

Project HEAL

Insurance Navigation Resource Guide

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Reach out to insurance@theprojectheal.org if you or a loved one have questions about insurance or are seeking eating disorder-related insurance support.

To apply for additional treatment access support, please visit www.theprojectheal.org/apply-for-support

QUICK TIPS:

What Do I Really Need To Know About My Insurance Coverage?

Have a copy of your insurance policy handy.

It will be helpful to know what your policy does and does not cover, whether or not you are actively in treatment. Find out the information you need to know when looking for treatment options, either by calling your insurance plan, or by signing up and accessing your insurance company's online website.

- Does my plan pay for eating disorder-specific treatment? What levels of care does it cover?
- Does my plan pay for outpatient therapy or outpatient medical nutrition therapy?
- Does my plan have out-of-network benefits? If it does, how do I work with an out-of-network provider?
- What is the cost of my deductible, out-of-pocket max, co-pay?
- If I don't have out-of-network benefits, and there are no in-network options available to me is a Single Case Agreement possible?

Your insurance plan can offer you resources.

They can provide you an emailed list of in-network providers, treatment centers in your area, and aftercare planning when you are getting ready to step-down or discharge from a higher level of care.

Ask to be assigned a Behavioral Health Case Manager.

In some insurance plans, a Behavioral Health Case Manager may be referred to as a Case Manager or Care Coordinator. Being assigned a Case Manager is included, at no cost, within your insurance plan. A Case Manager will act as your advocate from within insurance, and they can also directly provide you resources for providers, treatment, etc. Call your Member Services number to ask about being assigned a Case Manager.

You have the right to appeal!

An appeal for denied services can be completed at any level of care (Inpatient, Residential, Partial Hospital, Intensive Outpatient, and Outpatient Therapy/Nutrition Therapy).



HEALTH INSURANCE GLOSSARY:

Terminology to Know

Affordable Care Act (ACA): the name of the health care reform law finalized in March 2010 that allowed people to purchase their own insurance as individuals, regardless of pre-existing conditions.

Allowed Amount: the negotiated rate and maximum amount your insurance company and provider have agreed upon for a covered health care service. Your co-payments and co-insurance will be based on this amount. This may also be called “eligible expense,” “payment allowance,” or “negotiated rate.” If your provider charges more than the plan’s allowed amount, you may have to pay the difference.

Annual Limit: the amount an insurance plan will pay in total benefits over a year. Once you hit the cap, your policy will not pay again until the next year. The ACA prohibits annual limits on essential health benefits with the exception of grandfathered plans.

Balance Billing: when a provider bills you for the difference between the provider’s charge and the allowed amount. For example, if the provider’s charge is \$100 and the allowed amount is \$70, the provider may bill you for the remaining \$30. A preferred provider (in-network provider) may not balance bill you for covered services. Balance billing typically occurs when a provider is out-of-network.

Benefits: the healthcare items or services covered under a health insurance plan.

Co-Payment: the amount you pay when you receive care. The co-payment amount is set by the insurance company not the doctor’s office. This can be a percentage or flat rate amount. For example, the amount you pay may be \$30.00 each time with the insurance company picking up the rest of the cost.

Co-Insurance: the amount you pay after you meet the plan’s deductible. For example, an 80/20 co-insurance rate means the insurance company pays 80% and you pay the remaining 20%. Co-Insurance usually does not start until you pay an amount equal to the deductible.

Deductible: the amount you pay out-of-pocket for medical expenses before your plan pays anything for the healthcare services you received.

For example, if your deductible is \$1,000, your plan won’t pay their portion for a covered service until you’ve hit your \$1,000 limit. Premiums do not count toward meeting your deductible.



Excluded Services: services your health insurance company or specific plan doesn't pay for.

Exclusive Provider Organization (EPO) Plan: this plan services are covered only if you use doctors, specialists, or hospitals in the plan's network (except in an emergency). Unlike HMOs, you do not need to select a PCP.

Explanation Of Benefits (EOB): an EOB is created after a claim payment has been processed by your health care plan. It explains the actions taken on a claim such as the amount that will be paid, the benefit available, discounts, reasons for denying payment and the claims appeal process. EOBs are available both as a paper copy and online.

Formulary or Drug List: a list of prescription drugs your health plan covers. Generic medications are typically covered in a formulary, whereas only some brand names are not.

Flexible Benefits Plan: a benefit program that gives employees a choice between cash, life insurance, vacations, retirement plans, and childcare. Although there are usually some requirements, flexible benefit plans offer a choice for the remaining benefits.

Health Insurance: a contract that requires your health insurer to pay for a portion (or all) of your healthcare services in exchange for a premium.

Health Insurance Marketplace: website where individuals, families, and businesses based in the US can research, compare and choose a health insurance plan that's best for them.

Health Maintenance Organization (HMO) Plan: this plan usually limits coverage to care from doctors who work for or contract with the HMO. It generally won't cover out-of-network care except in an emergency. An HMO may require you to live or work in its service area to be eligible for coverage. You must select a PCP on an HMO.

In-Network or Preferred Provider: a physician, healthcare provider or healthcare facility that has a contract with your plan to provide their members services at a lower cost to the insurance company.

Medical Necessity Criteria: standards used by health plans to decide whether treatments or health care supplies recommended by your mental health provider are reasonable, necessary and appropriate. If the health plan decides the treatment meets these standards then the requested care is considered medically necessary.

Network: the contract between your insurance and your healthcare provider.



Open Enrollment: the yearly period in the fall when you can enroll in a health insurance plan via the Insurance Marketplace on [healthcare.gov](https://www.healthcare.gov) for the next calendar year.

Out-of-Network: a physician, healthcare provider or healthcare facility that does not have a contract with your plan. Using healthcare services that are not covered in your plan will greatly increase the amount you have to pay.

Out-of-Pocket Limit: the amount you pay out of your own pocket when treatment or service is not covered by your plan. For example, some plans do not cover laboratory tests, x-rays, or medication.

Out-of-Pocket Maximum: the highest amount of money a person will have to pay during their plan period. It includes the money spent within the deductible amount, co-insurance, co-pays. Once you reach this limit, the insurance company will pay 100% of the allowable amount of costs for all covered benefits. Out-of-pocket maximum is higher than your deductible and does not include medication costs or services that are listed as excluded within your plan language. Today most plans have separate medication and medical out-of-pocket maximums.

Point of Service (POS) Plans: this plan allows you to pay less if you use doctors, hospitals, and other health care providers that belong to the plan's network. POS plans require you to get a referral from your primary care doctor in order to see a specialist.

