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

You need to get Plan approval for services and follow a treatment plan we approve in order to get benefits. When you receive services as part of an approved treatment plan, cost-sharing and limitations for Plan mental health and substance abuse benefits are 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.
- If you are utilizing In-Network providers, it is their responsibility to preauthorize any hospital stays. If you utilize our National Network or an Out-of-Network provider it is **YOUR RESPONSIBILITY TO PREAUTHORIZE** any hospital stays.
- **Under Standard Option,** there is no calendar year deductible and you must use In-Network providers in order to receive benefits.
- **Under High Option,** the calendar year deductible for In-Network Providers is $500 per person ($1,000 per family). The calendar year deductible for Out-of-Network Providers is $1,000 per person ($3,000 per family). Deductibles for In-Network providers and Out-of-Network providers are accumulated separately. The calendar year deductible applies to almost all benefits in this Section. The phrase "(No deductible)" is used to show when the calendar year deductible does not apply.
- 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 THESE SERVICES.** Benefits are payable only when we determine the care is clinically appropriate to treat your condition and only when you receive the care as part of a treatment plan that we approve. The treatment plan may include services, drugs, and supplies described elsewhere in this brochure. To be eligible to receive full benefits, you must follow the preauthorization process and get Plan approval of your treatment plan.
- We will provide medical review criteria or reasons for treatment plan denials to enrollees, members or providers upon request or as otherwise required.
- OPM will base its review of disputes about treatment plans on the treatment plan's clinical appropriateness. OPM will generally not order us to pay or provide one clinically appropriate treatment plan in favor of another.

Benefit Description	You Pay After the calendar year deductible…	
Note: The calendar year deductible applies to almost all benefits in this Section. We say "(No deductible)" when it does not apply.		
Professional services	**High Option**	**Standard Option**
When part of a treatment plan we approve, we cover professional services by licensed professional mental health and substance abuse practitioners when acting within the scope of their license, such as psychiatrists, psychologists, clinical social workers, licensed professional counselors, or marriage and family therapists.	Your cost-sharing responsibilities are no greater than for other illnesses or conditions.	

Benefit Description	You Pay After the calendar year deductible…	
Professional services (continued)	**High Option**	**Standard Option**

Diagnosis and treatment of psychiatric conditions, mental illness, or mental disorders. Services include: • Diagnostic evaluation • Crisis intervention and stabilization for acute episodes • Medication evaluation and management (pharmocotherapy) • Psychological and neuropsychological testing necessary to determine the appropriate psychiatric treatment • Treatment and counseling (including individual or group therapy visits) • Diagnosis and treatment of alcoholism and drug abuse, including detoxification, treatment and counseling • Professional charges for intensive outpatient treatment in a provider's office or other professional setting • Electroconvulsive therapy	$20 copayment for a primary care physician (No deductible) $20 copayment for a specialist physician (No deductible)	$20 copayment for a primary care physician (No deductible) $20 copayment for a specialist physician (No deductible)
Diagnostics	**High Option**	**Standard Option**
• Outpatient diagnostic tests provided and billed by a licensed mental health and substance abuse practitioner • Outpatient diagnostic tests provided and billed by a laboratory, hospital or other covered facility • Inpatient diagnostic tests provided and billed by a hospital or other covered facility	$20 copayment for a primary care physician (No deductible) $20 copayment for a specialist physician (No deductible) $100 copayment (No deductible) Nothing	$20 copayment for a primary care physician (No deductible) $20 copayment for a specialist physician (No deductible) $100 copayment (No deductible) Nothing
Inpatient hospital or other covered facility	**High Option**	**Standard Option**
Inpatient services provided and billed by a hospital or other covered facility • Room and board, such as semiprivate or intensive accomodations, general nursing care, meals and special diets, and other hospital services	$100 copayment (no deductible)	$200 copayment
Outpatient hospital or other covered facility	**High Option**	**Standard Option**
Outpatient services provided and billed by a hospital or other covered facility • Services in approved treatment programs, such as partial hospitalization, half-way house, residential treatment, full-day hospitalization, or facility-based intensive outpatient treatment	$100 copayment (no deductible)	$200 copayment