Other Helpful Tips

Understanding Coverage Policies for Needed Services and Medications

Once you are enrolled in your employer's plan, it is helpful to know what steps to take to access needed service and medications. To do this, it is good to know the answer to two questions:

1. Does your plan cover all of the services or medications you need or may need? Does the plan have any limits on services or medications you need or think you will need in the future?

2. If the plan does not cover or places limits on needed services or medications, how do you request access to these services and medications?

If you are not sure how to answer these questions, use these two tools:

Summary of Benefits and Coverage This document can be found on your plan's website and gives you information about your benefits. Find the section called, "If you have mental health, behavioral health, or substance abuse needs." In the "Limitations & Exceptions" column, you will see if any limitations or exceptions apply to these benefits.

SAMPLE OF AN SBC

COMMON MEDICAL EVENT	SERVICES YOU MAY NEED	YOUR COST IF YOU USE AN IN-NETWORK PROVIDER	YOUR COST IF YOU USE AN OUT-OF-NETWORK PROVIDER	LIMITATIONS & EXCEPTIONS
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$5-40 copay	Not covered	None
	Mental/Behavioral health inpatient services	5%-25% coinsurance	Not covered	Pre-authorization required for plan to pay
	Substance use disorder outpatient services	$5-40 copay	Not covered	None
	Substance use disorder inpatient services	5%-25% coinsurance	Not covered	Pre-authorization required for plan to pay

Formulary A formulary lists the medications your plan covers. The plan's website should provide a link to the formulary. Look up whether the plan covers each of the medicines you use.

The American Foundation for Suicide Prevention (AFSP) is the nation's leading organization bringing together people across communities and backgrounds to understand and prevent suicide, and to help heal the pain it causes. Individuals, families, and communities who have been personally touched by suicide are the moving force behind everything we do. For further information please send an email to advocacy@afsp.org or call (202) 449-3600.

The National Council for Behavioral Health is the unifying voice of America's community mental health and substance use treatment organizations. Together with our 2,200 member organizations, we serve our nation's most vulnerable citizens — the more than eight million adults and children living with mental illnesses and substance use disorders. We are committed to ensuring all Americans have access to comprehensive, high-quality care that affords every opportunity for recovery and full participation in community life. Learn more at www.TheNationalCouncil.org.

Appeals and Exceptions: How to Access Behavioral Health and Substance Use Services Under Employer-Sponsored Insurance Plans

The majority of employer-sponsored health insurance plans cover mental health and substance use services. However, the specific services, providers, and medications covered by each plan vary. A plan may also limit some of the services or medications it covers. If your plan does not cover the medications and services you need, you have the right to appeal the plan's denial of coverage or request an exception.

AMERICAN FOUNDATION FOR Suicide Prevention

MENTAL HEALTH FIRST AID NATIONAL COUNCIL FOR BEHAVIORAL HEALTH Healthy Minds, Strong Communities.

Understanding How to Access Behavioral Health Services

If Your Plan Does Not Cover the Care You Need

Plans may not cover all of the benefits or medications you need. If you feel you are not getting access to what you need, you have the right to request that your plan cover these services and medications. Keep reading for more information on how to request access to services and medications you need.

If Your Plan Limits the Care You Need

Check if your plan limits coverage for the services and medications you use. Commonly used limits are described below. This information will likely appear in the Summary of Benefits and Coverage and in the formulary, but you may need to call the plan to request this information.

Prior Authorization Requires a healthcare provider to contact the plan for approval of coverage for some services or medications before you can access them.

Quantity Limits Limits the number of services or medication refills you can receive in a specified time period.

Step Therapy Requires you to try other services or prescriptions before the plan will cover service or medication you or your doctor prefers you to use.

Putting This Knowledge into Practice

1. Look up the plan's coverage of the mental health and substance use disorder services and medications you use.
2. Determine if the plan places any limits on access to these services or medications.
3. Request an exception if you and your provider agree that you need access to a service or medication that is not covered or has limited coverage.
4. If it's necessary, file an appeal for a denied exception.

Requesting Access to Services and Medications You Need

There are three main processes you may need to go through to request access to services or medications not covered or limited.

Prior Authorization Request If your health plan requires prior authorization to access certain services or medications, your provider must fill out and submit the paperwork.

Often health plans will have a "prior authorization request form." You can find this form on the health plan's website. You will need to get your physician to sign the form, fill out required information, and submit it on your behalf.

Exception If your health plan does not cover a service or medication you need or there is a quantity limit or step therapy requirement, you have the right to request an exception. Plans have different rules about requesting exceptions.

Health plans may have a special form or a phone number for requesting exceptions. Either way, you should work with your physician to make the request for the plan to cover the service or medication you need.

Appeal If the health plan denies your request for an exception or prior authorization, you have the right to appeal the decision. Most plans have an appeals process in place. There may be a time limit after your plan denies your request to submit the appeal.

If the plan denies your appeal, you have the right to ask an independent entity (not your health plan) to review the appeal request.

Getting help from your physician or healthcare provider to file these requests is helpful. If your insurer denies your claim, most health plans will tell you why your request was denied and how you can dispute their decision through the exceptions and/or appeals process.

Health plans make information about requesting prior authorizations, exceptions, and appeals available on their websites. You can also work with your HR department or benefits manager to understand how to file these requests.