SUMMARY OF MARYLAND STATE EMPLOYEES & RETIREES

MENTAL HEALTH AND SUBSTANCE ABUSE PLAN

2010-2011

Call APS Healthcare, Inc. Toll-Free: 1-877-239-1458
Website: www.apshelplink.com  Company Code: SOM2002
Eligibility for Mental Health/Substance Abuse Coverage

Mental Health and Substance Abuse (MHSA) benefits are available to all individuals and their dependents that carry medical plan coverage with the State of Maryland. The State’s Mental Health and Substance Abuse plan for individuals enrolled in the Preferred Provider Organization (PPO) and Point of Service (POS) medical plans is administered by APS Healthcare, Inc. (APS). If you are enrolled in an EPO medical plan, you receive all mental health and substance abuse benefits through your EPO.

You automatically have mental health and substance abuse benefits when you enroll in any of the State sponsored medical plans. However, your mental health and substance abuse benefits vary depending on the medical plan in which you are enrolled. You cannot obtain mental health and substance abuse benefits through the State if you do not enroll in a State medical plan.

POS and PPO Medical Plans: If you are enrolled in a PPO or POS plan, APS administers your mental health and substance abuse benefits. You pay no additional premium. The cost of your coverage is included in your medical plan premium. The State currently offers CareFirst (BCBS) PPO and POS, United Health PPO and POS, and Aetna POS.

EPO Medical Plan: If you are enrolled in an EPO medical plan, all of your mental health and substance abuse benefits will be provided by your EPO.

Management Referred Employee Assistance Program (EAP): The State’s EAP is a service available to all State employees, regardless of medical plan enrollment. You must be referred by your supervisor for EAP services. Employees cannot self-refer for this service.

APSHelpLink: This is a State-provided benefit through APS available to all State of Maryland employees, retirees and dependents. APSHelpLink provides online consumer information, interactive self-help and life management tools to help you address issues that impact your health, quality of life and well being. APSHelpLink has an online provider locator. You can also print a temporary ID card or order a new one if needed. You have the opportunity to explore APSHelpLink in complete privacy, 24 hours a day, seven days a week via the Internet. Simply click on the APS link displayed on the Department of Budget and Management Health Benefits webpage www.dbm.maryland.gov or use the Internet by typing www.apshelplink.com. In either case, you will need to enter your company code, which is SOM2002.

How to Receive Mental Health and Substance Abuse Benefits

To maximize your benefits, you must contact APS before receiving any services. The professionals at APS will work with you to select an appropriate referral for care. Your mental health and substance abuse benefits include coverage for the following types of treatment for mental health and substance abuse:

- inpatient facility and professional services,
- partial hospitalization,
- outpatient therapy, and
- intensive outpatient program services

*IMPORTANT NOTE:* If you are enrolled in an EPO medical plan, all mental health and substance abuse services must be authorized by your EPO plan administrator. Please contact your medical plan for more details.
Frequently Asked Questions (for covered PPO/POS Members):

What is “Parity?”
The Wellstone-Domenici Mental Health Parity and Addiction Equity Act of 2008 requires health benefit plans to cover mental health conditions and substance use disorders, including alcoholism, the same as any other illness. This means that financial requirements, such as co-pays, deductibles and out-of-pocket limitations and any treatment limitations (such as number of permitted visits or treatment-setting restrictions) that apply to mental health and substance abuse benefits may be no more restrictive than the financial requirements and treatment limitations for physical health benefits. The State of Maryland is implementing parity for its employees and retirees effective July 1, 2010.

How has my Mental Health and Substance Abuse benefit changed as a result of Parity?
Please see the new benefit chart starting on page 5 of this booklet. There are a few changes especially in the administration of outpatient services, so please call the APS Help Line at 1-877-239-1458 if you have any questions about your benefits.

Will I have to pay a deductible to receive mental health or substance abuse services?
No. You will not have a separate deductible (other than what you will pay for your medical services) under the new Parity benefit.

Is there a limit to the number of times I can see my behavioral health provider?
No. As long as the care is determined to be medically necessary, there are no limits on your mental health or substance abuse benefits.

What should I do in the event of an emergency?
Call the APS State of Maryland Dedicated Help Line at 1-877-239-1458 for immediate assistance if you are experiencing a non-life-threatening emergency or crisis. If the emergency is life threatening, you should seek treatment at the nearest emergency room. You must notify APS within 24 hours of an emergency admission to certify your care. APS staff is available 24 hours a day, seven days a week, 365 days a year.

What happens when I call the APS Help Line?
You will speak to an APS team representative, who will assist you or your covered family member in finding the resources you need and or determining the appropriate treatment for your situation. APS team representatives include member referral and customer service specialists and licensed mental health professionals experienced in dealing with mental health and substance abuse problems.

How do I check to see if my provider is in the APS network?
You can obtain this information in any one of the following ways:

1) Call the APS Help Line at 1-877-239-1458. An APS representative will help you to determine your provider’s current network status. Providers can call APS directly to request to join our network.

