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EBSA/PUBLIC DISCLOSURE

2010 MAY -3 PM 1:08

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April 30, 2010

FILED VIA HAND-DELIVERY

Office of Health Plan Standards and Compliance Assistance
Employee Benefits Security Administration
Room N-5653
Attention: TIN 1210-AB30
U.S. Department of Labor
200 Constitution Avenue NW
Washington, DC 20210

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Hubert H. Humphrey Building, Room 445-G
Attention: CMS-4140-IFC
200 Independence Avenue, SW
Washington, DC 20201

Internal Revenue Service
Courier's Desk
CC:PA:LPD:PR (REG-120692-09)
1111 Constitution Avenue, NW,
Washington, DC 20224

RE: **Comments** on Interim Final Rules Under the Paul Wellstone and Pete
Domenici Mental Health Parity and Addiction Equity Act of 2008
Published at 75 Fed. Reg. 5410 (February 2, 2010)

Dept. of Labor EBSA File No.: Attention RIN 1210-AB30
Dept. Health & Human Servs. CMS File No.: CMS-4140-IFC
Dept. of Treasury IRS File No.: CC:PA:LPD:PR (REG-120692-09)

Dear Sirs and Madam:

Nelson Mullins Riley & Scarborough, LLP ("Nelson Mullins") is writing on behalf of its Substance Use Disorder Healthcare Provider clients to submit comments to the Interim Final Rules published in Volume 75 of the Federal Register at page 5410 on February 2, 2010,

under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (“MHPAEA”). Nelson Mullins appreciates the actions taken by the Department in the Interim Final Rules and further appreciates the opportunity to provide comments to the Departments on those issues upon which the Department has requested comments and to share its clients’ first-hand knowledge and experience with ways in which plans have historically applied and currently apply both financial requirements and treatment limitations under substance use disorder benefits in manners not on par with medical and surgical benefits.

Comments to Interim Final Rules for Implementation of MHPAEA

In the Interim Final Rules issued by the Department of the Treasury, Department of Labor and Department of Health and Human Services (the Departments) on January 29, 2010 and published in the Federal Register on February 2, 2010 (the regulations), the Departments invited comments on whether and to what extent MHPAEA addresses the scope of services or continuum of care provided by a group health plan or health insurance coverage. 75 Fed. Reg. 5416 - 5417.

The Departments also invited comments on additional examples that may be helpful to illustrate the application of the nonquantitative treatment limitation rule to other features of medical management or general plan design. 75 Fed. Reg. 5416. In addition, during the Departments’ January 29, 2010 telephonic constituency group briefing on the regulations, the issue of state law preemption was also presented and is commented on herein.

Comment 1: Continuum of Care/Scope of Services

A. Treatment Setting/Facility Type Exclusions Constitute Impermissible Limitation on Scope of Services and Impermissible NQTL

1. Statutory and Regulatory Background

ERISA §712(a) [29 USC 1185a] (3)(A)(ii) and (B)(ii) and (iii) were added to require that in the case of a group health plan (or health insurance coverage offered in connection with such a plan) that provides both medical and surgical benefits and mental health or substance use disorder benefits, the treatment limitations applicable to mental health or substance use disorder benefits are no more restrictive than the predominant treatment limitations applied to substantially all medical and surgical benefits covered by the plan, and that there are *no separate treatment limitations that are applicable only with respect to mental health or substance use disorder benefits*. A treatment limitation is considered to be predominant if it is the most common or frequent of such type of limit. “The term ‘treatment limitation’ includes limits on the frequency of treatment, number of visits, days of coverage, *or other similar limits on the scope or duration of treatment*.” (Emphasis supplied.)

The preamble to the Interim Final Rules, (herein referred to as the “regulations”) states: “The Departments recognize that not all treatments *or treatment settings* for mental health conditions or substance use disorders correspond to those for medical/surgical benefits. The Departments also recognize that MHPAEA prohibits plans and issuers from imposing treatment limitations on mental health and substance use disorder benefits that are more restrictive than those applied to medical/surgical benefits.” 75 Fed. Reg. 5416. (Emphasis supplied).

2. Recommendation

The Departments’ Final Rules should require that **group health plans recognize and include as covered healthcare providers under the MH/SUD benefit, appropriately state licensed and/or nationally accredited non-hospital facilities, such as freestanding psychiatric and substance abuse treatment facilities and freestanding residential treatment centers, which are uniquely appropriate to provide treatment services under the MH/SUD benefit.**

3. Rationale

With the evolution of MH/SUD treatment, standard clinical treatment modalities and treatment settings have changed dramatically from early days. As noted in a 2009 Health Affairs issue, the former President of CIGNA Health Solutions stated that a major challenge for health plans in implementing mental health parity and addiction equity is the elimination of “any vestiges of structural differences between coverage of MH/SUD treatment benefits and benefits for general medical care.”¹ Decades ago, those suffering from MH/SUD’s were placed in psychiatric wards of hospitals, often in lock-down, or in detoxification beds in hospitals. Much has changed regarding the medical community’s clinical understanding of such disorders, and along with knowledge, treatment settings and programs have changed as well. According to SAMHSA 2007 National Survey of Substance Abuse Treatment Services (N-SSATS), as of 2007, 13,648 substance abuse treatment facilities provided medication, counseling, behavioral therapy, case management, and other types of services to persons with substance use disorders.² (See **Composite Exhibit A**, National Survey excerpts with Tables 2.3 and 3.2).³ Of these 13,648 facilities, 4,716 provided inpatient services. Of the 4,716 facilities providing inpatient services, 3,716 or 79% were residential non-hospitals, and merely

¹ Keith Dixon, “Implementing Mental Health Parity: The Challenge For Health Plans”, Health Affairs, 28(3):663(May-Jun 2009).

² SAMHSA 2007 National Survey of Substance Abuse Treatment Services (N-SSATS), available at: <http://www.oas.samhsa.gov/nssats2k7/NSSATS2k7Hi.htm>. See also, National Institute on Drug Abuse, Principles of Drug Addiction Treatment: A Research Based Guide, Second Edition (2009) available at: <http://www.drugabuse.gov/PODAT/TreatmentUS.html>.

³ Salient portions of the Exhibits attached hereto are highlighted for ease of reference.

1,000 or 21% were hospital-based treatment providers.⁴ (See Comp. Ex. A). The National Survey shows that during 2007, 118,512 individuals obtained inpatient substance abuse treatment. Of these 118,512 individuals, 103,709 or 87.5% received inpatient treatment in a residential, non-hospital facility, and merely 14,803 or 12.5% received inpatient treatment in a hospital setting. (See Comp. Ex. A).

Each state has its own substance abuse licensing agency, with a codified regulatory licensure scheme to ensure clinical quality standards of treatment facilities and the levels of care and services they are licensed to provide.⁵ In addition, just as with hospitals on the medical/surgical side, MH/SUD freestanding treatment facilities may also be Joint Commission accredited to demonstrate compliance with national accreditation standards. Such state licensed freestanding treatment facilities, rather than general hospitals, are the far more typical and *available* inpatient treatment setting for the provision of MH/SUD treatment services. These freestanding treatment facilities are specifically licensed to provide the appropriate levels of care along the continuum of care for MH/SUD treatment, including medical detoxification, intensive inpatient rehabilitation, residential treatment, partial hospitalization and intensive outpatient care. Thus, *freestanding substance abuse treatment facilities that are properly licensed for each level of care they provide are the equivalent of properly licensed hospitals on the medical/surgical side.*

The 2010 Government Employees Health Association, Inc. (GEHA) Benefit Plan under the Federal Employees Health Benefits (FEHB) Program is highly instructive on this point. In compliance with MHPAEA, the 2010 GEHA FEHB Plan made changes to its benefit plan design, specifically providing that: "Admissions to out-of-network Residential Treatment Centers are now covered subject to medical necessity review." (See **Exhibit B**, 2010 GEHA FEHB Plan page excerpts, p. 9, Section 2). Thus, the Mental Health and Substance Abuse benefits setting description provides "Inpatient hospital and inpatient residential treatment centers" as being covered. (See Ex. B., p. 58). This is consistent with the added provision that: "Licensed Professional Counselors...are now covered providers when services are performed within the scope of their license." (See Ex. B, p. 9). With respect to more intensive inpatient levels of care, the 2010 GEHA FEHB plan also defines Hospital to *include* duly licensed freestanding substance abuse facilities that meet clinical staffing and clinical services requisites.⁶ (See Ex. B, p. 12).

⁴ Full set of Tables to SAMHSA 2007 National Survey of Substance Abuse Treatment Services (N-SSATS), available at: <http://www.oas.samhsa.gov/nssats2k7/NSSATS2k7Tb12.3.htm>.

⁵ See SAMHSA's Directory of State Substance Abuse Agencies, available at: <http://findtreatment.samhsa.gov/ufds/abusedirectors>.

⁶ Ex. B, GEHA FEHB 2010 Plan at Section 3, p. 12, definition of "Hospital" includes: "(3) An institution which is operated pursuant to law, under the supervision of a staff of doctors and with 24 hours a day nursing service and which provides services on the premises for the diagnosis, treatment, and care of persons with mental/substance abuse disorders and has for each patient a written treatment plan which must include diagnostic assessment of the patient and a description of the treatment to be rendered and provides for follow-up assessments by or under the direction of the supervising doctor."

Historical inequities in benefit design include, most markedly, the exclusion of freestanding adult and adolescent substance abuse treatment facilities, freestanding residential treatment facilities and freestanding adolescent psychiatric treatment facilities from coverage under a plan's MH/SUD benefit.⁷ Many plans continue to restrict MH/SUD benefits to services rendered only by hospitals or facilities affiliated with hospitals. As a result, many group health plans do not include appropriately licensed and accredited freestanding treatment facilities in their definition of "hospital" or "qualified treatment facility." Other plans expressly exclude freestanding psychiatric and substance abuse treatment facilities and/or freestanding residential facilities from the scope of coverage, notwithstanding appropriate state licensure and/or national accreditation. For example, one of the largest national employer group plans containing both inpatient and outpatient medical/surgical and MH/SUD benefits, effective January 1, 2010 provides: "Treatment received at a freestanding residential substance abuse treatment center or at a freestanding psychiatric residential treatment facility is not a covered benefit." (See Exhibit C, 2010 large employer group health benefits plan, excerpts p.p. 93-94). This inequity in health plan benefit design deprives participants and beneficiaries of the ability to access covered treatment from the very healthcare providers that specialize in and are specifically licensed to render those services that member requires.

Not only does the exclusion of properly licensed facilities from the scope of coverage under the MH/SUD benefit constitute a treatment limitation applicable to MH/SUD benefits that is more restrictive than the predominant treatment limitations applied to substantially all medical/surgical benefits covered by the plan, as well as a separate treatment limitation applicable only with respect to MH/SUD benefits, it also constitutes a preauthorization determination based on the *setting* in which the care is provided, rather than whether or not the service is medically necessary. Parity cannot be achieved if the implementing regulations do not prohibit this type of treatment limitation on the scope of services. Without closing this significant loophole in plan benefit design, plan participants are left with a tremendous obstacle in accessing their MH/SUD benefits.

B. Level of Care Exclusions under the MH/SUD Benefit are Impermissible under MHPAEA and the Regulations.

1. Statutory and Regulatory Background

ERISA §712(a) [29 USC 1185a] (3)(A)(ii) and (B)(ii) and (iii) were added to require that in the case of a group health plan (or health insurance coverage offered in connection with such a plan) that provides both medical and surgical benefits and mental health or substance use disorder benefits, the treatment limitations applicable to mental health or substance use disorder benefits *are no more restrictive than* the predominant treatment limitations applied to substantially all medical and surgical benefits covered by the plan, and that there are *no*

⁷ SAMHSA's National Expenditures for Mental Health Services and Substance Abuse Treatment published in 2007 shed light on the lack of access to these treatment settings.

separate treatment limitations that are applicable only with respect to mental health or substance use disorder benefits. A treatment limitation is considered to be predominant if it is the most common or frequent of such type of limit. “The term ‘treatment limitation’ includes limits on the frequency of treatment, number of visits, days of coverage, *or other similar limits on the scope or duration of treatment.*” (Emphasis supplied.)

The preamble to the regulations provides: “These regulations specify, in paragraph (c)(2)(ii), six classifications of benefits: Inpatient, in-network; inpatient, out-of-network; outpatient in-network; outpatient out-of-network; emergency care; and prescription drugs....These regulations provide that the parity requirements for financial requirements and treatment limitations are generally applied on a classification-by-classification basis and these are the only classifications used for purposes of satisfying the parity requirements of the Act.” 75 Fed. Reg. 5413. The preamble also states that: “The Departments recognize that not all treatments or treatment settings for mental health conditions or substance use disorders correspond to those for medical/surgical benefits. The Departments also recognize that MHPAEA prohibits plans and issuers from imposing treatment limitations on mental health and substance use disorder benefits that are more restrictive than those applied to medical/surgical benefits.” 75 Fed. Reg. 5416.

2.(a) Recommendation

The Departments’ Final Rules should specify that group health plans are required to cover under the MH/SUD benefit, all levels and types of medical/surgical care covered for substantially all medical/surgical benefits (i.e., continuum of care) that are largely analogous under the MH/SUD benefit. Thus, exclusions of levels of care or services along the continuum of care, such as inpatient rehabilitation and/or residential treatment and/or partial hospitalization and/or intensive outpatient services, under the MH/SUD benefit, where there are no such exclusions of analogous levels of care along the continuum of care under the medical/surgical benefit, should constitute a violation of MHPAEA’s “no more restrictive” standard and “separate treatment limitation” prohibition. Group health plans should be required to cover a scope of services and continuum of care under the MH/SUD benefit that is largely comparable to the scope of services and continuum of care provided for substantially all of the medical/surgical benefits under that group plan.

Plans should *not* be permitted to either: 1) create a new classification of benefits in order for those benefits to fall outside the ambit of MHPAEA; or 2) to exclude clinically recognized licensed levels of care from the MH/SUD benefit based on the plan’s determination that such level of care does not fall within one of the six classifications; or 3) not cover a level of care under the MH/SUD benefit using the justification that there is no directly corresponding medical/surgical benefit. If a plan is offering only one or two types of service or levels of care in each MH/SUD classification, while offering many within

each medical/surgical classification, the plan is applying a treatment limitation to the MH/SUD benefit that is more restrictive than the predominant treatment limitation applied to substantially all medical/surgical benefits in the same classification. The plan is also applying separate treatment limitations applicable only to the MH/SUD benefit. In these cases, the plan has violated the requirements of both MHPAEA (also referred to herein as “the Act”) and the regulations.