Preauthorization (aka: prior-authorization or pre-approval): an insurance plan may require prior approval for certain services, drugs, or equipment to consider any charges. Preauthorization is not a guarantee that the insurance plan will cover the cost of the service, however, this is generally the first step for those requiring services that are not currently in-network with their insurance plan.

Preferred Provider Organization (PPO) Plan: this plan will allow you to pay less if you use providers in the plan's network. You can use doctors, hospitals, and providers outside of the network without a referral for an additional cost.

Premium: the amount you pay monthly, quarterly or yearly for your health insurance plan. If you have insurance through the workplace, your employer may pay a portion of your premium on your behalf as part of your employee benefit package.

Provider: a physician, healthcare provider or healthcare facility licensed, certified or accredited as required by law.



Specialist: this type of provider focuses on a specific area of medicine or illness. Some specialists may not be in-network with your plan.

Superbill: A superbill is a detailed, itemized receipt given to clients by a healthcare provider when:

- The provider cannot or does not submit out-of-network claims to a client's payer
- The client does not have health insurance
- A client is self-pay for any reason, such as:
 - Benefits do not include medical nutrition therapy (MNT)
 - Their diagnosis is not a covered benefit

A superbill may be used by clients for Health Savings Accounts (HSAs), Flexible Spending Accounts (FSAs), tax purposes, or to try to obtain reimbursement from their health plan.

A superbill does not guarantee an insurance provider will reimburse the client for the services provided. The ability of a health plan member to obtain reimbursement from a health plan is dependent on individual member benefits and coverage, as well as health plan policies regarding member reimbursement.

Medicare beneficiaries are unable to submit superbills for nutrition therapy provided by an out-of-network provider. For Medicare plans, outpatient nutrition sessions are only covered for diabetes, kidney disease, and three years following a kidney transplant.

Utilization review (or utilization management): process used by insurers to decide whether the requested mental health care is medically necessary, efficient and in line with accepted medical practice. In line with accepted medical practice means that the mental health treatment or service is proven to be effective based on scientific evidence.



NAVIGATING YOUR BENEFITS:

Eating Disorder Insurance Q & A

Health insurance policies can be overwhelming and tricky.

There is a lot of different information that varies by policy, and it can be confusing to understand what your plan does and does not cover, how much the cost is per service, etc.

Q: What do all the different payment terms mean?

A: A few different factors go into paying for treatment. Most insurance plans have a *premium*, which is a monthly fee that the patient pays for their insurance plan. Many patients also have an *insurance deductible*, which is a set amount that the patient has to pay out-of-pocket *before* their insurance benefits kick in. After the deductible is met, patients are typically responsible for a *copay* (a set dollar amount per visit) or *co-insurance* (a set percentage of the total cost of the visit) each time they receive treatment. Many insurance plans also have an *out-of-pocket maximum (OOPM)*, which is a cap on the amount that the patient pays per year in copays and/or co-insurance.

Q: What are common reasons an insurance company denies coverage of eating disorder treatment or payment for services?

A: While there are many reasons a health insurance plan may deny coverage of eating disorder treatment or payment for such services, there are some common reasons you may be experiencing, depending on your plan and the services you are seeking coverage for.

- Level of care (or services) deemed not “medically necessary”
- Not eligible for coverage of services requested under your health plan and/or lack of your plan including a benefit (such as eating disorder residential level of care)
- Failure to attempt treatment a lower level of care prior to requesting coverage for a higher level of care
- Not eligible for coverage of services requested until trying “X” services (generally preferred in-network option or one geographically closer)
- Eating disorders are not an explicitly named “row” of issues covered on your health plan’s Explanation of Benefits (EOB) and therefore quickly dismissed without adequate exploration by the payor

Q: What is the difference between Medicare and Medicaid?

A: Medicaid is a state-run health insurance for people whose income is below a certain level. Medicare is a federally-run health insurance for people above the age of 65 and who have certain qualifying disabilities. Medicaid coverage can vary by state and managed Medicaid plan, while Medicare is accepted in many states regardless of the plan.



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Q: What ED treatment do Medicare and Medicaid cover, and why is it so limited?

A: Currently, most Medicare and Medicaid plans limit their coverage of eating disorder treatment to inpatient (hospital-based) and outpatient programs. It's important, however, to keep in mind that every plan is different and that you should contact your insurance company to verify your benefits and coverage options.

The coverage of eating disorder treatment for those with Medicare and Medicaid is so limited because of how those programs have been designed. The Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) is a federal law that generally requires group health plans and health insurance payors to provide mental health or substance use disorder benefits to have equal benefit coverage of mental health diagnoses as medical diagnoses. However, because medical issues are treated either in a hospital or via office visits, the MHPAEA limits mental health coverage to the same treatment options, i.e. inpatient or outpatient. This then excludes any other levels of care that are often required for mental health conditions like eating disorders, including residential, most partial hospitalization programs (unless they are hospital-based), and most intensive outpatient programs (unless they are hospital-based).

Medicare also does not cover Medical Nutrition Therapy for eating disorders. Medicare will cover outpatient nutrition sessions when struggling with kidney issues or Diabetes, but not nutrition therapy solely for an eating disorder diagnosis.

The Nutrition CARE Act (2018) is an initiative proposed by the **Eating Disorders Coalition** to "modify the Medicare benefit design to include outpatient Medical Nutrition Therapy (MNT) as a covered benefit under Medicare Part B."

Q: How do I know which providers are in-network?

A: In-network providers are those who are "preferred" or covered by your insurance plan. To find who is in your network, it may be easier to call your Member Services number and request a list to be emailed to you, listing in-network providers you are looking for (Therapist, dietitian, psychiatrist, etc.).



These providers may be available on the insurance website when entering your area code in a search tool, and if you are purchasing an insurance plan on the Insurance Marketplace, you can enter your providers in a tool to show which plans match your current providers. Another way to check if your providers take your specific plan is to call your selected provider's office, and they will inform you if they are in- or out-of-network and provide a benefits check before your scheduled appointment.

Q: My insurance plan does not have any in-network outpatient specialized eating disorder therapists. Is there anything I can do to avoid paying a provider out-of-pocket?

A: Depending on the specific insurance plan, there are likely steps you can take to avoid taking on out-of-pocket costs. Specifically, you will want to follow up with a representative from your insurance company who can let you know whether or not your plan has an option to coordinate a single case agreement (SCA) or special coverage agreements. An SCA is a contract between an insurance company and an out-of-network health care provider for a specific patient that enables the patient to receive in-network coverage for an out-of-network provider for an established period of time. Calling the Member Services number, typically located on the back of your insurance card, will connect you to an insurance representative.

Q: What do I need to do to see a provider out-of-network?

A: If you do need to see a provider who is not in your network or, out-of-network, due to the services you are seeking not being available in-network or in your area, there are additional and different steps you may need to take per your plan's out-of-network policy.