2) Go online to use www.APShelplink.com, your interactive Internet tool, to locate your provider. Simply click on APS link displayed on the Department of Budget and Management Health Benefits Plans webpage or use the Internet by typing www.apshelplink.com. In either case, you will need to enter your company code, which is SOM2002.

Must I get pre-authorization before benefits are paid on care I receive?
Yes, for inpatient services, you or your provider MUST pre-authorize care in order to be eligible for benefit coverage. To pre-authorize services, you or your provider must call the APS Help Line at 1-877-239-1458. APS staff is available 24 hours a day, seven days a week, 365 days a year.

Can I use a non-APS provider?
Yes, you may choose to receive care from a provider that is not in the APS network, but you may be liable for any expenses incurred beyond allowed amounts when receiving out-of-network services.

Are detoxification and rehabilitation services covered?
Yes, detoxification and rehabilitation services are covered and administered in the same manner as mental health services.
Will I have to file claims?

**In-Network Services**
If you receive services from an in-network provider, you do not have to file any claims. Your in-network provider will submit a claim to APS for in-network reimbursement. Please be aware that providers sometimes include both mental health charges, which must be submitted to APS, and medical charges, which must be submitted to your medical plan.

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### How to File a Claim for Out-of-Network Services Received

1. The provider may ask you to pay the bill at the time of service. If this happens, pay the provider and submit a claim form and an itemized bill to APS for reimbursement. Call the Help Line at 1-877-239-1458 for a claim form if you do not have one.

2. The itemized bill should be on the provider’s letterhead stationery and should include:
   - diagnosis and type of treatment rendered (CPT code);
   - the charges for the services performed;
   - the date of service;
   - patient name, patient date of birth and Subscriber’s APS Member ID (found on APS ID card)

3. Mail your completed information to:
   - APS Healthcare, Inc.
   - SOM Claims
   - P.O. Box 1440
   - Rockville, MD 20849-1440

4. APS will send the payment for covered services directly to you, the Subscriber. You will also receive an Explanation of Benefits (EOB) any time APS processes a claim. An EOB is not a bill; it is an explanation of the disposition APS has taken on your claim.

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**How much time does my provider or I have to file a claim after the service has taken place?**
Claims must be submitted to APS Healthcare within 180 days of the date of service or inpatient discharge. If claims are submitted after the timely filing limit, they will be denied for payment, subject to applicable state and federal laws.

**Does this timely filing limit apply to Medicare and Coordination of Benefits (COB) claims?**
No, Medicare and Coordination of Benefits (COB) timely filing limits are in excess of one year.

**Other Questions?**
If you have any further questions concerning coverage, exclusions, or limitations, please contact APS at 1-877-239-1458.
<table>
<thead>
<tr>
<th>Benefit</th>
<th>In-Network:</th>
<th>Out-of-Network:</th>
<th>Coverage Limits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient Facility and Professional Services, Partial Hospitalization &amp; Residential Crisis Services</td>
<td>100% of APS’ negotiated fee maximums</td>
<td>80% of APS’ negotiated fee maximums</td>
<td>No benefit coverage if preauthorization is not obtained, regardless of whether provider is in-network or out-of-network. Member may be liable for any expenses incurred beyond allowed amounts when receiving out-of-network services. No limit to medically necessary and treatable preauthorized inpatient days.</td>
</tr>
<tr>
<td>Intensive Outpatient Services</td>
<td>$15 co-pay per visit</td>
<td>80% of APS’ negotiated fee maximums</td>
<td>Member may be liable for any expenses incurred beyond allowed amounts when receiving out-of-network services. No limit to medically necessary and treatable preauthorized IOP days. <strong>The State will NOT pay for facility charges for outpatient services provided by hospital-based providers.</strong></td>
</tr>
<tr>
<td>Outpatient Facility</td>
<td>$15 co-pay per visit</td>
<td>80% of APS’ negotiated fee maximums</td>
<td>No limit on the number of medically necessary/treatable visits per benefit year. No limit on out-of-pocket expenses. <strong>The State will NOT pay for facility charges for outpatient services provided by hospital-based providers.</strong></td>
</tr>
<tr>
<td>Office and Professional Services,</td>
<td>$15 co-pay per visit</td>
<td>80% of APS’ negotiated fee maximums</td>
<td>No limit on the number of medically necessary/treatable visits per benefit year. No limit on out-of-pocket expenses. <strong>The State will NOT pay for facility charges for outpatient services provided by hospital-based providers.</strong></td>
</tr>
<tr>
<td>Outpatient Medication Management Services</td>
<td>$15 co-pay per visit</td>
<td>$15 co-pay per visit</td>
<td>No limit on the number of medically necessary visits per benefit year. No limit on out-of-pocket expenses. <strong>The State will NOT pay for facility charges for outpatient services provided by hospital-based providers.</strong></td>
</tr>
<tr>
<td>Outpatient Laboratory Services</td>
<td>Refer to medical plan for coverage level.</td>
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<td></td>
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<tr>
<td>Coordination of Benefits (COB)-Non-Medicare</td>
<td>As a secondary payer, your non-Medicare COB will be based on the coinsurance in effect on the secondary payer plan and adjudicated based on the allowed amount of the secondary payer plan.</td>
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<tr>
<td>Coordination of Benefits (COB)-Medicare</td>
<td>(1) When coordinating benefits for Medicare members, Medicare is primary and the State Behavioral Health plan is secondary, APS will pay claims based upon the higher of the two allowed amounts for the service. (2) When coordinating benefits for Medicare members, APS requires prior authorization/preauthorization/pre-certification for inpatient services. (3) When Medicare is primary, the State's outpatient coinsurance amounts are applied as indicated in the Benefit Chart above.</td>
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</tbody>
</table>
Exclusions:
A provider may prescribe, order, or recommend a service; however, that does not automatically make it medically necessary. Subject to clinical review, a service may not be covered, even if it is not specifically listed below as exclusion.