3.(a) Rationale

As the Departments have recognized, not all treatment services and settings for MH/SUD benefits will correspond to those for medical/surgical benefits. Mental health and substance use disorders are often complex and chronic, featuring medical, psychological, behavioral and social dimensions, rather than strictly medical. The Departments have also recognized that the plain language of MHPAEA prohibits treatment limitations under MH/SUD benefits that are more restrictive than the predominant treatment limitations applied to substantially all medical/surgical benefits. In addition, the regulations require that when a plan “provides [MH/SUD] benefits in any classification of benefits” described in the rule, MH/SUD benefits “must be provided in every classification in which medical/surgical benefits are provided.” 75 Fed. Reg. 5413. While this statement clearly requires parity *across* classifications in the scope of services that are offered for particular conditions, the Act and the regulations taken as a whole, clearly require parity *within* classifications as well.

There have been historical group health plan exclusions of certain levels of care under the MH/SUD benefit design. Since the effective date of MHPAEA, many group health plans continue to exclude from coverage entire levels of care that are clinically recognized and state licensed, while covering what is viewed by many state licensing boards as analogous clinically recognized levels of care under the medical/surgical benefit (See **Composite Exhibit D**, exemplar Medical Insurance Verification form (insurance benefits quote), with corresponding 2010 benefit plan excerpts). Because both the Act and the regulations make clear that the six classifications of benefits are the *only* classifications to be used, and also make clear that MHPAEA prohibits treatment limitations under the MH/SUD benefit that are more restrictive than under the medical/surgical benefit, it necessarily follows that ***all MH/SUD and medical/surgical services and levels of care must fit into one of these six classifications.*** Moving certain services or levels of care outside the six classes to evade the requirements of parity would be a clear violation of Congressional intent.

To illustrate the human consequences of how this discriminatory plan design is affecting today’s behavioral health marketplace, a member obtaining SUD treatment may typically be admitted to detoxification level of care, followed by intensive inpatient rehabilitation and monitoring, followed by residential treatment, followed by day treatment/partial hospitalization, followed by intensive outpatient treatment, followed by outpatient counseling or group therapy. As SAMHSA’s 2007 National Survey reveals, of the 103,709 individuals who received treatment in a residential, non-hospital setting, 96,173 or 92.7% received either

short-term or long-term residential level of care services (See Ex. A, Table 3.2). Yet, many plans restrict access to MH/SUD care by *excluding* one or more of the rehabilitation and/or residential and/or partial hospitalization and/or intensive outpatient levels of care (See Composite Exhibit D; See Composite Exhibit E, exemplar Medical Insurance Verification forms (insurance benefits quotes); See Composite Exhibit F, 2010 large employer group plan provides inpatient and outpatient MH/SUD benefits, yet benefits quoted as “*residential not covered*”, and concurrent medical management review reveals “*partial hospitalization not covered*” as well).

Thus, for example, an insured patient admitted into detoxification may receive authorization for 4 days of treatment at that level of care, followed by authorization for 6 days of intensive inpatient rehabilitation. Thereafter, the patient’s residential treatment, followed by partial hospitalization/day treatment would be denied as simply not covered, or as “Intermediate” (i.e., a new classification outside “inpatient” or “outpatient”) care not covered under MH/SUD benefit. (See Comp. Ex. D, pp.1-2 for “Intermediate” plan language). The patient is thereby relegated to a strictly outpatient setting for the remainder of his/her treatment, regardless of medical necessity. *In contrast*, a member under the same plan may obtain medical/surgical services that span the full continuum from admission to inpatient surgery, followed by intensive care in a monitoring unit, followed by continued hospitalization in a general patient room, followed by rehabilitative therapy in a skilled nursing facility, followed by outpatient rehabilitation and therapy, without facing such treatment limitations.

In addition, certain 2010 group health benefit plans *exclude* from the scope of services under the MH/SUD benefit, “Mental Health Services and Substance Abuse Services that extend beyond the period necessary for short-term evaluation, diagnosis, treatment or crisis intervention,” (as well as “Residential treatment services”), while no such exclusion exists under the medical/surgical benefit (See Comp. Ex. D, p.p. 4-5; See Exhibit G, large employer group health benefits plan, p.22),

Absent equitable coverage across the full continuum of care, albeit with appropriate utilization management protocols, parity is not being realized. This is clearly *not* what Congress intended when it sought to remedy the discrimination that has existed under many group health plans with respect to MH/SUD benefits. The Act clearly provides that there be “no separate treatment limitations that are applicable only with respect to mental health or substance use disorder benefits.” The statute also defines the term ‘treatment limitation’ to include “other similar limits on the scope or duration of treatment.” The exclusion of licensed levels of care along the continuum of care on the MH/SUD side, where analogous levels of care are covered on the medical/surgical side, constitutes a more restrictive limit on the scope and duration of treatment and a separate treatment limitation that violates the parity requirements of the Act.

2.(b) Recommendation

The Departments' Final Rules should clarify that, **in cases where there is arguably no analogue between a MH/SUD treatment service or level of care and treatment services or levels for other covered medical/surgical conditions, a group health plan may not refuse to cover a MH/SUD service or level of care because there is no medical/surgical analogue, unless the plan also refuses to cover a medical/surgical service or level of care because there is no MH/SUD analogue.** Otherwise, the exclusion of a level of care or treatment service under the MH/SUD benefit would be deemed a violation of MHPAEA's "no more restrictive" standard and "separate treatment limitation" prohibition.

3.(b) Rationale

Group health plans may justify the exclusion of levels of care from the MH/SUD benefit by stating that there is no corresponding medical/surgical level of care, and therefore such treatment services are not required to be covered under MHPAEA. For example, a plan may contend that because a "residential" level of care does not exist under the medical/surgical benefit, it is not required to be covered under the MH/SUD benefit. (See **Exhibit H**, exemplar Medical Insurance Verification form (insurance benefits quote)). A plan that refuses to cover a MH/SUD service or level of care because there is no medical/surgical analogue, on its face limits the scope or duration of benefits for treatment under a plan. Thus, such a decision is a nonquantitative treatment limitation (NQTL) subject to the "comparable" and "no more stringent" standards set forth in the regulations. As stated in the regulations:

"Any processes, strategies, evidentiary standards, or other factors used in applying the nonquantitative treatment limitation to mental health or substance use disorder benefits in a classification must be comparable to, and applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation with respect to medical surgical/benefits in the classification." 75 Fed Reg. 5416.

The regulations require NQTLs to be "comparable." A treatment limitation that prohibits coverage for MH/SUD treatments that have no medical/surgical analogue, but does not prohibit coverage for medical/surgical services that have no MH/SUD analogue, is not comparable on its face. If group health plans do not apply this treatment limitation comparably, the plan would be in violation of the regulations. Moreover, the treatment limitations section of MHPAEA states that health plans must ensure that "there are no separate treatment limitations that are applicable only with respect to mental health or substance use disorder benefits." A plan that refuses to cover a MH/SUD service that has no analogue in medical/surgical, but does not apply a similar standard to medical/surgical benefits, violates the parity requirements of the Act because it imposes a separate treatment limitation "applicable only with respect to" MH/SUD benefits.

Comment 2: MHPAEA and the Regulations Provide Preemption of State Parity and Mandate Laws that Prevent Application of MHPAEA – e.g., Geographic Location of Facility Restrictions

1. Statutory and Regulatory Background

ERISA §731 [29 USC 1191(a)] provides that ERISA supersedes provisions of state law which establish, implement or continue in effect any standard or requirement relating to health insurance issuers in connection with group health plans when such state law standards or requirements prevent the application of §712.

ERISA §712(a) [29 USC 1185a] (3)(A)(ii) and (B)(ii) and (iii) were added to require that in the case of a group health plan (or health insurance coverage offered in connection with such a plan) that provides both medical and surgical benefits and mental health or substance use disorder benefits, the treatment limitations applicable to mental health or substance use disorder benefits are no more restrictive than the predominant treatment limitations applied to substantially all medical and surgical benefits covered by the plan, and that there are no separate treatment limitations that are applicable only with respect to mental health or substance use disorder benefits. A treatment limitation is considered to be predominant if it is the most common or frequent of such type of limit. "The term 'treatment limitation' includes limits on the frequency of treatment, number of visits, days of coverage, or other similar limits on the scope or duration of treatment."

ERISA §712(g) [29 USC 1185a] was added to require that the Secretary of Labor, in Cooperation with the Secretaries of Health and Human Services and Treasury, as appropriate, "shall publish and widely disseminate guidance and information for group health plans, participants and beneficiaries, applicable State and local regulatory bodies, and the National Association of Insurance Commissioners concerning the requirements of this section and shall provide assistance concerning such requirements and the continued operation of applicable State law..."

The regulations state that MHPAEA requirements are not to be "construed to supersede any provision of State law which establishes, implements, or continues in effect any standard or requirement...*except to the extent that such standard or requirement prevents the application of a requirement of MHPAEA.*" 75 Fed. Reg. 5418. (Emphasis supplied).

The regulations state that: "A group health plan may not impose a nonquantitative treatment limitation with respect to mental health or substance use disorder benefits in any classification unless, under the terms of the plan as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the nonquantitative treatment limitation to mental health or substance use disorder benefits in the classification are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation with respect to medical/surgical

benefits in the classification, except to the extent that recognized clinically appropriate standards of care may permit a difference.” 75 Fed. Reg. 5436.

2. Recommendation

The Departments’ Final Rules should direct that **state insurance laws, including mandates and parity laws, and group plan benefit designs that follow said state laws, that contain requirements which prevent the application of MHPAEA, by including treatment limitations that are more restrictive than the predominate treatment limitations applied to substantially all the medical/surgical benefits, and/or that include separate treatment limitations applicable only to MH/SUD benefits (e.g. geographic location of facility restrictions), are required to be augmented to either meet or exceed the federal MHPAEA standards.**

3. Rationale

Group health plans often include restrictions as prompted by state mandates and parity laws. Such mandates and parity laws are not preempted *only* to the extent that they do not prevent the application of MHPAEA. For example, a State law that mandates the inclusion of MH/SUD benefits in fully insured group health plans clearly “does not prevent the application of MHPAEA.” However, that State mandate may include requirements for state-specific facility and clinician licensure for coverage under the MH/SUD benefit, while state-specific hospital and clinician licensure is not required under the medical/surgical benefit. Thus, under the plan, members are covered under the MH/SUD benefit only if they receive treatment from facilities and/or clinicians licensed by the state in which the plan is issued. The medical/surgical benefit in such plans requires that facilities and/or clinicians are appropriately licensed by the state in which the health care provider is located and, accordingly, the state in which the services are rendered. Such licensure restrictions under the MH/SUD benefit result in geographic restrictions on participants, thereby resulting in treatment limitations that do not exist (and are therefore in no way comparable) under the medical/surgical benefit.

To illustrate, a participant in a group health plan issued in the state of Kansas, that contains an out-of-network benefit, may obtain covered medical/surgical treatment from an out-of-state center of healthcare excellence licensed and located in New York. However, that participant under the same plan cannot leave the state of Kansas in order to obtain covered MH/SUD treatment from a reputable, licensed provider of his/her choosing, because the state mandate and hence the plan benefit design requires that the MH/SUD treatment facility be licensed under Kansas statutes. In this case, the portion of the state law mandate that prevents the application of MHPAEA should be required to be augmented to provide parity between the medical/surgical out-of-network benefit and the MH/SUD out-of-network benefit, and the plan benefit design should be required to eliminate such geographic restrictions accordingly.

Comment 3: Nonquantitative Treatment Limitations (NQL's)

A. The Need for Consistent Processes, Strategies and Evidentiary Standards in Medical Management

1. Statutory and Regulatory Background

ERISA §712(a) [29 USC 1185a] (3)(A)(ii) and (B)(ii) and (iii) were added to require that in the case of a group health plan (or health insurance coverage offered in connection with such a plan) that provides both medical and surgical benefits and mental health or substance use disorder benefits, the treatment limitations applicable to mental health or substance use disorder benefits are no more restrictive than the predominant treatment limitations applied to substantially all medical and surgical benefits covered by the plan, and that there are *no separate treatment limitations that are applicable only with respect to mental health or substance use disorder benefits*. A treatment limitation is considered to be predominant if it is the most common or frequent of such type of limit. "The term 'treatment limitation' includes limits on the frequency of treatment, number of visits, days of coverage, *or other similar limits on the scope or duration of treatment*." (Emphasis supplied.)

The regulations state that: "A group health plan may not impose a nonquantitative treatment limitation with respect to mental health or substance use disorder benefits in any classification unless, under the terms of the plan as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the nonquantitative treatment limitation to mental health or substance use disorder benefits in the classification are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation with respect to medical/surgical benefits in the classification, except to the extent that recognized clinically appropriate standards of care may permit a difference." 75 Fed. Reg. 5436. The regulations illustrate that: "*Nonquantitative treatment limitations include - (A) Medical management standards limiting or excluding benefits based on medical necessity or medical appropriateness...*" 75 Fed. Reg. 5436. (Emphasis supplied). The regulations further state explicitly that the no more stringently standard was "included to ensure that any processes, strategies, evidentiary standards, or other factors that are comparable on their face are applied in the same manner to medical/surgical and to MH/SUD benefits." 75 Fed. Reg. 5416.

2. Recommendation

The Departments' Final Rules should require **group health plans to use consistent processes, strategies and evidentiary standards by which medical necessity criteria are to be utilized and applied for both medical/surgical treatment services and MH/SUD services alike.**

Agencies within the Department of Health and Human Services, private health plans, the American Society of Addiction Medicine, and the Substance Abuse and Mental Health Services Administration (SAMSHA) funded and participated in the development of an evidence-based managed care approach to providing the appropriate level of services across the continuum of care. In the SUD area, this continuum of care is represented by the **Patient Placement Criteria of the American Society of Addiction Medicine (“ASAM”).**⁸ These criteria, initially published in 1991, provide a nationally recognized standard, using common language, for appropriate placement of individuals within the continuum of care for treatment of SUDs. Such a nationally recognized standard utilized in the implementation of parity, would result in far greater consistency in the processes, strategies and evidentiary standards used in applying medical management standards that limit or exclude benefits based on medical necessity or medical appropriateness.

