CONSUMER GUIDE TO UNDERSTANDING YOUR HEALTH INSURANCE COVERAGE FOR

MENTAL HEALTH & SUBSTANCE USE CONDITIONS






Maryland
INSURANCE ADMINISTRATION

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INSURANCE ADMINISTRATION

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INTRODUCTION

Understanding your health insurance coverage for mental health and substance use conditions is an area that many people find difficult. This toolkit will help you better understand your coverage.

TIPS FOR SELECTING A HEALTH PLAN

Shopping for healthcare coverage can be confusing. To make an informed choice, it is important to understand:

1. what services are covered;
2. the premium (the price of the policy);
3. any healthcare costs you will be responsible to pay, such as coinsurance, copays or a deductible;
4. whether your healthcare providers are in-network or out-of-network.

When choosing a plan, read plan documents carefully to make sure that you understand all of the rules and costs associated with the insurance. Make sure that the covered services and supplies fit your needs. Below are some tips you should consider when comparing different plans.

Summary of Benefits and Coverage – If you are enrolling in your employer's group health plan, or you are buying an individual health plan, you should read the Summary of Benefits and Coverage for each option. You may have to look on the website to find it. This Summary must tell you information about coverage for mental health and substance abuse treatment.

Open Enrollment – If you do not have health coverage through a group policy, you will need to shop for an individual policy. Individual policies without medical underwriting are only available during the annual open enrollment period[1] unless you qualify for a special enrollment period. Tax credits may be available to reduce the premium you have to pay. You can contact the Maryland Health Connection or a licensed insurance producer (agent/broker) for help. If you do not enroll during an open or special enrollment period, you may be able to obtain a short term medical policy, but this may not cover pre-existing conditions.

1 Go to *www.marylandhealthconnection.gov* to find out more about the open enrollment period.

Stop. Call. Confirm. – If someone tries to sell you a policy, make sure it's a legitimate policy and that the person is permitted under Maryland law to enroll you. Please call the Maryland Insurance Administration toll free at 1-800-492-6116 to make sure the company is licensed and the person who is trying to sell you a policy is authorized to sell insurance.

Keep a record of payment. – Consider paying by check, money order, or bank draft made out to the insurance company[2].

KEY INSURANCE TERMS

Allowable Amount (Payment allowance or negotiated rate) – The maximum amount the insurance company will pay for a covered health care service. If your health care provider is out-of-network, you may have to pay the difference between what your provider charges and the insurance company's allowable amount. See *Balance Billing* and *Out-of-Network Providers* below.

Assignment of Benefits – A legal contract used to transfer the rights to benefits under a health care plan from you (the insured) to the health care provider. If there is an assignment of benefits, the health plan[3] will pay its allowable amount for the services directly to the provider. It eliminates the need for you to pay the provider in full and then seek reimbursement of the allowable amount. Keep in mind, however, that you may still owe the provider a copayment, coinsurance, and the balance between the allowed amount and the provider's billed amount. See *Balance Billing* below. Ambulance companies can also agree to an assignment of benefits. You may ask the provider for such an agreement or the provider may ask you to sign one.

Balance Billing – Balance billing happens when a health care provider (a doctor, for example) bills a patient after the patient's health insurance company has paid its share of the bill. This can happen when a patient receives covered health care services from an out-of-network provider or an out-of-network facility (a hospital, for example) The balance bill is for the difference between the provider's charge and the price the insurance company set, after the patient has paid any copays, coinsurance, or deductibles.

In-network providers agree with an insurance company to accept the insurance payment in full, and don't balance bill. Out-of-network providers don't have this same agreement with insurers.

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2 The term "insurance company" includes HMOs and non-profit health service plans, as well as insurers.

3 Throughout this document, "insurance company" and "health plan" have the same meaning.

Under the federal No Surprises Act, you cannot be balance billed if you receive emergency services from an out-of-network provider, emergency facility, or if you receive covered air ambulance services provided by an out-of-network provider of air ambulance services. In most cases, you also cannot be balance billed if you receive covered non-emergency services from an out-of-network provider while visiting an in-network health care facility. You can, however, still be balance billed if you agree in advance to be treated by an out-of-network provider in some situations, such as when you choose an out-of-network surgeon knowing the cost will be higher. The provider must give you information in advance about what your share of the costs will be.

