

YOUR INSURANCE RIGHTS

MENTAL HEALTH AND SUBSTANCE USE DISORDER SERVICES

5 TIPS TO HELP YOU UNDERSTAND YOUR TREATMENT RIGHTS

Many people need mental health or substance use disorder (MH/SUD) treatment and want to know what is covered under their insurance plan. Here are 5 important tips to help you better understand and utilize your (or a loved one's) MH/SUD health care benefits.

1. LOOK FOR EQUAL COVERAGE OF MH/SUD BENEFITS

The Mental Health Parity and Addiction Equity Act (Parity Act) is a federal law that requires most insurance companies and Medicaid programs to provide the same level of coverage for MH/SUD care as they do for other health conditions. In other words, insurance companies cannot make it more difficult to get or stay in treatment for conditions like depression or substance use than for conditions like asthma or diabetes.

2. COMPARE TYPES OF TREATMENT

There are different types of treatment for all health conditions: outpatient treatment, inpatient treatment, prescription medication, and emergency services. **If your plan offers MH/SUD benefits, and is required to follow the Parity Act, your plan must cover MH/SUD services in each category of care that a medical benefit is offered.**



3. REVIEW YOUR COVERAGE

To find out which MH/SUD benefits are covered under your health plan and which benefits are not (excluded benefits), you can:

- Review your **health plan summary of benefit coverage** or **insurance contract**.
- Log on to your health plan's online portal.
- Talk with your treatment provider.
- Call your insurance company (look for the phone number on the back of your insurance card).
- Talk to your Human Resources office if you have insurance through your employer.



IMPORTANT TERMS

Health plan summary of benefit coverage:

This document is provided by your insurance company and gives an overview of the benefits that are covered, the out-of-pocket costs you pay for services and certain limits on covered services.

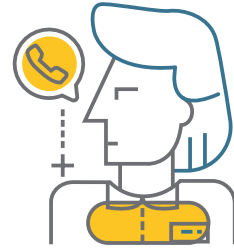
Insurance contract: This document (also called "evidence of coverage") is provided by your insurance company and it describes, in detail, the benefits covered and how to file a complaint if you are denied services.

UNDERSTAND YOUR INSURANCE RIGHTS

4. QUESTIONS TO ASK YOUR INSURANCE COMPANY

Every health plan is different. To learn more about your specific benefits, ask your insurance company:

- What mental health and substance use disorder services and medications are covered under my health plan?
- I am seeking services for _____. Do you cover that?
- Are there any limits on these services? For example, is there a limit on the number of times I can see my treatment provider or the medications I can take?
- Do I need **pre-authorization** from you before I can start treatment?
- Do I need a referral for treatment?
- Once I start treatment, how do I know if you will continue to cover it?
- What providers in your network offer the services I'm looking for, and which of these in-network providers are taking new patients?



Pre-authorization: When your insurance company requires you or your provider to get approval for a health care service before you receive it. Without approval, you may have to pay out of your own pocket for the service.

5. LOOK OUT FOR PARITY VIOLATION WARNING SIGNS

If these examples sound familiar, your insurance company may be violating your rights. Talk with your treatment provider about what you can do.



"I pay a lot more out-of-pocket to see my mental health counselor than my primary care physician."



"I had to call and get permission from my insurance company before I started substance use treatment, but when I needed treatment for my diabetes, I just scheduled an appointment."



"My provider recommended residential treatment, but my insurance would only cover once-a-week visits with a psychologist. That's never happened when seeking care for a physical illness."

Is Your Insurance Company

VIOLATING YOUR RIGHT

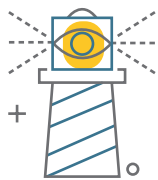
to Equal Mental Health and
Substance Use Disorder Treatment?

3 PARITY WARNING SIGNS

The Mental Health Parity and Addiction Equity Act (Parity Act) is a federal law that requires most insurance companies and Medicaid programs to provide the same level of coverage for mental health and substance use disorder (MH/SUD) care as they do for other health conditions. In other words, insurance companies cannot make it more difficult to get or stay in treatment for conditions like depression or substance use disorder than for conditions like asthma or diabetes.

IF YOU SEE ANY OF THE FOLLOWING WARNING
SIGNS, YOUR INSURANCE COMPANY MAY BE
VIOLATING YOUR RIGHTS.

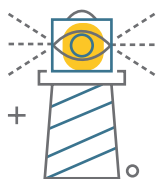
1. DIFFERENCES IN THE AMOUNT OF MH/SUD TREATMENT COVERED BY YOUR INSURANCE COMPANY COMPARED TO THE MEDICAL CARE AMOUNT



The **number of times** you can see a MH/SUD provider or the **number of MH/SUD treatment days** that are covered seems different compared to medical treatment.