3. Rationale

Medical necessity determinations are a critical aspect of establishing equity and parity between medical/surgical and MH/SUD benefits. Under the MH/SUD benefit, determinations are made in the context of specific levels of care along the continuum of care. One of the most difficult and frustrating aspects of MH/SUD medical necessity determinations is the fact that the definitions of terms and the various dimensions that are considered as part of a determination vary widely across health plans and employer groups. A critical issue for the implementing regulations to provide guidance on is the need for plans to have an equitable and consistent process as to the medical criteria used under the medical/surgical and MH/SUD benefit alike.

As MII/SUD providers continue to be faced with a multitude of widely varied medical necessity criteria both within and among plans, the opportunity for the Departments to provide guidance as to consistency in the context of MHPAEA implementation is both highly appropriate and timely. Of note are the observations made in the SAMHSA sponsored Special Report on Medical Necessity in Private Health Plans: Implications for Behavioral Health Care (“SAMHSA Special Report”).⁹ The Special Report provides an exhaustive review of research findings and case law as well as state and federal laws pertaining to medical necessity reviews and determinations. In the Executive Summary, the authors note that: “Rather than turning simply on whether a proposed treatment meets professional medical standards, the prevailing definition of medical necessity is broadly framed, multidimensional, and controlled by the insurer, not the treating professional.”¹⁰

⁸ American Society of Addiction Medicine Patient Placement Criteria for the Treatment of Substance-Related Disorders (2nd edition) ASAM PPC-2 (1996), ASAM PPC-2R (2001).

⁹ Rosenbaum, S., Kamoie, B., Mauery, D.R., Walitt, B. Medical Necessity in Private Health Plans: Implications for Behavioral Health Care, Substance Abuse and Mental Health Services Administration (SAMHSA) DHHS Pub. No. (SMA) 03-3790 (Nov. 2003).

¹⁰ *Id.*

The SAMHSA Special Report suggests that a major challenge in making medical necessity determinations for MH/SUD services, compared to medical/surgical services, is an underlying debate among health plans and review organizations as to whether “medical necessity” is the appropriate term, or, whether “clinical appropriateness” is a more accurate term for evaluating services under the MH/SUD benefit. This is because medical necessity reviews for MH/SUD benefits focus less on the clinical services to be rendered and more on an assessment of “what level of services in which settings are most clinically appropriate for a given patient in light of his or her clinical social needs.”¹¹ Thus, medical necessity determinations of MH/SUD services often focus on the “form and manner” of treatment, rather than on whether treatment services will be provided.

The SAMSHA Special Report also notes that in “behavioral health, unlike general medicine, most inpatient admissions are unplanned and occur because a person (or family member or provider on behalf of that person) seeks emergency crisis admission.”¹² Although these types of services may be approved initially, disputes about the medical necessity of subsequent services are common and are related to the review criteria which are considered the “guideposts” used by utilization review staff. Nationally recognized criteria, such as the ASAM Patient Placement Criteria, would provide operational consistency in medical management processes, strategies and evidentiary standards that limit or exclude benefits based on medical appropriateness.

B. The Need For Clear Definition of “Recognized” Clinically Appropriate Standard of Care and Adoption of Best Practices

1. Regulatory Background

The regulations state that: “A group health plan may not impose a nonquantitative treatment limitation with respect to mental health or substance use disorder benefits in any classification unless, under the terms of the plan as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the nonquantitative treatment limitation to mental health or substance use disorder benefits in the classification are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation with respect to medical/surgical benefits in the classification, *except to the extent that recognized clinically appropriate standards of care may permit a difference.*” 75 Fed. Reg. 5436. (Emphasis supplied).

2. Recommendation

The Departments’ Final Rules should provide a clear definition of “*recognized*” in the analysis of whether a NQTL is permitted because “*recognized clinically appropriate*

¹¹ *Id.* at 14.

¹² *Id.* at 15.

standards of care may permit a difference.” In so doing, CMS should adopt recognized best practices in defining “recognized clinically appropriate standards of care.”

3. Rationale

The regulations provide useful guidance in defining the term “recognized” clinically appropriate standards of care, and do indicate that the standards must meet a basic threshold. Example 3 of Section (c)(4) of the regulations discusses a plan that uses evidentiary standards in determining whether a treatment is medically appropriate. 75 Fed. Reg. 5436. The standards are developed based on “recommendations made by panels of experts with appropriate training and experience in the fields of medicine involved.” *Id.* The plan in this instance complies with parity, in part because “[t]he processes for developing the evidentiary standards” are comparable and applied no more stringently between medical/surgical and MH/SUD benefits. *Id.* In addition, other parts of the regulation provide a useful guide for how to determine which standards are “recognized.” The regulations state that plan terms defining benefits for MH/SUD conditions must be consistent with “generally recognized independent standards of current medical practice.” 75 Fed. Reg. 5412. In defining these terms, the regulations state that a plan “may follow the most current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM), the most current version of the International Classification of Diseases (ICD), or a State guideline.” *Id.* Thus, the regulations demonstrate that there are a number of recognized sources for defining which standards are “recognized.”

CMS also provides useful guidance. CMS regularly relies on independent expertise when making its coverage determinations. For example, there is clear precedent for CMS to take a rigorous view of the evidentiary basis for Medicare reimbursement of drugs, devices and procedures. In the National Coverage Determination (NCD) process, CMS evaluates all pertinent data, including the scientific data that requesters submit, peer-reviewed medical, technical and scientific literature, and recommendations from expert panels. The Medicare Coverage Advisory Committee (MCAC) plays a role in assisting the agency in making sound coverage decisions. MCAC provides independent, expert advice based upon the reasonable application of scientific evidence through members who possess the scientific and technical competence to provide these assessments.¹³

It is foreseeable that, absent the establishment of adequate requirements for when a standard is recognized, the parity requirements may be readily evaded. Attempts to circumvent the parity requirements will simply involve finding a “recognized clinically appropriate” standard of care. For example, a plan could claim the exception simply because its own employees or hired consultants deem a standard “recognized” with no independent verification. (See plan language from Ex. G., p. 22 “according to prevailing national standards of clinical practice, *as reasonably determined by the Mental Health/Substance Abuse Designee.*” (Emphasis supplied)). This potential loophole would weaken parity protections, and

¹³ 68 Fed. Reg. 55440.

is not what Congress intended. Congress intended to ensure meaningful parity between MH/SUD and medical/surgical benefits and was clear that treatment limitations should be “no more restrictive” in MII/SUD benefits than in medical/surgical benefits. Permitting an exception to parity based on a plan’s internal review alone would surely weaken this intended protection.

Based on the intent of the Act, other definitions in these regulations and other HHS/CMS practices, the regulators should clearly define “recognized” standards of care. Various best practices exist for developing recognized standards of care, including: (1) gathering input from multiple stakeholders and experts such as academic researchers, senior practicing clinicians, and consumer and advocacy leaders with subject matter expertise; (2) ensuring that the standard has acceptance from multiple provider and national consumer organizations; (3) basing the standard on objective scientific evidence in the field, such as published controlled research trials or expert consensus panels; and (4) approving the standard through accrediting or credentialing organizations, such as the National Quality Forum (NQF) Standards of Care, National Standards for the Treatment of Substance Use Conditions: Evidence-Based Practices. To ensure the strong parity protections envisioned by Congress, CMS should adopt these or other recognized best practices in defining “recognized clinically appropriate standards of care.”

C. NQTL’s Must Meet Both Predominant and Substantially All and the “Comparable” and “No More Stringently” Tests.

1. Statutory and Regulatory Background

ERISA §712(a) [29 USC 1185a] (3)(A)(ii) and (B)(ii) and (iii) were added to require that in the case of a group health plan (or health insurance coverage offered in connection with such a plan) that provides both medical and surgical benefits and mental health or substance use disorder benefits, the treatment limitations applicable to mental health or substance use disorder benefits are no more restrictive than the predominant treatment limitations applied to substantially all medical and surgical benefits covered by the plan, and that there are no separate treatment limitations that are applicable only with respect to mental health or substance use disorder benefits. A treatment limitation is considered to be predominant if it is the most common or frequent of such type of limit. “The term ‘treatment limitation’ includes limits on the frequency of treatment, number of visits, days of coverage, or other similar limits on the scope or duration of treatment.”

The regulations state that: “A group health plan may not impose a nonquantitative treatment limitation with respect to mental health or substance use disorder benefits in any classification unless, under the terms of the plan as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the nonquantitative treatment limitation to mental health or substance use disorder benefits in the classification are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary

standards, or other factors used in applying the limitation with respect to medical/surgical benefits in the classification, except to the extent that recognized clinically appropriate standards of care may permit a difference.” 75 Fed. Reg. 5436.

2. Recommendation

The Departments’ Final Rules should clarify that, consistent with the plain language and intent of MHPAEA, **the regulations should be interpreted to apply both the “predominant” and “substantially all” standard under MHPAEA, and the “comparable” and “no more stringently” standards of the regulations to NQTLs.**

3. Rationale

MHPAEA set forth that treatment limitations applicable to MH/SUD benefits must be “no more restrictive than the predominant treatment limitations applied to substantially all” medical/surgical benefits covered by the plan. This phrase contains three separate tests: (1) is the limitation applied to substantially all medical/surgical benefits; (2) is it the predominant treatment limitation; and (3) is it more restrictive in the MH/SUD benefit than in the medical/surgical benefit? The regulations adopt this test as the “general parity requirement” and use this statutory language repeatedly. 75 Fed. Reg. 5412-13, 5419, 5440, 5446. MHPAEA applies the three-part test to *all* treatment limitations, which “... includes limits on the frequency of treatment, number of visits, days of coverage, or other similar limits on the scope or duration of treatment.” The use of the word “includes” means that the listed treatment limitations are examples, not an exhaustive list of all possible treatment limitations subject to parity. Thus, the regulations’ inclusion of both quantitative treatment limitations (QTLs) and NQTLs under the definition of treatment limitations is consistent with MHPAEA. 75 Fed. Reg. 5413.

The regulations also establish a methodology for implementing the predominant and substantially all standards. The regulations state that a treatment limitation applies to substantially all benefits in a classification if “it applies to at least two-thirds of the benefits in that classification.” 75 Fed. Reg. 5414. If the treatment limitation does not meet this test, it cannot be applied in the MH/SUD benefit. The next step involves identifying the predominant treatment limitation. The predominant treatment limitation is the level that applies to more than one-half of medical/surgical benefits subject to treatment limitations in that class. *Id.* Once the predominant treatment limitation that applies to substantially all medical/surgical benefits is identified, a plan is prohibited from implementing a “more restrictive” treatment limitation.

Under the regulations, the “more restrictive” test for QTLs is expressed and applied numerically (c.g., a plan covering 25 outpatient days per year under the MH/SUD benefit, and 40 outpatient days per year under the medical/surgical benefit, is applying a more restrictive QTL). Because NQTLs are not expressed numerically, the regulations apply the comparable

and no more stringently standards to determine whether a NQTL is more restrictive. For example, pre-certification processes can be a limited or multifaceted process applied differentially and with very different results. The comparable and applied no more stringently test operationalizes MHPAEA' no more restrictive standard for NQTLs by ensuring that pre-certification requirements are demonstrably comparable in operation and application. Under this interpretation of the regulations, the comparable and no more stringently standards are in addition to the predominant and substantially all standard. If the predominant and substantially all test is not applied to NQTLs, a plan could apply a NQTL to a nominal percentage of medical/surgical benefits and then apply the same NQTL to a much greater percentage of benefits on the MH/SUD side. This is inconsistent with the clear language of MHPAEA which applies the predominant and substantially all standard to *all* treatment limitations.

D. The True Test of Whether NQTLs Are Being Applied is Medical Loss Ratio Reporting Specific to MH/SUD Benefits as compared with Medical Loss Reporting for Medical/Surgical Benefits

1. Statutory and Regulatory Background

ERISA §712(f) [29 USC 1185a] was added to require that the Secretary of Labor “shall, by January 1, 2012, and every two years thereafter, submit to the appropriate committees of Congress a report on compliance of group health plans (and health insurance coverage offered in connection with such plans) with the requirements of this section. *Such report shall include the results of any surveys or audits on compliance of group health plans (and health insurance coverage offered in connection with such plans) with such requirements and an analysis of the reasons for any failures to comply.*” (Emphasis supplied).

MHPAEA at Section 512(h), entitled GAO Study on Coverage and Exclusion of Mental Health Substance Use Disorder Diagnoses, at subsections (1) and (2) requires that the U.S. Comptroller General “shall conduct a study that analyzes the *specific rates, patterns, and trends in coverage and exclusion of specific mental health and substance use disorder diagnoses by health plans and health insurance.* The study shall include an analysis of – (A) *specific coverage rates* for all mental health conditions and substance use disorders; (B) which diagnoses are most commonly covered or excluded; (C) whether implementation of this Act has affected trends in coverage or exclusion of such diagnoses; and (D) the impact of covering or excluding specific diagnoses on participants’ and enrollees’ health, their health care coverage, and the costs of delivering health care.” (Emphasis supplied).

2. Recommendation

The Departments’ Final Rules should that direct that **audits on the compliance of group health plans, which are to be included in the Secretary of Labor’s report of January 2012, and every two years thereafter, and/or the GAO Study on Coverage and Exclusion of MH/SUD Diagnoses, as required under MHPAEA, shall include medical loss**

ratio (MLR) reporting specific to the MH/SUD benefit. As the true test of whether parity is being achieved in the marketplace is evidenced by expenditures rather than benefits, MLR reporting is an effective mechanism by which to actually determine whether NQTLs are being imposed, in operation, under the MH/SUD benefit.

3. Rationale

In looking back upon the Mental Health Parity Act of 1996 (MHPA), that law contained a September 30, 2001 sunset provision. In preparation for the sunset and potential reauthorization of MHPA, Chairman James M. Jeffords of the Senate Committee on Health, Education, Labor, and Pensions, requested the U.S. General Accounting Office (GAO) to prepare a report on: 1) the extent to which employers were complying with MHPA and how they had revised their health plans; 2) MHPA's effect on claims costs; and 3) the steps federal agencies had taken to ensure compliance with MHPA.¹⁴ The May 2000 GAO Report revealed that the impact of MHPA was very limited. As noted in the MHPAEA regulations:

[M]any employer-sponsored group health plans contained plan design features that were more restrictive for mental health benefits than for medical/surgical benefits. For example, data on private insurance arrangements from the pre-MHPAEA era show that after MHPA 1996, the most significant disparities in coverage for mental health substance use treatment involve limits on the number of covered days of inpatient care and the number of outpatient visits. [75 Fed. Reg. 5421].

