UNDERSTANDING
YOUR MENTAL HEALTH AND SUBSTANCE USE DISORDER BENEFITS

This publication has been developed by the U.S. Department of Labor, Employee Benefits Security Administration (EBSA).

To view this and other publications, visit the agency's **website**.

To order publications, or to speak with a benefits advisor, contact **EBSA**.

Or call toll free: **1-866-444-3272**

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This booklet constitutes a small entity compliance guide for purposes of the Small Business Regulatory Enforcement Fairness Act of 1996.

Federal law requires parity between mental health/substance use disorder benefits and medical/surgical benefits. This means that health plans can't impose barriers on your access to mental health and substance use disorder benefits that don't apply to medical and surgical benefits. This guide will help you understand your rights to parity. If you have questions, call an EBSA Benefits Advisor at 1-866-444-3272. The call and assistance are free to you. We can help.

The goal of mental health parity protections under the law is to ensure that mental health and substance use disorder benefits you expect to receive are covered just like medical/surgical benefits, without barriers and roadblocks to access that don't apply to medical/surgical benefits. This guide:

- helps you figure out whether your health plan must provide parity and follow these rules;
- explains the protections the law provides;
- highlights "red flags" to look out for;
- tells you how to learn about your mental health and substance use disorder benefits; and
- walks you through what to do if coverage of your mental health and substance use disorder benefits has been denied.

What is Mental Health Parity?

Mental health parity is the legal requirement that group health plans and group health insurance issuers provide mental health benefits in a similar way as medical/surgical benefits.

While mental health parity does not require health plans to cover services for mental health benefits, if mental health benefits are offered, they must be covered equally (in parity) with other medical/surgical benefits.

The Mental Health Parity and Addiction Equity (MHPAEA) Act is the federal law that requires parity between covered mental health benefits, including substance use disorder benefits, and medical or surgical benefits. In other words, as an example, a health plan should provide the same access to and level of benefits to someone with depression, or an eating disorder, or a drug addiction as the plan would provide for someone with a medical condition, such as diabetes or heart disease.

Does Mental Health Parity Apply to Me?

It depends on what type of plan you are enrolled in. Mental health parity protections are available to people who are enrolled in:

- employment-related group health plans that are either "insured" (purchasing insurance from an issuer in the group market) or "self-funded" (where the plan pays claims itself from its own funds) that offer both medical/surgical benefits and mental health benefits;
- individual and small group employer-based health plans (between 2 and 50 employees) purchased through the Health Insurance Marketplace®;
- some Medicaid plans, including Medicaid-managed care plans; or
- the Children's Health Insurance Program (CHIP).

Under the Affordable Care Act, most group health plans are required to provide essential health benefits. These include benefits for mental health and substance use disorder services.

Mental health parity **does not apply** to people enrolled in:

- retiree-only plans;
- Medicare plans;
- church-sponsored plans; and
- certain small employer plans.

How Can Mental Health Parity Help Me?

If your plan offers both medical/surgical and mental health benefits, the following must be treated comparably:

- financial requirements, such as copayments, deductibles, coinsurance, or out-of-pocket maximums;
- treatment limitations, such as limits on the number of visits you get annually or in a lifetime; and
- other limits on the duration and scope of treatment.

Financial and Treatment Limitations

Health benefits fall under different classifications. The six that are covered under mental health parity rules are:

- inpatient, in-network;
- outpatient, in-network;
- inpatient, out-of-network;
- outpatient, out-of-network;
- emergency care; and
- prescription drugs.

Examples of Benefit Classifications

MENTAL HEALTH BENEFITS	MEDICAL/SURGICAL BENEFITS
Inpatient: Detoxification	**Inpatient**: Appendectomy
Outpatient: Psychologist visit	**Outpatient**: Primary care visit for cold/flu symptoms
Emergency Care: ER for overdose	**Emergency Care**: ER for heart attack
Prescription Drugs: Antidepressant medication	**Prescription Drugs**: Blood pressure medication

Under the parity rules, mental health and substance use disorder benefits must be offered in every classification if medical/surgical benefits are offered. There cannot be different financial requirements or treatment limitations on benefits that are in the same classification.

For example, if a health plan charges a $50 copayment to see an in-network psychiatrist and a $25 copayment for an in-network primary care provider visit, that would likely violate mental health parity, since both providers are in the same classification (outpatient, in-network). The financial requirement that applies to mental health benefits is not comparable to the requirement applied to medical/surgical benefits.

Other Treatment Limitations

When a plan imposes a nonquantitative treatment limitation (NQTL) on benefits, the limitation generally is not expressed as a number (such as the number of visits covered or the copayment charged), but it still limits the scope or duration of benefits for treatment. NQTLs for mental health benefits must be **comparable** to and applied **no more stringently** than those used for medical/surgical benefits.

Some examples of NQTLs include:

- criteria to determine whether the treatment or services are medical necessity or appropriate;
- requiring approval from the health plan prior to care;
- list of covered prescription drugs;
- step-therapy or fail-first policies (i.e., steps you need to go through before you can get a certain treatment);
- coverage exclusions based on failure to complete a course of treatment; and
- coverage restrictions based on geographic location, facility type, provider specialty.

For example, a participant has been diagnosed with depression and high blood pressure. Their plan requires prior authorization every time the participant's psychiatrist prescribes an antidepressant. However, prior authorization is not required when the participant's primary care provider prescribes blood pressure medication. This violates the mental health parity rules.