- You are limited to 15 counseling sessions each year, but have no annual limit on primary care visits.
- You are entitled to coverage for one weekly appointment with a therapist to manage a mental health condition, but have no limitations on visits to manage another chronic illness, such as Type 2 diabetes.

2. DIFFERENCES IN THE STEPS YOU NEED TO TAKE TO START OR CONTINUE MH/SUD TREATMENT COMPARED TO MEDICAL CARE

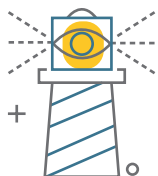


For example, if your insurance company:

- Requires approval (prior authorization) for most or all MH/SUD services and medications but not for most medical services.
- Requires your treatment provider to submit information to show your MH/SUD treatment is “medically necessary” more often than is required for medical care.
- Requires you to try a lower level of MH/SUD care (for example, meeting with a counselor once a week) before approving higher level of care (for example, meeting with a counselor three times a week).
- Will not cover certain prescription drugs to treat MH/SUD conditions.
- Will not cover MH/SUD treatment because the last time you got treatment, you stopped before finishing the program.
- Restricts where you can get MH/SUD services without restricting where you can get medical services (for example, a residential treatment program located outside your state).

Prior authorization is when your insurance company requires you or your provider to get approval for a health care service before you receive it. Without approval, you may have to pay out of your own pocket for the service.

3. DIFFERENCES IN OUT-OF-POCKET PAYMENTS FOR VISITS TO YOUR MH/SUD PROVIDER VERSUS YOUR MEDICAL PROVIDER



Your out-of-pocket cost for each visit to your MH/SUD treatment provider should not be more than your out-of-pocket cost for each visit with your medical provider. For example, if your insurance company charges a \$40 co-pay for outpatient MH/SUD care but charges a \$20 co-pay for outpatient medical care, the company may be violating parity laws.

Co-payment (co-pay) is the amount that you pay out of your own pocket for a mental health, substance use disorder, or medical service that is covered by your health plan.

TO LEARN MORE ABOUT WHO TO CALL AND HOW TO TAKE ACTION IF YOU SEE ANY OF THESE WARNING SIGNS, VISIT:

parityat10.org

Filing a Health Insurance Appeal

MARYLAND

Medicaid Plans

Did Medicaid deny your request for mental health or substance use disorder (MH/SUD) services? If so, Medicaid may be violating your health insurance rights. You can challenge the decision by filing an appeal.

The Mental Health Parity and Addiction Equity Act (Parity Act) is a federal law that requires most Medicaid programs to provide the same level of coverage for MH/SUD care as they do for other health conditions. In other words, Medicaid cannot make it more difficult to get or stay in treatment for conditions like depression or substance use than for conditions like asthma or diabetes.

WHEN SHOULD YOU APPEAL?

- If Medicaid denies your request for MH/SUD treatment or will only cover part of your treatment, you have the right to appeal that decision. You can also challenge Medicaid if you see any of the [Parity Act warning signs](#).

HOW CAN AN APPEAL HELP YOU?

- Medicaid's decision may be **overturned**, and you will not have to pay for the services Medicaid is supposed to cover.
- If you are receiving treatment, Medicaid will continue to pay for it **during** the appeals process if you appeal within **10 days** of the denial.

WHEN SHOULD YOU FILE AN APPEAL?

- As **soon** as you know you have been denied MH/SUD treatment.
- You must file your appeal with Medicaid within **90 days** of the date on your denial letter.

WHAT SHOULD YOU DO IF YOUR CONDITION IS URGENT?

- Contact Medicaid immediately to ask for an **expedited appeal**.

IMPORTANT TERMS

Expedited appeal: If your condition is very serious, you can ask Medicaid to review your appeal and make a decision as quickly as possible. Contact the Office of Health Services to learn what counts as an "urgent condition."

Medical Necessity Criteria: A set of standards used by Medicaid to decide what level of care, such as inpatient or outpatient treatment, is needed to treat your health condition.

State fair hearing: An appeal of Medicaid's decision to not cover your treatment. A state fair hearing officer will decide whether Medicaid should cover your treatment and may overturn Medicaid's decision in your favor.

Reason for denial: The explanation from Medicaid that describes why it denied your treatment.

HOW TO FILE AN APPEAL



SEND AN APPEAL LETTER TO THE MARYLAND DEPARTMENT OF HEALTH, OFFICE OF HEALTH SERVICES ASKING FOR A STATE FAIR HEARING

Explain why you need the services and include back-up medical information from your treatment provider.

