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Will My Insurance Cover That? 11 Surprising Things Your Plan May Pay For

KEY POINTS

- **Most people use only a fraction of what their insurance actually covers**—benefits like acupuncture, nutrition counseling, and in-home physical therapy often go unclaimed because patients assume they aren't covered.
- **Federal law bars most plans that cover mental health from limiting it more strictly than physical health**, so if your therapy claims have been denied or your sessions arbitrarily capped, that may be a violation you can appeal.
- **Denied claims are not final**—about half of the denied commercial insurance claims that get appealed are overturned, but most patients never appeal. Knowing what you're owed—and having someone to fight for it—makes all the difference.

- **Durable Medical Equipment (DME)** including CPAP machines, adjustable beds, and mobility scooters can be covered by insurance when a doctor documents medical necessity and an approved supplier is used.
- **Solace advocates are covered by insurance**, making professional advocacy accessible to patients managing a chronic condition, a complex diagnosis, or an ongoing insurance dispute.

This article is about commercial insurance, the kind you get through an employer or the ACA marketplace, not Medicare or Medicaid, which follow different rules. It is for informational purposes only and does not replace medical advice. Information is subject to change. For medical guidance, consult your healthcare provider.

You pay your premiums every month. You hit your deductible. You navigate referrals and prior authorizations and in-network requirements. And somehow, even after all of that, most people are still leaving benefits on the table.

Here are 11 things your commercial insurance plan may already cover that are worth a conversation with your insurer before you pay out of pocket.

Does Insurance Cover Massage Therapy?

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Cover Massage
Therapy?

Does Insurance
Cover
Acupuncture?

More plans cover it than you'd expect, but the details matter a lot.

Standalone massage for relaxation is rarely covered. But massage prescribed by a physician as part of treatment for a specific medical condition—chronic pain, muscle injury, post-surgical recovery, or certain neurological



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Adjustable Beds:

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occupational therapist, rather than a standalone visit to a massage therapist, and many plans cap the number of sessions per year.

Employer-sponsored plans vary the most here. Some large employers have added massage therapy to their benefits packages in recent years, particularly as chronic pain management has become a priority. The key is how the service is coded and ordered: a prescription from your doctor, tied to a specific diagnosis, changes the picture entirely compared to a self-referred wellness visit.

What to do next: Don't assume the answer is no. Call the member services number on the back of your insurance card and ask specifically: Is massage therapy covered when prescribed by a physician for a medical condition? Ask what diagnosis codes qualify, whether a referral is required, whether the massage has to be delivered through a physical therapy provider, and how many sessions per year are covered. Your HR benefits portal may also list this under "rehabilitation services."

Physical Therapy:

You Have More Coverage Than You Think—But the System Isn't Going to Tell You

Does Insurance Cover Acupuncture?

Coverage has expanded significantly, and your employer plan may already include it.

Driven largely by the opioid crisis and growing interest in non-pharmacological pain management, acupuncture coverage in commercial insurance has expanded considerably over the past decade. Many employer-sponsored plans now cover acupuncture for chronic pain conditions—most commonly chronic low back pain, migraines, and osteoarthritis—as a standard benefit rather than an add-on.

Most commercial plans simply require that the acupuncturist be licensed in your state and in-network. Session limits, copay structures, and whether a physician referral is required all vary by plan and by year. It's worth checking your current benefits even if you checked before.

Many plans cap coverage at somewhere between 12 and 20 visits per year, and some require prior authorization before treatment or additional authorization once you pass a set number of visits.

What to do next: Log into your insurer's member portal and search for acupuncture under covered services, or call member services directly. Ask what conditions are covered, how many visits per year you get, whether you need a referral, and whether prior authorization is required. If your preferred acupuncturist is out-of-network, ask whether your plan has out-of-network

benefits—some PPO plans cover a portion of out-of-network acupuncture costs. A Solace advocate can help you verify your benefits, confirm a provider is in-network, secure any required prior authorization, and push for additional sessions when you hit your plan's cap.

Does Insurance Cover a Patient Advocate?

It depends on your plan, but coverage is more common than most people realize, and it's always worth checking.

If you're managing a chronic condition, a new diagnosis, or a complicated insurance dispute, you already know how much time and energy the healthcare system can consume. Chasing referrals, deciphering explanation of benefits statements, fighting a denial while you're also trying to get well—it adds up fast.

A patient advocate takes that burden off your plate. They know the system, they understand how insurance works, and they handle the calls, paperwork, and coordination that would otherwise fall on you.

Solace connects patients with dedicated healthcare advocates—registered nurses and other experienced healthcare professionals whose only job is to fight for your care. They work for you, not for your insurer or your hospital.

Here's what a Solace advocate can do:

- Identify covered benefits you didn't know you had
- Appeal denied claims

- Find in-network specialists and coordinate appointments
- Keep your care team aligned so nothing falls through the cracks
- Join your appointments remotely and help you ask the right questions
- Handle the insurance calls and paperwork that eat up your time

Solace is covered by most commercial insurance plans nationwide. Depending on your specific plan, deductible, and cost-sharing structure. After working with an advocate, 98% of patients feel more in control of their care, and 92% see better healthcare outcomes.