The 2000 GAO Report was a necessary tool by which to determine compliance with MHPA and the actual impact of the law in light of health insurance issuers' and group health plans' measures to offset the impact of parity in annual and lifetime dollar limits. The GAO Report was focused on providing data and analyses that were indicative of whether insurance issuers and plans were complying with MHPA and what changes were being made to their health plans. The Report revealed that 87% of compliant plans contained at least one more restrictive provision for MH benefits, the most prevalent being limits on the number of day limits and office visit limits.¹⁵ Through the data provided in the Report, Congress was able to gain a clear understanding of the reductions in MH benefits that employers made to counterbalance the MHPA required enhancements, and were lead toward measures that would further the advancement of real parity.

In the context of ensuring compliance with MHPAEA, specifically, whether NQTLs, *known and unknown*, are being applied to MH/SUD benefits, it is important to draw upon the

¹⁴ GAO/HEHS-00-95. Implementation of the Mental Health Parity Act of 1996. available at: www.gao.gov/archive/2000/he00095.pdf.

¹⁵ *Id.* at 5.

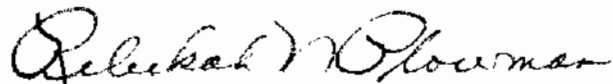
medical loss ratio (MLR) reporting that has recently been legislated as part of Section 2718 of the Public Health Service Act. The Departments' Request for Information on Medical Loss Ratios, 75 Fed. Reg. 19297, provides: "Section 2718 of the Public Health Service Act (PHS Act) was added by Sections 1001 and 10101 of the Patient Protection and Affordable Care Act (PPACA), Public Law 111-148, enacted on March 23, 2010. Section 2718 of the PHS Act requires health insurance issuers offering individual or group coverage to submit annual reports to the Secretary on the percentages of premiums that the coverage spends on reimbursement for clinical services and activities that improve health care quality, and to provide rebates to enrollees if this spending does not meet minimum standards for a given plan year." 75 Fed. Reg. 19298. Section 2718(b)(1)(A) of the PHS Act sets forth applicable minimum standards for the ratio of the amount of premiums the issuer spends on reimbursement for clinical services, to the total amount of premium revenues for the plan. Thus, Congress has recognized the efficacy of MLR reporting in seeking to ensure "value for consumers so that premiums are used for clinical services and quality improvements." 75 Fed. Reg. 19299.

The plain language of MHPAEA requires the Secretary of Labor to "submit to the appropriate committees of Congress a report on compliance of group health plans (and health insurance coverage offered in connection with such plans) with the requirements of this section." The Act further states that: "Such report shall include the results of any surveys or audits on compliance of group health plans (and health insurance coverage offered in connection with such plans) with such requirements and an analysis of the reasons for any failures to comply." In addition, the Act requires a GAO Study on coverage and exclusion of MH/SUD diagnoses, including analyses of specific rates, patterns, and trends in coverage and exclusion of MH/SUD diagnoses by plans and insurers. Thus, MHPAEA clearly authorizes the Departments to direct MLR reporting specific to MH/SUD benefits. In this way, MLR comparisons between medical/surgical and MH/SUD benefits can be made in order to ascertain whether NQTLs are, in fact, being applied to the MH/SUD benefit.

Such MLR reporting provides tell tale data on expenditures, rather than merely data on benefit plan design. In other words, this audit process will facilitate the *checking of what is paid instead of what is promised*. MLR reporting comparison between medical/surgical and MH/SUD benefits is an essential and effective mechanism by which to determine compliance – specifically, whether or not NQTLs are, in operation, being applied to the MH/SUD benefit by health insurance issuers and group health plans in the marketplace.

Please feel free to contact us if you have any questions or require further information regarding our comments to the Interim Final Rules.

Best regards,



Rebekah N. Plowman

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2007 National Survey of Substance Abuse Treatment Services (N-SSATS)

Highlights

This report presents results from the 2007 National Survey of Substance Abuse Treatment Services (N-SSATS), an annual census of facilities providing substance abuse treatment. Conducted by the Substance Abuse and Mental Health Services Administration (SAMHSA), N-SSATS is designed to collect data on the location, characteristics, and use of alcoholism and drug abuse treatment facilities and services throughout the 50 States, the District of Columbia, and other U.S. jurisdictions. Selected findings are given below.

- The N-SSATS facility response rate in 2007 was 94.5 percent. Thirty-four States or jurisdictions had response rates that equalled or surpassed the overall rate [Tables 1.1 and 6.1].
- A total of 14,359 facilities completed the survey. The 13,648 facilities eligible for this report had a one-day census of 1,135,425 clients enrolled in substance abuse treatment on March 30, 2007 [Tables 1.1 and 3.1].
- There were 85,518 clients under age 18 in treatment on March 30, 2007, making up 8 percent of the total population in treatment on that date [Table 6.4a and 6.4b].

Trends in Facility and Client Characteristics

- The *facility retention rate* (facilities responding to N-SSATS that had also responded to the previous year's survey) was between 86 and 90 percent in every year from 2003 to 2007. About 10 to 15 percent of the facilities had closed or were no longer providing substance abuse treatment, but were replaced by similar numbers of new facilities [Table 2.1].
- The *total number* of substance abuse treatment facilities remained relatively constant between 2003 and 2007, while the number of clients in treatment increased slightly. There were 13,623 facilities reporting in 2003 and 13,648 facilities in 2007. The number of clients in treatment on the survey reference date increased by 4 percent, from 1,092,546 in 2003 to 1,135,425 in 2007 [Tables 2.2 and 3.1].
- The *operational structure* of the substance abuse treatment system changed very little from 2003 to 2007. Private non-profit organizations operated 61 percent of all facilities in 2003 and decreased slightly but steadily to 58 percent in 2007. However, the proportion of clients in private non-profit facilities remained at 55 to 56 percent of all clients during that period. Private for-profit organizations operated 25 percent of all facilities in 2003, increasing slightly but steadily to 29 percent in 2007. The proportion of clients in private for-profit facilities also increased, from 26 percent in 2003 to 30 percent in 2007. Government-operated facilities maintained stable proportions of both facilities and clients between 2003 and 2007 [Tables 2.2 and 3.1 and Figures 1 and 5].
- The *primary focus of activity* of facilities changed slightly from 2003 to 2007. Facilities whose primary focus was the provision of substance abuse treatment services made up 61 to 62 percent of all facilities between 2003 and 2007, and treated 68 to 69 percent of all clients. Facilities providing a mix of mental health and substance abuse treatment services increased slightly as a percentage of all facilities, from 26 percent in 2003 to 29 percent in 2007; the proportion of clients treated in these facilities also increased slightly, from 23 percent in 2003 to 26 percent in 2007. Facilities whose primary focus was the provision of mental health services made up 7 to 8 percent of all facilities and treated 4 to 5 percent of all clients. Facilities whose primary focus was general health care made up only 1 to 2 percent of all facilities and treated only 1 or 2 percent of all clients [Tables 2.2 and 3.1 and Figure 2].
- The *major types of care*—outpatient, residential (non-hospital), and hospital inpatient—were stable between 2003 and 2007 in terms of the proportions of both facilities and clients in treatment. Outpatient treatment was provided by 80 to 81 percent of all facilities from 2003 to 2007, and 89 to 90 percent of all clients received outpatient care. Residential (non-hospital) treatment was provided by 27 to 28 percent of all facilities, and 9 to 10 percent of all clients received this type of care. Hospital inpatient treatment was provided by 7 to 9 percent of all facilities, and 1 percent of all

clients received this type of care [Tables 2.3 and 3.2 and Figures 3 and 6].

- *Opioid Treatment Programs* certified by SAMHSA for the provision of therapy with methadone and buprenorphine were provided by 8 to 9 percent of all facilities between 2003 and 2007. The proportion of clients receiving methadone ranged from 21 percent to 23 percent in that period [Tables 2.3 and 3.2 and Figures 3 and 6].
- *Agreements or contracts with managed care organizations* were reported by 51 percent of all facilities in 2003; this proportion fell to 47 percent in 2007. Similarly, the proportion of clients in facilities with managed care agreements or contracts fell from 52 percent of all clients in 2003 to 48 percent in 2007 [Tables 2.4 and 3.4 and Figures 4 and 7].
- The *client substance abuse problem treated* fluctuated slightly between 2003 and 2007. Clients in treatment for both drug and alcohol abuse made up 45 to 47 percent of all clients from 2003 to 2007. Clients in treatment for drug abuse only increased slightly but steadily, from 33 percent in 2003 to 36 percent in 2007. The proportion of clients treated for alcohol abuse ranged from 18 to 20 percent between 2003 and 2007 [Table 3.3].
- *Clients under age 18* made up 8 percent of all clients in treatment in every year from 2003 through 2007. The type of care received by clients under age 18 differed little from that received by adults, and was stable between 2003 and 2007. Outpatient care was received by 87 to 88 percent, residential (non-hospital) care by 11 to 12 percent, and hospital inpatient care by 1 percent. The proportion of clients under age 18 in treatment facilities with special programs or groups for adolescents ranged from 82 to 85 percent between 2003 and 2007 [Tables 3.5, 6.3b, and Figure 8].

Facility Operation

- Private non-profit organizations operated 58 percent of all facilities on March 30, 2007, and were treating 55 percent of all clients. Private for-profit organizations operated 29 percent of all facilities on March 30, 2007, and were treating 30 percent of all clients. Local governments operated 6 percent of all facilities on March 30, 2007, and were treating 8 percent of all clients, State governments operated 3 percent of all facilities on March 30, 2007, and were treating 4 percent of all clients. The Federal government operated 2 percent of all facilities on March 30, 2007, and was treating 3 percent of all clients. Tribal governments operated 1 percent of all facilities on March 30, 2007, and were treating 1 percent of all clients [Tables 4.1 and 5.1].

Primary Focus

- The provision of substance abuse treatment services was the primary focus of activity of 61 percent of facilities on March 30, 2007, with 68 percent of all clients in treatment. A mix of mental health and substance abuse treatment services was the primary focus of 29 percent of facilities on March 30, 2007, with 26 percent of all clients in treatment. The provision of mental health services was the primary focus of 7 percent of facilities on March 30, 2007, with 4 percent of all clients in treatment. General health care was the primary focus of 1 percent of facilities on March 30, 2007, with 1 percent of all clients in treatment [Tables 4.1 and 5.1].

Type of Care

- Outpatient treatment was offered by 81 percent of all facilities on March 30, 2007, and reported 1,016,913 clients (90 percent of all clients) in treatment on that date. On March 30, 2007:
 - Regular outpatient care was offered by 74 percent of facilities and had 52 percent of clients.
 - Intensive outpatient care was offered by 44 percent of facilities and had 12 percent of clients.
 - Outpatient day treatment/partial hospitalization was offered by 15 percent of facilities and had 2 percent of clients.
 - Outpatient detoxification was offered by 11 percent of facilities and had 1 percent of clients.
 - Outpatient methadone/buprenorphine maintenance was offered by 10 percent of facilities and had 22 percent of clients [Tables 4.2b, 5.2a, and 5.2b].
- Residential (non-hospital) treatment was offered by 27 percent of all facilities on March 30, 2007, and reported 103,709 clients (9 percent of all clients) in treatment on that date. On March 30, 2007:
 - Residential (non-hospital) long-term treatment was offered by 22 percent of facilities and had 6 percent of clients.
 - Residential (non-hospital) short-term treatment was offered by 13 percent of facilities and had 2 percent of clients.
 - Residential (non-hospital) detoxification was offered by 7 percent of facilities and had less than 1 percent of clients [Tables 4.2b, 5.2a, and 5.2b].
- Hospital inpatient treatment was offered by 7 percent of all facilities on March 30, 2007, and reported 14,803 clients (1 percent of all clients) in treatment on that date. On March 30, 2007:
 - Hospital inpatient detoxification was offered by 6 percent of facilities and had less than 1 percent of clients.

- Hospital inpatient treatment was offered by 5 percent of facilities and had less than 1 percent of clients [Tables 4.2b, 5.2a, and 5.2b].

Client Substance Abuse Problem and Co-occurring Mental Health Disorders

- On March 30, 2007, 45 percent of all clients were in treatment for both alcohol and drug abuse, 36 percent were in treatment for drug abuse only, and 19 percent were in treatment for abuse of alcohol alone [Tables 4.3 and 5.3].
- Eighty-seven percent of facilities had clients in treatment for co-occurring mental health and substance abuse disorders. Forty percent of all clients were in treatment for these disorders [Tables 4.3 and 5.3].
- In the United States, there were 459 clients in treatment per 100,000 population aged 18 and older on March 30, 2007. The rate was highest for persons with both alcohol and drug problems (203 per 100,000 population aged 18 and older), followed by drug abuse only (170 per 100,000), and alcohol abuse only (86 per 100,000) [Table 6.33].

Facility Size

- The median number of clients in substance abuse treatment at a facility on March 30, 2007, was 42 [Table 4.4].
- Facility size varied by type of care offered. In facilities offering outpatient care, the median number of clients in treatment on March 30, 2007, was 48. By type of outpatient care, however, the median ranged from 1 client in outpatient detoxification to 30 clients in regular outpatient care and to 132 clients receiving outpatient methadone/buprenorphine maintenance. In facilities offering residential (non-hospital) care, the median number of clients was 18, and in hospital inpatient facilities, it was 9 [Table 4.4].
- Facilities whose focus was the provision of mental health services tended to be smaller than facilities whose focus was the provision of substance abuse treatment [Table 4.5].

Facility Capacity and Utilization Rates

- On March 30, 2007, 92 percent of all residential (non-hospital) beds and 84 percent of all hospital inpatient beds designated for substance abuse treatment were in use [Tables 4.6 and 4.7].
- Facilities with residential (non-hospital) beds had generally higher utilization rates than facilities with hospital inpatient beds. Sixty percent of facilities with residential (non-hospital) beds had utilization rates of 91 to 100 percent or more, while 43 percent of facilities with hospital inpatient beds had utilization rates in that range [Tables 4.6 and 4.7].

Services Provided

- Screening for substance abuse, comprehensive substance abuse assessment or diagnosis, individual counseling, group counseling, drug or alcohol urine screening, discharge planning, aftercare/continuing care, substance abuse education, and case management were each provided by 75 percent or more of all facilities [Tables 4.8 and 4.9].
- Screening for mental health disorders; family counseling; breathalyzer or other blood alcohol testing; social skills development; HIV or AIDS education, counseling, or support; mental health services; and assistance with obtaining social services were each provided by between 50 and 74 percent of all facilities [Tables 4.8 and 4.9].

