Behavioral health insurance, in plain English

Clear questions. Useful next steps. Space to make a plan.

Begin with the plan you actually have

Helping someone find care can already feel like a full-time job. You do not need to master every insurance term. Start by finding the documents that answer three questions: what services are covered, which providers participate, and how your share is calculated.

Five terms worth knowing

Term	What it means for your family
Deductible	What you pay toward covered services before the plan shares those costs. Some services have exceptions; individual and family amounts may differ. [I01]
Copay / coinsurance	A copay is a set charge; coinsurance is a percentage of the allowed amount. Ask whether the deductible applies first. [I05]
Allowed amount	What the plan recognizes for a covered service, which may be less than the billed charge. Cost-sharing percentages generally use this amount. [I02]
Out-of-pocket limit	A ceiling on qualifying in-network cost sharing during the plan year. Premiums, non-covered care, and balance bills do not count toward this protection. [I03]
Plan year	The period your plan uses to track benefits. Ask when the deductible and out-of-pocket totals reset, particularly if treatment could cross that date.

Keep two documents beside you

Request the Summary of Benefits and Coverage, or SBC, for the current plan year. It offers a standardized overview, not every condition of coverage. Also request the complete policy or plan description, including behavioral-health benefits and exclusions. If coverage comes through work, ask the benefits office where the governing plan documents are kept. [I04, I11]

Make the question specific

Replace 'Does my insurance cover treatment?' with 'What does this policy cover for the recommended service at this location on these dates?' A carrier logo alone does not identify your exact network or benefits. Keep the answer with the representative's name, date, and reference number.

Before the next call: write down the plan name, member-services number, proposed start date, and one question you most need answered. Keep full member numbers in a secure place, not in shared family messages.

SOURCES FOR THIS PAGE / LINKED TITLES / ACCESSED 08 SEPTEMBER 2026

[I04] HealthCare.gov: Summary of Benefits and Coverage (SBC) (n.d.).

[I11] DOL / EBSA: Top 10 Ways to Make Your Health Benefits Work for You (n.d.).

[I01] HealthCare.gov: Deductible (n.d.).

[I05] CMS: Health insurance terms you should know (2026-08-25).

[I02] HealthCare.gov: Allowed amount (n.d.).

[I03] HealthCare.gov: Out-of-pocket maximum/limit (n.d.).

Check the service, not just the name

A program can be right clinically and still create unexpected costs if the billing details are unclear. Before a non-emergency start, ask the provider and the plan to describe the same proposed service. Write down differences instead of trying to settle everything from memory.

Ask before the first day

Check	Get a specific answer
Recommended service	What level of care or appointment is being requested? Which codes and service location will the provider use when asking the plan about coverage?
Initial approval	Is prior authorization required? Who sends the request? What is approved: dates, visits, days, or units? Request the decision or authorization reference. [I06]
Ongoing review	Ask whether later sessions require another review, who tracks that deadline, and how you will be told if authorization changes before the next scheduled service.
Changing levels	Before a step-down or transfer, ask whether the new service needs a separate authorization and whether different cost sharing or network rules apply.

Confirm every billing entity

In-network means a provider or facility has a contract with your plan; accepting an insurance card is not the same confirmation. Ask for the legal billing name, location, and provider identifiers, then have the plan check them. Confirm separately billed clinicians, laboratories, medications, and testing rather than assuming one answer covers the whole program. [I05]

Understand the out-of-network question

Ask whether the plan has out-of-network benefits and what charges could remain beyond its allowed amount. Federal surprise-billing protections cover specified emergency and in-network-facility situations, not every out-of-network office or treatment setting. Do not assume a planned outpatient service is protected; ask the plan about your circumstances. [I02, I07]

Prior authorization is not a payment guarantee. Eligibility, covered-service rules, approved dates, and the processed claim still matter. For an urgent medical need, seek appropriate care rather than delaying for this worksheet. [I06]

Keep the verification usable

Record the representative, date, reference number, proposed service, and exact billing name. Separate a general benefit description from confirmation of this location and service. Mark unknown answers and the person who will follow up; do not fill a missing estimate with a guess.

SOURCES FOR THIS PAGE / LINKED TITLES / ACCESSED 08 SEPTEMBER 2026

[I05] CMS: Health insurance terms you should know (2026-08-25).
[I06] HealthCare.gov: Preauthorization (n.d.).
[I02] HealthCare.gov: Allowed amount (n.d.).
[I07] CMS: Know your rights with insurance (2026-08-25).

