

CONSUMER GUIDE TO
UNDERSTANDING YOUR HEALTH
INSURANCE COVERAGE FOR
**MENTAL HEALTH
& SUBSTANCE USE
DISORDERS**



INSURANCE
ADMINISTRATION

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INTRODUCTION

Understanding your health insurance coverage for mental health and substance use disorders 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 period¹ 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 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 company².

KEY INSURANCE TERMS

Allowable Amount – The maximum amount the insurance company will pay for a covered health care service. This is sometimes referred to as “payment allowance” or “negotiated rate.” 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 plan³ 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 – If you receive covered services from an out of-network provider, and the cost of these services is more than the allowable amount, the provider may be permitted to bill you for the difference. In some circumstances, you may be protected from balance billing. For example, if you are treated by a Maryland doctor in an emergency room, the law may protect you. If you have a choice of providers, and you choose an out-of-network provider, you may have to pay the full amount of the provider’s bill.

Coinsurance – This is your share of the costs of a covered health care service. The coinsurance is applied after any deductible is satisfied. Your share is a percentage, such as 20%, of the allowable amount for the service. Here is an example of how it works:

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.

- 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 – This is a set dollar amount that you must pay for a particular 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 of money you must pay towards covered services before your insurance company will begin making 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.

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 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, 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 health care 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 DISORDER, AND SUBSTANCE USE DISORDER EMERGENCIES

To start the process of obtaining authorization for an inpatient admission for mental illness, emotional health disorder or a substance use disorder, **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. The insurance company will tell you what documents they need in order to make a determination about 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.

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 disorder, or substance use disorder, the insurance company must make a decision on whether to pre-authorize the treatment within 2 hours of receiving the requested documents.

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 in emergencies when care has not yet been rendered. In an emergency, the MIA will make a decision within 24 hours.

If the MIA does not regulate the health insurance plan, your complaint will be sent to the agency that does regulate the plan.

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 disorder benefits or prescription drugs may not require pre-authorization for prescription drugs used for substance use treatment of an opioid use disorder and 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. It's also important that you understand 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 web site. 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 how much money you will owe. Visit the health plan's website, specifically the online provider directory to see if your health care provider participates in the plan or not. 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. Your health benefit plan may not pay for services if you see an out-of-network provider and ***you will 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. Review your plan to make sure you know the rules.

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.

What do I do if I cannot find an in-network specialist?

If your health plan does not have an in-network specialist who can provide medically necessary services, you can ask for approval from the health plan to see an out-of-network specialist. Health plans subject to Maryland law are required to allow you to see an out-of-network specialist if there is no in-network specialist who can provide medically necessary services and certain conditions are met. Your claims will be paid based on your in-network deductible, coinsurance, or copayment. Your specialist may agree to a fee with the health plan, but may balance bill you if there is no agreement.

You should ask for approval before receiving services. Your policy should include information on how to request approval. You can call the customer service number on your membership identification card to ask how to request approval. You should be clear that it is medically necessary for you to see an out-of-network specialist because there is no in-network specialist. If you are in a health plan that requires referrals, your primary care physician may be able to help you.

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.

If 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.

YOUR RIGHTS

WHEN YOUR HEALTH INSURER OR HEALTH MAINTENANCE ORGANIZATION (HMO) WILL NOT PAY FOR HEALTH CARE SERVICES

If your health care provider tells you that a certain health care service is needed, but your health insurer or HMO disagrees, you have the right to appeal that decision to the insurance company or HMO and have it reviewed by an independent medical expert.

Here's how the process works:

Step 1: After you submit a claim with the insurance company, you will receive a letter from your health insurer or HMO notifying you of its decision to pay for services. An adverse decision letter may also be called a first denial letter or adverse benefit determination.

Step 2: If you want to ask the insurance company to reconsider its decision (known as filing a “grievance”), follow the instructions in the first denial letter. 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: Once you file a grievance with your insurance company, the adverse decision will be 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 the insurance company’s decision is upheld, then you may file a complaint. If your policy allows you to file a complaint with the MIA, the agency will send your case to an independent medical expert for review and an opinion. 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 insurance company will send your case to an independent medical expert. Your first denial letter from your health insurer or HMO will tell you where to file a complaint. There are time limits for filing a complaint, so please read your letter carefully.

You may skip to Step 4 and file a complaint directly with the Maryland Insurance Administration before receiving the health insurer or HMO’s decision on your grievance, but only under the following circumstances: (1) If the health insurer or HMO waives its requirement that you first appeal to it; (2) if the health insurer or HMO does not follow any part of its internal appeal process; or (3) if you show a compelling reason. A compelling reason includes a 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.

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.