- The denial letter from Medicaid will tell you where to send your appeal letter and give the deadline for filing your appeal.
- The Appeals Coordinator at the Office of Health Services will send your state fair hearing request to the Maryland Office of Administrative Hearings.
- The Maryland Office of Administrative Hearings will send you information about the state fair hearing date and process and the location of the state fair hearing.



REQUEST THE REASON FOR DENIAL

You have the right to know **why** your treatment was denied.

- If Medicaid did not give you the reason for its denial, ask for the reason.
- Request the **Medical Necessity Criteria** used to make its decision.



GET HELP FROM YOUR TREATMENT PROVIDER

- Your treatment provider may ask Medicaid to reconsider its decision before you file your appeal. If that does not fix the problem, include a **letter** from your treatment provider explaining why you need this treatment.
- Your treatment provider can file the appeal for you with your consent.



GET HELP FROM MEDICAID

- Call the Appeals Coordinator at the Office of Health Services at 1-410-767-1696 and ask for help with a state fair hearing request. Fax your letter to 1-410-333-5154 or send it to Maryland Department of Health, Office of Health Services, Attention: Appeals, 201 W. Preston Street, Room 127, Baltimore, Maryland 21201.
- Call the Office of Administrative Hearings at 1-410-229-4100 and ask for a person who works on Medicaid appeals to make sure the office received your appeal. The address is 11101 Gilroy Road, Hunt Valley, Maryland 21031.



CALL LEGAL AID FOR HELP

- Ask your local Maryland Legal Aid Office for help with your state fair hearing. The Maryland Legal Aid Bureau state directory is found at www.mdlab.org/contact.
- Maryland Volunteer Lawyers Service can also help identify legal assistance. Call 1-800-510-0050.

IF YOUR APPEAL IS DENIED



YOU HAVE A RIGHT TO FILE A COURT ACTION

- If the state fair hearing officer denies your appeal, get legal advice about filing a court action.

**MAKE COPIES OF ALL MATERIALS YOU SEND TO MEDICAID AND THE OFFICE OF ADMINISTRATIVE HEARINGS AND KEEP NOTES ON YOUR CONVERSATIONS.
KEEP THESE MATERIALS FOR YOUR OWN RECORDS.**

Filing a Health Insurance Appeal

MARYLAND

Private Insurance Plans

Did your insurance company deny or limit your request for mental health or substance use disorder (MH/SUD) services? If so, your insurance company may be violating your health insurance rights. You can challenge the decision by filing an appeal.

The Mental Health Parity and Addiction Equity Act (Parity Act) is a federal law that requires most insurance companies and Medicaid programs to provide the same level of coverage for MH/SUD care as they do for other health conditions. In other words, insurance companies cannot make it more difficult to get or stay in treatment for conditions like depression or substance use than for conditions like asthma or diabetes.

WHEN SHOULD YOU APPEAL?

- If your insurance company denies your request for MH/SUD treatment or will only cover part of your treatment, you have the right to appeal that decision. You can also challenge your insurance company if you see any of the Parity Act [warning signs](#).

HOW CAN AN APPEAL HELP YOU?

- The decision may be **overturned** and you will not have to pay for the services your insurance company is supposed to cover.

WHEN SHOULD YOU FILE AN APPEAL?

- As **soon** as you know you have been denied MH/SUD treatment.

WHAT SHOULD YOU DO IF YOUR CONDITION IS URGENT?

- Contact your insurance company immediately and ask for an **expedited appeal**.
- If your insurance company delays, file an **external review** immediately.

IMPORTANT TERMS

Internal appeal: When you ask your insurance company to review and reconsider its decision to deny your treatment.





Expedited appeal: If your condition is urgent, you can ask your insurance company to review your appeal and make a decision very quickly. Your insurance company can tell you what counts as an “urgent condition.”

Reason for denial: The insurance company’s description of why it denied your treatment.


External review: An independent decision-maker reviews your insurance company’s decision to deny your treatment and may overturn the decision.

Medical Necessity Criteria: A set of standards used by insurance companies to decide what level of care, such as inpatient or outpatient treatment, is appropriate for treating a particular health condition.



