Maricopa County Behavioral Health Benefit Plan Description

Effective July 1, 2020

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Plan Description

Maricopa County Behavioral Health Benefits Plan

Administrative Information:

Plan Name:	Maricopa County Behavioral Health Benefit Plan
Plan Sponsor:	Maricopa County
Type of Plan:	Mental Health and Substance Abuse
Claims Administrator:	Magellan Health, Inc.
Address:	4801 E. Washington Street Phoenix, AZ 85034
Funding Method:	Self-Insured
Plan Year:	July 1 to June 30

About this Document

This Plan Description is intended to describe your behavioral health benefit plan. Every effort has been made to ensure the information contained in this document is accurate. If there is a discrepancy in the information, the Plan Sponsor will make the final determination.

The Plan Sponsor reserves the right to amend or terminate any benefit described in this document at any time. Notices of changes will be communicated through Maricopa County's website or through Open Enrollment materials.

The plan and/or Magellan has the right to deny benefits for any services received in a manner that does not conform to generally accepted medical or psychiatric practices or that are received in a manner that does not conform to the plan design.

When the words "we", "us", "our", and "plan" are used in this document, they refer to Maricopa County. When the words "you" and "your" are used, they refer to employees, covered dependents, and COBRA beneficiaries enrolled in the Cigna HMO or UnitedHealthcare PPO medical plans offered through Maricopa County.

The Maricopa County Employee Benefits Division has two websites for employee use. The address of the Internet site is www.maricopa.gov/benefits, and the Intranet site is located at http://mymc.maricopa.gov. Both of these websites are collectively referred to as the "Benefits Home Page" in this document.

Schedule of Benefits

Note: Eligible In-Network Mental Health and Substance Abuse out-of-pocket costs for covered services will accumulate under the medical plan out-of-pocket maximum.

Level of Care	In-Network Benefit	In-Network Rules	Out-of-Network Benefit	Out-of-Network Rules
Inpatient Hospitalization	30 days per year (in- and out-of-network combined); $25 co-pay per day	Preauthorization required (except for emergency care)	30 days per year (in- and out-of-network combined); $500 deductible; Plan pays $250 per day after deductible is met. All other costs after Plan payment of $250 per day are member's responsibility.	Preauthorization required. It is the member's responsibility to obtain pre-authorization for initial and concurrent reviews. Failure to obtain preauthorization results in no reimbursement.
Partial Hospitalization	Benefit is derived from trading unused inpatient hospitalization days for up to 30 partial hospitalization days per year. 60 partial days per year (in- and out-of-network combined); Benefit is traded at 2 partial days for 1 inpatient day. $20 co-pay per day.	Preauthorization required	Benefit derived from trading unused inpatient hospitalization days for up to 30 partial hospitalization days per year. 30 partial days per year (in- and out-of-network combined); Benefit is traded at 2 partial days for 1 inpatient day. $250 deductible; Plan pays $125 per day after deductible. All costs after Plan payment of $125 per day are member's responsibility.	Preauthorization required. It is the member's responsibility to obtain pre-authorization for initial and concurrent reviews. Failure to obtain pre-authorization results in no reimbursement.
Residential Treatment	60 days per year; $12.50 copay per day	Preauthorization required	No benefit	N/A
Intensive Outpatient(IOP)	45 IOP visits per year (in- and out-of-network combined); $100 co-pay per program	Preauthorization Required. $100/program copay applies to a continuous episode of care in IOP. If patient discontinues & restarts program, anew $100 copay is applied.	45 IOP visits per year (in- and out-of-network combined); Plan pays $40 per visit. All other costs after Plan payment of $40 per visit are member's responsibility.	Preauthorization required. It is the member's responsibility to obtain pre-authorization for initial and concurrent reviews. Failure to obtain pre-authorization results in no reimbursement.
Outpatient therapy (individual, family, and medication evaluation)	Unlimited visits; $25 co-pay per visit.	Preauthorization required.	Unlimited visits; Plan pays $25 per visit. All other costs after Plan payment of $25 per visit are member's responsibility.	No preauthorization required
Outpatient Group Psychotherapy	Unlimited visits; $15 co-pay per visit.	Preauthorization required	Unlimited visits; Plan pays $15 per visit. All other costs after Plan payment of $15 per visit are member's responsibility.	No preauthorization required

Ongoing Medication Management	Unlimited visits; $10 co-pay per visit	Preauthorization required	Unlimited visits; Plan pays $25 per visit. All other costs after Plan payment of $25 per visit are member's responsibility	No preauthorization required
Lifetime Maximums	No lifetime maximum		No lifetime maximum	
Autism Coverage	No maximum limit Coverage for applied behavioral analysis (ABA) for a primary diagnosis of Autism Spectrum Disorder (ASD). Authorization required for these services. Please seek authorization of care from Magellan as described herein.			