If your plan has an out-of-network benefit, this will likely be covered by the plan, but this will usually be at a higher deductible and/or co-pay. Often if out-of-network benefits are available, there may be a \$4,000 deductible for in-network services, for example, and a \$8,000 deductible for out-of-network. Your in-network copay may be \$25 to see your PCP, whereas the out-of-network copay may be \$50.

It is often the case that eating disorder providers or treatment centers will be out-of-network (a frequent and understandable frustration). Eating disorder providers may be out-of-network if your insurance plan does not cover eating disorder services, or there are no specialists available in your area or network.

In these cases, if it is an outpatient provider you are seeking for an eating disorder and they are out-of-network, this will often have to be paid out-of-pocket. Many outpatient providers offer a sliding scale, and you may be able to discuss with them a smaller amount they are willing to bill for your sessions. If an eating disorder treatment center is out-of-network, many plans will allow a Single Case Agreement, a one-time, negotiated contract between provider and insurance payor to set up coverage for your treatment. The amount billed and paid for this service will be discussed ahead of time.



Q: What is pre-authorization and utilization review?

A: A pre-authorization review occurs when your health insurance company reviews a patient's request for treatment. During the authorization request, your health insurance company will decide whether they are able to cover the requested treatment. A utilization review, typically completed by your treatment facility and/or provider, is a request for continued stay and additional days in treatment. During the utilization review, your insurance company will request information to meet medical necessity criteria according to *The Milliman Care Guidelines ("MCG")*, a set of health industry best practices, guidelines and diagnostic criteria published by MCG Health for providers and health plans.

Q: What are my options if my health insurance denied pre-authorization for my treatment or covering treatment services already rendered?

A: If your insurance company denies coverage for treatment services, you can submit an appeal for your health insurance to review their decision. The appeal process differs by health insurance company; you can find more information on your health insurance's appeal process on their website or by calling Member Services. You can find more information about health insurance appeals [here](#) and [here](#). If your appeal is denied, you may want to resubmit. If you believe the denial was unfair to the point of being illegal, you should consult an attorney.

Q: How do I submit a Single Case Agreement (SCA)?

A: The process of coordinating a SCA varies by insurance provider. However, since SCAs involve both your insurance and your treatment provider, it is recommended to be in touch with both parties throughout the process so that everyone is on the same page.

****Read more on starting the SCA process further on in these insurance guides.**

Q: Will my health insurance cover treatment expenses from a facility located in a state different from where I live?

A: It depends on your insurance provider. Most insurance providers' websites have a list of all of their in-network treatment providers, so it's important to check there before your first treatment appointment.



Q: What is the Mental Health Parity and Addiction Equity Act (MHPAEA)?

A: The MHPAEA is a federal law that was signed in 2008. This law requires that insurance companies provide equivalent coverage for mental health and substance use services that they would for other health services. This law paved the way for in-network mental health coverage. However, it is underenforced. It is also proving insufficient for eating disorder treatment because medical care only includes hospital visits or office visits, while eating disorder treatment also includes residential, PHP, and IOP, which are not included under parity.

The Mental Health Matters Act, passed in the US House of Representatives on September 29, 2022 significantly expands the US Department of Labor's authority to enforce or file civil litigation with respect to mental health parity violations under the MHPAEA and eliminates discretionary clauses.

Health Plans that MUST follow parity:

- Group health plans for employers with 51+ employees
- Most group health plans for employers with 50 or fewer employees unless they have been “grandfathered,” which means it was created before the federal parity laws went into effect
- The Federal Employees Health Benefits Program
- Medicaid Managed Care Plans (MCOs)
- State Children's Health Insurance Programs (S-CHIP)
- Some state and local government health plans
- Any health plans purchased through the Health Insurance Marketplaces
- Most individual and group health plans purchased outside the Health Insurance Marketplaces unless “grandfathered”

Health plans that DO NOT have to follow parity:

- Medicare (except for Medicare's cost-sharing for outpatient mental health services do comply with parity)
- Medicaid fee-for-service plans
- “Grandfathered” individual and group health plans that were created and purchased before March 23, 2010.
- Plans who received an exemption based on increase of costs related to parity

The Federal Center for Medicaid and Medicare (CMS) can also enforce parity if states do not enforce the law. If you have concerns that your insurance plan is not following parity, contact the CMS help line.

1-877-267-2323 Ext 6-1565

[Read more on the MHPAEA here.](#)



Q: Who can I talk to when I have questions about billing, coverage, etc.?

A: When having questions related to billing or coverage of your insurance plan, it is best to call the Member Services number on the back of your insurance card. Depending on your plan, there may be different Member Services numbers to call, a separate one for medical and one for behavioral health. If you need to reach a separate department, a customer service representative will transfer you to the appropriate department.

Q: How to obtain a copy of my insurance benefits?

A: A copy of your insurance benefits with the plan you have chosen should often be provided to you when you first enroll in your plan. This will often be in the form of a PDF, outlining the covered services, costs, premium, etc. If you do not have a copy of this, try looking on your insurance website, or speaking to your employer's HR department (if insurance is through work), to obtain a copy. You may also call Member Services to request this document be emailed to you.

Q: My insurance does not cover pre-existing conditions and considers my eating disorder a pre-existing condition. How do I get treatment covered?

A: As of 2014, Obamacare will prohibit insurance companies from excluding anyone with a pre-existing medical condition from coverage. If your insurance companies still reports they will not cover a pre-existing condition, you can seek help from a legal aide or other treatment advocate to assist in fighting for your eating disorder treatment to be covered.

HOW DO I KNOW WHAT MY INSURANCE COVERS?

Figuring out what your plan covers can be an overwhelming and exhausting process, and overall, a lot of work.

Every insurance plan is different. Here are some ways you can find out what your insurance plan covers:

- If you have access to it, read your insurance manual. There should be a Summary of Benefits section that lists out covered services, costs, etc.
- Visit your health plan's website. Your mental/behavioral health benefits should be listed under covered benefits on the site. Your insurance card may include the web address. If you do not already have one, you may need to create an online account to view your plan information.
- Call your insurance company's Member Services number, a toll-free number typically listed on the back of your insurance card. Ask to speak to a customer representative about coverage for mental health services. Ask them to explain your benefits. If you have a diagnostic code, that may help you get accurate information. Diagnosis codes are a combination of numbers and letters typically used by treatment providers and insurance companies to identify covered benefits, claims, and payment. If you have a provider, you can ask them what your diagnosis code is for insurance purposes. Please remember – you are not your diagnosis. These labels are used to help describe, for insurance, and not to define.