Additionally, beginning on January 1, 2023, if you are approved to see an out-of-network specialist for mental health or substance use condition services, you cannot be balance billed.

Coinsurance – A percentage of the cost that you pay for a covered health care service after you pay your deductible. Here is an example of how it works:

- Your x-ray costs $200.
- The insurance company has an allowable amount of $150.
- Your coinsurance is 20%.
- Assuming your deductible has already been satisfied, you pay 20% of $150, which is $30 and the insurance company pays the remaining $120.

Copay – A fixed amount you pay for a covered health care service. The amount may be different based on the type of service and whether the service is provided by an in-network or out-of-network provider. For example, your plan may require a $20 copay for an office visit to an in-network provider and a $40 copay for an office visit for an out-of-network provider. This fee may be in addition to any deductible for which you are responsible under the plan.

Deductible – This is the amount you pay towards covered services before your insurance company makes payments. The deductible may not apply to all services that are covered by your policy or plan. Contact your insurance company for a list of services that are not subject to a deductible under your policy or plan. For a service subject to the deductible, you or your health care provider will submit a claim(s) to your insurance company. The insurance company will then apply the allowable amount for each covered service to your deductible. When the total of the allowable amounts equals your deductible (also known as "meeting" your deductible), the insurance company will begin to pay claims. Until you meet your deductible, you will need to pay the allowable amount to your health care provider. After you meet your deductible, you will pay only any applicable coinsurance or copay. Generally, you will have to meet your deductible every year.

Remember, even though your provider may agree to submit a claim(s) on your behalf, you are legally responsible for paying the provider for services.

In-Network Provider – An in-network provider has a contract with your insurance company. If you receive covered services from an in-network provider, generally you will only need to pay your deductible and any applicable copay or coinsurance. You may not be balance billed by an in-network provider.

Out-of-Network Provider – An out-of-network provider does not have a contract with your insurance company. If you receive covered services from an out-of-network provider, the insurance company may not be required to pay any portion of the charges, or your copay or coinsurance may be higher than if the services had been provided by an in-network provider. In some circumstances, you will not have to pay more for an out-of-network visit, such as in an emergency, when you received certain non-emergency treatment at an in-network facility, for air ambulance services, or if you were approved by your health plan to see an out-of-network provider for mental health services.

Out-of-Pocket Maximum – This is the maximum amount that you pay before your insurance company will pay the allowable amount for covered health care services. Depending upon the terms of your policy or plan, the out-of-pocket maximum can include deductibles as well as copays and coinsurance. Check with your insurance company to determine what is included in this amount under your policy or plan.

Premium – The amount you and/or your employer pay to your insurance company for your policy or plan. This amount may be paid monthly, quarterly, or yearly. Failure to pay the premium will result in the cancellation of your policy or plan. For more information on how insurance companies determine premiums, see *Frequently Asked Questions: Health Insurance Rates and the Review Process* at *www.insurance.maryland.gov.*

Preventive Services – You do not need to meet your deductible before you receive, and the insurance company pays for, MOST preventive services from an in-network provider. You also do not have to pay a copayment or coinsurance for preventive services you receive from an in-network provider. Preventive services include screenings and immunizations, as well as other services. For a complete listing of preventive services that are covered under your health plan without cost to you, check with your insurance company. Usually, preventive services do not include diagnosis or follow-up visits and services for problems. If you visit your healthcare provider and discuss a health problem, you may be charged your deductible or coinsurance or copay for the part of the visit dealing with the problem, even if the initial purpose of the visit was preventive.

HOW TO OBTAIN PRE-AUTHORIZATION

FOR PRIVATE HEALTH INSURANCE COVERAGE FOR MENTAL ILLNESS, EMOTIONAL HEALTH CONDITIONS, AND SUBSTANCE USE EMERGENCIES

To start the process of obtaining authorization for an inpatient admission for mental illness, emotional health condition or a substance use condition, **call the number on the back of the patient's health insurance ID card first.**

The insurance company will ask what facility you would like to use for the patient and/or what treatment is required, and also tell you what documents are needed to make the determination of coverage. Maryland requires that health plans use the *Uniform Treatment Plan Form* if the health plan is subject to Maryland law. A *Uniform Treatment Plan Form* is a document where a provider records the information necessary for the health plan to determine whether it will pre-authorize the requested services and/or facility.