Eligibility

If you are eligible for and enrolled in the Cigna HMO or UnitedHealthcare PPO medical coverage under Maricopa County, you and your eligible dependents are automatically enrolled in Mental Health and Substance Abuse Coverage under this plan which is administered by Magellan Health (Magellan). Employees who are married to a Maricopa County employee are not eligible to have behavioral health coverage through the county as both an employee and a dependent. Dependent children are also not eligible for dual enrollment. Enrollees in the Cigna High Deductible Health Plan and the United Healthcare High Deductible Health Plan are covered through different behavioral health programs administered by the appropriate vendors.

Behavioral Health Benefits

What This Plan Pays

Behavioral health benefits are payable for covered services incurred by a covered person for behavioral health services received from either in-network providers or out-of-network providers as described in the **Schedule of Benefits**.

To receive the in-network, higher level of benefits, the covered person must call Magellan before *any* services are obtained (see **Notification Requirements and Utilization Review**). To receive the out-of-network level of benefits, the covered person must call Magellan before inpatient hospitalization, intensive outpatient programs or partial hospitalization services are obtained.

Each covered person must satisfy certain copayments, co-insurance and/or deductibles before any payment is made for certain behavioral health services. The plan will then pay the applicable amount of covered expenses shown in the Schedule of Benefits.

A covered expense is incurred on the date that the behavioral health service is given. Covered behavioral health services are services and supplies which are:

- Clinically necessary, as determined by Magellan; and
- Given while the covered person is covered under this plan and has not used up available benefits for the Plan Year; and given by one of the following providers:
    - Physician
    - Psychologist
    - Licensed Counselor
    - Hospital
    - Residential Treatment Center

Behavioral health services include but are not limited to the following:

Assessment

Diagnosis

- Treatment planning
- Medication management
- Individual, family and group psychotherapy
- Psychological testing
- Alcohol and drug (substance abuse) treatment
- Post-Traumatic Stress Disorder (PTSD)

Services and supplies will not automatically be considered clinically necessary because they were prescribed by a health care provider.

Services or supplies are clinically necessary, as determined by Magellan, if they meet all the following:

- They are consistent with the symptoms and signs of diagnosis and treatment of the covered person's mental disorder
- They are consistent in type and amount with regard to the standards of good clinical practice
- They are not solely for the convenience or preference of the covered person, or his/her health care provider
- They are the least restrictive and least intrusive level of service or appropriate supplies which can be safely provided to the covered person

Magellan may consult with professional clinical consultants, peer review committees or other appropriate entities for recommendations regarding whether particular services, supplies or accommodations to be provided to a covered person are clinically necessary.

Notification Requirements and Utilization Review

To receive the in-network level of benefits under this plan and not incur penalties, the covered person must call Magellan before behavioral health services are received. **The toll- free number is 1-888-213-5125. Magellan is ready to take the covered person's call 7 days a week, 24 hours a day.** This call starts the utilization review process. The covered person will be referred to a network provider who is experienced in addressing his/her specific issues.

Except in connection with an emergency, no benefits are available under this plan if the covered person does not get preauthorization from Magellan before inpatient behavioral health services are received.

If the covered person is not satisfied with an in-network provider, he/she may call Magellan and ask for a referral to another in-network provider. The covered person may do this more than once, but he/she will only be referred to one in-network provider at a time.

This plan only pays for behavioral health services that are clinically necessary as determined by Magellan.

Emergency care

Although emergency care does not require a referral from Magellan to an in-network provider, it is recommended that, when possible, the covered person or his/her representative contact Magellan before obtaining emergency care for behavioral health treatment in order to obtain guidance from Magellan in selecting an appropriate hospital.

When emergency care is required for behavioral health treatment, the covered person (or his/her representative or his/her health care provider) must call Magellan within one calendar day after the admission to emergency care. If it is not reasonably possible to make this call within one calendar day, the call must be made as soon as reasonably possible.

When the emergency care has ended, the covered person must obtain authorization from Magellan before any additional services will be covered at the in-network level. If the covered person does not obtain authorization as required, benefits will be denied.

Copayments and Deductibles

A copayment (copay) is a fixed amount the covered person must pay to a network provider at the time covered services are given.

The amount of each copay is shown in the **Schedule of Benefits**.

