Volunteers of America
MINNESOTA AND WISCONSIN

VONA
CENTER FOR MENTAL HEALTH™

Understanding Your Insurance Coverage

Vona Center for Mental Health recommends contacting your insurance company when starting services to understand your coverage. This document provides suggested questions you can ask. While these are questions you can ask before receiving services, the Explanation of Benefit documents you receive from your insurance company show the final determination of coverage. To reach your insurance company, please call the phone number for Member Services found on the back of your insurance card.

1) ***Are Mental Health Services covered by my plan?***

   It is important to be sure your plan covers mental health/counseling/psychiatry services. These are the categories of services that Vona Center for Mental Health provides.

2) ***Is Vona Center for Mental Health or Volunteers of America-MN an in-network provider for my plan?***

   Knowing if Vona or its parent company Volunteers of America-MN are in or out of network will help you know whether you will have in-network or out-of-network coverage.

3) ***If Vona is an in-network provider, what are my in-network deductible, co-insurance, and/ or co-payment responsibilities?***

   This will help you understand your financial responsibilities for services received by an in-network provider.

4) ***If Vona is an out-of-network provider, what are my out-of-network deductible, co-insurance, and/ or co-payment responsibilities?***

   This will help you understand your financial responsibilities for services received by an out-of-network provider.

5) ***How much is my annual individual deductible? How much is my annual family deductible?***

   Knowing this will help you understand how much you will need to pay before insurance starts to pay (each year).

6) ***What is my co-payment amount or my co-insurance amount once I meet my deductible?***

   This is to understand how much or what percentage of service cost you will be financially responsible for, each time you are seen for services.

7) ***Does the amount I pay in co-payments or co-insurance go towards my out-of-pocket maximum for the year?***

   Find out if the co-payments or co-insurance you pay goes to the maximum amount you owe each year.

8) ***Is there a certain number of visits covered during the year? Can additional visits be requested?***

   Some insurance plans will have limits to how many services they will cover in a year. Knowing this will help you determine how often you can be seen during the year and if you need authorization for additional visits.

9) ***Do I need prior authorization for services? If so, what services need to be authorized?***

   This is to find out if you will need approval by your insurance company to receive services from Vona before starting services.

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Common Health Insurance Terms and Their Definitions

1) **Co-Insurance:** The amount due that is split between the insurance company and the member after the deductible has been met. (Usually a percentage of the bill.) Example: Member pays their deductible of $1,000.00 for the year, co-insurance for them is an 80/20 plan in which their insurance company will pay 80% of the cost and they will pay 20% of the cost. Service cost is $100.00. Insurance will pay $80.00 and the member will pay $20.00.
2) **Co-Payment**: The amount due by the member for services received, generally a fixed amount each time services are provided. Example: A member goes to a provider and is charged a fee of $25.00 each visit.
3) **Coordination of Benefits:** Member has two insurance plans in which one is the primary, the other is secondary. The primary pays then sends on to the secondary. The member will owe whatever the balance is after both have paid (if there is a balance). Example: Member has Medicare Primary and Medical Assistance secondary. Medicare will pay then send on to MA to pay their portion. Member has Blue Cross Commercial primary and Aetna commercial secondary, BCBS will pay first and Aetna will pay their portion second. The member may still owe a portion.
4) **Deductible:** The amount the member owes out of pocket prior to insurance paying for any service. Often there is an individual deductible and a family deductible. Depending upon a member's insurance plan, they may continue to pay for a portion of the cost through co-payments or co-insurance after a deductible has been met. Example: The insurance company has a yearly deductible of $1,000.00, the member will pay out of pocket the first $1,000.00. Once a member has met their individual or family deductible, the insurance company pays 80% of future service costs and the member pays 20%.
5) **Explanation of Benefits:** A document prepared by an insurance company that shows how much of a service cost they will pay for and how much the member is responsible for paying.
6) **Insurance Company's Allowed Amount:** The negotiated amount an insurance company will pay a Provider for a service. The cost of a service varies based on the amount negotiated with your insurance company and a member's financial responsibility will be based on this amount.
7) **In-Network:** Providers who have a contract with your insurance company to provide services to you and be paid an allowed amount. Example: Seeking services from In-Network Providers most likely means smaller co-payments or co-insurance amounts for you.
8) **Out of Network:** Providers who do not have a contract with your insurance company, in which case you will likely pay more in service costs than you would for an in-network provider. Example: A member may be expected to pay higher co-insurance amounts or co-payments to go outside of the network.
9) **Out of Pocket Maximum**: The most the member will pay for the year before insurance pays at 100% (this may vary based on whether the insurance company counts co-insurance or co-payments toward the out-of-pocket maximum). Example: Insurance company has a $1,000.00 per year deductible but a $5,000.00 per year out of pocket maximum. If the member has paid the $5,000.00 for the year, they may be exempt from paying any more co-pay or co-insurance.
10) **Prior Authorization:** The requirement that a Provider obtain written approval from an insurance company before delivering a service. Not all services and not all insurance companies have this requirement. It is most common for Psychological Testing or DBT services. Example: Your insurance company requires a prior authorization before you start Psychological Testing which our Provider obtains by completing required paperwork. Example: Specific Pre-paid insurance plans will only allow members to go out of network if they obtain a prior authorization.