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: ________________________________
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