Office Visit Copayment

The office visit copay applies to services given by an in-network provider. It applies to all services and supplies given in connection with an office visit.

Inpatient Copayment

The inpatient copay applies to all services and supplies given in connection with each admission in an in-network provider facility.

Cost Accumulation

Eligible In-Network Mental Health and Substance Abuse out-of-pocket costs for covered services will accumulate under the medical plan out-of-pocket maximum.

Not Covered

This plan does not cover any expenses incurred for services, supplies, medical care or treatment relating to, arising out of, or given in connection with, the following:

1. Treatments, services or supplies that are not prescribed, recommended or approved by an attending physician or other provider covered by the plan.

2. Treatment that has not been preauthorized by Magellan, except for care that is (i) emergency care or (ii) outpatient care by an out-of-network provider.

3. Any court-ordered treatment or therapy, or any treatment ordered as a condition of parole, probation, or custody or visitation evaluation, unless such treatment is clinically necessary.

4. Treatment of organic mental disorders associated with permanent dysfunction of the brain except for acute exacerbations of the condition, except Autism Spectrum Disorder (ASD).

5. Remedial and social skills education services, such as treatment of developmental disorders (including, but not limited to, learning disabilities, learning disorders, academic skills disorders, developmental language disorder, motor skills disorders, or communication disorders); behavioral training; or cognitive rehabilitation except Autism Spectrum Disorder (ASD).

6. Treatment of any condition categorized as an Axis II condition under the current Diagnostic and Statistical Manual of the American Psychiatric Association without any clinical likelihood of improvement, except for acute exacerbations of the condition.

7. Developmental, corrective, and other supportive services in connection with developmental disabilities (for example, speech-language pathology, audiology services,

physical therapy, occupational therapy, therapeutic recreation, and social work services, including orientation and mobility services) and services aimed at the development of employment and other adult living objectives or the acquisition of daily living skills except Autism Spectrum Disorder (ASD).

8. Examinations and diagnostic services in connection with obtaining employment or a particular employment assignment, admission to or continuing in school, securing any kind of license (including professional licenses), or obtaining any kind of insurance coverage.

9. Counseling for activities of an educational nature, including academic or vocational counseling, guidance, or placement services

10. Counseling for borderline intellectual functioning, including mental retardation, except in connection with acute behavioral or emotional symptoms of mental retardation

11. Counseling for occupational problems.

12. Marriage counseling, except for treatment of a behavioral health condition.

13. Counseling related to consciousness rising.

14. Vocational or religious counseling.

15. Psychological testing, unless such testing is integral to diagnosis or treatment of a behavioral health condition, including Autism Spectrum Disorder (ASD).

16. Treatment of detoxification in newborns.

17. Treatment of obesity.

18. Acupuncture.

19. Biofeedback and hypnotherapy.

20. Prescription or non-prescription drugs, unless prescribed in the course of clinically necessary inpatient treatment for a behavioral health condition.

21. Laboratory tests, pharmacy services and ancillary services, unless (i) provided during the course of clinically necessary inpatient treatment or emergency room treatment for a behavioral health condition or (ii) an anesthesia service related to a psychiatric condition.

22. Health care services, treatment or supplies provided as a result of a Workers' Compensation law or similar legislation or obtained through, or required by, any governmental agency or program, whether federal, state or any subdivision thereof or caused by the conduct or omission of a third party for which the member has a claim for damages or relief, unless such covered person provides the plan with a lien against such claim for damages or relief in a form and manner satisfactory to the plan.

23. Health care services, treatment, or supplies for military service disabilities for which treatment is reasonably available under governmental health care programs.

24. Health care services, treatment, or supplies primarily for rest, custodial, domiciliary or convalescent care.

25. Services, treatment or supplies determined to be experimental services.

26. Room and board that is not required in connection with inpatient treatment for a behavioral health condition.

27. Private hospital rooms and/or private duty nursing, unless determined to be clinically necessary and preauthorized by Magellan.

28. More than one treatment service by the same provider to the same member on the same day unless the two services rendered are different types of therapy (for example, individual therapy and group therapy).

29. Any service or supply that is otherwise not covered under your Maricopa County medical plan.

Non-Covered In-Network Provider Charges

An in-network provider has contracted to participate in Magellan's Provider Network and provides services at a negotiated rate. Under this contract, an in-network provider may not charge the plan or the covered person for certain expenses, except as described in the next paragraph.

A covered person may agree with the in-network provider to pay any charges for services and supplies which are not clinically necessary. In this case, the in-network provider may bill for charges to the covered person. The covered person will be asked to sign a patient financial responsibility form agreeing to pay for the services that are found to not be clinically necessary. However, these charges are not covered expenses under this plan and are not payable by Magellan.