Questions to ask when you call for insurance benefits:

- Is mental health a covered benefit?
- Is mental health covered for outpatient and higher levels of care such as Intensive Outpatient, Partial Hospital, Residential, and Inpatient?
- Is Medical Nutrition Therapy covered?
- Are there a limited number of visits covered within the plan (for mental health therapy, medical nutrition therapy, inpatient, etc.)?
- What is my copay for (service requested)?
- What is my deductible?
- What is my out-of-pocket max?
- Do I have out-of-network benefits?
- Are there any limitations or exclusions specific to eating disorder services?



- Can you send me a copy of my benefits, and/or can I access it on the insurance website?
 - Ask for a copy of the guidelines your insurance company uses to determine the level of care (they're required to give it to you).
- You can also call a treatment center or provider and provide your health insurance information. They will reach out to insurance for you and run a “Verification of Benefits” and break down what your benefits look like and what is covered.

What is a Medical Necessity? Is that different from a covered service?

Medical necessity is a term you may come across when seeking mental health and eating disorder treatment. Medical necessity is not the same as a covered medical benefit.

A medical benefit is something that your insurance plan has agreed to cover. Medical necessity is treatment, such as higher levels of care of eating disorder treatment, that your provider feels is necessary for you to receive. Insurance may not agree with what is medically necessary. Insurance companies often deny coverage for medically necessary eating disorder treatment or approve treatment only for a lower level of care.

If your insurance company denies your treatment, you have the right to appeal their decision. If working with a provider, they can help guide you through the appeal process. Your insurance company will also provide you information needed to appeal their decision yourself. Be persistent and advocate for yourself as much as possible.

Denials can be reversed. Do not give up!



AFFORDABLE CARE ACT

& *THE INSURANCE MARKETPLACE*

What is the Affordable Care Act?

The Affordable Care Act (ACA), also known as “Obamacare,” was developed to help individuals access affordable health insurance through a health insurance Marketplace.

The Affordable Care Act helps create a competitive private health insurance market, designed to put people in charge of their health coverage and care. These State-based, competitive marketplaces provide millions of Americans and small businesses with "one-stop shopping" for affordable coverage.

To purchase a plan through the insurance marketplace, sign up must be during open enrollment (a period each year when you can sign up for health insurance or change your plan). You may still be eligible to sign up for a plan outside of open enrollment if you had a qualifying life event (changing jobs, losing a job, getting married/divorced, moving, having a baby, etc).

The marketplace has several health insurance companies with many pros and cons varying in provider networks, deductibles, and other costs. The marketplace is set up to compare each plan and the pros and cons easily on the site.

Source:

<https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Marketplaces>

What is the Marketplace?

The health insurance Marketplace, varying in by state, is an online marketplace in which people can purchase health insurance. You can view and compare insurance for coverage and affordability, due to the ACA.



Common Questions Asked About The Insurance Marketplace:

Q: Can I apply for insurance through the Marketplace any time?

A: Marketplace plans can be purchased in the following circumstances:

1. **During the Open Enrollment Period**
2. **During a Special Enrollment Period**
3. **If you are eligible for Medicaid or CHIP**
4. **If you applied for Medicaid or CHIP during open enrollment and find out you're ineligible after open enrollment ends**
5. **If you are Native American**
6. **NY, MN, and MA residents with "fairly low income"**

The **Open Enrollment Period** is the yearly period in the fall when you can enroll in a health insurance plan via the Insurance Marketplace on healthcare.gov for the next calendar year. Open Enrollment occurs at the end of the year November 1 through December 15 (sometimes ending at a later date, as this end date varies by state). Once you enroll, your new insurance coverage will begin on January 1 of the New Year.

With a **Special Enrollment Period**, you must have qualifying life event for an individual or family to purchase health insurance outside of the annual ACA open enrollment period. Examples of qualifying life events are loss of other insurance coverage, the birth or adoption of a child, marriage, divorce, moving, or certain other life changes. If eligible, you may qualify for help paying for coverage, even if you weren't eligible in the past. **There is a 60-day window through the marketplace that triggers a special enrollment period when an individual experiences a qualifying life event. For Medicare coverage, most qualifying events trigger 2-month special enrollment periods, but there are exceptions.**

**Although loss of existing minimum essential coverage is a qualifying event that triggers a special open enrollment period for ACA-compliant individual market plans, short-term policies are not considered minimum essential coverage, so the loss of short-term coverage is not a qualifying event.*

Through **Medicaid or the Children's Health Insurance Program (CHIP)**, You can apply any time and can enroll immediately if you're eligible. If you are denied coverage and deemed ineligible for Medicaid or CHIP after open enrollment ends, you will be able to apply for a new insurance plan through the Marketplace.

To be eligible as a **Native American** for open enrollment, you must be a member of a recognized Indian tribe, band, or nation, according to the Indian Healthcare Improvement Act.



New York (the Essential Plan) and Minnesota (MinnesotaCare) both offer year-round enrollment and are available to residents with income up to 200% of the poverty level.

Massachusetts (ConnectorCare) is available to residents with income up to 300% of the poverty level.

Q: How do I report changes to my income, family, or address?

A: You can report changes to the Marketplace 3 ways: online, by phone, or in person — not by mail. It's important to report any changes as soon as possible. These changes may affect your coverage and savings.

Q: How do I submit documents?

A: You can upload the documents online, which is the fastest and easiest way to get them processed. Or you can mail copies instead.

Q: How do I pay my monthly premium to complete my enrollment?

A: When you have Marketplace insurance, you'll pay your premiums directly to the insurance company — not to the Health Insurance Marketplace®. Your coverage won't start until you pay your first premium.

Q: What if I am not a U.S. Citizen? Can I apply for insurance through the marketplace?

A: Yes, though there are certain circumstances to qualify for insurance through the Marketplace. [Click here to learn more.](#)

Q: Who is eligible to enroll in health insurance plans through the Marketplace?

A: You must:

- Live in the United States
- Be a US citizen or national, or be lawfully present in the US
- Not be incarcerated, though you can enroll once you are no longer
- Not have an active Medicare plan

You *can* have both a Marketplace plan and Medicaid, but you're not eligible to receive advance payments of the premium tax credit or other cost savings to help pay for your share of the Marketplace plan premium if you are enrolled in Medicaid.



Q: How do I choose an insurance plan on the Marketplace?

A: If you are qualified for a health plan through the Affordable Care Act (through open enrollment or a qualifying life event), you can start by going to, you can apply for health coverage in several ways:

- Online at healthcare.gov
- By phone
- With the help of someone in your community
- Through an agent/broker
- Through certified enrollment partner websites
- With a paper application
- The most common, and easiest, way to review and choose a health plan is to go to healthcare.gov. This will allow you to visually view health plans side-by-side to compare coverage.

