Insurance Navigation and Paying for Treatment

Health insurance is a signed contract with a health insurance company that requires the company to pay for some of your health care costs. It does not mean they will pay for everything. You will still be responsible for paying some costs, like monthly premiums or copays when you visit a provider. There are different types of insurance programs people may be eligible for. Many people receive health insurance through their employer as a benefit. If you are under the age of 26, you may still be considered a dependent and eligible to receive health insurance benefits through a family plan. Other people receive Medicaid, which is insurance from the state. There are also other health insurance programs, like Medicare, which is for seniors aged 65 or older. Some students may opt to receive health insurance through the University's Student Health Insurance Plan while they are living on campus. For more information, visit the Student Health Insurance webpage.

Common Health Insurance Terms

Premium | The amount you pay each month to your insurance company to have insurance.

Copay | Short for copayment. A set amount of money you must pay each time you need medical care. Different plans have different copays. Some have no copay at all. Some require different copays for different medical services or specialty providers.

Deductible | Some insurance plans have a deductible. This is a set amount of money you must pay before the insurance company starts to pay for certain services. Once you reach your deductible for the year, then your insurance company may pay for a larger part of your healthcare costs.

Co-Insurance | Depending on your plan, your insurance might only pay a percentage of your health care cost. For example, if your insurance pays 80% of X-ray costs and your X-ray is $100, your insurance will pay $80, and you will pay $20.

Out-of-Pocket Maximum | A limit to how much you can pay for health care in a year.

In-Network Provider | A health care provider who accepts your insurance plan. If you want to obtain health care outside the network, you may have to pay for it on your own or pay a larger part of the total cost.

Out-of-Network Provider | Some insurance plans will allow you to see an out-of-network provider by paying more for the appointment, but it is your responsibility to check if your provider receives your insurance. Some health insurance plans will also offer reimbursement for out-of-network services after you pay for them out-of-pocket and submit a claim. Many out-of-network therapists offer "superbills" for services which can be submitted to insurance companies for reimbursement.

Health Maintenance Organization (HMO) | On an HMO plan, your insurance will only pay for doctors, hospitals and other health care if they are part of your insurance plan's network.

Preferred Provider Organization (PPO) | With a PPO plan, you can choose any doctor or hospital. If you choose a provider that is part of the insurance plan's network, it will cost less.

Pre-Authorization | Depending on your insurance plan and the type of treatment you are seeking, you may need to get pre-approval from your insurance company before you receive coverage.

Claim | A bill you or a therapist submits to the insurance company to seek reimbursement.

For more information, visit Mental Health America to download their insurance guide (available in multiple languages).