Clinical/Therapeutic Approaches

- Substance abuse counseling and relapse prevention were used often by almost all facilities (96 percent and 91 percent, respectively). Cognitive-behavioral therapy, a 12-step approach, anger management, motivational interviewing, and brief intervention were each used sometimes or often by 80 to 90 percent of all facilities. Trauma-related counseling was used sometimes or often by 65 percent, and contingency management by 50 percent [Table 4.10].

Programs or Groups for Specific Client Types

- Overall, 82 percent of facilities offered programs or groups designed to address the specific needs of specific client types. Special programs or groups for clients with co-occurring mental health and substance abuse disorders were provided by 37 percent of facilities, for adult women by 32 percent, for adolescents and DUI/DWI offenders by 31 percent each, for criminal justice clients by 27 percent, and for adult men by 25 percent. Less frequently offered were programs or groups for pregnant or postpartum women (14 percent), persons with HIV or AIDS (10 percent), seniors

Table 2.3
Facilities by type of care offered and facilities with Opioid Treatment Programs: 2003-2007¹
Number and percent

Type of care offered and facilities with Opioid Treatment Programs	Number of facilities ²					Percent ²				
	2003	2004	2005	2006	2007	2003	2004	2005	2006	2007
Total	13,623	13,454	13,371	13,771	13,648					
Type of care offered										
Outpatient	10,893	10,853	10,807	11,152	11,078	60.0	60.7	60.8	61.0	61.2
Regular	9,967	9,649	9,690	10,177	10,099	73.2	71.7	72.5	73.9	74.0
Intensive	5,902	5,643	5,698	6,199	6,055	43.3	41.9	42.6	45.0	44.4
Detoxification	1,501	1,369	1,455	1,664	1,445	11.0	10.2	10.8	12.1	10.8
Day treatment/partial hospitalization	2,156	1,871	1,859	2,071	2,000	15.8	13.9	13.9	15.0	14.7
Methadone/buprenorphine maintenance	955	904	1,226	1,398	1,433	7.0	6.7	9.2	10.1	10.5
Residential (non-hospital)	3,793	3,680	3,578	3,834	3,716	27.8	27.4	27.5	27.8	27.2
Detoxification	957	942	905	991	996	7.0	7.0	6.8	7.2	7.3
Short-term treatment (30 days or fewer)	1,596	1,524	1,579	1,720	1,722	11.7	11.3	11.8	12.5	12.6
Long-term treatment (more than 30 days)	3,142	3,027	3,034	3,214	2,995	23.1	22.5	22.7	23.3	21.9
Hospital inpatient	1,013	1,073	986	925	1,000	7.4	8.0	7.4	6.7	7.3
Detoxification	900	874	834	817	884	6.6	6.5	6.2	5.9	6.5
Treatment	662	724	653	620	685	4.9	5.4	4.9	4.5	4.9
Facilities with Opioid Treatment Programs³	1,067	1,070	1,089	1,203	1,106	7.8	8.0	8.0	8.7	8.1

¹ Survey reference dates were: March 31, 2003-2006, and March 30, 2007. See Appendix A for changes in the survey base, methods, and instruments that affect analysis of trends over time.

² Types of care sum to more than the Total row and percentages sum to more than 100 percent because a facility could provide more than one type of care.

³ Only those facilities certified as Opioid Treatment Programs by the Substance Abuse and Mental Health Services Administration are included.

SOURCE: Office of Applied Studies, Substance Abuse and Mental Health Services Administration, National Survey of Substance Abuse Treatment Services (N-SSATS), 2003-2007.

Table J.2
Clients in treatment by type of care received and clients receiving methadone or buprenorphine: 2003-2007¹
Number and percent distribution

Type of care received and clients receiving methadone	Number of clients					Percent distribution				
	2003	2004	2005	2006	2007	2003	2004	2005	2006	2007
Total	1,082,546	1,072,251	1,081,049	1,130,881	1,135,425	100.0	100.0	100.0	100.0	100.0
Type of care received										
Outpatient	968,719	954,551	961,805	1,008,915	1,016,913	88.7	89.0	88.0	89.2	89.6
Regular	587,975	584,300	589,272	589,542	585,459	53.8	52.6	52.7	52.1	52.4
Intensive	128,127	121,862	125,573	128,706	132,977	11.7	11.4	11.8	11.4	11.7
Detoxification	11,770	12,064	13,474	12,579	12,705	1.1	1.1	1.2	1.1	1.1
Day treatment/partial hospitalization	27,728	28,133	24,926	24,039	22,297	2.5	2.6	2.3	2.1	2.0
Methadone/buprenorphine maintenance	213,119	228,192	228,558	254,049	253,476	19.5	21.3	21.1	22.5	22.3
Residential (non-hospital)	108,592	101,713	104,015	107,790	103,709	9.9	9.5	9.8	9.5	9.1
Detoxification	9,081	7,021	7,306	6,487	7,536	0.8	0.7	0.7	0.6	0.7
Short-term treatment (30 days or fewer)	22,826	21,758	23,360	22,234	24,171	2.1	2.0	2.2	2.0	2.1
Long-term treatment (more than 30 days)	76,665	72,934	73,349	78,069	72,002	7.0	6.8	6.8	7.0	6.3
Hospital inpatient	15,235	15,987	15,228	14,176	14,803	1.4	1.5	1.4	1.3	1.3
Detoxification	7,067	8,214	6,381	5,220	6,319	0.6	0.6	0.6	0.5	0.6
Treatment	8,168	9,773	8,848	8,956	8,484	0.7	0.9	0.8	0.8	0.7
Clients receiving methadone or buprenorphine										
Total	227,003	243,358	240,935	265,786	265,716	20.8	22.7	22.3	23.5	23.4
Clients receiving methadone	227,003	240,961	235,836	258,752	262,684	20.8	22.5	21.8	22.9	23.1
Clients receiving buprenorphine	--	2,397	5,099	7,034	3,032	--	0.2	0.5	0.6	0.3

¹ Survey reference dates were: March 31, 2003-2006, and March 30, 2007. See Appendix A for changes in the survey base, methods, and instruments that affect analysis of trends over time.

SOURCE: Office of Applied Studies, Substance Abuse and Mental Health Services Administration, National Survey of Substance Abuse Treatment Services (N-SSATS), 2003-2007.

Government Employees Health Association, Inc. Benefit Plan

(800) 821-6136
<http://www.geha.com>



2010

A fee-for-service (high and standard option) health plan with a preferred provider organization

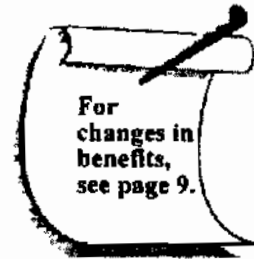
Sponsored and administered by:

Government Employees Health Association, Inc.

Who may enroll in this Plan: All Federal employees and annuitants who are eligible to enroll in the Federal Employees Health Benefits Program may become members of GEHA. You must be, or must become a member of Government Employees Health Association, Inc.

To become a member: You join simply by signing a completed Standard Form 2809, Health Benefits Registration Form, evidencing your enrollment in the Plan.

Membership dues: There are no membership dues for the Year 2010.



Enrollment codes for this Plan:

311 High Option - Self Only
312 High Option - Self and Family
314 Standard Option - Self Only
315 Standard Option - Self and Family



URAC accreditation: GEHA for Health Network



URAC UM accreditation: InforMed for Health Utilization Management

JCAHO accreditation: Medco for Home Care Pharmacy Dispensing Services



Authorized for distribution by the:



United States
Office of Personnel Management
Center for
Retirement and Insurance Services
<http://www.opm.gov/insure>

RI 71-006

Section 2. How we change for 2010

Do not rely only on these change descriptions; this Section is not an official statement of benefits. For that, go to Section 5 Benefits. Also, we edited and clarified language throughout the brochure; any language change not shown here is a clarification that does not change benefits.

Program-wide changes

- In Section 10, under **Definitions**, we have clarified cost categories associated with clinical trials. See page 88.

Changes to this Plan

- On High and Standard Option the calendar year deductible now applies to the out-of-pocket maximums. (see page 16)
- Cost sharing and limitations for out-of-network mental health and substance abuse treatments will be no greater than for similar benefits for other illness and conditions. The separate inpatient and outpatient hospital/intensive day treatment deductible no longer applies. Outpatient visits for psychotherapy visits are no longer limited to 30 visits per calendar year. Inpatient hospital days and inpatient physician hospital visits are no longer limited to 100 per calendar year. Inpatient treatment for alcoholism and drug abuse is no longer limited to 30 lifetime days. Outpatient Intensive Day Treatment is no longer limited to 60 days per calendar year. All benefits are subject to medical necessity review. Admissions to out-of-network Residential Treatment Centers are now covered subject to medical necessity review. Your coinsurance on covered expenses is 25% on High Option and 35% on Standard Option. Coinsurance is no longer subject to the separate \$8,000 maximum. (see pages 57-59)
- Precertification is now required for out-of-network Intensive Day Treatment. (see page 13)
- Licensed Professional Counselors and Licensed Marriage and Family Therapists are now covered providers when services are performed within the scope of their license. (see pages 11 and 57)
- Inpatient confinements at Skilled Nursing Facilities are now covered following transfer from acute inpatient confinements when skilled care is required. Benefits are limited to \$700 per day for a maximum of 14 days. If Medicare pays the first 14 days no benefits are payable. (see page 52)
- Routine eye examinations are covered for children under age 22. Benefit is limited to one routine examination per year and will be paid at 100% of Plan allowance. (see page 27)
- Oral specialty medications and self injectable specialty medications dispensed by a physician's office, home health agencies or outpatient hospital will be added to the GEHA Specialty Drug Benefit. (see pages 31-33)
- We have modified the definition of Plan allowance to include we use Medicare participating provider allowance and current schedule used by Office of Workmen's Compensation. We have also clarified how we determine Plan allowance for overseas claims and for claims which do not include itemized charges. (see pages 90-91)

Changes to our High Option only

- Your share of the non-Postal premium will decrease 13.1% for Self Only and increase .4% for Self and Family. (see page 104)
- The \$100 (PPO) or \$300 (non-PPO) per in-hospital admission deductible now applies to the out-of-pocket maximums. (see page 18)

Changes to our Standard Option only

- Your share of the non-Postal premium will increase 8% for Self Only and increase 8% for Self and Family. (see page 104)
- Coinsurance on Brand Name medications is now limited to \$200 for up to a 30-day supply at network retail pharmacy and \$500 for up to a 90-day supply at Medco Pharmacy. (see pages 64-69)

We have clarified the following:

- The charges for hearing aids are not subject to the deductible. (see page 35)

- All treatment within 120 days following a transplant is subject to the \$100,000 limit if a plan designated organ transplant facility is not used. (see page 47)
- We have included updated information on Medco procedures and contact information. (see page 63)
- We have added additional information on requirements and procedures for precertifying physical, occupational and speech therapy. (see pages 34-35)
- Admission to skilled nursing facilities, long term acute care facilities and rehabilitation facilities require precertification with OrthoNet. (see page 13)
- Marrow Failure and Related Disorders and Paroxysmal Nocturnal Hemoglobinuria have been added as covered allogeneic transplants and require precertification. (see pages 44-45)

- **Hospice**

A facility which meets all of the following:

- (1) primarily provides inpatient hospice care to terminally ill persons;
- (2) is certified by Medicare as such, or is licensed or accredited as such by the jurisdiction it is in;
- (3) is supervised by a staff of M.D.'s or D.O.'s, at least one of whom must be on call at all times;
- (4) provides 24 hour a day nursing services under the direction of an R.N. and has a full-time administrator; and
- (5) provides an ongoing quality assurance program.

- Skilled Nursing Facility licensed by the state or Medicare certified if the state does not license these facilities. See limitations on page 52.

- **Hospital**

- (1) An institution which is accredited as a hospital under the Hospital Accreditation Program of the Joint Commission on Accreditation of Healthcare Organizations (JCAHO); or
- (2) A medical institution which is operated pursuant to law, under the supervision of a staff of doctors, and with 24 hour a day nursing service, and which is primarily engaged in providing general inpatient care and treatment of sick and injured persons through medical, diagnostic, and major surgical facilities, all of which facilities must be provided on its premises or have such arrangements by contract or agreement; or
- (3) An institution which is operated pursuant to law, under the supervision of a staff of doctors and with 24 hour a day nursing service and which provides services on the premises for the diagnosis, treatment, and care of persons with mental/substance abuse disorders and has for each patient a written treatment plan which must include diagnostic assessment of the patient and a description of the treatment to be rendered and provides for follow-up assessments by or under the direction of the supervising doctor.

The term hospital does not include a convalescent home or skilled nursing facility, or any institution or part thereof which: a) is used principally as a convalescent facility, nursing facility, or facility for the aged; b) furnishes primarily domiciliary or custodial care, including training in the routines of daily living; or c) is operating as a school.

What you must do to get covered care

It depends on the kind of care you want to receive. You can go to any provider you want, but we must approve some care in advance.

- **Transitional care**

Specialty care: If you have a chronic or disabling condition and

- lose access to your specialist because we drop out of the Federal Employees Health Benefits (FEHB) Program and you enroll in another FEHB plan, or
- lose access to your PPO specialist because we terminate our contract with your specialist for reasons other than for cause,

you may be able to continue seeing your specialist and receiving any PPO benefits for up to 90 days after you receive notice of the change. Contact us or, if we drop out of the Program, contact your new plan.

If you are in the second or third trimester of pregnancy and you lose access to your PPO specialist based on the above circumstances, you can continue to see your specialist and your PPO benefits continue until the end of your postpartum care, even if it is beyond the 90 days.

High and Standard Option

Section 5(e). Mental health and substance abuse benefits

You may choose to get care In-Network or Out-of-Network. You must get precertification for certain services. Cost-sharing and limitations for mental health and substance abuse benefits will be no greater than for similar benefits for other illnesses and conditions.

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- The calendar year deductible is \$350 per person (\$700 per family) under the High and Standard Option. The calendar year deductible applies to almost all benefits in this Section. We added "(No deductible)" to show when the calendar year deductible does not apply.
- A High Option per admission deductible applies of \$100 (In-Network PPO) and \$300 (Non-PPO) for inpatient hospital services.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- **YOU MUST GET PREAUTHORIZATION FOR INPATIENT HOSPITAL SERVICES, INPATIENT RESIDENTIAL TREATMENT CENTERS AND OUTPATIENT INTENSIVE DAY TREATMENT.** Failure to do so will result in a minimum of \$500 penalty. See the instructions after the benefits descriptions below.