Claims Information

How to File a Claim

The covered person does not need to file a claim form when an in-network provider is used.

Submission of a claims form is required when treatment is received from an out-of- network provider.

The following steps must be completed when submitting bills for payment:

1. Get a claim form from Magellan by calling toll free 888-213-5125. If the requested claim form is not received within 15 calendar days, the covered person can file a claim by sending the bills with a letter addressed to Magellan. Out- of- network claims should be mailed to Magellan, P. O. Box 1098, Maryland Heights, MO 63043.
   (The claim form is also available on the Benefits Home Page)
2. Complete the employee portion of the form
3. Have the provider complete the provider portion of the form 4. Send the form and bills to the address shown on the form

Make sure the bills and the form include the following information:

- The employee's name and identification number (either Social Security Number or Alternative ID number)
- The employer's name (Maricopa County)
- The patient's name
- The diagnosis
- The date the services or supplies were incurred
- The specific services or supplies provided

When Claims Must be Filed

The covered person must file a claim with Magellan, including written proof of loss, within 12 months after the date the expenses are incurred.

Magellan will determine if enough information has been submitted to enable proper consideration of the claim. If not, more information may be requested.

No benefits are payable for claims submitted after the 12-month period, unless it can be shown that:

• It was not reasonably possible to submit the claim during the 12-month period; and • Written proof of loss was given to Magellan as soon as was reasonably possible.

How and When Claims Are Paid

All payments for out-of-network treatment will be paid to the covered person as soon as Magellan receives satisfactory proof of loss, except in the following cases:

- If the covered person has financial responsibility under a court order for a dependent's medical care, Magellan will make payments directly to the provider.
- If the covered person requests in writing that payments be made directly to a provider. This is done when completing the claim form and assigning benefits to the provider.

Magellan pays benefits directly to in-network providers.

These payments will satisfy the plan's obligation to the extent of the payment.

Magellan will send an Explanation of Benefits (EOB) to the covered person. The EOB will explain how Magellan considered each of the charges submitted for payment. If any claims are denied or denied in part, the covered person will receive a written explanation.

Appeals

The covered person may appeal a utilization review decision or claim denial. The appeal process consists of two levels of review. Magellan has responsibility for the appeal process.

How to Appeal a Claim Decision

If you disagree with a utilization review determination or a claim determination, you can contact Magellan in writing to formally request an appeal. Your request should include:

- The patient's name and the identification number
- The date(s) of service(s)
- The provider's name
- The reason you believe the services should be covered and/or the claim should be paid
- Any documentation or other written information to support your request

Your appeal request must be submitted to Magellan within 180 calendar days after you receive the utilization review or claim denial decision.

Your appeal rights include the right to review the contents of your case file, to present evidence and testimony and to submit additional records or information.

If you are not satisfied with the first level appeal decision, you have the right to request a second level appeal. Your second level appeal request must be submitted to Magellan within 60 calendar days from receipt of the first level appeal decision.

Appeals Determinations

Pre-Service and Post-Service Appeals

You will be provided written or electronic notification of the decision on your appeal as follows:

For appeals of pre-service determinations, the first level appeal will be conducted and you will be notified of the decision within 15 calendar days from receipt of a request for review of a denied claim or request for authorization. If you request a second level appeal, the appeal will

be conducted and you will be notified of the decision within 15 calendar days from receipt of your request for review of the first level appeal decision.

For appeals of post-service determinations, the first level appeal will be conducted and you will be notified of the decision within 30 calendar days from receipt of a request for review of a denied claim or request for authorization. If you request a second level appeal, the appeal will be conducted and you will be notified of the decision within 30 calendar days from receipt of your request for review of the first level appeal decision.

For procedures associated with Urgent Care, see **Urgent Appeals that Require Immediate Action** below.

Urgent Appeals that Require Immediate Action

You may request an urgent appeal if your provider believes the appeal decision is urgently needed, or in the opinion of your provider, deciding your appeal within the standard timeframe could seriously jeopardize your life, health or ability to regain maximum function or cause you pain that cannot be adequately controlled.

The appeal does not need to be submitted in writing. You or your provider should call Magellan as soon as possible.

Magellan will provide you with a written or electronic determination within 72 hours following receipt of your request for review of the determination, taking into account the seriousness of your condition. If you request a second level appeal, the appeal will be conducted and you will be notified of the decision within 30 calendar days from receipt of your request for review of the first level appeal decision.