Q: What is ACA-Compliant coverage?

A: With ACA plans through the insurance marketplace, you can't be denied coverage or denied the minimum 10 essential health benefits these plans must cover. ACA plans can offer additional benefits, but these 10 must be included in any ACA-compliant plan. You cannot apply for ACA-compliant medical plans at any time of year. To apply for one of the ACA medical plans, you must enroll during the open enrollment period or during a special enrollment period.

The 10 minimum essential health benefits are:

1. Outpatient care
2. Prescription drugs
3. Emergency services
4. Mental-health and addiction treatment
5. Hospitalization
6. Rehabilitative services and devices
7. Preventive, wellness, and chronic disease treatment
8. Laboratory services
9. Pediatric care
10. Maternity and newborn care



Q: What if I need help enrolling in an insurance plan through the marketplace that meets my needs?

A: Project HEAL offers annual 1:1 support via phone or Zoom call to help assist in choosing a plan that will meet individual and treatment. An Open Enrollment Webinar is also located on our website [here](#).

Out2Enroll is a "a national initiative launched in September 2013 to connect our communities—LGBTQ+ people and our families, friends, and allies—with the new health insurance coverage options available under the Affordable Care Act." Out2Enroll also lists Transgender Health Resource Guides, by state [here](#).



HEALTH INSURANCE CATEGORIES & PLANS

Health Plan Categories:

Health plan categories are based on how you and your plan split the costs of your health care. They have nothing to do with quality of care.

Plans will be available and vary by income.

- **Bronze Plan** – Estimated to cover 60% of medical bills, leaving the insured member to pay the remaining 40% up to established out-of-pocket maximum.
- **Silver Plan** – Estimated to cover 70% of medical bills up to established out-of-pocket maximum.
- **Gold Plan** – Covers 80% of medical bills up to established out-of-pocket maximum.
- **Platinum Plan** – Estimated to cover 90% of medical bills up to established out-of-pocket maximum.

	Insurance Pays	You Pay
Bronze	60%	40%
Silver	70%	30%
Gold	80%	20%
Platinum	90%	10%

**Based on chart located on [healthcare.gov](https://www.healthcare.gov)*



Health Insurance Plans:

There are different types of plans designed to meet different needs. Some plans restrict your provider choices or encourage you to get care from the plan's in-network of providers and medical services.

Health Maintenance Organization (HMO) Plan: this plan usually limits coverage to care from doctors who work for or contract with the HMO. It generally won't cover out-of-network care except in an emergency. An HMO may require you to live or work in its service area to be eligible for coverage. You must select a PCP on an HMO.

Exclusive Provider Organization (EPO) Plan: this plan services are covered only if you use doctors, specialists, or hospitals in the plan's network (except in an emergency). Unlike HMOs, you do not need to select a PCP.

Point of Service (POS) Plan: this plan allows you to pay less if you use doctors, hospitals, and other health care providers that belong to the plan's network. This plan offers out-of-network benefits at a higher cost for in-network providers (compared to an HMO). POS plans require you to get a referral from your primary care doctor in order to see a specialist.

Preferred Provider Organization (PPO) Plan: this plan will allow you to pay less if you use providers in the plan's network. You can use doctors, hospitals, and providers outside of the network without a referral for an additional cost. The biggest difference between a PPO and POS is flexibility. POS plans will typically cost less but offer fewer choices.



Step-by-Step Guide: How to apply for health insurance on the Marketplace

1

Go to healthcare.gov.
Click "Take the first
step to apply" or Login
to renew/ change
plans"

2

Login if you have an
account, or choose your
state from the
dropdown. You will be
directed to your state's
insurance marketplace.

3

Create a new
account or Login to
existing account on
your state's
Marketplace.

4

Complete a new
application per
your state
Marketplace's
instructions.

5

Once completing your
application and confirming
your eligibility, click on
"Shop for Plans."
You can also view plans
prior to completing
application.

6

All plans within your
eligibility will appear on the
site. You have the option to
enter in your providers, to see
if they accept the available
health policies, and to filter
preferences to narrow down
or compare the plans.

This can be a difficult and
overwhelming decision.

If you feel you need additional
guidance before selecting your
plan and would like to ask some
questions, you may call:

1-800-318-2596

Available 24/7, other than on
holidays.

APPLYING FOR MEDICAID

Because each state manages its own Medicaid program, eligibility varies from one state to another. If you have questions about qualifying, contact your state Medicaid agency, or apply online at the website for your state Medicaid agency to see if you qualify.

[Click here to learn about Medicaid eligibility in each state.](#)

Who does Medicaid serve?

Medicaid programs serve specific groups of people, including:

- Pregnant women with low income
- Children of low-income families
- Children in foster care
- People with disabilities
- Seniors with low income
- Parents or caregivers with low income
- States can also choose to expand eligibility to other groups, such as people with low income who may or may not have children.

Medicaid plans *must* include **mandatory health benefits** under federal law. Some Medicaid plans may offer additional, optional benefits.

Each state decides the full range of benefits that it covers under Medicaid. As a result, the populations and benefits covered by Medicaid and CHIP vary across states.

In all states, Medicaid provides health care coverage for some low-income people, families and children, pregnant women, the elderly, and people with disabilities. In some states, Medicaid also covers all low-income adults below a certain income level. This group is sometimes called “**expansion adults.**”

CHIP (Children's Health Insurance Program), provides low-cost insurance for children whose families do not meet the income eligibility requirements for Medicaid. CHIP may also provide coverage for pregnant women in some states but does not cover adults for children who qualify for CHIP.

Federal law requires states to provide certain “mandatory” benefits and allows states to cover other “optional” benefits in Medicaid and CHIP.



A **Dual Special Needs Plan** (or dual-eligible health plan) is a type of health insurance plan for people who have both Medicaid and Medicare. These people are “dual-eligible” because they’re eligible to receive Medicaid benefits as well as Medicare benefits.

Dual Special Needs Plans provide extra help to those who need it. That may be because of income, disabilities, age and/or health conditions.

Dual Special Needs Plans will work together with your Medicaid plan. You’ll keep all your Medicaid benefits. Most dual health plans also give you more benefits and features than you get with Original Medicare.