APS does not cover services and supplies:
- for treatment of learning disabilities and mental retardation;
- for treatment of marital discord;
- rendered or billed by schools, residential treatment centers or halfway houses or members of their staffs (Crisis Residential Services as defined by HB 896 Chapter 394 are covered if pre-approved by APS);
- care when, in the Carrier’s judgment, an admission or portion thereof, is not medically necessary that are not pre-authorized and medically necessary;
- not prescribed, performed, or guided by eligible practitioners;
- for inpatient treatment (or for an inpatient stay) for conditions that require only observation, diagnostic examinations, or diagnostic laboratory testing;
- for inpatient treatment that might be safely and adequately rendered in a home, provider’s office, or at any lesser level of institutional care;
- that APS determines are experimental or investigative in nature or for services related to them. Experimental or investigative describes any service or supply that is judged to be experimental or investigative by APS in its sole discretion. APS will apply the following criteria to decide this: any supply or drug used must have received final approval to market by the U.S. Food & Drug Administration; there must be enough information in the peer-reviewed medical and scientific literature to let APS judge the safety and efficacy; the available scientific evidence must show a good effect on health outcomes outside of a research setting as current diagnostic or therapeutic options: for lab tests and prescription drugs;
- when you are not legally obligated to pay for the charge, or where the charge is made only to insured persons;
- for telephone consultations, for failure to keep a scheduled visit, for completion of forms, or other non-medical or administrative services;
- charged through separate billings by a provider’s employee normally included in such provider’s charges and billed for by them;
- provided as a result of failure or refusal to obtain treatment or follow a plan of treatment prescribed or directed by a practitioner;
- that are a part of a hospital, facility or institutional stay if the patient is discharged and readmitted to the hospital, facility, or institution within 14 days in order to qualify for insurance coverage where the patient was not previously covered;
- for travel whether or not it is prescribed by a practitioner;
- for guests meals, telephones, televisions, and other convenience items;
- for routine examinations or testing;
- for the treatment or any injury, illness, or medical condition that is not medically necessary;
- for illnesses resulting from an act of war or relating to the commission of a felony;
- for treatment of organic brain syndrome;
- for acupuncture;
- for examinations of an inpatient that are not related to the diagnosis;
- for educational or teacher’s services, or separate charges by interns, residents, house physicians, or other health care professionals employed by the covered facility;
- for smoking cessation;
- for weight loss and weight management programs;
- for court-ordered treatment (unless medically necessary);
- for psychoanalysis to complete degree or residency requirements;
- for experimental treatment or treatment performed for the purposes of research;
- for marriage counseling, educational therapy, speech therapy, behavior therapy, vocational therapy, coma-stimulation therapy, activities therapy, and recreational therapy;
- for pastoral counseling;
- for psychological testing for education purposes.
State of Maryland

Employee/Retiree/Dependent Claims Submission Form
MEMBER PAY**

Date: ____________________________

Patient Name: ____________________________

Patient’s Date of Birth: ____________________________

Subscriber’s APS ID #: ____________________________

Please attach an itemized, legible provider bill that includes:

- The charges for services rendered
- The date(s) of service
- Provider name, credentials, tax identification #, and address
- ICD-9 Diagnosis and type of treatment provided (CPT code)
- Patient’s name and date of birth

**If you or your provider submit a CMS 1500 form with this cover sheet for reimbursement to the member, please DO NOT SIGN Box 13 (assignment of benefits).

**If you would like to have your provider reimbursed directly by APS, please ask your provider to submit a CMS 1500 form (no cover sheet required) directly to APS. You should then sign Box 13 of the CMS 1500 form to assign payment to your provider.

Send claims to:
APS/SOM Claims Unit
P.O. Box 1440
Rockville, MD 20849-1440

For any further questions regarding submission of claims, please call the APS dedicated State of Maryland Team at: 1-877-239-1458