HOW TO FILE AN APPEAL

-  **SEND AN APPEAL LETTER TO YOUR INSURANCE COMPANY**
Explain why you need the services and include back-up medical information from your treatment provider.
 - The denial letter from your insurance company will tell you where to send your letter and give the deadline for filing your appeal.
-  **REQUEST THE REASON FOR DENIAL**
You have the right to know **why** your treatment was denied.
 - If your insurance company did not give you the reason for its denial, ask for the reason.
 - Request the **Medical Necessity Criteria** your insurance company used to make its decision.
-  **GET HELP FROM YOUR TREATMENT PROVIDER**
 - Include a **letter** from your treatment provider explaining why you need this treatment.
-  **GET HELP FROM THE MARYLAND ATTORNEY GENERAL OR MARYLAND INSURANCE ADMINISTRATION**
 - The Maryland Attorney General's Health Education and Advocacy Unit can help you file an appeal (free of charge). Contact them at 1-877-261-8807 or go to <http://www.marylandattorneygeneral.gov/Pages/CPD/HEAU/default.aspx>.
 - The Maryland Insurance Administration Consumer Hotline will provide information about the appeals process including important deadlines. Call 1-410-468-2244 or go to www.insurance.maryland.gov/Consumer/Pages/AppealsAndGrievances.aspx.

AFTER YOU FILE YOUR APPEAL

-  **DECISION TIMELINE**
 - Check your insurance documents for the amount of time your insurance company has to give you a decision.

IF YOUR APPEAL IS DENIED

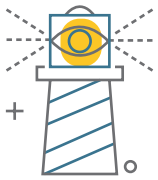
-  **YOU CAN REQUEST AN EXTERNAL REVIEW**
An independent third-party will review the decision and could overturn your insurance company's decision.
 - To request a review, send a letter to the Maryland Insurance Administration that includes the information identified here: <https://insurance.maryland.gov/Consumer/Pages/AppealsAndGrievances.aspx>. You can also fill out the form found here: <https://insurance.maryland.gov/Consumer/Documents/lh-agcomplaintform08-17rev.pdf>.
 - The Health Education and Advocacy Unit can help you file this appeal.
-  **YOU CAN FILE A COURT ACTION**
If the third-party review still denies your treatment, get legal advice about filing a complaint in court.

MAKE COPIES OF ALL MATERIALS YOU SUBMIT TO THE INSURANCE COMPANY AND KEEP NOTES ON YOUR CONVERSATIONS. KEEP THESE MATERIALS FOR YOUR PERSONAL RECORDS.

HELP PATIENTS RESPOND TO INSURANCE BARRIERS

Treatment providers are often the “first responders” when health insurance plans deny, delay, or limit a patient’s mental health or substance use disorder (MH/SUD) treatment. The Mental Health Parity and Addiction Equity Act (Parity Act) can help you fight barriers to care. Here are some steps you can take.

**YOUR PATIENTS HAVE RIGHTS.
SO DO YOU.**



KNOW THE FACTS ABOUT PARITY

- The Parity Act requires most health insurance plans and Medicaid programs to provide the same level of coverage for MH/SUD care as they do for medical care.
- An insurance company must always give the treatment provider the reason for denying a requested service and the Medical Necessity Criteria used to make this decision.
- An insurance company’s benefit denial or limits can always be appealed.
- Your State Insurance Department and State Department of Medicaid are required to enforce federal and state parity laws and can help you if you identify problems.

THE PARITY ACT APPLIES TO:

- Patients’ out-of-pocket costs.
- Limits on how long a patient can stay in treatment.
- Range of covered treatment services and medications.
- Steps providers must take to get approval for a patient’s treatment.
- Provider reimbursement rates.
- Admission to a plan’s provider network.



KNOW HOW TO SPOT A POSSIBLE VIOLATION

An insurance company may be violating the Parity Act if the plan:

- Requires that the patient try a lower level of care before authorizing the prescribed care.
- Requires prior authorization for all MH/SUD services or frequent continuing authorization.
- Refuses to cover certain prescription drugs or levels of care, such as residential treatment or methadone treatment.
- Has few or no in-network providers to deliver covered services to plan members.
- Will not negotiate on reimbursement rates.



TAKE ACTION

Most patients will need your help to appeal a coverage denial by their insurer.

Help your patients get the services that their health insurance is supposed to cover.

- Know who in your organization handles health insurance problems and work with them to help the patient get the recommended care and reimbursement.
 - Give your patients fact sheets that answer health insurance questions or provide guidance on how to file an appeal.
- Contact the patient's health insurance company.
 - Ask about covered MH/SUD benefit(s) and the health insurance plan's reason for denying or limiting services.
- Help your patient file an appeal.
 - With your patient's consent, call the insurance company and request an appeal.
 - Submit the necessary paperwork.
- Ask your billing office to track health insurance plans that deny or refuse payment for services.
 - Identify patterns that may indicate a parity violation.
 - A complaint tracking tool is available at parityat10.org.

Inform your State Insurance Department and State Department of Medicaid about insurer practices that limit access to MH/SUD treatment.

- Your patient's health insurance plan determines where you report possible parity violations. For more information, go to: www.hhs.gov/programs/topic-sites/mental-health-parity/mental-health-and-addiction-insurance-help/index.html.