III. MENTAL HEALTH/SUBSTANCE USE DISORDER BENEFITS

Mental Health/Substance Use Disorder Benefits are administered by Beacon Health Options. Accessing your mental health benefits is confidential.

PROGRAM REQUIREMENTS

If you or an enrolled dependent faces a mental health or Substance Use Disorder problem, you can seek treatment twenty-four (24) hours a day, seven (7) days a week by calling the toll-free hotline number: 1-866-909-6472. **You must call 1-866-909-6472 to access benefits, except for the first ten (10) outpatient office/home visits of non-network treatment. If you do not call on or before the 10th visit there is no coverage for any visits after the 10th until you call.** If you do not call for precertification before starting treatment with a Network provider, your treatment will be covered under the non-network benefit which is explained on page 5. As such, until you call there will be no coverage at all beyond the 10th visit.

Who Must Abide by These Program Requirements? Everyone, for whom the EMHP is the primary benefit plan, including your enrolled spouse/domestic partner and enrolled dependent children, must follow the Program Requirements. The Program Requirements have several features you and your enrolled dependents are required to use to help control health care costs.

The Program Requirements do not apply to enrolled retirees for whom Medicare is primary, or to participants of another health benefits plan, which pays benefits first.

Precertification or certification, as the case may be is required for all services including access to EMHP as secondary payer to other insurance benefit plans including Medicare. You must call to access benefits. However, precertification is not required for the first ten visits of non-network outpatient treatment. In an emergency services situation, certification is required for coverage as soon as possible, but no later than 48 hours from the onset of incident.

Care Must be Medically Necessary

The service or care received must be medically necessary. Medically necessary care is defined as:

1. medically required;
2. having a strong likelihood of improving your condition; and
3. provided at the least restrictive setting, for your specific diagnosed condition, in accordance with both generally accepted psychiatric and mental health practices and the professional and technical standards adopted by Beacon Health Options;

Although a practitioner or facility may recommend that a covered person receives a service or be confined to an approved facility, that recommendation does not mean:

1. that such service or confinement will be deemed to be medically necessary; or
2. that benefits will be paid under this program for such service or confinement.

You should call Beacon Health Options at 1-866-909-6472 if you have questions about your coverage.

Covered Providers, Facilities and Modalities

Outpatient Treatment: Mental Health/Substance Use Disorder

To qualify for coverage for a condition with a psychiatric diagnosis all treatment must be medically necessary and rendered by a properly licensed mental health practitioner. In New York State, the following professionals and facilities meet that description:

- psychiatrist (MD or DO)
- psychologist (Ph.D., EdD or PsyD)
- licensed certified social worker/masters level (LCSW)
- psychiatric nurse/masters level (MS/RN)
- for Substance Use Disorder group sessions only - certified alcoholism and Substance Use Disorder counselor (CASAC) or similarly credentialed practitioner of a licensed Substance Use Disorder treatment program
- Licensed outpatient mental health or Substance Use Disorder facilities.

Treatment may include the following:

- Individual and group sessions
- Family therapy
- Marital/conjoint therapy
- Intensive outpatient programs
- Partial hospitalization
- Biofeedback
- Psychiatric medication monitoring
- Psychological testing (for treatment planning only – See Section 4.)

Inpatient Treatment: Mental Health

Inpatient treatment must be rendered in a properly licensed psychiatric hospital or the psychiatric unit of a general hospital for a diagnosed psychiatric condition. This includes all standard necessary professional services. All special consultations or treatment modalities, for example, shock treatment (ECT), require prior certification by the Beacon Health Options clinical care manager.

Inpatient Treatment: Substance Use Disorder

Detoxification and rehabilitative treatment for Substance Use Disorder must be rendered in either a hospital or properly licensed free standing rehabilitation facility.