Mandatory Medicaid Benefits:

- Inpatient hospital services
- Outpatient hospital services
- Early and periodic screening, diagnostic and treatment services (EPSDT)
- Nursing facility services
- Home health care services
- Physician services
- Rural health clinic services
- Federally qualified health center services
- Laboratory and X-ray services
- Family planning services
- Nursing midwife services
- Certified pediatric and family nurse practitioner services
- Freestanding birth center services (when licensed or otherwise recognized by the state)
- Transportation to medical care
- Tobacco cessation counseling for pregnant women

Optional Medicaid Benefits:

- Prescription drugs
- Clinic services
- Physical therapy
- Occupational therapy
- Speech, hearing, and language disorder services
- Respiratory services
- Other diagnostic, screening, preventive and rehabilitative services
- Podiatry services
- Optometry services/eyeglasses
- Dental services/dentures



- Prosthetics
- Chiropractic services
- Private duty nursing services
- Personal care
- Hospice
- Case management
- Services for individuals aged 65 or older in an institution for mental disease (IMD)
- Services in an intermediate care facility for Individuals with intellectual disability
- Self-directed personal assistance services
- TB-related services
- Inpatient psychiatric services for individuals under age 21
- Other services approved by the Secretary of Health and Human Services
- Health homes for enrollees with chronic conditions

APPLYING FOR MEDICARE

Who does Medicare serve?

Medicare serves specific groups of people, including:

- People age 65 or older
- People under age 65 with certain disabilities
- People of all ages with End-Stage Renal Disease

Medicare Part A (Hospital Insurance)

Helps cover inpatient care in hospitals, skilled nursing facility care, hospice care, and home health care

Medicare B (Medical Insurance)

Helps cover services from doctors and other health care providers, outpatient care, medical equipment, and preventive services

Medicaid Parts A & B are often referred to as "**Traditional Medicare.**"

To help pay out-of-pocket costs with traditional Medicare (typically a 20% coinsurance), you can also buy supplemental coverage, like Medicare Supplement Insurance Medigap, have secondary coverage from a former employer or union, or Medicaid.

If Medicare is primary with a secondary Medicaid, or Dual Medicare/Medicaid plan, the Medicaid benefits can only be used if the provider/treatment center also takes Medicare.

Medicare Advantage Plans (AKA Medicare C)

A Medicare-approved plan from a private insurance company that offers an alternative to traditional Medicare. These “bundled” plans include Part A, Part B, and usually Part D (drug coverage). These plans may have lower out-of-pocket costs than traditional Medicare.

Medicare Part D (Prescription Drug Coverage)

Available to everyone with Medicare. To get Medicare prescription drug coverage, people must join a plan approved by Medicare that offers Medicare drug coverage. Most people pay a monthly premium for Part D.

[Click here to learn how to apply for Medicare.](#)



SINGLE CASE AGREEMENTS (SCAs)

What is a SCA?

A **Single Case Agreement (SCA)** is a one-time contract between an insurance company and an out-of-network provider so the patient can see that provider using their in-network benefits. It is essentially an exception to the network so that the patient will only have to pay their routine in-network co-pays for sessions after meeting their in-network deductible (if any). The fee per session that will be paid by the insurance company is negotiated by the insurance company and the provider as part of the SCA.

SCA can be justified when:

- The outpatient provider/treatment program has a clinical specialty, which is not available among any in-network provider
- The in-network provider does not treat people of your age, gender, or religious preference
- The geographical location of the patient does not have any in-network providers
- A patient who has recently changed their insurance plan or is stepping down to a different level of care at the same facility (continuity of care)
- All in-network providers are full and have no availability
- There is proof that the available in-network providers are inappropriate or would cause harm (e.g. the patient is transgender and they need a provider with expertise in transgender expertise)
- If a plan does have out-of-network benefits, the deductible, out-of-pocket max, and/or co-pay may be too costly financially
- SCAs can be obtained and are often needed Medicaid plans, when there are often no in-network options and no out-of-network benefits are available. This is especially common in Medicaid plans when residential level-of-care is being requested
- SCAs are possible for some Medicare plans, but it may be more difficult to obtain a SCA with Medicare than private plans or Medicaid plans - the best first step to request a SCA for Medicaid and Medicare is to request a behavioral health case manager (or Medicaid/Medicare may refer to case manager as case coordinators)

How do I set up a SCA?







SCAs are typically negotiated directly between your healthcare provider and your insurance company. When you first reach out to your healthcare provider for treatment, you can ask them whether they would be willing to negotiate a SCA with your insurance company. Be prepared to provide details about your medical history and whether you have received eating disorder treatment in the past. The stronger your case is that your chosen provider is the best care for you, the more likely your insurance company will agree to a SCA.



How long does a SCA last?

SCAs typically last for the length of your treatment. However, if you complete treatment with your provider and decide to resume treatment at a later date, you would need to negotiate a new SCA with your insurance company.

Steps To Set Up and Advocate For a SCA:

-  Start by contacting member services at your insurance company (behavioral/mental health number will often be on the back of your insurance card) to request a list of in-network (INN) providers/treatment facilities that specialize in eating disorders.
-  If there are no INN providers available, ask if you have out-of-network benefits. Many insurance plans do not have out-of-network benefits. In this case, ask who you can speak to to determine if a single case agreement is possible. Inform them you have “exhausted all resources” and “there are no known residential eating disorder facilities INN” with your plan that meets _____ needs.
-  When speaking with your insurance company, ask to be assigned a behavioral health case manager, if you do not already have one. This is a free enrollment, and your case manager will be your advocate from inside the insurance company, helping connect you to INN resources. Your case manager will be your point of contact at the insurance company. Tell the representative on the call this is urgent and contingent on you finding immediate treatment - this will hopefully lead to them getting back to you sooner rather than later. If you haven't heard back in 1-2 weeks, do not be afraid to call back and be a squeaky wheel!
-  If you do not have INN providers that meet your needs, research and call eating disorder treatment admissions to ask if they will work with your insurance by requesting a SCA. This will often vary by plan, and certain facilities will not work with Medicaid. Start with in-state or closer-by facilities, if possible - these are sometimes more likely to be approved for a SCA.
-  Once you find a treatment center willing to work with your insurance, they will guide you through next steps in the process to be assessed and request the SCA.
-  If you have outpatient providers (therapist/dietician/psychiatrist/PCP), it may be helpful to have them communicate with the treatment center to provide more rationale for your recommendation to a higher level of care and the need for a SCA. This may be helpful in gathering more information for insurance to meet “medical necessity criteria” for a SCA.

APPEALING INSURANCE DENIALS

If your health insurance denies coverage for your treatment, you can submit an **appeal**.
There are two types of insurance appeals:

- **Internal appeal:** your insurance company does a “full and fair review” of its decision to deny coverage for treatment. You can learn more about internal appeals [here](#).
- **External review:** an independent third party determines whether your insurance company should have denied coverage for treatment. You can learn more about external reviews [here](#).

Appeal Letter Template 1

(Source: [University of Rochester Medical Center](#))

Dear [Appeals Analyst]:

I am writing, on behalf of [name of Plan member if other than yourself], to appeal the [name of Health Plan] decision to deny [name of service, procedure, or treatment sought] for [name of Plan member if other than yourself].

