**Partners for Behavioral Health and Wellness**

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**FAQ’s About Insurance**

If you are a new patient with our practice, it is important that you understand your insurance benefits. As a new year approaches or a renewal date on your insurance enrollment comes some things with your insurance may change. You may have a new insurance company and/or plan, or you may keep your current insurance but have a change in deductible amount or out of pocket max. Please keep in mind that your potential costs are a contractual obligation with your insurance company and the terms of your agreement. The best way to fully understand your benefits and potential cost we encourage you to contact your insurance company. Below are some common insurance terms and a brief description:

**Virtual Visits**-In order to fully understand your benefits and potential cost, contact your insurance company and ask if virtual visits are included in your plan if not, what your financial responsibility might be.

**Deductible**- A “deductible” usually starts over at the beginning of the calendar year. If your medical insurance has a deductible, your insurance will not pay your medical bills until you have paid out of pocket and reached your deductible for the calendar year. It’s reasonable to assume you will be paying somewhere between $65.00-$100.00 per session until your deductible has been met.

**Co-Payment**- A “Co-Pay” is a specific dollar amount that the insurance company requires the patient to pay at each visit. In health insurance, a “Co-Insurance” (see below) is sometimes used synonymously with a “Co-Payment”.

**Co-Insurance**- “Co-Insurance” is a type of policy where the patient and the insurance company share the total cost of a covered medical service after the deductible has been met. This is set as fixed percentages. An example: 80% (covered by insurance) and 20% (patient is responsible for).

**Out-of-Pocket Maximums**-The yearly out-of-pocket maximum is the highest or total amount the insurance company requires the patient to pay towards the cost of health care for the year.

Out-of-pocket expenses are what the patient pays for health-related services above and beyond the monthly premium. Depending on the health insurance plan, these expenses may include an annual deductible, co-insurance, and/or co-payment for doctor visits and prescription drugs. In most cases, once the patient reaches the out-of-pocket maximum the insurance company will cover 100% of the costs, they consider to be medically necessary.

Some health plans do not count all out-of-pocket expenses when determining the out-of-pocket maximum. For example, a plan may not include the annual deductible and some plans may not include the co-payments associated with outpatient procedures. That is why it is very important to always check on your benefits with your insurance company.

**Coordination of Benefits**- “Coordination of Benefits” is a denial of a claim by the insurance company. This denial simply means that the insurance company has been trying to reach the patient (policy holder) to verify they do not have any other insurance coverage, or if they do, which is primary and which is secondary. Claims will not process if this is not done by the patient (policy holder), the balance of the unpaid claims will be patient responsibility until this is completed and the claims are processed. **PLEASE CONTACT YOUR INSURANCE COMPANY AS SOON AS POSSIBLE IF YOU RECEIVE A DENIED EXPLINATION OF BENEFITS OR A BILL FROM US FOR THE FULL AMOUNT OF THE VISIT.**