DEPARTMENT OF
BUDGET & MANAGEMENT
Employee Benefits Division

FORM TO REQUEST DOCIMENTATION FROM AN EMPLOYER-SPONSERD HEALTH PLAN OR AN INSURER CONCERNING TREATMENT LIMITATION

Background: This is a tool to help you request information from your employer-sponsored health plan or your insurer regarding limitations that may affect your mental health or substance use disorder benefits. You can use this form to request general information about coverage limitations or specific information about limitations that may have resulted in denial of your benefits. Your plan is required by law to provide you this information in certain instances, and the information will help you determine if the coverage you are receiving complies with the law.

Under a federal law called the Mental Health Parity and Addiction Equity Act, many health plans must make sure that there is "parity" between mental health and substance use disorder benefits, and medical and surgical benefits. This generally means that coverage limits applied to mental health and substance use disorder benefits can't be more restrictive than the coverage limits applied to medical and surgical benefits. In other words, coverage limits cannot be applied to mental health and substance use disorder benefits unless those limits are comparable to limits applied to medical and surgical benefits. The types of limits covered by parity protections include:

- Financial requirements – such as deductibles, copayments, coinsurance, or out-of-pocket limits;
- Treatment limits – such as limits on the number of days or visits covered, or other limits on the scope or duration of treatment (for example, being required to get prior authorization)

If you, a family member, or someone you are representing obtains health coverage through a private employer health plan, federal law requires the plan to provide certain plan documents about your benefits, including coverage limitations on you benefits, at your request. For example, you may want to obtain documentation as to why your health plan is requiring pre-authorization for visits to a therapist before it will cover the visits. Generally, the plan must provide the documents you request within thirty (30) calendar days of the plan's receipt of your request.

(OMB Control Number 1210-0138)

This for will help you request information from your plan about treatment limits. Many common types of treatment limits are listed on this form. If the type of treatment limit being imposed by your plan is not on the list, you may insert a description of the treatment limit you would like more information about under "Other."

Instructions:

Complete the attached form to request general information from your plan about coverage limitations or specific information about why your mental health or substance use disorder benefits were denied. This information can help you appeal a claim denial. You do not have to use this form to request information from your plan.

If you have any questions about this form and you are enrolled in a private employer health plan, you may visit the Employee Benefits Security Administration's (EBSA's) Website at www.dol.gov/ebsa for answers to common questions about your private employer health plan. You may also contact EBSA electronically at www.askebsa.dol.gov or call toll few 1-866-44-3272.

You can also use this form if you are enrolled in coverage other than through a private employer health plan, for example if you have individual health coverage or coverage sponsored by a public sector employer, like a city or state government. You may contact the centers for Medicare & Medicaid Services at phig@cms.hhs.gov or 1-877-267-2323 ext. 6-1565 for questions about your individual health coverage or public sector health plan.

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMC control number for this information collection is 1210-0138, which expires on XX XX, 20XX. The time required to complete this information collection is estimated to average 5 minutes per response, including the time to review instructions, gather necessary data, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.orp@dol.gov and reference the OMB Control Number 1210-0138

FORM TO REQUEST DOCIMENTATION FROM AN EMPLOYER-SPONSERD HEALTH PLAN OR AN INSURER CONCERNING TREATMENT LIMITATION

Date: _____

Mental Health and Substance Use Disorder Parity Disclosure Request

To: _____
(Name of health plan or issuer)

(If you are a provider or another representative who is authorized to request information for the individual enrolled in the plan, complete this section.)

I am an authorized representative requesting information for the following individual enrolled in the plan: _____

(Check the box to indicate whether your request is for general information or specific information related to your claim or denial for benefits)

General information

- ☐ I am requesting information on the plan's limitations related to coverage for :
  - ☐ Mental health and substance use disorder benefits, generally.
  - ☐ The following specific condition or order: _____.

Claim/Denial Information Request

- ☐ I was notified that a claim for coverage of _____ [Insert mental health condition or substance use disorder] was, or may be, denied or restricted for the following reason[s]:

(Check all that apply)

- o I was advised that the treatment was not medically necessary.
- o I was advised that the treatment was experimental or investigational.
- o The plan requires authorization before it will cover the treatment.
- o The plan is requiring me to try a treatment that is lower in cost before authorizing the treatment that my doctor recommends.
- o The plan will not authorize any more treatments based on the fact that I failed to complete a prior course of treatment.
- o The plan's prescription drug formulary design will not cover the medication my doctor is prescribing
- o My plan covers my mental health or substance use disorder treatment, but does not have any reasonably accessible in-network providers for my mental health and/or substance use disorder related treatment.

- I am not sure the methods my plan uses to calculate payment for out-of-network service, such as its methods for determining usual, customary and reasonable charges, complies with parity protections.
- Other: *(Specify basis for denial of, limitation on, reduction in coverage):*
  _____
  _____
  _____

Because my health coverage is subject to the parity protections, coverage limits cannot be applied to mental health and substance use disorder benefits unless those limits are comparable to limits applied to medical and surgical benefits. Therefore, for the limitations or terms of the benefit plan specified above, within thirty (30) calendar days of the date of this request, I request that the plan:

1. Provide the Specific plan language regarding the limitation and identify all of the medical/surgical and mental health and substance use disorder benefits to which it applies in the relevant benefit classification;
2. Identify the factor used in the development of the limitation and the evidentiary standards used to evaluate the factor;
3. Identify the methods and analysis used in the development of the limitation; and
4. Provide any evidence to establish that the limitation is applied no more stringently, as written and in operation, to mental health and substance use disorder benefits that to medical and surgical benefits.

_____

Printed Name of Individual Enrolled in the Plan or his or her Authorized Representative

_____

Signature of Individual Enrolled in the Plan or his or her Authorized Representative

_____

Member Number (number assigned to the enrolled individual by the plan)

_____

Address

_____

Date

Submit completed form to:
Employee Benefits Division
Attn: Compliance Manager
301 West Preston Street – Room 510
Baltimore, MD 21201