

In-Network vs. Out-of-Network?

An "In-Network" psychologist has contracted with your insurer and has agreed to terms set by that company. Typically, this is an agreement to accept reimbursement rates lower than regular fees. Such contracts allow your insurance company to reduce its costs by limiting the amount of money it pays for psychological services. They also allow your insurance company to limit your out-of-pocket expenses. In-Network psychologists receive most payments directly from your insurance company. If your plan includes any co-payments or deductibles, In-Network psychologists must still collect those payments from you.

There are a number of reasons why a psychologist might not contract with health insurance companies. If a psychologist does not contract with your insurance plan, that psychologist is considered "Out-of-Network." Your health plan might reimburse for services from an Out-of-Network psychologist, but your out-of-pocket costs will be higher (since the psychologist is not obligated to accept the insurance company's discounted rates). You are likely to have access to a greater number of psychologists if you consider working with a psychologist who is Out-of-Network.

Limits to Privacy

There are financial advantages to using insurance benefits. Some of your personal health information, however, will not remain private if you choose to do so. Your insurance company will require a mental health diagnosis before authorizing any payment or reimbursement. Some insurers will also require detailed information about your specific symptoms, treatment goals, and progress. Contact your insurance company if you have concerns about how they will use your treatment information.

If you can't afford services...

If treatment costs are too great with or without insurance benefits, you may still have options for obtaining psychological care. Some psychologists offer reduced fees, or may be able to refer you to lower-cost care in the community. You are encouraged to talk with your psychologist about your options.

What if my claim is denied?

Advocating for yourself is part of taking charge of your health care. If your insurance company denies payment on a claim, you and/or your psychologist may contact the health plan to learn why. It may be due to an error that can be easily corrected.

If your claim was denied for another reason, health plans have appeal processes for contesting reimbursement decisions. If you decide to appeal a denied claim, your health insurer should provide you with information about how to do this.

If you participate in a group insurance plan purchased by your employer, and you are comfortable sharing information about your health care, the Human Resources department at your company may be able to help. Your Human Resources Benefits Manager coordinates the company's health insurance plans; often, he or she is in a good position to advocate for you regarding any health plan issues.

If you feel a claim has been incorrectly denied, you can also file a complaint with the **Oregon Insurance Division**. Contact the Insurance Division by calling 1-888-877-4894 or by visiting www.insurance.oregon.gov. The Division's website also provides extensive easy-to-understand information about health insurance plans and laws governing their operations.

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Take Charge of Your Psychological Care

Know your mental
health insurance
benefits, your legal
rights, and your
options for care.

Insurance and Psychological Care

Generally, health insurance purchased by an employer provides coverage for some psychological services. State and Federal parity laws require most, but not all, insurance plans to provide mental health benefits that are equivalent to the benefits provided for other medical issues. Health plans that are exempt from these laws may offer limited mental health benefits, or no mental health coverage at all.

Psychologists provide a variety of services, including individual therapy, group therapy, couples/family therapy, and psychological testing. Even if your insurance includes mental health benefits, your specific plan may pay for some of these psychological services and not for others. In Oregon, a referral from your primary care provider is no longer required for you to receive psychological care. This also means your insurance plan might not be obligated to cover some services, even if those services were recommended by your physician.

Regardless of your health insurance company's practices, you are in charge of your health care choices. Your health insurance company is only in charge of what it will cover. No matter what your coverage, psychological services can be a valuable investment in your well-being and/or the well-being of your family. You can decide to pay for any treatment you and your psychologist believe is right for you, just as you can purchase other professional services. Obtaining psychological services without involving an insurance company is an option to consider.

Knowing Your Benefits

Health insurance plans vary in their coverage and policies, but ultimately you will be responsible for the costs of your care. Therefore, it is important to know your health plan's benefits, requirements and limitations if you are going to seek reimbursement for any service costs. Your psychologist might check benefits on your behalf as well, but verifying your own coverage can help prevent unwanted financial surprises. The worksheet in this brochure outlines some questions to ask your insurance company. Taking charge of your psychological care is easier when you learn about your health plan's policies.

WHAT TO ASK YOUR HEALTH INSURANCE COMPANY

Knowing the details of your health plan can help you get the most from your policy; it will also help you plan for your out-of-pocket costs in advance. Start by calling the customer service number on the back of your insurance card, and ask the following questions. This phone call may take some time, so be sure to start when you do not have other pressing obligations. Don't give up until you have all your questions answered.

This worksheet can help you record important information:

Date of contact _____ Name of person quoting benefits _____

Phone number of that person _____ Extension _____

1. Does my policy include mental health benefits? yes___ no___
2. What company administers my mental health benefits? _____
Name, phone number, and address of that company? _____
3. Do psychotherapy services need to be pre-authorized? yes___ no___ If so, what are the procedures for authorizing services? _____
4. Does my policy limit the number of treatment sessions or dollar amount? yes___ no___ If so, what is that limit and when does the period restart for additional coverage? _____
5. Are there any *excluded diagnoses* in my plan? yes___ no___ If so, what mental health diagnoses are excluded? _____
6. Are there any *excluded procedures* (like group or family therapy)? yes___ no___ If so, what mental health services/procedures are excluded? _____
7. Does my plan cover psychological testing? yes___ no___ If so, what are the pre-authorization requirements and/or limits on hours? _____
8. Is there a deductible before my plan covers part of my services? yes___ no___ If so, what is my deductible amount and how much of it have I already met? When will it renew? _____
9. Once any deductible is met, what is my co-pay or percentage-per-session payment amount? \$ _____
10. Is the psychologist I plan to see contracted as an In-Network provider? yes___ no___
If 'no,' will you cover part of this psychologist's service fees? yes___ no___ What percent of your allowed amount is covered? _____% What are your allowed amounts for these services? _____