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UNDERSTANDING YOUR OUTPATIENT PSYCHOTHERAPY INSURANCE BENEFITS

Some insurance plans (Health Maintenance Organizations or HMOs) will only allow you to see providers who are part of their network. Other plans (Preferred Provider Organizations or PPOs) have a network of preferred providers but also will allow you to see therapists who are out of their network. Usually, you will pay a higher amount (e.g. a larger deductible or higher co-pay) to see an out-of-network provider. You may also be required to pay the provider directly and obtain reimbursement from your insurance company. However, your choice of therapist will not be limited by your insurance plan.

To determine your benefits and coverage, you should contact the Mental Health/Substance Abuse number on the back of your insurance card. This call will likely connect you with a customer service representative at the insurance company. They may ask you for the "CPT" or procedure code related to the treatment you are seeking. The CPT codes are 90791 for an initial evaluation and 90834 for individual therapy.

The following questions may be helpful in understanding your benefits:

1. What are my outpatient psychotherapy benefits?
2. Do I have an out-of-network benefits?
3. Do I have a deductible, and what is it (in network vs. out of network)?
   How much of my deductible has been met to date?
4. Do I have a co-pay or co-insurance amount, and what is it (in network vs. out of network)?
5. Do I have an out-of-pocket maximum, and what is it (in network vs. out of network)?
6. Is there a limit to the number of visits covered per year (in network vs. out of network)?
   If so, is that a calendar year or benefit year?
   How many of the allotted visits have been used to date?
7. Do I need to obtain any kind of authorization in order to start treatment (in network vs. out of network)?
8. If I pay for any procedure out of my own pocket, how do I obtain reimbursement for doing so?