External Reviews

In addition to the appeal process through Magellan, if the denial decision involves medical judgment, you may have the right to an external review by an independent review organization (IRO). You must submit your request for an external review to Magellan within four (4) months of your receipt of Magellan’s final appeal decision.

Magellan will determine your eligibility for external review and provide notice of acceptance as follows: immediate verbal notice of acceptance for an urgent external review and written notice within five business days for a standard external review.
External appeals are not available for adverse benefit determinations pertaining to eligibility for coverage or other matters that do not require medical judgment.

Magellan assigns eligible external reviews to an IRO and provides the assigned IRO with all documents and information considered in the denial and internal appeal determinations. The IRO will notify you of its acceptance of the review and request any additional information needed and contact you directly to notify you of its decision (72 hours for urgent external

reviews and 45 days for standard external reviews). The IRO’s decision is final and binding. If the IRO’s decision conflicts with our decision on this matter, we will comply with the IRO’s decision by conducting a medical necessity review (admin and claims only), authorizing treatment or services, and/or reprocessing claims for payment, as applicable.

Neither the plan, Magellan nor the IRO will charge you for pursuing an external review. If you choose not to request an external review, the plan will not assert in any court proceeding that you failed to exhaust your administrative remedies because of that choice. If you do request an external review, the plan will not make any claim that you were late in filing a lawsuit due to the time it takes to complete the external review.

Urgent External Review

You may request an urgent external review, orally or in writing, whenever you are eligible for an urgent appeal, or in the opinion of your provider, deciding your external review within the standard timeframe for external review could seriously jeopardize your life, health or ability to regain maximum function, or the subject of review relates to an admission, availability of care, continued stay, or health care item or service for which you received emergency services and you have not been discharged from the facility at the time of your request.

Standard (non-urgent) External Review

Request for standard, non-urgent external review must be submitted in writing following the completion of the internal appeal process. A standard external review may be requested before the internal appeals are completed if Magellan fails to comply with requirements under applicable law regarding denials and appeals (unless the failure to comply was a minor error that is not likely to cause prejudice or harm to you and was for good cause or a situation beyond Magellan’s control.

Coordination of Benefits

Coordination of benefits applies when:

- A covered person has health coverage under this plan and one or more other plans.
- One of the plans involved will pay the benefits first: that plan is primary. The other plans will pay benefits next: those plans are secondary. The rules shown in this provision determine which plan is primary and which plan is secondary.
- Whenever there is more than one plan, the total amount of benefits paid in a plan year under all plans cannot be more than the allowable expenses charged for that plan year.
- Eligible In-Network Mental Health and Substance Abuse out-of-pocket costs for covered services will accumulate under the medical plan out-of-pocket maximum.

Definitions

“Other Plans” are any of the following types of plans which provide health benefits or services for medical care or treatment:

- Group policies or plans, whether insured or self-insured (this does not include school accident-type coverage)

- Group coverage through HMOs and other prepayment, group practice and individual practice plans
- Group-type plans obtained and maintained only because of membership in or connection with a particular organization or group
- Government or tax supported programs (not including Medicare or Medicaid)

"Primary Plan": A plan that is primary will pay benefits first. Benefits under that plan will not be reduced due to benefits payable under other plans.

"Secondary Plan": Benefits under a plan that is secondary may be reduced due to benefits payable under the plan that is primary.

"Allowable Expenses" means the necessary, reasonable and customary expense for health care when the expense is covered in whole or in part under at least one of the plans.

The difference between the cost of a private hospital room and the cost of a semi-private hospital room is not considered an allowable expense unless the patient's stay in a private hospital room is clinically necessary either in terms of generally accepted medical practice, or as defined in the plan.

When a plan provides benefits in the form of services, instead of a cash payment, the reasonable cash value of each service rendered will be considered both an allowable expense and a benefit paid.

How Coordination Works

When this plan is primary, it pays its benefits as if the secondary plan or plans did not exist. When this plan is a secondary plan, its benefits are reduced so that the total benefits paid or provided by all plans during a plan year, are not more than total allowable expenses.

Which Plan Pays First

When two or more plans provide benefits for the same covered person, the benefit payment will follow the following rules in this order:

1. A plan with no coordination provision will pay its benefits before a plan that has a coordination provision

2. The benefits of the plan which covers the person other than as a dependent are determined before those of the plan which covers the person as a dependent

3. The benefits of the plan covering the person as a dependent are determined before those of the plan covering that person as other than a dependent, if the person is also a Medicare beneficiary and both of the following are true:
    - Medicare is secondary to the plan covering the person as a dependent

- Medicare is primary to the plan covering the person as other than a dependent (example, a retired employee)

4. When this plan and the other plan cover the same child as a dependent of parents who are not separated or divorced, the benefits of the plan of the parent whose birthday falls earlier in a year are determined before those of the plan of the parent whose birthday falls later in that year. This is called the "Birthday Rule." The year of birth is ignored.