Note: **The Mental Health/Substance Use Disorder Plan covers medically necessary acute care, as approved by a Beacon Health Options clinical care manager. It does not cover chronic conditions requiring residential or custodial care.**

Mental Health Coverage

All services must be medically necessary.[1]

BENEFIT	NETWORK[2]	NON-NETWORK[2]
Inpatient Mental Health Services	**- Precertification required** - No deductible	**- Precertification required** - Annual deductible of $2,000 per person[3] - Plan pays 50% of reasonable and customary or provider's charges, whichever is less - Maximum 30 days per calendar year
Group Home, Halfway House, Residential Treatment Center, 23 hour bed, 72 hour bed, Intensive Outpatient, Psych Day Treatment	**-Precertification required** - No deductible	**- Precertification required** - Annual deductible of $2,000 per person [3] - Plan pays 50% of reasonable and customary or provider's charges, whichever is less - Maximum 30 days per calendar year
Inpatient: Professional Services	**- Precertification required** - No deductible	**- Precertification required** - Annual deductible of $500 per person[4] - Plan pays 50% of reasonable and customary or provider's charge, whichever is less - Maximum 30 visits per calendar year
Partial (Day) Hospitalization: Mental Health Services	**- Precertification required** - No deductible - Plan pays 100%	**- Precertification required** - Annual deductible of $2,000 per person[3] - Plan pays 50% of reasonable and customary or provider's charges, whichever is less - Maximum 30 days per calendar year
Outpatient: Mental Health Services (Office/Home Visits)	**- Precertification required** - No deductible - After your $20 copayment per visit, the Plan pays 100%	**- Precertification required for all visits after 10th** - Annual deductible of $500 per person [4] - Plan pays 50% of reasonable and customary or provider's charge, whichever is less - Maximum 30 visits per calendar year

[1]*Precertification or certification, as the case may be, is required for all services including access to the EMHP as secondary payer to other benefit plans including Medicare. You must call to access benefits. However, precertification is not required for the first ten visits of non-network outpatient office/home visits. In an emergency service situation, certification is required for coverage as soon as possible, but no later than 48 hours from the onset of incident.*

[2]*Network coverage is unlimited when medically necessary. No annual or lifetime dollar maximums for coverage.*

[3]*$2,000 per employee, $2,000 per spouse and $2,000 aggregate for all children.*

[4]*$500 per employee, $500 per spouse and $500 aggregate for all children.*

Substance Use Disorder Coverage

All services must be medically necessary.[1]

BENEFIT	NETWORK [2]	NON-NETWORK [2]
Inpatient: Detoxification	- **Precertification required** - No deductible - Plan pays 100% - Three stays per lifetime[5]; more approved on a case-by-case basis	- **Precertification required** - Annual deductible of $2,000 per person[3] - Plan pays 50% of reasonable and customary or provider's charge, whichever is less - One stay per year[5]. - Three stays per lifetime[5].
Inpatient: Rehabilitation	- **Precertification required** - No deductible - Plan pays 100% - Three stays per lifetime[5]; more approved on a case-by-case basis	- **Precertification required** - Annual deductible of $2,000 per person[3] - Plan pays 50% of reasonable and customary or provider's charge, whichever is less - One stay per year[5]. - Three stays per lifetime[5].
Group Home, Halfway House, Residential Treatment Center, Substance Use Disorder Day Treatment	- **Precertification required** - **No deductible** - **Plan pays 100%** - Three stays per lifetime[5]; more approved on a case-by-case basis	- **Precertification required** - **Annual deductible of $2,000 per person[3]** - Plan pays 50% of reasonable and customary or provider's charge, whichever is less - One stay per year[5]. - Three stays per lifetime[5].
Partial (Day) Hospitalization: Substance Use Disorder Services	- **Precertification required** - No deductible - Plan pays 100%	- **Precertification required** - Annual deductible of $2,000 per person[3] - Plan pays 50% of reasonable and customary or provider's charge, whichever is less - One stay per year[5]. - Three stays per lifetime[5].
Outpatient: Includes Intensive Outpatient, Outpatient Detox.	- **Precertification required** - No deductible - Plan pays 100%	**Precertification required for all visits after 10th** - Annual deductible of $500 per person[4]. - Plan pays 50% of reasonable and customary or provider's charge, whichever is less - Maximum 30 visits per calendar year

[1]Precertification or certification, as the case may be, is required for all services including access to the EMHP as secondary payer to other benefit plans including Medicare. You must call to access benefits. However, precertification is not required for the first ten visits of non-network outpatient office/home visits. In an emergency service situation, certification is required for coverage as soon as possible, but no later than 48 hours from the onset of incident.