Sometimes, you may not be able to get the health care that you need from a specialist who is in your insurance company's network. The in-network specialist may be unreasonably far away, or might not have an appointment for an unreasonably long time, or may not be able to treat your condition. When that happens, and you have to go to a specialist that is out-of-network, your insurance company may have to cover the out-of-network specialist the same as they would an in-network specialist. Your health insurance company has to have a process that you can use to find out how to get in-network coverage for care by an out-of-network specialist. And when you make your request, they have to respond quickly. You can contact your health plan using the number on the back of your card, or use the link: *https://bit.ly/miaccp* to find out the process to use for your insurance company.

IMPORTANT: *You must use the company process. If you do not and you choose to see an out-of-network specialist, and in-network specialists were available, the services will be covered only if you have out-of-network benefits and only for the amount allowed for out-of-network coverage.*

If a patient is in imminent danger to self or others, and the determination is made by the patient's physician or psychologist and a member of the medical staff of the facility who has admitting privileges, then a health insurance company cannot deny the first 24 hours of an admission based on medical necessity. Notify the insurance company as soon as possible.

For an emergency inpatient admission for treatment of a mental illness, emotional health condition, or substance use condition, the insurance company must decide on whether to pre-authorize the treatment within 2 hours of receiving the requested documents and inform the hospital or facility of the decision.

If the insurance company denies the request for an admission, call the Maryland Insurance Administration (MIA) at 1-800-492-6116. The MIA is available 24 hours a day for complaints that are considered emergencies. In an emergency, the MIA will make a decision within 24 hours.

If the MIA does not regulate the health insurance plan, you will be provided with the contact information for the correct regulatory authority.

An insurance company is not allowed to retaliate against a provider for filing an appeal of a denial with the insurance company or a complaint with the MIA.

The Health Education and Advocacy Unit of the Office of the Attorney General of Maryland can assist with filing an appeal or complaint. They can be reached at 410-528-1840 (in Baltimore) or 1-877-261-8807.

If you believe that the insurance company is not following the law, or it denies an emergency admission, call the Maryland Insurance Administration at 1-800-492-6116.

An insurer, nonprofit health service plan, or HMO that provides coverage for substance use condition benefits or prescription drugs may not require pre-authorization for prescription drugs used for substance use treatment of opioid use if the prescription contains methadone, buprenorphine or naltrexone.

HOW YOUR HEALTH PLAN WORKS

Before you seek medical attention, it's important that you understand how your health care plan works, what is covered by insurance and what you may need to pay.

How can you learn more about the type of benefit plan that you have and what you will owe?

- You can call the health plan's customer service department or visit the company's website. If you get your health benefits from your employer, you may also call your human resources department.

- Sometimes you will be told that a provider "participates" with your health plan or "accepts" payment directly from your health plan. A provider who "accepts" your insurance may be out-of-network. Ask whether the provider is an in-network provider.

- If the provider is out-of-network, ask questions to determine how much it will cost to receive services.

- Unless it is an emergency or when you have no control over which provider you will see, ***you should always find out whether a provider is in-network or out-of-network before receiving services.*** This information is critical to know since it determines what you will owe. Visit the health plan's website, specifically the online provider directory, to see if your health care provider does or does not participate in the plan. You can also call the health plan's customer service department.

What does it mean to be an "in-network" provider? What will you need to pay when you use an "in-network" provider?
An "in-network" provider is a health care provider, such as a doctor, hospital, and other health care professional who is licensed or authorized to provide health care services in Maryland, that has agreed to accept a set dollar amount from your health plan to provide you with covered services and has a contract with your insurance company. When receiving care from an in-network provider, you may need to pay a copayment, coinsurance, and a deductible but you cannot be balanced billed. Check with your health care plan and provider to see if a provider is in-network and find out how much you have to pay when using an in-network provider.

What does it mean to be an "out-of-network" provider?
If there is no contract between the provider and your health plan, that provider is known as an "out-of-network" provider.

