can result in civil or criminal charges.

PREADJUSTED DEDUCTIBLE:
The deductible that applies only when you have reached the out-of-pocket maximum.

PREFERRED PROVIDER ORGANIZATION (PPO):
An organization that contracts with providers to offer services at discounted rates. PPOs are more flexible than HMOs, but generally require higher deductibles and copayments.

PROVISIONAL PAYMENT:
A payment that is not final and is subject to change based on further review of the claim.

SUMMARY PLAN DESCRIPTION (SPD):
A document that provides a detailed explanation of the health insurance plan offered by an employer or government agency. The SPD must be provided to employees within 60 days of enrolling in the plan.

THIRD PARTY LIABILITY:
Insurance that covers medical expenses that are not covered by the primary insurance policy. Third-party liability insurance can be purchased separately or as part of a comprehensive insurance package. It is often used to cover hospital bills, doctor's fees, and other medical expenses.