It is our understanding that [name of Health Plan] is denying coverage on the basis that “[cite Health Plan’s language in the denial letter].” [Attach denial letter.] We believe that [name of service, procedure, or treatment sought] is medically necessary to treat [name of Plan member if other than yourself]’s medical condition and that [name of service, procedure, or treatment sought] is a covered plan benefit.

[Name of Health Plan] covers medically necessary services that are not expressly excluded, which are described in the Evidence of Coverage and which are authorized by the member’s PCP and in some cases approved by an Authorized Reviewer. [Attach relevant section from Evidence of Coverage.]

The entire treatment team has recommended that [name of service, procedure, or treatment sought] is medically necessary. [Attach supporting medical letter.]

Contrary to your letter, [name of service, procedure, or treatment sought] is a covered service. [Name of service, procedure, or treatment sought] is stated as a covered benefit in your HMO Member Handbook, is implicitly covered in the Evidence of Coverage, and is not expressly excluded as a covered service in the Evidence of Coverage. [Quote from Member Handbook and Evidence of Coverage to establish that the service, procedure, or treatment is a covered benefit and not expressly excluded.] [Cite your state’s mandated benefit laws requiring that the health plan provide this coverage.]



[Describe member's health condition, and why the service, procedure, or treatment would benefit the member and the consequences if the patient does not receive this treatment.]

[If the treatment is out-of-network, establish that there are no comparable services offered within the network.]

[Finally, if you feel they won't cover the service because of the precedent, ask them to consider covering it as an extra-contractual benefit, and to pay for the service, procedure, or treatment out of the Health Plan's catastrophic payment pool.]

[If the member requires immediate treatment for the condition, request an expedited hearing – request that they respond within 72 hours of mailing of the letter. Note that ACA now requires a 72-hour expedited internal review for urgent care. This time frame is required for plan years or policy years beginning on July 1, 2012.]

[Attach a letter from your treating physician describing the person's condition.]

Thank you for your immediate attention to this matter.

*Sincerely,
[Your name]*

cc: [Possible people to whom you should consider sending copies of your letter including Health Plan Medical Director; Medical Group; Medical Director; Your primary care or treating physician; Your state representative if you expect more denials]



Appeal Letter Template 2

(Source: Journal of Psychiatric Practice: Providing a Routine Medical Necessity Letter to Improve Access to Care for Our Patients)

By Joseph Feldman, MBA Mark DeBofsky, JD Eric M. Plakun, MD Cheryl Potts, MBA

Date:

To Whom It May Concern:

This letter describes my clinical assessment and the medically necessary treatment for my patient [patient]. I have been treating [patient] since approximately [date].

[Provider credentials and practice]— include a brief summary of your training, medical or other professional school, residency, fellowship and internship training, hospital affiliations, years in practice, peer-reviewed publications in the area in question, relevant specialties relevant to the specific patient, and any other description of your qualifications that inform your professional judgment. The information included here will establish your qualifications to make the clinical determination to be described below.

[Substantiated clinical assessment]— include a brief summary of your diagnosis/assessment, focusing on the particulars relevant to the medically necessary treatment that you have determined is appropriate including:

- *Related observations that informed your determination of the treatment plan.*
- *Peer-reviewed standards and medical treatment guidelines that informed your judgment. (Guidelines may include LOCUS,⁸ CALOCUS,⁸ ASAM,⁹ DSM-5,¹³ Psychiatry Online guidelines,¹⁰ AACAP primary case guidelines,¹¹ Nice (UK) guidelines,¹² and institutional guidelines.) To the extent that this particular patient's needs vary from or are atypical vis-à-vis standards and guidelines, it would be helpful to include relevant commentary.*
- *Considerations related to standards of care and other references based on the Wit v United Behavioral Health lawsuit (see Appendix B "Suggested Text for Potential Inclusion in a Medical Necessity Letter"). (It is neither necessary nor appropriate (a) to speculate on the probability of success with any particular course of treatment, (b) to explore any "what ifs" regarding the potential evolution of the treatment, or (c) to assess whether or not the insurance policy will cover the treatment. Your current assessment is sufficient.)*

[Course of treatment]— description of the course of treatment that you have determined to be medically necessary, including:

- *Summary rationale for your medical decision-making.*
- *When possible, link your recommendation for medically necessary treatment to a professional society multidimensional assessment instrument, such as the Level of Care Utilization System for Psychiatric and Addiction Services (LOCUS)⁸ or the Child and Adolescent Level of Care Utilization System (CALOCUS)⁸ developed by the American Association of Community Psychiatrists or the American Society of Addiction Medicine (ASAM) criteria.⁹ Also include reference to the relevant elements of effective treatment from the Wit lawsuit (specific suggestions are provided in Appendix B to this article).*
- *Be sure to use the words “determined to be medically necessary”; leave no doubt that “medically necessary” is the standard for your treatment decision.*
- *Identify (a) specific harms that could occur, (b) avoidable risks that could be mitigated, and/or (c) clinical gains that could be lost absent your planned course of treatment.*
- *This letter is neither a recommendation for approval nor the persuasive presentation of evidence for evaluation by others. Rather, it introduces you and your expertise, summarizes your relationship with and assessment of the patient, and your (by now, obviously qualified) determination.*

*Sincerely,
[Signature]*

Click below to view more sample appeal letters:

[Sample Letters To Use With Insurance](#)

[Submitting Appeals To Insurance For OSFED Treatment Denial](#)

APPEALS PROCESS

for eating disorder higher levels of care

1. Peer to Peer

A Peer to Peer is a phone conversation between your treatment provider (typically a psychiatrist or licensed therapist) and a doctor (MD) at the insurance company. This occurs when a request for services is being considered for denial by insurance.

2. Level 1 Internal Appeal

If the MD denies services in the peer to peer, an internal appeal may be requested to assess whether or not the correct determination was made when the services were denied. This may involve another conversation between your treatment team and MD, or a review of medical records, or both. Typically, this will be requested as an "expedited appeal" and will take place within 48-72 hours.

3. Level 2 Internal Appeal

Reconsideration of the denial will take place with a different MD at the insurance company. This may be completed by chart review, a live conversation involving the treatment team, and in some cases, family members and/or client, to dispute the denial. This appeal may take longer.

4. External Appeal

If the denial continues to be upheld through each level of internal appeal, you may request an independent external review. A third party, called an Independent Review Organization, will be selected by the insurance company. The determination may take up to 45 days. If the denial is overturned, insurance is legally obligated to pay for services.