Can I receive services from an "out-of-network" provider?
Your health benefit plan may not pay for services if you see an out-of-network provider and may be responsible for the entire bill. Some health benefit plans place limits on when you can see an out-of-network provider and some plans will pay a smaller portion of the bill if you receive services out-of-network than if you go in-network. However, if certain conditions are met, you may be able to see an out-of-network provider with the same cost sharing as an in-network provider.

What do I do if I cannot find an in-network specialist?
In some cases, an in-network specialist may be unreasonably far away, or might not have an appointment for an unreasonably long time, or may not be able to treat your condition.

Under Maryland law, if your health insurance plan does not have an in-network specialist who can provide medically necessary services to treat your condition or disease without requiring you to travel an unreasonable distance or wait an unreasonable amount of time, you can ask for approval from the health plan to see an out-of-network specialist. *Beginning on January 1, 2023, if you are approved to see an out-of-network specialist for mental health or substance use condition services, your health plan must pay the costs of the out-of-network specialist's services other than your cost-sharing amount (deductible, copay, coinsurance), which you must pay.* Your health plan must ensure that the approved out-of-network services cost you no more than you would have paid if you received the services from a provider on the plan's provider panel. This means there will be no balance bill.

If your request is denied, you have the right to appeal the denial. If the health plan denies the request because it is not medically necessary for you to see the out-of- network specialist, the denial is treated like any other denial based on medical necessity. Review your plan to make sure you know the rules. Your health benefit plan may not pay for services from an out-of-network provider in certain situations where you did not follow the health plans process for approval to see the out of network specialist. You can find information about the process for specific health plans at: *https://bit.ly/miaccp*.

What about situations where I am not able to choose my provider in advance?
Sometimes you may not be able to choose a provider who is in your plan's network. You may need emergency treatment, or you may see an out-of-network provider at an in-network hospital. Under the federal No Surprises Act, you cannot be balance billed when:

1. You receive covered emergency services from an out-of-network provider or an out-of-network emergency facility.
2. You receive covered non-emergency services from an out-of-network provider while visiting an in-network health care facility, unless you willingly give written consent in advance to give up your protections. You can never be asked to waive your protections for emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, and intensivist services, and you will never be balance billed for these services at an in-network facility.
3. You receive covered air ambulance services provided by an out-of-network provider of air ambulance services.

Do I have to pay the health care provider up front for services and then get reimbursed, or can my health care plan pay the provider directly?
You can pay the health care provider directly and then seek reimbursement from your plan. But you can also authorize the plan to pay the provider directly by assigning benefits. To assign benefits, you will have to sign an "assignment of benefits," which is a legal agreement that authorizes your plan to pay the named provider for health care services they provided. You can assign payment to a health care provider, hospital or ambulance company.

YOUR RIGHTS

WHEN YOUR HEALTH INSURER[4] WILL NOT PAY FOR HEALTH CARE SERVICES

If your health care provider[5] tells you that a certain health care service is needed, but your health insurer disagrees, you have the right to appeal that decision and have it reviewed by an independent medical expert also known as an independent review organization (IRO)[6].

Here's how the process works:
Step 1: You will receive a letter from your health insurer notifying you of its decision.

Step 2: Follow the instructions in the first denial letter you receive from your health insurer or HMO to ask your health insurer to reconsider its decision. If you would like some help, contact the Health Education and Advocacy Unit in the Attorney General's Office at 877-261-8807 for assistance. Your health care provider, or someone else you authorize to help you, can also do this for you.

Step 3: If your health insurer upholds its original decision to deny payment for the health care service, you may have your case reviewed by an independent medical expert, who will decide if the health care service your health care provider recommended is medically necessary. The Health Education and Advocacy Unit can help you with this too.

Step 4: If your policy allows you to file a complaint with the Maryland Insurance Administration (MIA), the MIA will send your case to an independent medical expert. The MIA will send you a copy of the opinion of the independent medical expert. If your policy does not allow you to file a complaint with the MIA, your health insurer will send your case to an independent medical expert. Your letter from your health insurer will tell you if you can file a complaint with the Maryland Insurance Administration.