Professional Services	High Option	Standard Option
<ul style="list-style-type: none"> • Individual or group therapy by psychiatrists, psychologists, clinical social workers, licensed professional counselors, or marriage and family therapists • Medication management 	<p>PPO: \$20 copayment per office visit (No deductible)</p> <p>Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount</p>	<p>PPO: \$25 copayment per office visit (No deductible)</p> <p>Non-PPO: 35% of the Plan allowance and any difference between our allowance and the billed amount</p>
<ul style="list-style-type: none"> • Psychological tests (requires precertification) • Inpatient professional fees • Diagnostic tests • Laboratory tests to monitor the effect of drugs prescribed for your condition • Electroconvulsive therapy 	<p>PPO: 10% of the Plan allowance</p> <p>Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount</p>	<p>PPO: 15% of the Plan allowance</p> <p>Non-PPO: 35% of the Plan allowance and any difference between our allowance and the billed amount</p>
Lab Card, service of Quest Diagnostics	High Option	Standard Option
<p>You may use this voluntary program for covered outpatient lab tests. You show your Lab Card Program identification card and tell your physician you would like to use the Lab Card benefit. If the physician draws the specimen, he/she can call 800-646-7788 for pick up or you can go to an approved collection site and show your Lab Card along with the test requisition from your physician and have the specimen drawn there. Please Note: You must show your Lab Card each time you obtain lab work whether in the physicians's office or</p>	<p>Nothing (No deductible)</p> <p>Note: This benefit applies to expenses for lab tests only. Related expenses for services by a physician are subject to applicable copayments and coinsurance.</p>	<p>Nothing (No deductible)</p> <p>Note: This benefit applies to expenses for lab tests only. Related expenses for services by a physician are subject to applicable copayments and coinsurance.</p>

Lab Card, service of Quest Diagnostics - continued on next page
High and Standard Option Section 5(e)

High and Standard Option

Lab Card, service of Quest Diagnostics (cont.)	High Option	Standard Option
collection site. To find an approved collection site near you, call (800) 646-7788 or visit the website at http://www.geha.com/more_benefits_programs/labcard.html .		
Inpatient hospital and inpatient residential treatment centers	High Option	Standard Option
<ul style="list-style-type: none"> • Room and board, such as: • Ward, semiprivate, or intensive care accommodations • General nursing care • Meals and special diets <p>Note: We only cover a private room if we determine it to be medically necessary. Otherwise, we will pay the hospital's average charge for semiprivate accommodations. The remaining balance is not a covered expense. If the hospital only has private rooms, we will cover the private room rate.</p> <p>Note: When the hospital bills a flat rate, we prorate the charges to determine how to pay them, as follows: 30% room and board and 70% other charges.</p>	<p>PPO: Nothing (No deductible)</p> <p>Non-PPO: Nothing (No deductible)</p>	<p>PPO: 15% of the Plan allowance</p> <p>Non-PPO: 35% of the Plan allowance</p>
<p>Other hospital services and supplies:</p> <ul style="list-style-type: none"> • Services provided by a hospital 	<p>PPO: 10% of the Plan allowance (\$100 per admission deductible applies)</p> <p>Non-PPO: 25% of the Plan allowance (\$300 per admission deductible applies)</p>	<p>PPO: 15% of the Plan allowance</p> <p>Non-PPO: 35% of the Plan allowance</p>
Outpatient hospital	High Option	Standard Option
<ul style="list-style-type: none"> • Services provided by a hospital including partial hospitalization or Intensive Day Treatment Programs 	<p>PPO: 10% of the Plan allowance</p> <p>Non-PPO: 25% of the Plan allowance</p>	<p>PPO: 15% of the Plan allowance</p> <p>Non-PPO: 35% of the Plan allowance</p>
Emergency room - non-accidental injury	High Option	Standard Option
<ul style="list-style-type: none"> • Outpatient services and supplies billed by a hospital for emergency room treatment <p>Note: We pay Hospital benefits if you are admitted.</p>	<p>PPO: 10% of the Plan allowance</p> <p>Non-PPO: 25% of the Plan allowance</p>	<p>PPO: 15% of the Plan allowance</p> <p>Non-PPO: 35% of the Plan allowance</p>
Mental health and substance abuse	High Option	Standard Option
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • Services by pastoral, marital, drug/alcohol and other counselors including therapy for sexual problems • Treatment for learning disabilities and mental retardation • Telephone therapy 	<i>All charges</i>	<i>All charges</i>

Mental health and substance abuse - continued on next page

High and Standard Option

Mental health and substance abuse (cont.)	High Option	Standard Option
<p><i>Not covered - continued:</i></p> <ul style="list-style-type: none"> • <i>Travel time to the member's home to conduct therapy</i> • <i>Services rendered or billed by schools, or halfway houses or members of their staffs</i> • <i>Marriage counseling</i> • <i>Services that are not medically necessary</i> 	<i>All charges</i>	<i>All charges</i>

Precertification

To be eligible to receive full benefits for mental health and substance abuse, you must follow the authorization process:

- You must call InforMed at (800) 242-1025 to receive authorization for inpatient care and outpatient intensive day treatment. They will authorize any covered treatment.
- You should call our Medical Management Department (800) 821-6136 to precertify benefits for psychological testing. Psychological testing claims will be denied if we determine the testing is not medically necessary.

If you do not obtain precertification for inpatient care and outpatient intensive day treatment, we will decide whether the stay was medically necessary. If we determine the stay was medically necessary, we will pay the services less the \$500 penalty. If we determine that it was not medically necessary, we will only pay for any covered services that are otherwise payable on an outpatient basis. If you remain in the hospital beyond the days we approved and did not get the additional days precertified, we will pay inpatient benefits for the part of the admission that was medically necessary. See Section 3 for details.

See these sections of the brochure for more valuable information about these benefits:

- Section 4, *Your costs for covered services*, for information about catastrophic protection for these benefits.
- Section 7, *Filing a claim for covered services*, for information about submitting out-of-network claims.

- **Inpatient, partial hospitalization program and intensive outpatient program services**

- Coverage for inpatient hospitalization for Behavioral Health services is subject to the separate annual deductible and out-of-pocket maximum that you elect under your medical plan option.

- Coverage for partial hospitalization programs or intensive outpatient programs (IOP) for Behavioral Health services is subject to the annual deductible and out-of-pocket maximum that you elect under your medical plan option.

- Inpatient hospitalization, partial hospitalization programs or intensive outpatient programs for Behavioral Health services is subject to pre-notification.

- Inpatient hospitalization requires a participant to receive covered services 24 hours a day as an inpatient in a hospital. Treatment received at a freestanding residential substance abuse treatment center or at a freestanding psychiatric residential treatment facility is not a covered benefit. For assistance in locating a provider as a possible alternative to a freestanding center, contact [REDACTED] at [REDACTED].

- Partial hospitalization programs require the participant to receive covered services six to eight hours a day, five to seven days per week.

- Intensive outpatient programs require the participant to receive covered services lasting two to four hours a day, three to five days per week.

What is not covered by the AMP

In addition to the exclusions and limitations listed in this chapter, see **What is not covered by the AMP** section in the **Medical plan** chapter.

Diagnostic exclusions

The following are diagnostic exclusions to the Behavioral Health benefit.

- **Learning and educational disorders:** i.e., reading disorder, alexia, developmental dyslexia, dyscalculia, spelling difficulty and other learning difficulties
- **Relational problems:** Problems related to abuse and neglect and additional conditions except to the extent that such problems have arisen out of an act or acts of domestic violence.

Procedure exclusions

The following are procedure exclusions to the Behavioral Health benefit:

- **Biofeedback**
- **Health and Behavior Assessment/Intervention:** Evaluation of psycho-social factors potentially impacting physical health problems and treatments are not covered.
- **Hypnosis**
- **Neurofeedback**
- **Quantitative Electroencephalogram (QEEG)**
- **Transcranial Magnetic Stimulation**
- **Vagus Nerve Stimulation**

Treatment and service exclusions

The following are treatment and service exclusions to the Behavioral Health benefit:

- **Custodial or Respite Care:** Custodial care is services that are given merely as "care" in a facility or home to maintain a person's present state of health, which cannot reasonably be expected to significantly improve.
- **Experimental and/or Investigational Services:** Services defined as experimental and/or investigational according to protocols established by the Third Party Administrator.
- **Freestanding Residential Treatment Center:** Treatment received at a freestanding substance abuse residential treatment center or a freestanding psychiatric residential treatment center is not covered.
- **Marital Counseling:** Or counseling to assist in achieving more effective intra- or interpersonal development.
- **Nicotine and Caffeine Addiction:** Treatment of caffeine or nicotine addiction, smoking cessation programs and related medications and aids (including nicotine gum and nicotine patches).

- **Nonaccredited/Nonlicensed Doctors, Behavioral Health Care Workers or Institutions**
- **Residential Long-Term Care Facilities:** Mental health and eating disorder residential long term care facilities, youth homes, schools, therapeutic camps or any similar institutions are not covered.
- **Phone and Online Consultations**
- **Transgender Treatment/Sex Therapy:** Care, services or treatment for non-congenital transsexualism, gender dysphoria or sexual reassignment or change are not covered. This exclusion includes medications, implants, hormone therapy, surgery, medical or psychiatric treatment or other treatment of sexual dysfunction including prescription medication and sex therapy.
- **Sexual Dysfunction Services and Pharmaceuticals:** Including, but not limited to the use of Viagra® or any sexual dysfunction pharmaceuticals, even if prescribed for other medical conditions.
- **Weight Loss Programs, Medications and Aids:** Charges including medications, diet supplements, counseling (including nutritional counseling) and office visits for diet programs, appetite control, weight control and treatment of obesity or morbid obesity, including but not limited to gastric bypass, gastric restrictive or stapling procedures, or small bowel surgery to limit resorption, even if the participant has other health conditions that might be helped by the reduction of weight.

Filing a Behavioral Health claim

You should file your request for your claim under the instructions set out in the **Filing a medical claim** section in the **Medical plan** chapter.

Filing a Behavioral Health appeal

You have the right to appeal your urgent care, pre-service, concurrent or post-service claim. See the **Behavioral Health (mental health and substance abuse)** section in the **Claims and appeals** chapter for more information.

Date verified
12/1/2009

Medical Insurance Verification Form

Initial Verification [redacted]
Reverified by [redacted]

Patient ID [redacted]

Name **Bret H** [redacted] Employer [redacted]
DOB [redacted] SS_No [redacted] Still Employed? [redacted] Termination Date [redacted]
Phone [redacted] Work phone [redacted]
Pat Have COBRA? [redacted] COBRA Notes [redacted]

Benefits Summary

rm12/01/09 [redacted] s/w iaqulsha g [redacted] network, fully funded, w, no certs, s/w jackie m no claims, 30 DAYS PCY AVAIL REV-1/8/10 [redacted] s/w marsha m & john s and care adv steve d, care adv denise l, triage care adv robyn d, res is not excluded from major medical but is from s/a, sup doesn't know why, NO DAY OR \$ PCY MAX

Insurance Information

Insured Name: **Hannah H** [redacted] Insured Employer: [redacted] Still Employed: **Yes**
Insured Relation: **Spouse** How Long: **8 yrs** Terminated: [redacted]
Insured_SS_No: [redacted] Insured_DOB: [redacted]
Company: [redacted] Group_No: [redacted]
Ins Rep Name: [redacted] Policy_No: [redacted]
Ins Phone: [redacted] Phone 2: [redacted] Plan_no: [redacted]

Verification

Pre-existing limitation? **No Unknown**
Note: **no prex**
Effective Date? **1/1/2010**
Termination Date? [redacted]
Contract period: **jan-dec** Children Covered? [redacted]
OON Benefits? **Yes** To Age [redacted]
Plan_type: **POS** FT Student? [redacted]
Is This an HMO? **No** Physician [redacted] Physician Phone [redacted]
HMO note [redacted]

Chemical Dependency Benefit

CD Detox Benefits? **oon-\$2k ded(none met), 70%ucr, \$5500 oop max then 100%, 30 days pcy max, no \$ pcy max, no \$ per day max, \$2 mil lftm max, no sep, CERT REV-no day or \$ pcy max, no \$**
InPat CD Rehab Benefits? **oon-sub to ded, 70%ucr, comb w dtx 30 days pcy max, no \$ pcy max, no \$ per day max, no sep, CERT REV-no day or \$ pcy max, no \$ per day max**
InPat CD Res Benefits? **NOT COVERED REV-NOT COVERED Unknown why Parity does not apply this level**
PHP CD Benefits? **oon-sub to ded, 70%ucr, comb w dtx 2 for 1 30 days pcy max, no \$ pcy max, no \$ per day max, no sep, CERT REV-no day or \$ pcy max, no \$ per day max**
IOP CD Benefits? **oon-sub to ded, 70%ucr, comb w outpt 20 v pcy max, no \$ pcy max, no \$ per day max, no \$ per v max, no v per day max, no sep, CERT REV-no day or \$ pcy max, no \$ per day max**
OutPt CD Benefits? **oon-sub to ded, 70%ucr, 20 v pcy max, no \$ pcy max, no \$ per day max, no \$ per v max, no v per day max, no sep, CERT REV-no v or \$ pcy max, no \$ per day max, no \$ per v**
No **Any difference in benefits for the treatment of Drug Addiction and Alcohol?**
What Differences? **none**

Bret H [redacted]

Print this page

Patient Name: BRET [REDACTED]

SUBSTANCE ABUSE

Situation	[REDACTED] CHOICE PLUS [REDACTED] PLAN [REDACTED] MODIFIED	[REDACTED] CHOICE PLUS [REDACTED] PLAN [REDACTED] MODIFIED
Vendor [REDACTED] - Health Plan Division <ul style="list-style-type: none">• Must be prior authorized by [REDACTED] in order to receive benefits	Administered by: [REDACTED] Call [REDACTED]	Administered by: [REDACTED] Call [REDACTED]
Mental Health and Substance Abuse Services - Inpatient and Intermediate Mental Health and Substance Abuse Services received on an inpatient or Intermediate Care basis in a Hospital or an Alternate Facility. The Mental Health/Substance Abuse Designee, who will authorize the services, will determine the appropriate setting for the treatment. If an Inpatient Stay is required, it is covered	<u>Network Benefit</u> <i>(The Amount We Pay, based on Eligible Expenses)</i> Depending upon where the Covered Health Service is provided, Benefits for outpatient <i>Mental Health Services</i> will be the same as those stated under <i>Physician's Office Services - Sickness and Injury</i> , and Benefits for inpatient/intermediate <i>Mental Health Services</i> will be the same as those stated under <i>Hospital - Inpatient Stay</i> in this <i>Schedule of Benefits</i> .	<u>Non-Network Benefit</u> <i>(The Amount We Pay, based on Eligible Expenses)</i> Depending upon where the Covered Health Service is provided, Benefits for outpatient <i>Mental Health Services</i> will be the same as those stated under <i>Physician's Office Services - Sickness and Injury</i> , and Benefits for inpatient/intermediate <i>Mental Health Services</i> will be the same as those stated under <i>Hospital - Inpatient Stay</i> in this <i>Schedule of Benefits</i> .

on a Semi-private Room basis.