See how a cost estimate is built

The numbers below are invented to explain the arithmetic. They are not Eleve charges, a typical treatment price, or a prediction of your benefits. Ask your plan and provider for the inputs that apply to you before using any estimate to make a decision.

Follow the calculation

Step	Calculation	Result
Deductible first	First $800 of the $3,000 allowed amount	You pay $800
Amount left to share	$3,000 minus $800	$2,200 remains
Your coinsurance	20% of $2,200	You pay $440
Estimated responsibility	$800 plus $440	You pay $1,240
Plan's share	80% of $2,200	Plan pays $1,760

Illustrative allocation of the $3,000 allowed amount

Your deductible | Your coinsurance | Plan share

Assumptions for this example only

Imagine a covered in-network course of care with a $3,000 total allowed amount, $800 of deductible remaining, and 20% coinsurance after that deductible. Assume no separate copay, no excluded services, no other claims changing the deductible, and enough room before the out-of-pocket limit. Cost-sharing concepts come from the federal glossary; these dollar inputs are fictional. [I01, I02, I03, I05]

Change one assumption

If only $900 remained before the applicable in-network out-of-pocket limit, qualifying cost sharing in this simplified example would stop at $900, with the plan paying the other $2,100. This assumes every dollar in the calculation counts toward that limit. It does not make non-covered services or balance bills disappear. [I03]

Why the final bill can differ

The estimate may use expected visits rather than services actually delivered. Another claim may change the deductible, the plan year may reset, or a separate professional may submit another claim. Ask which assumptions are included and what would trigger an updated estimate. Do not add a provider's list price to this example: the calculation already begins with an allowed amount.

Your own calculation needs five verified inputs: covered service, allowed amount, deductible remaining, cost-sharing rule, and out-of-pocket progress. If one is unknown, label the estimate incomplete rather than filling the gap with a guess.

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[I01] HealthCare.gov: Deductible (n.d.).
[I02] HealthCare.gov: Allowed amount (n.d.).
[I03] HealthCare.gov: Out-of-pocket maximum/limit (n.d.).
[I05] CMS: Health insurance terms you should know (2026-08-25).

Leave the call with a usable answer

An unexpected bill deserves a careful look, not an immediate conclusion that you did something wrong. Start with the service and claim in question. Keep the provider's bill, the plan's explanation, and any estimate together so you can ask one clear question at a time.

Your estimate worksheet - write verified inputs only

Input	Your entry / what to verify
Proposed care	Service and location: _____ Billing entity: _____
Plan status	Active dates: _____ Network confirmed by: _____
Cost sharing	Allowed amount: $_____ Deductible remaining: $_____
Your plan rule	Copay / coinsurance: _____ Out-of-pocket remaining: $_____
Open question	Missing input: _____ Owner / follow-up date: _____

Compare before you pay twice

An explanation of benefits (EOB) is not a bill. Compare its patient responsibility with the provider bill and amounts already paid. Match service dates, billing names, and claim numbers. Ask the billing office to reconcile deposits, copays, duplicate entries, and unexplained differences before paying twice. [I13]

Build a useful appeal file

- Get the written denial, its reason, the deadline, and the correct correction or appeal route. Ask who will submit it and what records the plan needs. [I09]
- Keep copies and proof of submission. Ask about expedited review if waiting could seriously jeopardize health. Follow the actual notice rather than assuming every plan uses the same timeline. [I09]
- Ask about independent external review when available. Eligibility and instructions depend on the plan and process; a billing disagreement is not automatically eligible. [I10]

If you are not using insurance

Request a written good faith estimate. A qualifying bill at least $400 above that provider's estimate may be disputable; generally begin the federal process within 120 days of receiving the initial bill. Check eligibility and current instructions. [I08]

Leave with a named next step: who will clarify the bill, what they need, and when you should follow up. Keep unresolved questions marked as unresolved.

Before agreeing to financing

Ask about financial assistance and a written payment arrangement before signing for medical credit. Compare total cost, interest or deferred interest, fees, and due dates. Moving a bill to credit may affect provider assistance. A financing offer is not insurance approval. [I15]

SOURCES FOR THIS PAGE / LINKED TITLES / ACCESSED 08 SEPTEMBER 2026

[I13] CMS: How to read a health insurance explanation of benefits (n.d.).

[I09] HealthCare.gov: Appealing a health plan decision: Internal appeals (n.d.).

[I10] HealthCare.gov: Appealing a health plan decision: External review (n.d.).

[I08] CMS: Know your medical bill rights when not using insurance (2026-08-25).

[I15] Consumer Financial Protection Bureau: Medical credit cards and payment plans (2023-05-03).