There are time limits for filing a complaint, so please carefully read your letter. You may skip to Step 4 and file a complaint directly with the Maryland Insurance Administration before receiving the health insurer's decision if:

- **the health insurer waives its requirement that you first appeal to it, or**
- **if the health insurer does not follow any part of its internal appeal process, or**
- **if you show a compelling reason, such as showing that a delay could result in your death, serious impairment to a bodily function, serious dysfunction of a bodily organ, or could cause you to be a threat to yourself or others, or could cause you to continue to experience severe withdrawal symptoms.**

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4 In this brochure, health insurer includes health insurance companies, HMOs and non-profit health insurance plans.

5 A health care provider includes your doctor, a hospital or a person that is licensed to provide health care services, such as a psychologist, chiropractor, or physical therapist.

6 Under Maryland law, providers are permitted to appeal the decision on behalf of the patient if the patient provides consent.

You are considered to be a danger to yourself or others if you are unable to function in activities of daily living or care for yourself without imminent danger or consequences.

Step 5: If the independent medical expert finds the health care service recommended by your health care provider is medically necessary, the Insurance Commissioner, after considering all the facts of your case, may order your health insurer or HMO to pay for the health care service in accordance with your policy.

You have the right to appeal other coverage decisions made by your health insurer or HMO but those appeals may not necessarily be reviewed by an independent medical expert.

HOW TO FILE A COMPLAINT WITH THE MARYLAND INSURANCE ADMINISTRATION:

Complaints must be received in writing and include a signed consent form. Contact the MIA to learn how to submit a complaint at:

Maryland Insurance Administration
Attn: Consumer Complaint Investigation
Life and Health/Appeals and Grievance
200 St. Paul Place, Suite 2700
Baltimore, MD 21202

Telephone: 410-468-2000 or 800-492-6116
TTY: 1-800-735-2258
Fax: 410-468-2270 or 410-468-2260
(Life and Health/Appeals and Grievance)

Or visit our website at: *www.insurance.maryland.gov*.

Insurance Complaint Checklist

- ❑ Your Name, Address & Phone Number
- ❑ Insurance Company Name
- ❑ Type of Insurance (I.e. Health, Dental, Hmo, Medicare, Medicaid, Etc.)
- ❑ Insurance Policy & Group Number
- ❑ Insurance Company Address & Phone #
- ❑ Date of Service for the Claim
- ❑ Details Of Complaint (Service or Claim Denial, Billing Problem, Delays, Etc.)
- ❑ Who You Talked to at the Insurance Company and on What Dates
- ❑ Documents (Letters From Doctors Or Insurance Company, EOB, Complaint Sent to Insurance Company
- ❑ Response Received from Insurance Company

Prior to making a complaint with the MIA, review the checklist of items above that are needed to file a complaint.

HOW TO CONTACT THE HEALTH EDUCATION AND ADVOCACY UNIT:

Office of the Attorney General
Health Education and Advocacy Unit
200 St. Paul Place, 16th Floor Baltimore, MD 21202

Telephone: 410-528-1840 or 877-261-8807
Fax: 410-576-6571
Or visit the website at: *www.marylandattorneygeneral.gov/Pages/CPD/HEAU*

HEALTH RESOURCES

STATE AGENCIES

Health Education and Advocacy Unit
Office of the Attorney General of Maryland
200 St. Paul Place, Baltimore, MD 21202
410-528-1840 • 877-261-8807
www.marylandattorneygeneral.gov/pages/cpd/heau

Maryland Department of Aging
State Health Insurance Assistance Program (SHIP)
301 W. Preston Street, Suite 1007, Baltimore, MD 21201
410-767-1100 • 800-243-3425
https://aging.maryland.gov/Pages/state-health-insurance-program.aspx

Maryland Department of Budget and Management
Office of Personnel Services and Benefits
301 W. Preston Street, Baltimore, MD 21201
410-767-4765 • 800-705-3493
www.dbm.maryland.gov/Pages/DivOPSB.aspx

Maryland Department of Disabilities
217 E. Redwood Street, Suite 1300
Baltimore, MD 21202
410-767-3660 • 800-637-4113 (Toll-Free/TTY)
www.mdod.maryland.gov

Maryland Health Connection
P.O. Box 857, Lanham, MD 20703
855-642-8572
www.marylandhealthconnection.gov