These are some **red flags** that a health plan's limitation may violate mental health parity rules:

- The health plan requires preauthorization or concurrent review for all mental health benefits (for example, only approving a few days of benefits at a time before requiring another preauthorization.)
- The plan's network of providers of mental health treatment is much less complete than its network of medical providers, making it far harder or impossible for you to find providers who will give you covered treatment at in-network rates.
- The plan requires preauthorization every 3 months for medications prescribed to treat mental health conditions.
- The plan refuses to cover mental health treatment because you failed to complete previous treatment or because there is no "likelihood of improvement".
- The health plan requires that your treatment plan must be updated and submitted every 6 months or it will not be covered.

If you see a red flag from the above list, your health plan may be violating the mental health parity requirements. Contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-3272 for assistance.

Where Can I Learn More About My Plan's Mental Health Benefits?

You have the right to get certain information about your health plan. This information will help you understand what mental health benefits you are entitled to, and it will also help you learn whether your plan is complying with the mental health parity requirements.

Five steps to learn about your mental health benefits:

1. Check your plan's Summary Plan Description and/or Summary of Benefits and Coverage.
   - The Summary of Benefits and Coverage can usually be found on your health plan's website. If you don't have these documents, contact your plan to request them.
   - If these documents do not have all the information you need, you can write to your health plan to request the rules for accessing your benefits.
2. Ask your health plan if it has any prior authorization or medical necessity requirements for mental health benefits.
   - If it does, you should also ask how the criteria for these mental health benefit limitations were developed in comparison to those for medical/surgical benefits.
3. Request copies of all information your health plan uses to decide about co-payments, yearly limits, lifetime limits, medical necessity, and prior authorization.
   - Health plans must give you copies within 30 days of your request.
   - You can use this Department of Labor form **template** to request the information.
4. Call your health plan's customer service phone number (located on the back of your health plan's card and on your plan's Summary Plan Description and/or Summary of Benefits and Coverage) directly to ask for more information.
   - Always remember, you have the right to information about your benefits.
5. If you have tried to get information from your health plan but are having trouble getting the information or understanding the information you receive, consider calling the Department of Labor's Employee Benefits Security Administration at **1-866-444-3272** to speak with one of our Benefits Advisors.

What Can I Do If I Think My Health Plan Has Wrongfully Denied Mental Health Benefits?

Say you receive mental health benefits from a provider and the claim is submitted to your health plan for payment, but the health plan denies payment of your claim. If you feel the plan wrongfully denied your mental health benefits, here are three steps to take:

1. Call your health plan. Have the following information ready:
    - Bill for denied mental health services;
    - Explanation of Benefits (EOB); and
    - Your health plan's Summary Plan Description and/or Summary of Benefits and Coverage.
2. File an internal appeal with your plan.
    - Call your health plan and ask what information/documents to include with your internal appeal request and check the appeals procedures in the plan's Summary Plan Description.
    - The appeal should be submitted in writing.
    - You usually have 180 days from the date of the plan's determination of your claim to submit an appeal.
    - Generally, you must get a response from your health plan within 60 days of filing the appeal.
3. For most plans, you can request external review if your health plan still denies your mental health claim after you've completed all the internal appeal levels.
    - Your final internal appeal determination should have information on how to request an external review.
    - You must request an external review no later than 4 months after getting your final denial from your health plan.
    - The external reviewer's decision to overturn or agree with the denial must be made within 45 days.

You can learn more about how to file a claim or request an external review by going to the U.S. Department of Labor's publication *Filing A Claim for Your Health Benefits*.

For general information about the appeals process, go to EBSA's webpage on Internal Claims and Appeals and External Review.

If you need help, consider calling the Department of Labor's Employee Benefits Security Administration at 1-866-444-3272 for assistance.

Remember, just because mental health benefits were denied does not always mean a health plan violated mental health parity requirements. The following denials might not violate parity rules:

- The service is not considered medically necessary.
- The service is no longer appropriate in a specific health care setting or level of care. For example, based on current symptoms, residential treatment is no longer medically necessary, so your health plan will only pay for outpatient visits.
- The service is considered experimental or investigational.
- The service is not covered under the health plan as part of your benefits.

Resources

Below are helpful resources to learn more about mental health parity and whether your health plan is following the rules.

U.S. Department of Labor's Employee Benefits Security Administration (EBSA)

- Call **1-866-444-3272** to speak with an EBSA Benefits Advisor
- Visit the **EBSA website**

U.S. Department of Health and Human Services

- Call **1-877-267-2332** ext. 61565
- Visit the **HHS mental health parity website**

Your state's department of insurance

- Find your state's contact information on the **National Association of Insurance Commissioners website**

Substance Abuse and Mental Health Services Administration (SAMHSA)

- Visit **SAMHSA's website**

Visit EBSA's mental health parity webpage to view the following publications:

- ***Top 10 Ways to Make Your Health Benefits Work For You***
- ***Parity of Mental Health and Substance Use Benefits with Other Benefits: Using Your Employer-Sponsored Health Plan to Cover Services***
- ***FAQs for Employees about the Mental Health Parity and Addiction Equity Act***
- ***Consumer Guide to Disclosure Rights: Making the Most of Your Mental Health and Substance Use Disorder Benefits***
- ***Understanding Implementation of the Mental Health Parity and Addiction Equity Act of 2008***
- ***Know Your Rights: Parity for Mental Health and Substance Use Disorder Benefits***
- ***Warning Signs – Plan or Policy Non-Quantitative Treatment Limitations (NQTLs) that Require Additional Analysis to Determine Mental Health Parity Compliance***

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