Mental Health and Substance Abuse Services must be provided by or under the direction of the Mental Health/Substance Abuse Designee. Referrals to a Mental Health or Substance Abuse Services provider are at the discretion of the Mental Health/Substance Abuse Designee, who is responsible for coordinating all of your care. Contact the Mental Health/Substance Abuse Designee regarding Benefits for Inpatient/Intermediate Mental Health and Substance Abuse Services.

Prior Authorization Requirement

You must obtain prior authorization through the Mental Health/Substance Abuse Designee in order to receive Benefits. **Without authorization, you will be responsible for paying all charges and no Benefits will be paid.**

<p>Mental Health and Substance Abuse Services - Outpatient</p> <p>Mental Health and Substance Abuse Services received on an outpatient basis in a provider's office or at an Alternate Facility, including:</p> <ul style="list-style-type: none"> • Mental health, substance abuse and chemical dependency evaluations and assessment. • Diagnosis. • Treatment planning. • Referral services. • Medication management. • Short-term individual, family and group therapeutic services (including intensive outpatient therapy). • Crisis intervention. <p>Referrals to a Mental Health or Substance Abuse Services provider are at the discretion of the Mental Health/Substance Abuse Designee, who is responsible for coordinating all of your</p>	<p><u>Network Benefit</u> (The Amount We Pay, based on Eligible Expenses)</p> <p>Depending upon where the Covered Health Service is provided, Benefits for outpatient <i>Mental Health Services</i> will be the same as those stated under <i>Physician's Office Services - Sickness and Injury</i>, and Benefits for inpatient/intermediate <i>Mental Health Services</i> will be the same as those stated under <i>Hospital - Inpatient Stay</i> in this <i>Schedule of Benefits</i>.</p>	<p><u>Non-Network Benefit</u> (The Amount We Pay, based on Eligible Expenses)</p> <p>Depending upon where the Covered Health Service is provided, Benefits for outpatient <i>Mental Health Services</i> will be the same as those stated under <i>Physician's Office Services - Sickness and Injury</i>, and Benefits for inpatient/intermediate <i>Mental Health Services</i> will be the same as those stated under <i>Hospital - Inpatient Stay</i> in this <i>Schedule of Benefits</i>.</p>
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<p>care. Contact the Mental Health/Substance Abuse Designee regarding Benefits for outpatient Mental Health and Substance Abuse Services.</p> <p>Prior Authorization Requirement You must obtain prior authorization through the Mental Health/Substance Abuse Designee in order to receive Benefits. Without authorization, you will be responsible for paying all charges and no Benefits will be paid.</p>		
<p>Mental Health/Substance Abuse Exclusions</p>	<p>The following services are excluded from coverage for both <u>Network</u> and <u>Non-Network</u>:</p> <ul style="list-style-type: none"> • Services performed in connection with conditions not classified in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. • Mental Health Services and Substance Abuse Services that extend beyond the period necessary for short-term evaluation, diagnosis, treatment or crisis intervention. • Mental Health Services as treatment for insomnia and other sleep disorders, neurological disorders and other disorders with a known physical basis. • Treatment for conduct and impulse control disorders, personality disorders, paraphilias and other Mental Illnesses that will not substantially improve beyond the current level of functioning. 	

or that are not subject to favorable modification or management according to prevailing national standards of clinical practice, as reasonably determined by the Mental Health/Substance Abuse Designee.

- Services utilizing methadone treatment as maintenance, L.A.A.M. (1-Alpha-Acetyl-Methadol), Cyclazocine, or their equivalents.
- Treatment provided in connection with or to comply with involuntary commitments, police detentions and other similar arrangements, unless authorized by the Mental Health/Substance Abuse Designee.
- Residential treatment services.
- Services or supplies for the diagnosis or treatment of Mental Illness, alcoholism or substance abuse disorders that, in the reasonable judgment of the Mental Health/Substance Abuse Designee, are any of the following:
 - Not consistent with prevailing national standards of clinical practice for the treatment of such conditions.
 - Not consistent with prevailing professional research demonstrating that the services or supplies will have a measurable and beneficial health outcome.
 - Typically do not result in outcomes demonstrably better than other available treatment alternatives that are less intensive or more cost effective.
 - Not consistent with the Mental Health/Substance Abuse Designee's level of care guidelines or best practices as modified from time to time.

The Mental Health/Substance Abuse Designee may consult with professional clinical consultants, peer review committees or other appropriate sources for recommendations and information regarding whether a service or supply meets any of these criteria.

- Health services and supplies that do not meet the definition of a **Covered Health Service**

below:

Covered Health Service(s) -those health services, including services, supplies, or Pharmaceutical Products, which we determine to be all of the following:

- Provided for the purpose of preventing, diagnosing or treating a Sickness, Injury, Mental Illness, substance abuse, or their symptoms.

We do not Pay Benefits for Exclusions

We will not pay Benefits for any of the services, treatments, items or supplies described in this section, even if either of the following is true:

- It is recommended or prescribed by a Physician.
- It is the only available treatment for your condition.

Date verified
2/25/2010

Medical Insurance Verification Form

Initial Verification [redacted]
Reverified by [redacted]

Patient ID [redacted]

Name **Jonathan O** [redacted]

Employer [redacted]

DOB [redacted]

SS_No [redacted]

Still Employed?

Termination Date

Phone [redacted]

Work phone [redacted]

Pat Have COBRA?

COBRA Notes

Benefits Summary

kb 2/25/10 [redacted] s/w amy m & katie k fully funded group, parity applies, NO DAY OR \$ PCY MAX. REVERIFIED-qp 3/10/10 [redacted] s/w Barbara B (supervisor) - DTX AND OPT ONLY BENEFIT - claims plan complies with parity, says "Parity Permits them to exclude any level of care they see fit"

Insurance Information

Insured Name: [redacted]	Insured Employer: [redacted]	Still Employed: Yes
Insured Relation: Parent	How Long: 6 years	Terminated:
Insured_SS_No: [redacted]	Insured_DOB: [redacted]	
Company: [redacted]	Group_No: [redacted]	
Ins Rep Name: [redacted]	Policy_No: [redacted]	
Ins Phone: [redacted]	Phone 2: [redacted]	Plan_no: [redacted]

Verification

Effective Date? 1/1/2010	Pre-existing limitation? Yes Unknown
Termination Date?	Note: no prex
Contract period: Jan-dec	Children Covered? Yes
CON Benefits? Yes	To Age: 25
Plan_type: POS	FT Student? No
Is This an HMO? No Physician	Physician Phone:
HMO note: POS	

Chemical Dependency Benefit

CD Detox Benefits?	oon-\$500 ded(none met), 60% allowed, \$4k oop max then 100%(none met), no day or \$ pcy max, no \$ per day max, \$5 mil lftm max, no sep, CERT REV-same benes
InPat CD Rehab Benefits?	oon-sub to ded, 60% allowed, no day or \$ pcy max, no \$ per day max, no sep, REVERIFIED- NOT COVERED
InPat CD Res Benefits?	oon-sub to ded, 60% allowed, no day or \$ pcy max, no \$ per day max, no sep, REVERIFIED- NOT COVERED
PHP CD Benefits?	oon-sub to ded, 60% allowed, no day or \$ pcy max, no \$ per day max, no sep, REVERIFIED- NOT COVERED
IOP CD Benefits?	oon-sub to ded, 60% allowed, no day or \$ pcy max, no \$ per day max, no sep, REVERIFIED- NOT COVERED
OutPt CD Benefits?	oon-sub to ded, 60% allowed, no day or \$ pcy max, no \$ per day max, no sep, CERT REV-same benes
No	Any difference in benefits for the treatment of Drug Addiction and Alcohol?
What Differences?	none

Jonathan O [redacted]

Date verified
4/19/2010

Medical Insurance Verification Form

Initial Verification [redacted]
Reverified by [redacted]

[redacted] Patient ID [redacted]

Name **Terry Mc** [redacted] Employer [redacted]
DOB [redacted] SS_No [redacted] Still Employed? [redacted] Termination Date [redacted]
Phone [redacted] Work phone [redacted]
Pat Have COBRA? [redacted] COBRA Notes [redacted]

Benefits Summary

at 4/20/10 [redacted] s/w Adam F, guaranteed cost plan written out of CA, complies with parity, no day or \$ pcy max [redacted] s/w Sheila cobra paid through 4/30/10, [redacted] month, next payment due 5/5/10

Insurance Information

Insured Name [redacted] Insured Employer [redacted] Still Employed **No**
Insured Relation: **Spouse** How Long: **7 yrs** Terminated **1/19/2009**
Insured_SS_No [redacted] Insured_DOB: [redacted]
Company [redacted] Group_No [redacted]
Ins Rep Name [redacted] Policy_No [redacted]
Ins Phone: [redacted] Phone 2: [redacted] Plan_no: [redacted]

Verification

Pre-existing limitation? **No Unknown**
Note **no prex**
Effective Date? **1/1/2010**
Termination Date? [redacted]
Contract period **Jan-Dec** Children Covered? [redacted]
OON Benefits? **Yes** To Age [redacted]
Plan_type: **pos** FT Student? [redacted]
Is This an HMO? **No** Physician [redacted] Physician Phone [redacted]
HMO note **pos**

Chemical Dependency Benefit

CD Detox Benefits? **oon- \$900 ded (none met), \$250 co-pay per admit, 50% allowed, \$7k oop max, no days pcy max, no \$ pcy max, no \$ per day max, no sep, no cert**
InPat CD Rehab Benefits? **oon- sub to ded, 50% allowed, no days pcy max, no \$ pcy max, no \$ per day max, no sep, no cert**
InPat CD Res Benefits? **oon- not covered**
PHP CD Benefits? **oon- not covered**
IOP CD Benefits? **oon- sub to ded, 50% allowed, no v pcy max, no \$ pcy max, no \$ per day max, no \$ per v max, no v per day max, no sep, no cert**
OutPt CD Benefits? **oon- sub to ded, 50% allowed, no v pcy max, no \$ pcy max, no \$ per day max, no \$ per v max, no v per day max, no sep, no cert**
No Any difference in benefits for the treatment of Drug Addiction and Alcohol?
What Differences? **none**

Terry Mc [redacted]

Date verified

1/12/2010

Initial Verification

Medical Insurance Verification Form

Reverified by

Patient ID

Name Jewell M

Employer

DOB

SS_No

Still Employed?

Termination Date

Phone

Work phone

Pat Have COBRA?

COBRA Notes

Benefits Summary

bnh 1/13/10 s/w quondra w, self insured group, COMPLIES WITH PARITY, RES not showing under major medical,so not covered under SA?? NO DAY OR \$ PCY MAX AVAIL

Insurance Information

Insured Name Jewell M

Insured Employer

Still Employed?

Yes

Insured Relation: Guardian

How Long 5 years

Terminated

Insured_SS_No

Insured_DOB

Company

Group_No

Ins Rep Name:

Policy_No

Ins Phone:

Phone 2:

Plan_no

Verification

Pre-existing limitation?

No Unknown

Note: no prex

Effective Date? 1/1/2010

Termination Date?

Contract period: Jan-dec

Children Covered?

CON Benefits? Yes

To Age

Plan_type: PPO

FT Student?

Is This an HMO? No Physician

Physician Phone

HMO note ppo

Chemical Dependency Benefit

CD Detox Benefits? oon-\$500 ded (none met), 70% allowed, \$4k oop max then 100%, no day or \$ pcy max, no \$ per day max, no lftm max, no sep, CERT

InPat CD Rehab Benefits? oon-sub to ded, 70% allowed, no day or \$ pcy max, no \$ per day max, no sep, CERT

InPat CD Res Benefits? NOT COVERED

PHP CD Benefits? oon-sub to ded, 70% allowed, no day or \$ pcy max, no \$ per day max, no sep, CERT

IOP CD Benefits? oon-sub to ded, 70% allowed, no day or \$ pcy max, no \$ per day max, no sep, CERT

OutPI CD Benefits? oon-sub to ded, 70% allowed, no v or \$ pcy max, no \$ per day max, no \$ per v max, no v per day max, no sep, no cert

No Any difference in benefits for the treatment of Drug Addiction and Alcohol?

What Differences? none

Jewell M

Date Created	Contact	Prior Auth #	First Cert Date	Last Cert Date
03/01/2010	[REDACTED]	[REDACTED]0638	03/01/2010	03/04/2010

*** Monday, March 1, 2010, 11:47 AM ***

CR---CALLED CM C [REDACTED] FOR CSR AND GOT HER VM---LEFT 2 SEPARATE VM MESSAGES WITH UPDATED CLINICALS AND REQUESTED REHAB FOR 4 DAYS---WAITING FOR CB. SENT EMAIL TO THERAPIST [REDACTED] AND PROGRAM DIRECTOR [REDACTED] REGARDING POTENTIAL PHP TRANSFER DATE.

*** Monday, March 1, 2010, 04:00 PM ***

CR---RECEIVED VM FROM CM C [REDACTED] WITH CERT FOR 4 DAYS OF REHAB FOR 3/1 THRU 3/4 WITH AUTH # [REDACTED]0638. NEXT REVIEW DUE 3/5. C [REDACTED] SAID SHE CHECKED PT BENEFIT AND SHE DOES NOT APPEAR TO HAVE A PHP BENEFIT AVAILABLE WIHT THIS POLICY.

*** Monday, March 1, 2010, 04:31 PM ***

CR---CALLED CM C [REDACTED] AT THIS TIME AND GOT HER VM---LEFT MESSAGE REQUESTING CLARIFICATION OF PHP BENEFIT AS IT APPEARED TO US IN VERIFICATION PRIOR TO ADMIT THAT RESIDENTIAL WAS EXCLUDED, BUT PHP AND IOP BENEFIT WAS QUOTED. ASKED HER TO VERIFY OR LET ME KNOW WHO TO CALL TO VERIFY SO WE CAN APPROPRIATELY PLAN FOR STEP DOWN. SENT EMAIL TO [REDACTED] AND [REDACTED] TO UPDATE THEM ABOUT BENEFIT QUESTION.

