TIPS: Understanding Coverage Policies for Needed Services and Medications

To make sure you get the care you need, select a plan that covers the services, providers, and medications you use. Once you select a 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 has limits on your needed services or medications, how do you request access to these services and medications?

Not sure how to answer these questions? Use these two tools:

SUMMARY OF BENEFITS AND COVERAGE (SBC) This document gives you information about your benefits. This document is available on the marketplace website. 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.

FORMULARY A formulary lists the medications your plan covers. The marketplace website should provide a link to each plan's 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 Services in Qualified Health Plans

All plans offered in the health insurance marketplace must cover mental health and substance use disorder services. However, the specific benefits, providers, and medications each plan covers may differ. A plan may also limit some of the services or medications it covers. Importantly, all plans must cover your medications and services if medically necessary.

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 My Plan Does Not Cover the Care I 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 My Plan Limits the Care I 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 get approval from your plan for some services or medications before you can access them.

Quantity Limit 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.

Non-Covered Services Excludes coverage for some services. You can always request coverage if the service or medication you need is "medically necessary." To do so, apply for an exception or appeal.

Putting This Knowledge into Practice

1 Look up the plan's coverage of the mental health and substance use 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

There are three steps to request access to services or medications that are limited or not covered.

Prior Authorization If your 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 always need to get your physician to sign the form, fill out required information, and submit it on your behalf. In most cases, your plan is required to make a decision about your request within 72 hours or 24 hours, if the request is an emergency.

Exception If your 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 your plan denies your request for an exception or prior authorization, you have the right to appeal the decision. All plans must have an appeals process in place. For most appeals, you will have 60 days after your request is denied to submit the appeal.

> In most cases, your plan is required to issue a decision on your appeal within 72 hours or 24 hours, if the request is an emergency. 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. Health plans make Information about these requests available on their websites. If your insurer denies your claim, the health plan must tell you why your claim was denied and how you can dispute their decision.