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 of the 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/beau

Maryland Department of Aging

301 W. Preston Street, Suite 1007

Baltimore, MD 21201

410-767-1100 • 800-243-3425

410-333-7943 (Fax)

www.aging.maryland.gov

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 2160, Manchester, CT 06045

855-642-8572

www.marylandhealthconnection.gov

Maryland Life and Health Insurance Guaranty Corporation

6210 Guardian Gateway, Suite 195 APG

Aberdeen, MD 21005

410-248-0407

www.mdlifeqa.org

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/>

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>

Breast and Cervical Cancer Diagnosis and Treatment Program

410-767-6787 • 800-477-9774
http://phpa.health.maryland.gov/cancer/Pages/bccdt_home.aspx

Health Care Financing (HCF)

410-767-5343

Health Care Services Cost Review Commission (HSCRC)

4160 Patterson Avenue
Baltimore, MD 21215
410-764-2605 • 888-287-3229
www.hscrc.maryland.gov

Health Professional Boards and Commissions

4201 Patterson Avenue
Baltimore, MD 21215
410-764-4700
<http://health.maryland.gov/pages/boards.aspx>

Maryland AIDS Drug Assistance Program

410-767-6535 • 800-205-6308
<http://phpa.health.maryland.gov/OIDPCS/CHCS/pages/madap.aspx>

Maryland Children's Health Plan Program (MCHP)

855-642-8572 - Maryland Health Connection
<http://mmcp.health.maryland.gov/chp>

Maryland Commission on Kidney Disease

4201 Patterson Avenue, Baltimore, MD 21215
410-764-4799 • 866-253-8461
<http://health.maryland.gov/mdckd>

Maryland Health Care Commission

4160 Patterson Avenue
Baltimore, MD 21215
410-764-3460 • 877-245-1762
www.mbcc.maryland.gov

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>

Maryland Oral Health Resource Guide

<http://phpa.health.maryland.gov/oralhealth/Documents/OralHealthResourceGuide.pdf>

Maryland Prevention and Health Promotion Administration

410-767-6500 • 877-463-3464
<http://phpa.health.maryland.gov>

Office of Health Care Quality

Spring Grove Hospital Center
Bland Bryant Building
55 Wade Avenue, Catonsville, MD 21228
410-402-8000 • 877-402-8218
<http://health.maryland.gov/ohcq/Pages/Home.aspx>

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

Internal Revenue Service (IRS)

800-829-1040

www.irs.gov

United States Department of Labor

Employee Benefits Security Administration

200 Constitution Avenue, NW

Washington, DC 20210

866-444-EBSA (3272)

www.dol.gov/ebsa

OTHER RESOURCES

Senior Prescription Drug Assistance Program

628 Hebron Avenue, Suite 502

Glastonbury, CT 06033

800-551-5995 • 800-877-5156 (TTY/TDD)

www.marylandspdap.com

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.

Member Name

Member Insurance ID number

Patient Name and Date of Birth

Patient Relationship to You

- Guardianship paperwork
- Adult Patient - Authorization to Represent

Is the patient a threat to himself / herself or others?

Insurance Company Name

Insurance Company Phone Number

Insurance Plan Name or ID Number

Insurance Plan type:

- Individual Plan
- Group Plan
- Employer Benefit Plan
- Plan includes Out-of-Network Benefit for requested services
 - Limits on benefit, if any (such as a penalty or reduced payment for Out-of-Network services)
- Plan does not include Out-of-Network Benefit for requested services

Treating Provider Name and Contact Information

- Treating Provider is In-Network
- Treating Provider is Out-of-Network

Primary Care Doctor Name and Contact Information (if different than Treating Provider)

Provider Referral Letter (if required)
Provider Letter of Medical Necessity for Requested Services

Other Providers Involved in Treatment

Type of Services Requested:

- Mental Health
- Substance Use Disorder
- Electro Convulsive Therapy (ECT)
- Repetitive Transcranial Stimulation (rTMS)
- Applied Behavior Analysis (ABA)
- Psychological Testing
- BioFeedback
- Skilled Nursing
- Traumatic Brain Injury Rehabilitation
- Habilitative Services
 - Physical Therapy
 - Occupational Therapy
 - Speech Therapy
- Medication
- Medical Supplies, Equipment or Device
- Other _____

Location of Requested Services:

- Treating Provider's Office
- Home or School
- Outpatient
- Intensive Outpatient Program
- Partial Hospitalization Program
- Acute Inpatient
- Inpatient Rehab
- Acute Inpatient Detox
- Residential
- Skilled Nursing Facility
- Telehealth

Has the patient been treated for this before?
If yes:

- Dates of previous treatment(s)
- Provider(s) of previous treatment(s)
- Location of previous treatment(s)

Patient Share of Costs for Requested Services

- Co-payment amount
- Unmet Deductible
- Co-insurance amount or percentage
- Annual Out-of-Pocket Maximum

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Baltimore, MD 21202
410-468-2000
800-492-6116
800-735-2258 TTY

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