*** Tuesday, March 2, 2010, 09:57 AM ***

CR---RECEIVED CB FROM CM [REDACTED] AND SHE SAID PT DOES NOT HAVE ANY PHP BENEFIT AVAILABLE---SHE SAID THERE MAY HAVE BEEN AN ERROR IN QUOTING OF BENEFITS AND AT TIMES THEY QUOTE THE MENTAL HEALTH BENEFIT INSTEAD OF SUBSTANCE ABUSE. QUESTIONED WHETHER THERE IS IOP AVAILABLE AND C [REDACTED] SAID THERE IS IOP BENEFIT COMBINED WITH OIPT. SENT EMAIL TO [REDACTED] AND ALL PATIENT ADVOCATES REQUESTING BENEFIT RECHECK SO WE CAN PALN FOR STEP DOWN LOC. SENT EMAIL UPDATE TO PROGRAM DIRECTOR [REDACTED]

NEW [REDACTED] 2010 Benefit Summary

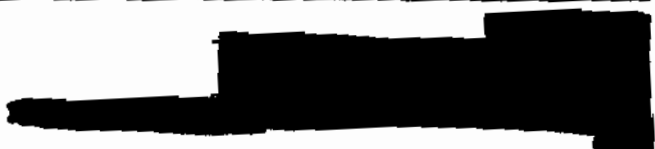
	In-Network	Out-of-Network
Plan Features		
In/Out of network benefits		
Out of area benefits	Coverage provided worldwide through the [REDACTED] program.	
Student/Dependent coverage	Dependents covered to age 19. Students covered to age 23.	
Plan Cost Sharing Highlights		
Office visit copay (PCP)	\$15 except where noted	Covered at 70%, subject to the deductible
Office visit copay (Specialist)	\$30 except where noted	Covered at 70%, subject to the deductible
Deductible	In-network: \$250 per member/\$500 per family Out-of-network: \$500 per member/\$1,000 per family Full family deductible must be met before services are covered	
Out of pocket maximum	In-network: \$2500 per member/\$5000 per family Out-of-network: \$4000 per member/\$8000 per family	
Lifetime maximum	None	
Plan Benefits		
Preventive Healthcare Services – Not subject to deductible		
Well child visits	Exams/labs/immunization: Covered in full	Covered at 70%, subject to the deductible
Adult routine physical exams	Covered in full	Covered at 70%, subject to the deductible
Adult immunizations	Covered in full	Covered at 70%, subject to the deductible
Mammography	Covered in full	Covered at 70%, subject to the deductible
Pap smear	Covered in full	Covered at 70%, subject to the deductible
Routine GYN Exam	Covered in full	Covered at 70%, subject to the deductible
Prostate cancer screening	Exam Covered in full. PSA Lab: Covered in full	Covered at 70%, subject to the deductible
Routine vision	Not Covered	Not Covered

*Pre-certification required on certain services. PLEASE NOTE: This is a summary of benefits please contact Customer Service for complete coverage details at [REDACTED]

NEW [REDACTED] 2010 Benefit Summary

	In-Network	Out-of-Network
Physicians Office Services		
Diagnostic office visits	Subject to copay	Covered at 70%, subject to the deductible
Diagnostic x-rays (MRI, PET, CAT scans)	Covered in full	Covered at 70%, subject to the deductible
Diagnostic laboratory and pathology	Covered in full	Covered at 70%, subject to the deductible
Allergy tests	Subject to copay	Covered at 70%, subject to the deductible
Allergy injections	Covered at 90%, subject to the deductible	Covered at 70%, subject to the deductible
Chemotherapy	Covered at 90%, subject to the deductible	Covered at 70%, subject to the deductible
Radiation therapy	Covered at 90%, subject to the deductible	Covered at 70%, subject to the deductible
Maternity Services		
Prenatal and postpartum care	Subject to copay. Delivery and global subject to deductible and coins.	Covered at 70%, subject to the deductible
Hospital care for mom (including delivery)	Subject to \$200 copay then covered at 90%	Covered at 70%, subject to the deductible
Newborn nursery care	Physician Fees: Subject to copay. Facility: Subject to \$200 copay then covered at 90%	Covered at 70%, subject to the deductible
Inpatient Hospital Benefits*		
Hospital benefits	Subject to \$200 copay then covered at 90% for unlimited days of room and board	Covered at 70%, subject to the deductible for unlimited days of room and board.
Physician visits in the hospital	Covered at 90%, subject to the deductible for unlimited visits	Covered at 70%, subject to the deductible for unlimited visits
Inpatient Physical Rehabilitation	Subject to \$200 copay then covered at 90% for unlimited days	Covered at 70%, subject to the deductible for unlimited visits
Surgery	Covered at 90%, subject to the deductible	Covered at 70%, subject to the deductible
Anesthesia	Covered at 90%, subject to the deductible	Covered at 70%, subject to the deductible

*Pre-certification required on certain services. PLEASE NOTE: This is a summary of benefits please contact Customer Service for complete coverage details at [REDACTED]



NEW [REDACTED] 2010 Benefit Summary

	In-Network	Out-of-Network
<u>Emergency Care</u>		
Emergency room care	Subject to \$100 copay then covered at 90%	Covered at 70%, subject to the deductible
Freestanding urgent care center	Subject to copay	Covered at 70%, subject to the deductible
Ambulance	Covered at 80%, subject to the deductible for emergency transportation - \$3,000 CALENDAR YEAR LIMIT	Covered at 80%, subject to the deductible for emergency transportation - \$3,000 CALENDAR YEAR LIMIT
<u>Outpatient Hospital Benefits</u>		
Diagnostic x-rays (MRI, PET, CAT scans)	Covered in full	Covered at 70%, subject to the deductible
Diagnostic laboratory and pathology	Covered in full	Covered at 70%, subject to the deductible
Surgical Care	Subject to \$100 copay then covered at 90%	Covered at 70%, subject to the deductible
Chemotherapy	Covered at 90%, subject to the deductible	Covered at 70%, subject to the deductible
Radiation Therapy	Covered at 90%, subject to the deductible	Covered at 70%, subject to the deductible
<u>Mental Health and Chemical Dependence Benefits</u>		
Inpatient mental health care	Subject to \$200 copay then covered at 90% for unlimited days	Covered at 70%, subject to the deductible for unlimited days.
Outpatient mental health care	Subject to \$100 copay then covered at 90% for unlimited days.	Covered at 70%, subject to the deductible for unlimited days.
Inpatient chemical dependence care	Subject to \$200 copay then covered at 90% for unlimited days for detoxification and rehabilitation.	Covered at 70%, subject to the deductible for unlimited days for detoxification and rehabilitation.
Outpatient chemical dependence care	Subject to \$100 copay then covered at 90% for unlimited days.	Covered at 70%, subject to the deductible for unlimited days.
<u>Other Services</u>		
Diabetic insulin & supplies	Covered at 80%, subject to the deductible	Covered at 70%, subject to the deductible

*Pre-certification required on certain services. PLEASE NOTE: This is a summary of benefits please contact Customer Service for complete coverage details at [REDACTED]

NEW [REDACTED] 2010 Benefit Summary

	In-Network	Out-of-Network
Skilled nursing facility	Covered at 90%, subject to the deductible for up to 100 days per calendar year	Covered at 70%, subject to the deductible for up to 100 days per calendar year
Home care	Covered in full for 90 visits per calendar year	Covered at 70%, subject to the deductible for 90 visits per calendar year
Hospice	Covered in full for unlimited visits	Covered at 70%, subject to the deductible for unlimited visits
Outpatient therapy	FACILITY: \$30 copay then covered at 90%. Physician: Subject to copay- \$2500 CALENDAR YEAR LIMIT COMBINED FOR PHYSICAL, OCCUPATIONAL AND SPEECH. \$5000 CAL. YR LIMIT FOR SERVICES TO TREAT DEVELOPMENTAL DELAYS FOR OCCUPATIONAL AND SPEECH THERAPY.	Covered at 70%, subject to the deductible - \$2500 CALENDAR YEAR LIMIT COMBINED FOR PHYSICAL, OCCUPATIONAL AND SPEECH. \$5000 CAL. YR LIMIT FOR SERVICES TO TREAT DEVELOPMENTAL DELAYS FOR OCCUPATIONAL AND SPEECH THERAPY.
Durable medical equipment	Covered at 80%, subject to the deductible, \$5000 max per calendar year	Covered at 70%, subject to the deductible, \$5000 max per calendar year
External prosthetics	Covered at 80%, subject to the deductible	Covered at 70%, subject to the deductible
Chiropractic	Subject to copay - \$500 max on spinal manipulation per calendar year	Covered at 70%, subject to the deductible - \$500 max on spinal manipulation per calendar year
Acupuncture	Not Covered	Not Covered
Dental	Covered at 80%, subject to the deductible for accidental injury to sound natural teeth.	Covered at 70%, subject to the deductible for accidental injury to sound natural teeth.
Hearing	Subject to copay	Covered at 70%, subject to the deductible

*Pre-certification required on certain services. PLEASE NOTE: This is a summary of benefits please contact Customer Service for complete coverage details at [REDACTED]



[REDACTED]

Insurance Company

[REDACTED]

[REDACTED]

Certificate of Coverage, Riders, Amendments, and Notices

for

[REDACTED] INC.

Group Number: [REDACTED] Health Plan: [REDACTED] Prescription Code: [REDACTED]
Effective Date: January 1, 2010

Offered and Underwritten by

[REDACTED]

This exclusion does not apply to:

- Disposable supplies necessary for the effective use of Durable Medical Equipment for which Benefits are provided as described under *Durable Medical Equipment* in *Section 1: Covered Health Services*.
 - Diabetic supplies for which Benefits are provided as described under *Diabetes Services* in *Section 1: Covered Health Services*.
 - Ostomy supplies for which Benefits are provided as described under *Ostomy Supplies* in *Section 1: Covered Health Services*.
2. Tubings and masks except when used with Durable Medical Equipment as described under *Durable Medical Equipment* in *Section 1: Covered Health Services*.

H. Mental Health/Substance Abuse

1. Services performed in connection with conditions not classified in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.
2. Mental Health Services and Substance Abuse Services that extend beyond the period necessary for short-term evaluation, diagnosis, treatment or crisis intervention.
3. Mental Health Services as treatment for insomnia and other sleep disorders, neurological disorders and other disorders with a known physical basis.
4. Treatment for conduct and impulse control disorders, personality disorders, paraphilias and other Mental illnesses that will not substantially improve beyond the current level of functioning, or that are not subject to favorable modification or management according to prevailing national standards of clinical practice, as reasonably determined by the Mental Health/Substance Abuse Designee.
5. Services utilizing methadone treatment as maintenance, L.A.A.M. (1-Alpha-Acetyl-Methadol), Cyclazocine, or their equivalents.
6. Treatment provided in connection with or to comply with involuntary commitments, police detentions and other similar arrangements, unless authorized by the Mental Health/Substance Abuse Designee.
7. Residential treatment services.
8. Services or supplies for the diagnosis or treatment of Mental illness, alcoholism or substance abuse disorders that, in the reasonable judgment of the Mental Health/Substance Abuse Designee, are any of the following:
 - Not consistent with prevailing national standards of clinical practice for the treatment of such conditions.
 - Not consistent with prevailing professional research demonstrating that the services or supplies will have a measurable and beneficial health outcome.
 - Typically do not result in outcomes demonstrably better than other available treatment alternatives that are less intensive or more cost effective.
 - Not consistent with the Mental Health/Substance Abuse Designee's level of care guidelines or best practices as modified from time to time.

The Mental Health/Substance Abuse Designee may consult with professional clinical consultants, peer review committees or other appropriate sources for recommendations and information regarding whether a service or supply meets any of these criteria.

i. Nutrition

1. Individual and group nutritional counseling. This exclusion does not apply to medical nutritional education services that are provided by appropriately licensed or registered health care professionals when both of the following are true:
 - Nutritional education is required for a disease in which patient self-management is an important component of treatment.
 - There exists a knowledge deficit regarding the disease which requires the intervention of a trained health professional.

Date verified
2/19/2010

Medical Insurance Verification Form

Initial Verification
Reverified by

Patient ID

Name **Teresa M**

Employer

DOB

SS_No

Still Employed?

Termination Date

Phone

Work phone

Pat Have COBRA?

COBRA Notes

Benefits Summary

vov 02/19/10 trans to s/w oliver n, self insured national acct, federal parity applies as of 01-01-10, STATES RES LEVEL of CARE DOES NOT EXIST THEREFORE IS NOT COV FOR ANY MED SERVICES, no claims or certs -- NO DAY or \$ PCY MAXES

Insurance Information

Insured Name	Insured Employer	Still Employed	Yes
Insured Relation: Spouse	How Long: 10 years	Terminated	
Insured_SS_No:	Insured_DOB:	Group_No:	
Company:	Policy_No:	Plan_no:	
Ins Rep Name:			
Ins Phone:	Phone 2:		

Verification

Pre-existing limitation? **No/Unknown**

Note: **no prex**

Effective Date? **1/1/2010**

Termination Date?

Contract period **Jan - dec**

Children Covered?

OON Benefits? **Yes**

To Age

Plan_type: **PPO**

FT Student?

Is This an HMO? **No** Physician

Physician Phone

HMO note: **PPO**

Chemical Dependency Benefit

CD Detox Benefits?	Don-\$2,250 ded (none met), 50%allowed, no oop max, no days pcy max, no \$ pcy max, no \$ per day max, no lftm max, no sep, CERT
InPat CD Rehab Benefits?	oon-sub to ded, 50%allowed, comb w/inpt no days pcy max, no \$ pcy max, no \$ per day max, no sep, CERT
InPat CD Rec Benefits?	oon-NOT COVERED
PHP CD Benefits?	oon-sub to ded, 50%allowed, comb w/inpt no days pcy max, no \$ pcy max, no \$ per day max, no sep, CERT
IOP CD Benefits?	oon-sub to ded, 50%allowed, comb w/inpt no days pcy max, no \$ pcy max, no \$ per day max, no sep, CERT
OutPT CD Benefits?	oon-sub to ded, 50%allowed, no v pcy max, no \$ pcy max, no \$ per day/ \$ per v or v per v max, no sep, CERT
No	Any difference in benefits for the treatment of Drug Addiction and Alcohol?
What Differences?	none

Teresa M