THIRD MODIFICATION

TO

BEHAVIORAL HEALTH BENEFITS ADMINISTRATION SERVICES CONTRACT

THIS THIRD MODIFICATION AGREEMENT is made this 29th of March, 2010 by and between APS Healthcare Bethesda, Inc. and the State of Maryland, acting through the Department of Budget and Management.

IN CONSIDERATION of the promises and the covenants herein contained, the parties agree to modify the Contract for Behavioral Health and EAP Benefit Administration Services dated April 20, 2006 and amended by a First Modification dates July 1, 2008 and a Second Modification dated October 22, 2008, by and between the State and APS Healthcare Bethesda, Inc., as follows:

1. (a) Effective July 1, 2010, the plan design for the behavioral and substance abuse benefits provided in connection with the Preferred Provider Organization and Point of Service benefits options of the State Employee and Retiree Health and Welfare Benefits Program is amended as follows:

Type of Service	In-Network Care	Out-of-Network Care
Inpatient Facility and Professional Services Pre-Authorization Required	100% of APS' negotiated fee maximums	80% of APS' negotiated fee maximums
Partial Hospitalization Services and Residential Crisis Services	100% of APS' negotiated fee maximums	80% of APS' negotiated fee maximums
Outpatient Facility	100% of APS' negotiated fee maximums	80% of APS' negotiated fee maximums
Office and Professional Services (excluding Intensive Outpatient Services)	$15 copay for PCP/Specialist	80% of APS' negotiated fee maximums
Intensive Outpatient Services	$15 copay for PCP/Specialist	80% of APS' negotiated fee maximums
Outpatient Medication Management Services	$15 copay for PCP/Specialist	80% of APS' negotiated fee maximums
Emergency Room Services In-network and Out-of-Network (Paid by medical plan, not APS)	100% of medical plan allowed benefit after $50 copay for ER Facility Care and $50 copay for ER Physician Services	
Annual Deductible Individual Family	Not Applicable	Not Applicable
Annual Out of Pocket Maximum Individual Family	None None	$3,000 $6,000
Lifetime Maximum	$2,000,000 per person	

Annual Out of Pocket Maximum and Lifetime Maximum are aggregated with medical/surgical services. Pre-authorization is not required for coverage of mental heath and substance use disorder services, except for in-patient facility services as noted above. The parties shall discuss in good faith and mutually agree upon changes to procedures and standards of review necessary to implement the removal of a pre-authorization requirement.

(b) Contractor shall disclose standards for medical necessity determinations relating to mental health or substance use disorder upon request and in the timing, manner, form and content compliant with the federal Department of Health and Human Services final interim regulations, published in the Federal Register (75 Fed. Reg. 5410) on February 2, 2010 (45 CFR §146.136). Contractor shall disclose the reason for any denial of coverage, payment, or benefits with respect to mental health or substance use disorder benefits in the timing, manner, form and content compliant with 45 CFR §146.136(d)(2) and 29 CFR §2560.503-1.

(c) Benefits shall be covered and claims processed on and after July 1, 2010 in accordance with this amended plan design.

(d) Contractor agrees to exchange claims and payment information with the medical plan Third Party Administrators (TPAs) identified by the Department; such data shall be appropriate claims data necessary for aggregate tracking of lifetime maximum accumulation and out-of-pocket coinsurance accumulation tracking. Contractor shall use and take into account information from the TPAs in applying the co-insurance required from participants for out-of-network benefits.

(e) Effective July 1, 2010, Contractor's implementation and use of non-quantitative treatment limitations shall be consistent with the requirements of 45 CFR §146.136(c)(4), based on information received from the Department and TPAs. Contractor shall use medical necessity criteria, network provider admission criteria, and other non-quantitative treatment limitations that are comparable to and applied no more stringently than such limitations in use in the PPO and POS health benefits plan options, based on information provided by the Department and the TPAs, except to the extent that recognized clinically appropriate standards of care may permit a difference. Such information shall be provided to Contractor at least thirty (30) days prior to the requested date of implementation of any change, and the parties shall discuss in good faith and mutually agree on the substance and timing of the change to be made.

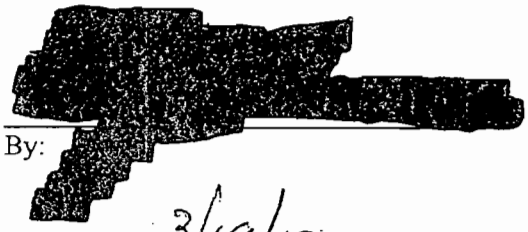
(f) Once the annual out of pocket maximum is reached, plan will pay 100% of Allowed Benefit or 100% of the Usual and Customary as applicable.

2. This Modification shall be interpreted and applied to permit the State Employee and Retiree Health and Welfare Benefits Program group health plan benefit options to comply with the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 and the applicable regulations promulgated thereto by the federal Department of Health and Human Services.

3. This Modification amends the Contract specifically as described herein. Except as specifically revised by the terms of this Modification, all of the terms of the Contract shall remain in full force and effect and shall apply to this Modification.

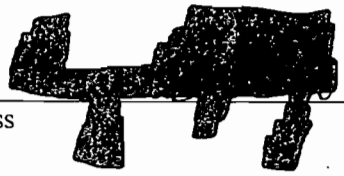
IN WITNESS THEREOF, the parties have executed this Third Modification.

CONTRACTOR:
APS HEALTHCARE BETHESDA, INC.



By: _____

3/19/10
Date

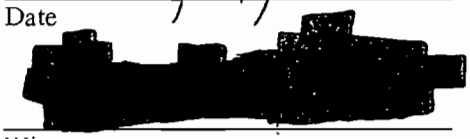


Witness

STATE OF MARYLAND:
DEPARTMENT OF BUDGET AND MANAGEMENT

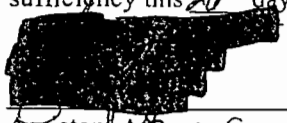
By: T. Eloise Foster
Secretary

3/29/10
Date



Witness

Approved for form and legal sufficiency this 26 day March 2010.



Assistant Attorney General