[2] Network and non-network coverage is unlimited when medically necessary. No annual or lifetime dollar maximums for coverage.

[3]$2,000 per employee, $2,000 per spouse and $2,000 aggregate for all children.

[4]$500 for employee, $500 for spouse/domestic partner, $500 aggregate for all children.

[5]A break in treatment is defined as sixty days without service for the same diagnosis. Therefore, a re-admission in less than 61 days for the same diagnosis will count as the same stay.

Crisis Intervention Coverage

All services must be medically necessary.[1]

BENEFIT	NETWORK[2]	NON-NETWORK[2]
Mental Health and Substance Use Disorder Crisis Intervention	- Notification within 48 hours - Plan pays 100% of network rates up to 3 visits per crisis	- No Crisis intervention coverage
Ambulance Service for Crisis Intervention	- Ambulance covered as approved	- Ambulance transport from non-network facility to Network Facility as approved

[1]*Precertification or certification, as the case may be, is required for all services including access to EMHP as secondary payer to other insurance benefit Plans including Medicare. You must call to access benefits. However, precertification is not required for the first ten visits of non-network outpatient treatment outside of a facility. In an emergency service situation, certification is required for coverage as soon as possible, but no later than 48 hours from the onset of incident.*
[2]*Network coverage is unlimited when medically necessary; there are no annual or lifetime dollar maximums. There is no non-network coverage.*

A. Network Coverage

You must call Beacon Health Options at 1-866-909-6472 to access a Network provider and receive the highest level of benefits. You will be referred to a provider to specifically meet your needs and who is within your geographic area (usually within 30 minutes from your home or office).

- Your out-of-pocket costs will be limited to the copayment for outpatient services, per session ($20 for mental health services; $10 for Substance Use Disorder treatment). You pay no deductibles; you will not receive a bill.
- Your treatment provider will have been screened, credentialed, and monitored to provide quality care.

If you are in an area that is not serviced by an appropriate Network provider, Beacon Health Options will locate and contract with a provider within forty-eight (48) hours. In the event that Beacon Health Options directs you to a non-network provider, you will be treated as if you were going to a Network provider. Specifically, you will be responsible for the appropriate in-network copayment.

B. Non-Network Coverage

1. Mental Health and Crisis Intervention Services

If you do not call Beacon Health Options at 1-866-909-6472 before you receive treatment from a provider, a substantially lower level of benefits is available for the first ten (10) outpatient office visits. You may also choose your own provider, as long as the proposed care meets medical necessity criteria. Non-network benefits are as follows:

- There is an annual $500 outpatient deductible per person, up to a maximum of $1,500 per family based upon reasonable and customary charges.
- There is an annual $2,000 inpatient deductible per person, up to a maximum of $6,000 per family based upon reasonable and customary charges.
- Once the deductible is met, you will be reimbursed for up to 50% of the reasonable and customary charge or 50% of the provider's charge, whichever is less.

You will be limited in the number of visits or days of care as follows:

- You will be covered for up to ten (10) outpatient visits without pre-certification. Approval for further coverage of up to twenty (20) additional outpatient visits per calendar year requires a phone call from you to Beacon Health Options at 1-866-909-6472. You may be covered for a maximum of thirty (30) outpatient visits per calendar year;

- Coverage beyond the 10th visit of outpatient treatment requires a prior authorization to the provider by a Beacon Health Options care manager;

- For inpatient treatment, you may be covered for up to thirty (30) days of care per calendar year.

All services must be medically necessary as determined by a Beacon Health Options care manager.

2. Substance Use Disorder

If you do not call Beacon Health Options at 1-866-909-6472 before you receive treatment from a provider, a substantially lower level of benefits is available for the first ten (10) outpatient office visits. You may also choose your own provider, as long as the proposed care meets medical necessity criteria. Non-network benefits are as follows:

- There is an annual $500 outpatient deductible per person, up to a maximum of $1,500 per family based upon reasonable and customary charges.

