EAST MOUNTAIN HOSPITAL

Understanding Your Health Insurance

Since 2008, America has witnessed monumental changes in the economy, the government and the environment. Health insurance plan adjustments have lent to an overwhelming transformation, making it ever more complicated to choose the best insurance option.

The right benefits protect us in the case of a medical emergency, and we need to make sure that the changing medical regulations are still relevant to our needs.

THE MENTAL HEALTH PARITY ACT

The Mental Health Parity Act and Addiction Equity Act, passed in 2008, requires private health insurance plans to provide equal amounts of mental health benefits as provided for medical/surgical benefits. However, not all plans are subject to parity, and it is the policyholder's responsibility to find out if their plan offers this benefit.

Knowing what your insurance plan covers before you have to use it will avoid surprise bills and denial of care.

MAKE A LIST OF QUESTIONS

Compile a list of questions you want answered in order to determine when and how to use your benefits. Some questions may include:

1. How much am I required to pay out-of-pocket?
2. What is my deductible?
3. How long are my benefits good for?
4. Which specialists participate under my plan?
5. Are reviews necessary and what is the process?
6. Which services require authorization?
7. Why does my policy state that I have 30 days of mental health insurance?

KEY TERMS TO KNOW

Prior to conducting an in-depth analysis of your benefits, it is important to understand the terminology. Here are a few terms you should familiarize yourself with:

Deductible: the amount you are responsible for paying to cover medical expenses before your insurance starts to pay in a given year.

Coinsurance: the shared costs between you and your insurance provider. Usually a ratio, for example, 80/20 means that the insurance provider will pay up to 80%, and you would be responsible for 20%. Not all plans have coinsurance.

Copayment: a fixed amount paid at the time of a doctor visit or prescription refill.

Out-of-pocket maximum: the amount you are responsible for paying for covered medical expenses in a given year until your insurance starts to pay 100% of covered expenses, after meeting your deductible and coinsurance.

In-network vs. out-of-network: If doctors, facilities, and specialists are listed as in-network under your plan, it means that they participate under your plan. If the doctors you wish to pursue are not on this list, they are considered out-of-network, and medical expenses will not be covered.

HOW TO GET YOUR QUESTIONS ANSWERED

Get your questions answered today in order to be prepared for tomorrow. Call your healthcare provider to speak to a representative and ask your list of questions. You can even discuss your plan with your employer's HR department in person.

For more information, visit www.EastMountainHospital.com