5. If both parents have the same birthday, the benefits of the plan which covered one parent longer are determined before those of the plan which covered the other parent for a shorter period of time.

6. If the other plan does not have a birthday rule, but instead has a rule based on the gender of the parent, and if, as a result, the plans do not agree on the order of benefits, the rule in the other plan will determine the order of benefits

7. If two or more plans cover a person as a dependent child of divorced or separated parents, benefits for the child are determined in this order:
   - First, the plan of the parent with custody for the child
   - Second, the plan of the spouse of the parent with custody of the child
   - Finally, the plan of the parent not having custody of the child

   However, if the specific terms of a court decree state that one of the parents is responsible for the health care expense of the child, and the entity obligated to pay or provide the benefits of the plan of that parent has actual knowledge of those terms, the benefits of that plan are determined first. The plan of the other parent shall be the secondary plan. This rule does not apply with respect to any claim for which any benefits are actually paid or provided before the entity has that actual knowledge.

8. If the specific terms of a court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the plans covering the child shall follow the order of benefit determination rules that apply to dependents of parents who are not separated or divorced.

9. If none of the above rules determines the order of benefits, the benefits of the plan which covered an employee, member or subscriber for the longer period are determined before those of the plan which covered that person for the shorter period.

Right to Exchange Information

In order to coordinate benefit payments, Magellan needs certain information about coverage under other plans. It may get needed facts from or give them to any other organization or person. Magellan need not tell, or get the consent of, any person to do this.

A covered person must give Magellan the information it asks for about other plans. If the covered person cannot furnish all the information Magellan needs, Magellan has the right to get this information from any source. If any other organization or person needs information to apply

its coordination provision, Magellan has the right to give that organization or person such information. Information can be given or obtained without the consent of any person to do this. If Magellan is unable to get the information it needs to coordinate benefit payments, this may impair the ability of Magellan to evaluate or process a claim and may be the basis for denying claims for benefits.

Right of Recovery

It is possible that Magellan pays benefits that should be paid by another plan or organization or person. Magellan may recover the amount paid from the other plan or organization or person.

It is possible that Magellan pays benefits that are in excess of what it should have paid. Magellan has the right to recover the excess payment.

Effect of Medicare and Government Plans

Medicare

When a covered person becomes eligible for Medicare, this plan pays its benefits in accordance with the Medicare Secondary Payer requirements of federal law.

When This Plan Pays Primary to Medicare

This plan pays primary to Medicare for covered persons who are Medicare-eligible if:

- Eligibility for Medicare is due to age 65 and the employee has “current active employment status” with the employer as defined by federal law and determined by the employer; or
- Eligibility for Medicare is due to disability and the employee has “current active employment status” with the employer as defined by federal law and determined by the employer; or
- Eligibility for Medicare is due to end stage renal disease (ESRD) under the conditions and for the time periods specified by federal law

When Medicare Pays Primary to this Plan

Medicare pays primary to this plan for covered persons who are Medicare eligible if:

- The employee is a retired employee
- Eligibility is due to disability and the employee does not have “current active employment status” with the employer as defined by federal law and determined by the employer
- Eligibility for Medicare is due to end stage renal disease (ESRD), but only after the conditions and/or time periods specified in federal law cause Medicare to become primary

Medicare Enrollment Requirements

When this plan is primary, and the covered person wants Medicare to pay after this plan, the covered person must enroll for Medicare Parts A and B. If the covered person does not enroll for Medicare when he or she is first eligible, the covered person must enroll during the special enrollment period which applies to that person when the person stops being eligible under this plan.

When Medicare is primary, benefits available under Medicare are deducted from the amounts payable under this plan, whether or not the person has enrolled for Medicare or receives benefits under Medicare. If Medicare pays first, the covered person should enroll for both Parts A and B of Medicare when that covered person is first eligible; otherwise, the expenses may not be covered by the plan or Medicare.

How This Plan Pays When Medicare Is Primary

If Medicare is primary, this plan pays benefits as described below. This method of payment only applies to those who are Medicare-eligible. It does not apply to any covered person unless that covered person becomes eligible under Medicare.

If the provider has agreed to limit charges for services and supplies to the charges allowed by Medicare (participating physicians), this plan determines the amount of covered expenses based on the amount of charges allowed by Medicare.