The best first step is to check whether Solace is covered under your plan.

[See If You're Eligible →](#)

Does Insurance Cover Adjustable Beds?

When the need is clinical, most plans will cover it—but the documentation has to back it up.

Commercial insurance plans generally cover hospital-style adjustable beds as Durable Medical Equipment (DME) when a physician documents that the equipment is medically necessary to treat a diagnosed condition at home. Qualifying conditions commonly include severe GERD, congestive heart failure, COPD, or significant mobility limitations following surgery or injury.

The most common reason these claims get denied isn't the condition itself—it's the paperwork. The physician's order needs to be specific: it should name the diagnosis, explain why the equipment is medically required, and document why standard alternatives won't work. A vague or incomplete order is almost always rejected on first submission.

What to do next: If your doctor recommends an adjustable bed for a medical condition, ask them to document the medical necessity explicitly in their written order before you contact a supplier. Confirm the supplier is approved by your insurer. A Solace advocate can review the documentation before submission to catch gaps that commonly lead to denials.

Does Insurance Cover Dietitian Visits?

Often yes — and in more situations than most people realize.

Under the Affordable Care Act, most commercial plans are required to cover nutrition counseling at no out-of-pocket cost for adults with obesity or elevated cardiovascular risk. Beyond that baseline, many plans cover structured Medical Nutrition Therapy (MNT) with a registered dietitian for conditions including type 2 diabetes, high cholesterol, hypertension, kidney disease, and eating disorders.

The coverage landscape here is more generous than it used to be, and many patients who were paying out of

pocket for dietitian visits for years are surprised to learn their plan covered it all along. The catch: the dietitian typically needs to be in-network, the visit needs to be billed under the right code, and some plans require a physician referral.

What to do next: Check your plan's Summary of Benefits or call member services and ask specifically about "medical nutrition therapy" or "dietitian services." Ask what conditions qualify, how many visits are covered per year, and whether a referral is needed. If you've been paying out of pocket for these visits, ask your insurer whether any past claims are eligible for reimbursement.

Does Insurance Cover Therapy Sessions?

Yes — and if your plan has been limiting your sessions, that may be a parity violation worth challenging.

The Mental Health Parity and Addiction Equity Act (MHPAEA) is a federal law that bars most commercial plans from placing more restrictive limits on mental health and substance use treatment than they place on comparable medical and surgical care. It doesn't force a plan to cover mental health, but if your plan does (and under the ACA, most must), it generally can't subject those benefits to tighter visit caps, higher copays, or tougher approval hurdles than it applies to medical care.

In practice, parity violations are common and frequently go unchallenged because patients don't know the law exists. Arbitrary session limits, step therapy requirements

for mental health medications, and higher cost-sharing for behavioral health than for comparable medical services are all potential violations worth questioning.

What to do next: When scheduling with a therapist, confirm they're in-network and accepting new patients with your specific plan. If you've had sessions denied, hit an unexplained cap, or been told your plan limits behavioral health visits in a way that feels inconsistent with your medical benefits, that's worth a closer look. A Solace advocate can help you identify and appeal potential parity violations.

Does Insurance Cover Hearing Aids?

It depends on your plan—and open enrollment is the best time to find out.

Hearing aid coverage in commercial insurance is genuinely variable—and most people don't know what their plan includes until they check. Some employer plans include a hearing benefit with a per-ear or annual allowance; others include nothing. ACA marketplace plans vary by state and tier. The only way to know is to check your specific plan's Summary of Benefits.

What has changed is that more employers are adding hearing benefits in response to employee demand, and state-level hearing aid coverage requirements vary, though they generally apply only to state-regulated plans and not to self-funded employer plans (which cover many workers). Check your state insurance commissioner's

website to understand what applies to your plan. If your current plan doesn't cover hearing aids, it's worth asking your HR team whether it's something the company has considered—especially during open enrollment planning.

Hearing loss that goes unaddressed has well-documented downstream health consequences, including increased risk of cognitive decline and social isolation, which makes this a benefits conversation worth having.

What to do next: Check your current plan's Summary of Benefits under "hearing services" or "durable medical equipment." If you're approaching open enrollment, compare plans specifically on hearing benefits—the difference between plans can be several thousand dollars. A Solace advocate can help you understand your current coverage and what your options are.

Does Insurance Cover CPAP Machines?

Yes, in most cases—and the ongoing supply coverage is just as important as the machine itself.

Most commercial insurance plans cover CPAP machines and related supplies as Durable Medical Equipment following a diagnosis of sleep apnea confirmed by a qualifying sleep study. Initial coverage typically includes the machine, mask, and starter supplies. Ongoing coverage for replacement supplies—masks, tubing, filters, and humidifier chambers—continues as long as the device is being used consistently, which most plans verify through usage data the machine transmits automatically.

