SUMMARY OF MARYLAND STATE EMPLOYEES & RETIREES

BEHAVIORAL HEALTH PLAN

2012-2013

Call APS Healthcare Toll-Free: 1-877-239-1458
Website: www.apshelplink.com Company Code: SOM2002

Year 2012-2013 Summary of Coverage for Maryland State Employees and Retirees Behavioral Health Plan

Administered by: APS Healthcare (APS)
Dedicated State of Maryland toll-free number: **1-877-239-1458**

Eligibility for Behavioral Health Coverage

Behavioral Health benefits are available to all individuals and their dependents enrolled in medical plan coverage with the State of Maryland. This coverage is automatic when you enroll in a medical plan, and you pay no additional premium. There is no coverage for behavioral health if you do not enroll in a medical plan. Your behavioral health benefits vary depending on the medical plan you choose.

PPO and POS Medical Plans: If you are enrolled in a PPO or POS medical plan, **APS** Healthcare administers your behavioral health benefits. The State currently offers CareFirst (BCBS) PPO and POS, United Healthcare PPO and POS, and Aetna POS.

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

APSHelpLink: This State-provided benefit through APS is 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 offers an online provider locator to assist you in choosing in-network providers so you receive the highest level of benefits. 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\benefits or use the Internet by typing **www.apshelplink.com**. In either case, you will need to enter your company code **SOM2002**.

Behavioral Health Benefits

Your behavioral health benefits include coverage for the following types of treatment for behavioral health:

- Inpatient facility and professional services - pre-authorization required
- Partial hospitalization services
- Intensive outpatient program services
- Outpatient facility services
- Office and professional services

Frequently Asked Questions (for covered PPO/POS Members):

What is "Parity?"
The Wellstone-Domenici Mental Health Parity and Addiction Equity Act of 2008 required health benefit plans to cover behavioral health conditions and 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 behavioral health benefits may be no more restrictive than the financial requirements and treatment limitations for physical health benefits. The State of Maryland implemented parity for its employees and retirees effective July 1, 2010.

How has my Behavioral Health benefit changed as a result of Parity?
Please see the benefit chart starting on page 6 of this booklet. You may also 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 behavioral health services?
There are no deductible requirements for the in-network benefits with APS. Please see the benefit chart on page 6 for information on your deductible if you use out-of-network providers.*

Will I have to pay any portion of my services (co-insurance)?
Yes. If you use in-network providers, APS will pay 90% of the negotiated rate for services rendered, and you will be responsible for the remaining 10% of the negotiated rate up to your out-of-pocket maximum. If you use out-of-network providers, APS will pay 70% of the negotiated rate for services rendered, and you will be responsible for the remaining 30% of the negotiated rate up to your out-of-pocket maximum. You will also be responsible for the deductible requirements when utilizing an out-of-network provider.

Will there be an out-of-pocket maximum on the amount of co-insurance I will be responsible to pay before services are covered at 100%?
Yes. If you use in-network providers and your co-insurance accumulated amount reaches $1000 for individual coverage or $2,000 for family coverage (two or more members) in a benefit year, in-network services will be covered at 100% until the start of the next benefit year. If you use out-of-network providers and your co-insurance accumulated amount reaches $ 3,000 for individual coverage or $6,000 for family coverage (two or more members) in a benefit year, out-of-network services will be covered at 100% until the start of the next benefit year.*

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 behavioral health benefits.

What should I do in the event of a behavioral health 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 or call 911. **APS** must be notified 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 in determining the appropriate treatment for your situation. **APS** team representatives include member referral and customer service specialists and licensed behavioral health professionals experienced in dealing with behavioral health problems.

How do I check to see if my provider is in the APS network?
You can obtain this information in 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 information on joining our network.

2) Go online to use www.APSHelpLink.com, your interactive Internet tool, and click on "Online Provider Locator". You can also access APS Helplink through the APS link displayed on the Department of Budget and Management Health Benefits Plans webpage. 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**, your provider **MUST** pre-authorize care within 24 hours of admission in order for services to be eligible for benefit coverage. **APS** pre-authorization staff is available 24 hours a day, seven days a week, 365 days a year at the APS Help Line 1-877-239-1458.