- There is an annual $2,000 inpatient deductible per person, up to a maximum of $6,000 per family based upon reasonable and customary charges.

- Once the deductible is met, you will be reimbursed for up to 50% of the reasonable and customary charge or 50% of the provider's charge, whichever is less.

You will be limited in the number of visits or days of care as follows:

You will be covered for up to ten (10) outpatient visits without pre-certification. Approval for further coverage of up to twenty (20) additional outpatient visits per calendar year requires a phone call from you to Beacon Health Options at 1-866-909-6472. You may be covered for a maximum of thirty (30) outpatient visits per calendar year;

Coverage beyond the 10th visit of outpatient treatment requires a prior authorization to the provider by a Beacon Health Options care manager;

- For inpatient treatment, you may be covered for up to thirty (30) days of care per calendar year.

All services must be medically necessary as determined by a Beacon Health Options care manager.

C. Emergency Mental Health Services

If you or your enrolled dependent requires emergency mental health services, call Beacon Health Options at 1-866-909-6472 within forty-eight hours from the onset of the incident. You or your enrolled dependent will be directed to the nearest network facility or to a psychiatrist for an immediate evaluation, whichever course of treatment is more appropriate. Transportation by ambulance may be available if needed. If hospitalization is medically necessary, the admission will be authorized immediately. From the point of admission, the treatment will be monitored by a Beacon Health Options clinical care manager.

If you or an enrolled dependent, who is other than the patient, needs to talk to someone, a clinical care manager is available at all times at 1-866-909-6472 for telephone assistance or for a next day referral to a network therapist.

D. Claim Filing Procedure for Mental Health/Substance Use Disorder Benefits

How to File Claims. If a Network provider is utilized, complete the portion of the claim form which includes your personal information, name, address, identification number, etc. and sign the form. The Network provider completes the remainder of the form and sends it directly to Beacon Health Options. Claim forms are provided at each Network provider's office. Payment is then made to the provider and an Explanation of Benefits (EOB) is forwarded to you indicating that the claim has been filed and paid. You are not responsible for charges other than the copayment(s).

Non-network claims should be forwarded to the following address:

Beacon Health Options
PO Box 1347
Latham, NY 12110-8847

Non-network claims should be submitted on the Plan's "Non-Network Provider" claim form. Copies can be obtained by calling Beacon Health Options at 1-866-909-6472 or EBU at (631) 853-4866 or via e-mail ebu@suffolkcountyny.gov. The forms can also be downloaded from the EMHP website at www.emhp.org.

The medical provider should complete required medical information and sign the form. If the form is not completed by the provider, an itemized statement that includes the diagnosis must be attached. The enrollee must complete the required information and submit the claim to Beacon Health Options. Missing information will delay the processing of the claim.

If enrolled in Medicare, a "Medicare Explanation of Benefits" form must be submitted with the completed claim form with detailed bills for all items to receive benefits in excess of Medicare payment. Make and keep a duplicate copy of the "Medicare Explanation of Benefit" form since it cannot be returned.

REMEMBER — If enrolled in Medicare for primary coverage, bills must be submitted to Medicare first.

When to File Claims. If a Network provider is utilized, the claim form should be signed when charges are incurred. The Network provider will then send it to Beacon Health Options.

If a non-network provider is utilized, claims may be submitted at any time after the annual deductible has been satisfied **but not later than ninety (90) days after the end of the calendar year (March 31) in which covered expenses were incurred.**

Claims Inquiries. When you have questions about a claim, you may call the following toll-free number at Beacon Health Options, 1-866-909-6472.

