## Checklist for My Health Plan Coverage

My health plan coverage is through:

__ My employer – check if:
- __ My plan is a fully-insured plan; any plan denials are eligible for state external review
- __ My plan is a self-funded plan; it is not regulated by state law-- federal parity law applies.

__ A policy I bought myself; any plan denials are eligible for state external review

__ An association-sponsored policy (such as a trade or educational organization); if it is self-funded, it's not regulated by state law, and federal parity law applies.

__ Other

My health plan:
__ Covers mental health
__ Manages mental health benefits directly
__ Contracts with an outside entity (e.g. MHBO) to manage the plan's mental health benefits

Plan phone number to call if I have a problem: _____

My primary care physician is: _____

My physician's phone number: _____

My mental health/substance use provider's phone number: _____

I need prior authorization for: _____

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_____

I do not need a referral from my primary care physician for:
__ Lab and x-ray tests
__ Other specialist visits
__ Other: _____

My primary care physician can refer me to specialists who:
__ Are part of his or her group practice
__ Are on the health plan network list
__ Are outside of the health plan network *only if there are no similar specialists within the network*
__ Are outside of the health plan network

I have reviewed the Exclusions and Limitations section in my Evidence of Coverage or Summary Plan Description. My health plan will not pay for or limits the following mental health/substance use services:

_____

_____

_____

Is my provider in my health plan network?

My plan will cover services at the following hospitals: _____

_____

_____

What should I do if I need care while I am outside of my plan's service area?

For non-urgent care: _____

Phone: _____

In an urgent situation: _____

Phone: _____

In an emergency: _____

Phone: _____

If you have a PPO or POS plan:
If I use in-network providers, I will pay:
__ $ _____ annual deductible
__ % _____ coinsurance for charges that exceed the deductible

If I use out-of-network providers, I will pay:
__ $ _____ annual deductible
__ %_____ coinsurance for charges that exceed the deductible