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 will pay more in deductible and co-insurance. You may also 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 behavioral health services.

Will I have to file claims?

No, as long as you receive services from an in-network provider. Your in-network provider will submit a claim to **APS** for in-network reimbursement. Please be aware that providers sometimes include both behavioral health charges, which must be submitted to **APS**, and medical charges, which must be submitted to your medical plan.

If you receive services from out-of-network providers, you must file your own claims.

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. The Claim Submission Form is found on the last page of this booklet, on the Department of Budget and Management website, and on the APS website at www.apshelplink.com. Enter company code SOM 2002 and under "News for You", click on "download claim submission form". You may also call the Help Line at 1-877-239-1458 if you have questions about completing or submitting this form.

2. The itemized bill should be on the provider's letterhead stationery and should include:

- 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 and Subscriber's APS Member ID (found on APS ID card)

3. Mail your completed information to:
APS Healthcare
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.

How much time will I or my provider 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 this timeframe, 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, the Medicare and Coordination of Benefits (COB) timely filing limit is one year.

Other Questions?
If you have any further questions concerning coverage, exclusions, or limitations, please contact **APS** at 1-877-239-1458.

* These benefits have changed for the 2012-2013 benefit year. Please refer to the following benefits chart for clarification, or call the APS Help Line for assistance.

Behavioral Health PPO and POS Benefits 2012-2013

Benefit	**In-Network:**	**Out-of-Network:**	**Coverage Limits** Member may be liable for any expenses incurred beyond allowed amounts when receiving out-of-network services.
Inpatient and Residential Crisis Facility and Professional Services	90% of APS' negotiated fee maximums	70% of APS' negotiated fee maximums	**No benefit coverage if facility preauthorization is not obtained, regardless of whether provider is in-network or out-of-network**. No limit to medically necessary preauthorized inpatient days.
Partial Hospitalization Services	90% of APS' negotiated fee maximums	70% of APS' negotiated fee maximums	No limit to medically necessary days.
Intensive Outpatient Services	$15 co-pay	70% of APS' negotiated fee maximums	No limit to medically necessary days.
Outpatient Facility Services	90% of APS' negotiated fee maximums	70% of APS' negotiated fee maximums	No limit on the number of medically necessary services.
Office and Professional Services	$15 co-pay for PCP/Specialist	70% of APS' negotiated fee maximums	No limit on the number of medically necessary visits.
Outpatient Medication Management Services	$15 co-pay	70% of APS' negotiated fee maximums	No limit on the number of medically necessary visits.
Emergency Room Services	100% of APS'negotiated fee maximums after $75 co-pay for ER Facility Care and $75 co-pay for ER Physician Services	100% of APS'negotiated fee maximums after $75 co-pay for ER Facility Care and $75 co-pay for ER Physician Services	No limit on the number of medically necessary visits.
Outpatient Laboratory Services	Refer to medical plan for coverage level.	Refer to medical plan for coverage level.	
Annual Deductible **Individual** **Family**	 Not Applicable	 $250 $500	Expenses for medical and behavioral services are combined to reach maximums. Deductibles do not apply when a co-pay is charged (office visits and Intensive Outpatient Services).
Annual Out-of –Pocket Maximum **Individual** **Family**	 $1,000 $2,000	 $3,000 $6,000	Expenses for medical and behavioral services are combined to reach out-of-pocket maximums.
Lifetime Maximum	Unlimited		
Coordination of Benefits (COB)-Non-Medicare	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.		
Coordination of Benefits (COB)-Medicare	(1) When coordinating benefits for Medicare members, Medicare is primary and the State offered behavioral health plan is secondary. APS will pay claims based upon the higher of the two allowed amounts for the service. 2) When providers do not participate with Medicare resulting in non-coverage by Medicare, APS will pay as secondary, just as if Medicare had paid for services as primary. (3) When coordinating benefits for Medicare members, APS requires prior authorization for inpatient services.		

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;
- for treatment 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 APS's judgment, an admission or portion thereof is not medically necessary and/or not pre-authorized as 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 and Subscriber's APS Member ID (found on APS ID card)**

**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