***This appeal process varies by policy and does not apply to Medicaid, Medicare, or Tricare policies.**

[Click Here to learn more about the Medicare appeals process](#)

[Click Here to learn more about the Tricare appeals process](#)

EATING DISORDER TREATMENT:

Levels of Care

LEVEL OF CARE	HOW DOES THE PATIENT QUALIFY	WHAT THE PATIENT CAN EXPECT	DOES INSURANCE PROVIDE COVERAGE
INPATIENT (IP)	<ul style="list-style-type: none"> • Patient is medically unstable • Patient needs 24/7 supervision to stay safe 	<ul style="list-style-type: none"> • Average stay ranges from 7 days - 1 month • All meals and snacks are supervised • Locked bathrooms • Most therapy and nutrition sessions are group-based • Patient lives on-site 	<ul style="list-style-type: none"> • Yes, but prior authorization is needed
RESIDENTIAL (RES or RTC)	<ul style="list-style-type: none"> • Patient is medically and/or psychologically stable, but they need a structured environment away from home in order to recover 	<ul style="list-style-type: none"> • Average length of stay ranges from a few weeks to one year • All meals and snacks are supervised • Program is a mix of group and individual therapy and nutrition sessions • Patient lives on-site 	<ul style="list-style-type: none"> • Often private insurance only, and prior authorization is needed • SCA possible for private and public health plans, depending on plan and program
PARTIAL HOSPITALIZATION PROGRAM (PHP) or DAY TREATMENT (DTP)	<ul style="list-style-type: none"> • Patient is physically and psychologically stable, but they need daily support to keep from declining 	<ul style="list-style-type: none"> • Average length of stay is 4-8 weeks • Program meets 5-7 days per week during the day • At least two supervised meals per day • Program is a mix of group and individual therapy and nutrition sessions • Patient lives off-site 	<ul style="list-style-type: none"> • Private insurance does • Government funded typically when the program is hospital-based • Prior authorization is often needed • SCA possible for private & public health plans



EATING DISORDER TREATMENT LEVELS OF CARE

LEVEL OF CARE	HOW DOES THE PATIENT QUALIFY	WHAT THE PATIENT CAN EXPECT	DOES INSURANCE PROVIDE COVERAGE
INTENSIVE OUTPATIENT (IOP)	<ul style="list-style-type: none"> • Patient no longer needs daily support, but they still need a structured environment for recovery 	<ul style="list-style-type: none"> • Average length of stay is 6-12 weeks • Program meets 3 days per week for 3 hours at a time • One supervised meal per session • Therapy and nutrition sessions may be individual and/or group-based • Patient lives off-site 	<ul style="list-style-type: none"> • Yes - often private insurance only, and prior authorization might be needed • SCA possible for private and public health plans
OUTPATIENT (OP)	<ul style="list-style-type: none"> • Patient needs support to recover, but can function in their day-to-day life with low risk 	<ul style="list-style-type: none"> • Treatment is ongoing, from a few months to a few years • Treatment includes: <ul style="list-style-type: none"> ◦ Individual therapy ◦ Group therapy ◦ Nutrition/dietitian therapy ◦ Psychiatry appointments ◦ Medical appointments 	<ul style="list-style-type: none"> • Yes, but it is usually limited to in-network providers and there is rarely a mechanism to search for eating disorder specialists
INTENSIVE FAMILY TREATMENT (IFT)	<ul style="list-style-type: none"> • Patient is 24 or younger and lives with family of origin 	<ul style="list-style-type: none"> • Entire family is included in treatment • One-week intensive 	<ul style="list-style-type: none"> • Rarely
FAMILY-BASED THERAPY (FBT)	<ul style="list-style-type: none"> • Patient is an adolescent or an adult who lives with family 	<ul style="list-style-type: none"> • Treatment is therapist-led • Focused on empowering parents to feed their child • Typically runs for 20 sessions 	<ul style="list-style-type: none"> • Rarely

SOURCE: NATIONALEATINGDISORDERS.ORG



LEGAL SUPPORT

Legal Practices that Work on Eating Disorder Litigation

Berger & Green (PA)-

"If you have been diagnosed with an eating disorder and are unable to work due to the physical and mental complications caused by an eating disorder, you may be eligible for Social Security disability benefits. It is very important for your Social Security disability claim that you are under the treatment of a physician. The law firm of Berger and Green has more than 35 years of experience helping people get the benefits that they deserve. If you would like a free consultation for your SSD or SSI claim or to speak with an eating disorders lawyer, call 412-219-5090."

Disability Insurance Law Group (FL)-

"At Disability Insurance Law Group, you will find a team of experienced health insurance attorneys who serve individual clients, their families and treatment facilities to obtain the health care coverage promised under health benefit policies. It is important to know we have the skill and experience to stand up on your behalf. We have the knowledge and passion to hold insurance companies accountable for the coverage they promised and the treatment our clients deserve. If you or your loved one has been denied treatment for an eating disorder, call us at 855-496-5356 today."

Kantor & Kantor, LLP (CA, OR, and WA)-

"Kantor & Kantor, LLP is one of the most experienced and highly respected law firms in the nation dealing with litigating insurance claims against insurance companies. Kantor & Kantor, LLP has developed a specialized legal practice representing clients whose claims for treatment of eating disorders, and dual diagnosis (substance abuse and other co-morbid conditions) have been unfairly denied by their health insurers or benefit plan. Kantor & Kantor, LLP's aggressive approach to litigation and legislation has brought justice for clients who have found themselves fighting for their insurance benefits when benefits were wrongfully denied. Contact us online or call 877-220-0556 to schedule a free consultation."

Q & A with Lisa Kantor: How to Get Coverage for the Treatment of My Eating Disorder

Law Offices of Scott Glovsky (CA)-

"Scott Glovsky is nationally recognized as an eating disorder lawyer. If your health insurer has denied treatment related to an eating disorder or payment for such treatment, we can help. We have substantial experience fighting insurance companies that have denied coverage for eating disorders. Call for a free case evaluation at 626-602-7333."



Legal Practices that Deal with Health Insurance and Parity Violations

[The Kennedy Forum](#)

[Crowell & Moring LLP \(Kathy Hirata Chin in particular\)](#) (NY)

[DeBofsky Sherman Casciari Reynolds P.C.](#) (IL)

[Epstein Becker & Green](#) (CA, CT, FL, IL, MD, MI, NJ, NY, TN, TX, and Washington DC)

[Hall Render Killian Heath & Lyman](#) (AK, CO, IN, MD, MI, NC, TX, WA, WI, and Washington DC)

[Napoli Shkolnik PLLC \(Matthew Lavin in particular\)](#) (Washington DC)

[Psych-Appeal](#) (CA)

[Zuckerman Spaeder](#) (FL, MD, NY, and Washington, DC)