Maryland Workers' Compensation Commission
10 E. Baltimore Street, Baltimore, MD 21202
410-864-5100 • 800-492-0479
www.wcc.state.md.us

Opioid Operational Command Center
800-422-0009 - Crisis Hotline
http://beforeitstoolate.maryland.gov/

Senior Prescription Drug Assistance Program
Maryland – SPDAP c/o International Software Systems Inc.
PO Box 749
Greenbelt, Maryland 20768-0749
800-551-5995 • 800-877-5156 (TTY/TDD)
www.marylandspdap.com

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Maryland Department of Health (MDH)
201 W. Preston Street, Baltimore, MD 21201
410-767-6500 • 877-463-3464
www.health.maryland.gov

Offices within MDH:

Behavioral Health Administration
Spring Grove Hospital Center
55 Wade Avenue, Catonsville, MD 21228
410-402-8300 • 410-402-8600
http://bha.health.maryland.gov

Health Professional Boards and Commissions
4201 Patterson Avenue, Baltimore, MD 21215
410-764-4700
http://health.maryland.gov/pages/boards.aspx

Maryland Children's Health Plan Program (MCHP)
855-642-8572 - Maryland Health Connection
201 W. Preston Street, Baltimore, MD 21201-2399
https://health.maryland.gov/mmcp/chp/Pages/Home.aspx

Maryland Commission on Kidney Disease
4201 Patterson Avenue, Baltimore, MD 21215
410-764-4799 • 866-253-8461
http://health.maryland.gov/mdckd

Maryland Medicaid
410-767-5800 • 800-492-5231
http://mmcp.health.maryland.gov

Maryland Medicaid Pharmacy Program (MPP)
800-492-5231, Option #3
http://mmcp.health.maryland.gov/pap

Office of Health Care Quality
Spring Grove Hospital Center Bland Bryant Building
55 Wade Avenue, Catonsville, MD 21228
410-402-8000 • 877-402-8218
https://health.maryland.gov/ohcq

FEDERAL AGENCIES

Centers for Medicare and Medicaid Services (CMS)
7500 Security Boulevard, Baltimore, MD 21244
410-786-3000 • 877-267-2323
Medicare Service Center: 800-633-4227
www.cms.gov

Federal Employees Health Benefits Program Office of Personnel Management
1900 E Street, NW, Room 3443, Washington, DC 20415
202-606-1800 • 800-877-8339 (TTY)
www.opm.gov

Substance Abuse and Mental Health Services Administration (SAMHSA) 988 Suicide & Crisis Lifeline
988 or 1-800-273-8255
www.988lifeline.org

United States Department of Labor Employee Benefits Security Administration
200 Constitution Avenue, NW
Washington, DC 20210
866-444-EBSA (3272)
www.dol.gov/ebsa

INFORMATION TO ASSIST WITH PRE-AUTHORIZATION AND RETROSPECTIVE CLAIMS

The following is a list of some information that you should have available that may assist you with getting pre-authorization for services, claim payment for services, or appealing a claim denial.

Pre-Authorization Checklist

Information you may need for getting pre-authorization for treatment services, claim payment for services or appealing a claim denial:

- ❑ Patient Name
- ❑ Date of Birth
- ❑ Patient's Insurance Member ID Number
- ❑ Patient's Insurance Group Number
- ❑ Insurance Company Name
- ❑ Insurance Company phone number
- ❑ Type of service being requested
- ❑ Is the service in-network or out-of-network?
- ❑ Name of referring provider

This consumer guide should be used for educational purposes only. It is not intended to provide legal advice or opinions regarding coverage under a specific policy or contract; nor should it be construed as an endorsement of any product, service, person, or organization mentioned in this guide.

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People with disabilities may request this document in an alternative format. Requests should be submitted in writing to the Chief, Communications and Public Engagement at the address listed below.

200 St. Paul Place, Suite 2700
Baltimore, MD 21202
410-468-2000
800-492-6116
800-735-2258 TTY
www.insurance.maryland.gov

www.facebook.com/MdInsuranceAdmin
www.twitter.com/MD_Insurance
www.instagram.com/marylandinsuranceadmin

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