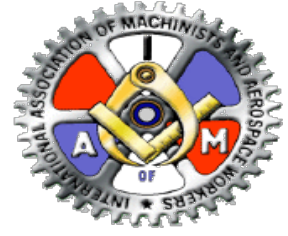




HELPING HANDS



How to Access Mental Health and Substance Use Benefits Utilizing Your Insurance

Compiled by CHTGPT5

Accessing Mental Health Benefits Through Individual Insurance Plans

Navigating the process of accessing mental health benefits can feel overwhelming, especially when working through the details of an individual health insurance plan. Yet, with awareness of your rights, coverage options, and step-by-step guidance, you can take full advantage of the care available to you.

Understanding Your Coverage

Most individual insurance plans today include mental health and substance use treatment benefits, thanks to the Mental Health Parity and Addiction Equity Act (MHPAEA) and the Affordable Care Act (ACA). These laws require insurers to cover mental health and substance use disorder services on par with medical and surgical benefits. This means that office visits, co-pays, deductibles, and treatment limits should be no more restrictive than those applied to physical health services.

Typical covered services include:

- Outpatient therapy (individual, group, or family counseling)
- Inpatient hospitalization for psychiatric needs
- Medication management with psychiatrists or primary care physicians
- Intensive outpatient or partial hospitalization programs
- Emergency care for mental health crises

Review your Summary of Benefits and Coverage (SBC), usually found in your plan documents or on your insurer's website. This document outlines what mental health services are included and the costs associated with them.



Step 1: Identify In-Network Providers



Most insurance plans operate within a network of approved providers. Using in-network clinicians usually means lower out-of-pocket costs. Start by:

1. Logging into your insurance member portal or contacting customer service.
2. Searching the provider directory for psychiatrists, psychologists, licensed counselors, or clinical social workers.
3. Narrowing results by specialty (e.g., trauma, addiction, family therapy) or location.

If your preferred therapist is out-of-network, ask your insurer what your out-of-network benefits are and whether a single case agreement may be possible if specialized care isn't available in-network.

Step 2: Understand Authorization Requirements

Some plans require pre-authorization before covering services like inpatient treatment or intensive outpatient programs. Call the number on your insurance card to confirm whether:

- You need prior approval to begin therapy.
- A referral from your primary care physician is necessary.

- There are visit limits per year (and whether additional sessions can be approved if medically necessary). Document the name of the representative you speak with and the details they provide for future reference.

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Step 3: Estimate Your Costs

Even with coverage, you may have out-of-pocket expenses. Review your plan for:

- Deductibles: The amount you must pay before insurance kicks in.
- Co-pays: Fixed amounts for each visit.
- Co-insurance: A percentage of costs you share after meeting your deductible.

Step 4: Make an Appointment

Once you've identified a provider, reach out directly to schedule your first session. Some clinicians have waitlists, so ask about estimated availability. Many insurers offer telehealth options for quicker access to care. If you need immediate support, remember that emergency services are covered. In crisis situations, you can go to the nearest emergency department or call 988, the Suicide & Crisis Lifeline, for immediate help.

Step 5: Explore Additional Resources

Beyond traditional therapy, your plan may include:

- Teletherapy platforms integrated with your insurance.
- Wellness programs, such as stress management or mindfulness apps.
- Pharmacy benefits for psychiatric medications.
- Care management programs, where a nurse or case manager helps coordinate services.



Accessing mental health benefits through an individual insurance plan requires some legwork, but understanding your coverage and taking proactive steps can help you get the support you need. By knowing your rights, identifying in-network providers, securing authorizations, and budgeting for costs, you can confidently move forward with treatment. Mental health care is essential to overall well-being—and with the right approach, your insurance plan can be an effective tool in helping you thrive.

Your EAP representative can help navigate benefits – they are listed in the box below:



IAM Peer Employee Assistance Program

The heart and soul of the District 141 Employee Assistance Program is the local lodge EAP peer coordinator. These dedicated men and women volunteer their personal time to assist other union members and their families who are experiencing personal difficulties. EAP peer coordinators do not make clinical diagnoses or clinical evaluations; they are trained to make a basic evaluation of your situation and refer you to an appropriate resource for a more detailed evaluation. EAP peer coordinators will follow up to ensure you have been able to access services that addressed the difficulty you were experiencing.

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Strategies for Accessing Insurance Benefits

Smart, legal strategies help you access insurance benefits more effectively. Read your Summary of Benefits and Coverage to know in-network providers and covered services. Use your employer's EAP, nurse line, or member services for referrals and benefit confirmation. Ask providers to obtain prior authorization when needed and verify billing codes. Choose generic medications, use telehealth for low-cost visits, and compare facility costs in-network. If a claim is denied, request an itemized bill, file an appeal with documentation, and ask for preauthorization or single-case agreements. Keep written notes of all calls and escalate to a patient advocate if problems persist promptly.