

SUMMARY OF MARYLAND STATE EMPLOYEES & RETIREES

BEHAVIORAL HEALTH PLAN



2011-2012

Call APS Healthcare Toll-Free: 1-877-239-1458

Website: www.apshelplink.com Company Code: SOM2002

Year 2011-2012 Summary of 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.

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/benefits or use the Internet by typing www.apsheplink.com. In either case, you will need to enter your company code, which is **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 requires 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 has 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 5 of this booklet. 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 behavioral health services?

No. You will not have a separate deductible (other than what you will pay for your medical services) under the 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 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 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 either 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**, your provider **MUST** pre-authorize care within 24 hours of admission in order for services 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 behavioral 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 behavioral health charges, which must be submitted to **APS**, and medical charges, which must be submitted to your medical plan.

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 Form is found on the last page of this booklet 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:

- 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
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 do 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, 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.

| <u>Benefit</u> | <u>In-Network:</u> | <u>Out-of-Network:</u> | <u>Coverage Limits</u> |
|---|---|---|---|
| | | | 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 | 100% of APS' negotiated fee maximums | 80% of APS' negotiated fee maximums | No benefit coverage if 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 | 100% of APS' negotiated fee maximums | 80% of APS' negotiated fee maximums | No limit to medically necessary days. |
| Intensive Outpatient Services | \$15 co-pay for PCP/Specialist | 80% of APS' negotiated fee maximums | No limit to medically necessary days. |
| Outpatient Facility Services | 100% of APS' negotiated fee maximums | 80% of APS' negotiated fee maximums | No limit on the number of medically necessary services. |
| Office and Professional Services (excluding Intensive Outpatient Services) | \$15 co-pay for PCP/Specialist | 80% of APS' negotiated fee maximums | No limit on the number of medically necessary visits. |
| Outpatient Medication Management Services | \$15 co-pay for PCP/Specialist | 80% of APS' negotiated fee maximums | No limit on the number of medically necessary visits. |
| Emergency Room Services | 100% of APS' negotiated fee maximums after \$50 co-pay for ER Facility Care and \$50 co-pay for ER Physician Services | 100% of APS' negotiated fee maximums after \$50 co-pay for ER Facility Care and \$50 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 | Not Applicable | |
| Annual Out-of-Pocket Maximum Individual Family | None None | \$3,000 \$6,000 | |
| Lifetime Maximum | Unlimited | | |

| <u>Benefit</u> | <u>In-Network:</u> | <u>Out-of-Network:</u> | <u>Coverage Limits</u> Member may be liable for any expenses incurred beyond allowed amounts when receiving out-of-network services. |
|--|--|------------------------|---|
| 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 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 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;
- 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