If the provider has not agreed to limit charges for services and supplies to the charges allowed by Medicare (non-participating physicians), this plan determines the amount of covered expenses based on the lesser of the following:

- The applicable out-of-network benefit shown in the **Schedule of Benefits**, or
- The amount of the limiting charge, as defined by Medicare.

This plan determines the amount payable without regard to Medicare benefits. Then this plan subtracts the amount payable under Medicare for the same expenses from the amount payable under the plan. This plan pays only the difference between plan benefits and Medicare benefits.

The amount payable under Medicare which is subtracted from this plan's benefits is determined as the amount that would have been payable to a Medicare-eligible covered under Medicare even if:

- The person is not enrolled for Medicare Parts A and B. Benefits are determined as if the Medicare-eligible person were covered under Medicare Parts A and B.
- The expenses are paid under another employer's group health plan which is primary to Medicare. Benefits are determined as if benefits under that other employer's plan did not exist.
- The person is enrolled in a Health Maintenance Organization (HMO) or Competitive Medical Plan (CMP) to receive Medicare benefits, and receives unauthorized services

(out-of-plan services not covered by the HMO/CMP). Benefits are determined as if the services were authorized and covered by the HMO/CMP.

Termination of Coverage

Employee & Dependent Coverage

Coverage ends on the earliest date below:

- the last day of the Month in which premium has been paid or your employment with the County ends
- the date the plan ends
- the last day of the Month in which premium has been paid or you stop making the required contributions
- the last day of the Month in which premium has been paid or you are no longer eligible

Mental Health Parity and Addiction Equity Act of 2008

Under a Federal law known as the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, as amended ("HIPAA"), group health plans must generally comply with the requirement listed below. However, the law also permits local governmental employers that sponsor health plans to elect to exempt a plan from these requirements for any part of the plan that is "self-funded" by the employer, rather than provided through a health insurance policy. Maricopa County has elected to exempt the Maricopa Benefits Plan from the following requirement:

Parity in the application of certain limits to mental health benefits. Group health plans (of employers that employ more than 50 employees) that provide both medical and surgical benefits and mental health or substance use disorder benefits must ensure that financial requirements and treatment limitations applicable to mental health or substance use disorder benefits are no more restrictive than the predominant financial requirements and treatment limitations applicable to substantially all medical and surgical benefits covered by the plan.

The exemption from these Federal requirements started with the 2010-11 Plan Year. The exemption will be in effect for the current plan year beginning July 1 through June 30, 2021. The election may be renewed for subsequent plan years.

HIPAA also requires the plan to provide covered employees and dependents with a "certificate of creditable coverage" when they cease to be covered under the plan. There is no exemption from this requirement. The certificate provides evidence that you were covered under this plan, because if you can establish your prior coverage, you may be entitled to certain rights to reduce or eliminate a preexisting condition exclusion if you join another employer's health plan, or if you wish to purchase an individual health insurance policy.

Glossary

BEHAVIORAL HEALTH TREATMENT

Behavioral health treatment is treatment for any of the following:

- Any condition which is identified on Axis I in the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM), including a psychological and/or physiological dependence or addiction to alcohol or psychoactive drugs or medications, regardless of any underlying physical or organic cause,
- Any sickness where the treatment is primarily the use of psychotherapy or other psychotherapeutic methods, and
- Applied Behavioral Analysis (ABA) for a primary diagnosis of Autism Spectrum Disorder (ASD)

Behavioral health treatment does not include treatment of (i) conditions listed as V codes on Axis I of DSM), (ii) conditions that are merely an expectable response to a particular event (for example, the death of a loved one), or (iii) conditions that cannot be expected to improve significantly through clinically necessary and appropriate therapy.

All inpatient services, including room and board, given by a residential treatment center or area of a hospital which provides mental health or substance abuse treatment for a sickness identified in the DSM, are considered behavioral health treatment, except in the case of multiple diagnoses.

If there are multiple diagnoses, only the treatment for the sickness which is identified in the DSM and which is provided by a physician or licensed counselor is considered behavioral health treatment.

Prescription drugs are not considered behavioral health treatment.

COVERED PERSON

The employee and eligible dependents who are covered under this plan.

CUSTODIAL CARE

Services and supplies furnished to a person mainly to help him or her in the activities of daily life. This includes board and room and other institutional care. The person does not have to be disabled. Such services and supplies are custodial care without regard to:

- by whom they are prescribed; or
- by whom they are recommended; or
- by whom or by which they are performed.