Verification of Claims Information. Beacon Health Options has the right to request from hospitals, approved facilities, doctors or other providers any information that is necessary for the proper handling of claims. **(All medical information is kept strictly confidential.)**

In order for Beacon Health Options to process your claim, it will be necessary for Beacon Health Options to obtain medical records and information from hospitals, skilled nursing facilities, doctors, pharmacists or other practitioners who treated you or your enrolled dependent. When you file a claim for benefits under the EMHP, you automatically give Beacon Health Options permission to obtain and use those records and that information. That permission extends to the doctors and other health care personnel with whom Beacon Health Options contracts to assist us in administering the EMHP and reviewing the medical necessity of services covered under the EMHP. If Beacon Health Options is unable to obtain medical records, it has the right to deny payment for that claim. **(All medical information is kept strictly confidential.)**

E. Limitations and Exclusions

The following list of treatments, services and supplies that **are not** covered by the plan are deemed to be illustrative and not all-inclusive. Other treatments, services and supplies which are not listed below may be limited in coverage, or excluded from coverage altogether. You should contact Beacon Health Options at 1-866-909-6472 with questions about coverage:

- Expenses incurred prior to your effective date of coverage or after termination of coverage.
- Services or supplies which are not Medically Necessary;
- Custodial Care. Payment will not be made for services rendered in connection with any stay for physical check-ups, custodial, domiciliary or convalescent care, rest cures or sanitarium-type care. Care is considered custodial when it is primarily for the purpose of meeting personal needs and could be provided by persons without professional skills or training. For example, custodial care includes help in walking, getting in and out of bed, bathing, dressing, eating and taking medicine.
- Services, treatment or supplies determined to be experimental or investigational;
- Diagnosis and treatment of developmental disorders, including, but not limited to, reading disorder, developmental arithmetic disorder, or developmental articulation disorder;
- Any court-ordered diagnosis and/or treatment, including diagnosis and/or treatment ordered as a condition of parole, probation or custody and/or visitation evaluation, except as such diagnosis and/or treatment is medically necessary;

- Psychological examination, testing or treatment for purposes of satisfying an employer's, prospective employer's or other party's requirements for obtaining employment, licensing or insurance, or for the purposes of judicial or administrative proceedings (including but not limited to probation or parole proceedings);

- Other psychological testing, except when conducted for the purpose of diagnosis of a Mental Health/Substance Use Disorder condition when such diagnosis is a part of the treatment planning process;

- Treatment for a chronic mental condition, except for initial diagnosis, stabilization of an acute episode of such disorder or management of medication. Services or supplies which are solely for the purpose of professional or personal growth, marriage counseling, development training, professional certification, obtaining or maintaining employment or insurance, or solely pursuant to judicial or administrative proceedings.

- Services to treat conditions that are identified in the current American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders as non-disorder conditions which may be a focus of clinical attention (V codes); except for family visits for Substance Use Disorder or alcoholism.

- Prescription drugs, except when medically necessary and when dispensed by an approved facility, residential or day treatment program to a covered individual who, at the time of dispensing, is receiving inpatient services for mental health and/or Substance Use Disorder care at that approved facility. Take-home drugs are not covered.

- Private duty nursing.

- Any charges for missed appointments, completion of a claim form, medical summaries and medical invoice preparations including, but not limited to, clinical assessment reports, outpatient review forms and statements of medical necessity.

- Travel, personal hygiene and convenience items such as air conditioners and physical fitness equipment expenses, whether or not recommended by a physician.

- Charges for services, supplies or treatments that are covered under any other portion of the EMHP including but not limited to detoxification of newborns and medically complicated detoxification cases.

- Services, treatment or supplies provided as a result of any Workers' Compensation Law or similar legislation, or obtained through, or required by, any governmental agency or program, whether federal, state or of any subdivision thereof.

- Services or supplies for which you are not required to pay, including amounts charged by a provider which are waived by way of discount or other agreements made between you and the provider of care.

- Charges for the professional or non-professional services performed by a person who ordinarily resides in your household or is related (by blood or law) to the covered person to include, but not limited to, a spouse, parent, child, brother, sister in law, etc.

- Services or supplies for which you receive payment or are reimbursed as a result of legal action or settlement other than from an insurance carrier under an individual policy issued to you.

- Conditions resulting from an act of war (declared or undeclared) or an insurrection, which occurs after December *5,* 1957.

- Services provided in a veteran's facility or other services furnished, even in part, under the laws of the United States and for which no charge would be made if coverage under the Mental Health and Substance Use Disorder Program were not in effect. However, this exclusion will not apply to services provided in a medical center or hospital operated by the U.S. Department of Veterans' Affairs for a non-service connected disability in accordance with federal law.