The supplier you choose matters: your insurer maintains an approved DME supplier list, and using an out-of-network supplier can result in the entire claim being denied, even when the equipment itself is covered.

What to do next: If you've been diagnosed with sleep apnea or suspect you might have it, ask your doctor for a referral for a sleep study. Once diagnosed, confirm your CPAP supplier is on your insurer's approved list before ordering anything. If your plan requires documentation of usage compliance to continue supply coverage, a Solace advocate can help you navigate that process.

Does Insurance Cover Mobility Scooters?

Yes, but the prior authorization process is where most claims run into trouble.

Most commercial insurance plans cover power-operated vehicles (POVs) as Durable Medical Equipment when a physician documents that the patient needs one for mobility inside the home and that less costly alternatives—a cane, walker, or manual wheelchair—are medically insufficient. Prior authorization is almost universally required, and the documentation bar is high.

The most common failure point isn't the diagnosis—it's the specificity of the physician's documentation. Generic language about mobility limitations is routinely rejected. The order needs to address the patient's specific functional limitations at home, why alternatives won't

work, and how the equipment will be used in the context of daily living.

What to do next: Talk to your doctor about your specific mobility needs at home and ask them to document functional limitations in detail rather than in general terms. Confirm your supplier is approved by your insurer and that prior authorization has been secured before any equipment is delivered. A Solace advocate can help coordinate the prior authorization and review documentation before submission.

Does Insurance Cover Transportation to Doctor Appointments?

It's not a standard benefit—but it's more available than most people think.

Non-emergency medical transportation (NEMT) is not a typical commercial insurance benefit, but it appears in more plans than people expect, particularly in employer-sponsored plans for organizations that have prioritized care access, and in certain ACA marketplace plans. Some states also mandate NEMT coverage for specific populations under state insurance regulations.

Beyond insurance, there's a parallel network of transportation resources—hospital systems, community health organizations, rideshare partnerships, and disease-specific nonprofits—that many patients never learn about because no one points them toward it. For patients managing ongoing treatment schedules, this can be a

meaningful access issue with real solutions that go beyond their insurance card.

What to do next: Check your plan's Summary of Benefits under "transportation" or "supplemental benefits." If it isn't covered, mention transportation access as a barrier to your care team—many hospital systems have social work or case management resources specifically for this. A Solace advocate can help identify available options in your area and arrange rides.

Does Insurance Cover In-Home Physical Therapy?

Yes—and it's one of the most underused benefits in commercial insurance.

Most commercial plans cover home health services, including physical therapy delivered at home, when a physician orders it as medically necessary. The most common trigger is a recent hospitalization or surgery, where home-based PT is ordered as part of the recovery plan.

Coverage can also apply outside of post-acute care, but home health benefits generally require that your condition makes leaving home difficult or unsafe, not simply that getting to a clinic is inconvenient. If you don't meet that bar, some plans will instead cover outpatient physical therapy delivered in your home as a separate benefit, with its own rules and cost-sharing.

The therapy must be ordered by a physician, delivered by a licensed physical therapist through an insurer-approved

home health agency, and documented as medically necessary rather than for general wellness or maintenance. Prior authorization requirements and approved agency lists vary significantly by plan.

One thing that catches people off guard: home health coverage for PT is often separate from outpatient PT benefits, with different authorization pathways and different cost-sharing. Understanding which pathway applies to your situation matters.

What to do next: If you're recovering from surgery, managing a condition that limits mobility, or finding it hard to leave home safely, ask your doctor whether home-based physical therapy is appropriate and request a referral. If leaving home isn't the issue but getting to a clinic still is, ask specifically about outpatient PT delivered at home. Confirm the home health agency is approved by your insurer before services begin. A Solace advocate can help coordinate the authorization and make sure the documentation is in order.

You Have More Coverage Than You Think—But the System Isn't Going to Tell You

You're busy. You're managing your health alongside everything else in your life—work, family, the hundred other things that don't stop because you're dealing with a diagnosis or a difficult recovery. The last thing you need is to spend hours on hold trying to figure out what your insurance actually covers.

The healthcare system was not designed to make this easy. Benefits go unclaimed. Denials go unappealed. People pay out of pocket for things their plan would have covered if only they'd known to ask.

Solace advocates help patients cut through that. They know what plans cover, how to document claims correctly the first time, and how to fight back when something gets wrongly denied. They handle the system so you don't have to.

[Get Started with Solace →](#)

This article is for informational purposes only and should not be substituted for professional advice. Information is subject to change. Consult your healthcare provider or a qualified professional for guidance on medical issues or healthcare benefits.

REFERENCES



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Solace

Solace puts an advocate in your corner—someone who's spent years in healthcare, knows the system, and takes on the toughest parts of your care. Don't do this alone.



Eligibility varies by plan. Advocates do not provide medical or legal advice or services.

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