EMERGENCY CARE

Immediate behavioral health treatment when the lack of the treatment could reasonably be expected to result in the patient harming himself or herself and/or other persons.

EMPLOYEE

A person on the payroll of the employer and regularly scheduled to work at least 20 hours per week, an elected official, or a contract employee whose contract specifies benefit eligibility.

EMPLOYER

Maricopa County

HEALTHCARE PROVIDER

A licensed or certified provider other than a physician whose services Magellan must cover due to a state law requiring payment of services given within the scope of that provider's license or certification.

HOSPITAL

An institution which is engaged primarily in providing medical care and treatment of sick and injured persons on an inpatient basis and which fully meets one or more of the following three tests:

It is accredited as a hospital by the Joint Commission on Accreditation of Healthcare Organizations

It is approved by Medicare as a hospital It

meets all the following tests:

- It maintains on the premises diagnostic and therapeutic facilities for medical diagnosis and treatment of sick and injured persons by or under the supervision of a staff of duly qualified physicians
- It continuously provides on the premises 24-hour-a-day nursing service by or under the supervision of registered graduate nurses
- It has at least one physician available 24 hours a day
- It is not mainly a place for rest, for the aged, for drug addicts, for alcoholics, or a nursing home.

IN-NETWORK PROVIDER

A health care provider, such as a hospital, physician, or treatment center which participates in the Magellan network by contract or letter of agreement.

INTENSIVE OUTPATIENT TREATMENT

Care that is delivered on an intense, structured basis over the course of a week in an environment that is less intensive than inpatient care, but more intensive than outpatient care. Intensive outpatient programs provide planned, structured services in which the patient can participate of at least 2 hours per day and 3 days per week, although some patients may need to attend less often. The services, which are offered to address a mental or substance abuse

related disorder, may include group, individual, family, or multi-family group psychotherapy, psycho-educational services, and adjunctive services such as medical monitoring.

LICENSED COUNSELOR

A person who specializes in behavioral health treatment and is a licensed professional counselor (LPC), licensed clinical social worker (LCSW), or licensed marriage and family therapist by the appropriate authority.

MEDICARE

The Health Insurance for the Aged and Disabled Program under Title XVIII of the Social Security Act.

OUT-OF-NETWORK PROVIDER

A health care provider, such as a hospital, physician, or treatment center which does not participate in the Magellan network through a contract or letter of agreement.

PARTIAL HOSPITALIZATION

Structured and medically supervised day, evening, and/or night treatment programs provided to patients at least 4 hours per day. Partial Hospitalization programs are available at least 3 days per week, although some patients may need to attend less often. The services are essentially the same in nature and intensity, including medical and nursing services, as provided in a Hospital except that the patient is in the program less than 24 hours per day.

PHYSICIAN

A legally qualified Doctor of Medicine (M.D.) or Doctor of Osteopathy (D.O.) who has completed a psychiatric residency program accredited by the Accreditation Council for Graduate Medical Education for Psychiatry or the American Osteopathic Association or who is board-certified in a primary care specialty (Internal Medicine, Family Practice, Pediatrics, or Obstetrics-Gynecology), and experience working with substance abuse patients.

POST-SERVICE DETERMINATIONS

Post-service claims are determinations that are made after behavioral health treatment has been received.

PRE-SERVICE DETERMINATIONS

Pre-service claims are determinations that are made prior to receipt of behavioral health treatment, where notification or approval is required prior to receipt of such treatment.

PSYCHOLOGIST

A person who specializes in clinical psychology and fulfills at least one of these requirements:

- A person licensed or certified as a psychologist.
- A member or Fellow of the American Psychological Association, if there is no government licensure or certification required.

RESIDENTIAL TREATMENT CENTER

A facility which provides a program of effective behavioral health treatment and meets all the following requirements:

- It is established and operated in accordance with applicable state law It provides a highly-structured program of behavioral health diagnosis and treatment approved by a physician and Magellan and monitored by a physician
- It has or maintains a written, specific and detailed regimen requiring regular, full- time residence and full-time participation by the patient
- It has 24-hour medical care availability and on-site nursing services

It provides at least the following basic services:

- Room and board
- Evaluation and diagnosis
- Counseling
- Referral and orientation to specialized community resources

URGENT CARE DETERMINATIONS

Urgent care determinations are determinations on requests for coverage of emergency care for which the application of the time periods for making non-urgent care determinations could seriously jeopardize the life or health of the patient or the ability of the covered person to regain maximum function.

UTILIZATION REVIEW

This is a review and determination as to the clinical necessity of services and supplies.