Your Behavioral Health Benefits from MHN
Welcome to MHN

This is a high-level summary only. Please call MHN or refer to your plan documents (Summary Plan Description, Evidence of Coverage, or your employer’s Group Services Agreement) for details about your benefits and terms of coverage. If there is ever a discrepancy between this member summary and your official plan documents, the terms of the official plan documents prevail.

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Call us for assistance!

Everyone needs help sometimes. That’s why we’re here – 24 hours a day, seven days a week. If you need mental health services or substance use disorder treatment, we’ll help you find the right care.

Call the MHN number listed on your ID card, or call 1-888-327-0010, and we will:

• Provide help right away if there’s a crisis or emergency.
• Find out your needs and suggest an MHN provider for you.
• Help you secure an appointment (within 48 hours if urgent or, if not urgent, within 10 business days).
• Answer questions about your benefits.
Your behavioral health benefits

Your MHN behavioral health plan covers medically necessary mental health services and substance use disorder treatment. Benefits generally include:

- Sessions with counselors, psychiatrists or psychologists.
- Treatment in settings that meet your medical needs – from care for a few hours per day, several days a week (referred to as “alternate levels of care”), to 24-hour care (referred to as “inpatient treatment”).
- Treatment follow-up and aftercare.

MHN does not provide or administer prescription drug or pharmacy benefits. Please consult your medical plan documents or your medical plan’s website for information about your prescription drug coverage.

Please call MHN or refer to your official plan documents (Summary Plan Description or Evidence of Coverage), or your employer’s Group Services Agreement for details about:

- Who is eligible for plan benefits (usually full-time employees and their dependents).
- What services require preauthorization.
- What services are covered when you use a MHN network provider.
- What services are covered when you use a provider who’s not in our network (some plans only cover in-network services).
- Your out-of-pocket costs.
- Benefit exclusions and limitations.

Choosing a provider

Finding a participating counselor, psychologist or psychiatrist is easy.

- We can help find a provider for you. Just call and tell us what kind of help you need.
- Or, try the provider search on MHN’s member website (www.members.mhn.com). You don’t need authorization for outpatient office visits, but please call us to let us know who you are going to see.

Some plans also cover visits with providers who are not in our network. However, we recommend using a network provider whenever possible. When you do:

- Your portion of the cost is usually much lower.
- You know the provider meets high standards of education, training and experience.
- If you have any problems with the provider, MHN can step in to help.
- There are no claims to file.
Review and authorization processes

We support your behavioral health providers’ efforts to deliver the best possible outcomes by collaborating with them to identify effective treatment plans and by following fair and consistent review, authorization, and (if necessary) modification or denial processes, as described below.¹

Review and authorization

MHN provides coverage for medically necessary treatment of mental health and substance use disorder illnesses. We use nationally recognized guidelines² to review clinical records and proposed treatment plans to see that:

- The level of care requested is appropriate based on your symptoms.
- The plan is based on clinical evidence and has a reasonable probability of providing a positive outcome.
- Long-term outcomes are considered.
- Treatment is prescribed for the least restrictive setting possible.

Upon review, at any stage, care may be authorized or approved, modified or denied. We use the following methods as part of this process:

Pre-service review and preauthorization

MHN requires preauthorization for the following:

- Psychological and neurological testing.
- Treatment that is more intense than routine outpatient visits but does not require an overnight stay (referred to as “alternate levels of care”).
- Treatment at a hospital or other overnight care facility (referred to as “inpatient treatment”), except in an emergency. (If you need emergency inpatient treatment, you or a family member or your doctor or hospital must call MHN within 24 hours of admission. We’ll make sure that your benefits are in place and assign a case manager to offer support.)

For these services, MHN reviews the proposed treatment before you receive care. If you have questions about whether or not you need preauthorization, please call MHN member services prior to scheduling treatment.

Concurrent review

An MHN care manager will review suggested inpatient treatment or alternate levels of care before you receive services and will review your care on a regular basis for the duration of your treatment. This is called “concurrent review,” and it is designed to ensure that patients are always receiving care in the most appropriate (least restrictive and most cost effective) setting.

¹ Not all plans require preauthorization or concurrent reviews for the same benefits or in the same circumstances. Always consult your plan documents for detailed benefit information, including a description of which benefits or services are subject to these processes.

² MHN bases all decisions on InterQual® Level of Care Criteria, the Centers for Medicare and Medicaid Services (CMS) National Coverage Determinations (NCDs) and Local Coverage Determinations (LCDs), and MHN internal criteria, as appropriate. MHN evaluates and adopts all criteria annually, including InterQual Level of Care Criteria; CMS’s NCD/LCD National and Local Coverage Determinations; and MHN criteria, including our level of care and treatment criteria, position statements, and standard definitions. MHN’s medical directors and peer reviewers review each case on its own merits and make an individualized, multi-factorial decision based on the appropriate level of care and treatment criteria.
Post-service review
When MHN is unable to perform pre-service or concurrent review – for example in an emergency – we will review treatment after it has occurred before approving benefits. Emergency care will be authorized as long as it meets the “prudent layperson standard” (a reasonable person with no clinical training would be likely to think, based on observing the symptoms, that emergency treatment was necessary).

Modifications and denials
Covered services will be authorized (pre-service or concurrently) as long as treatment is proceeding in a clinically appropriate manner. When we believe a requested service is not medically necessary or that a treatment plan should be reconsidered, we work with your provider to consider alternatives. We collaborate with your provider to resolve any differences in clinical judgment, and decisions are based on what is best for you, the patient, with consideration for your long-term needs. If we cannot approve services, we will send you a letter clearly explaining the reason for modification or denial and recommending alternatives.

Coverage for emergency room treatment for a non-emergency (based on the “prudent layperson standard” described above) may be denied. If denied, you will receive a letter explaining why.

As a member, you always have the right to appeal modification and denial decisions.

Our commitment to excellence
At MHN, we practice a patient-first clinical philosophy: Our goal is to ensure that all members receive appropriate care in a timely manner and that we only step in during treatment planning when we can add value.

MHN’s Clinical Leadership Committee meets regularly to review our clinical policies, practice guidelines, treatment position papers, and provider review methodology. This ensures that our clinical approaches are up to date and that we're working in concert with the treatment community to improve the mental well-being and quality of life of MHN’s members.

Member rights and responsibilities
As an MHN behavioral health plan member, you have a right to:

- Receive information about MHN services and clinical guidelines.
- Call MHN for assistance 24 hours a day, 365 days a year.
- Call 911 in an emergency.
- Ask questions about, and see documentation of, MHN network providers' credentials and experience.
- Receive prompt, competent and courteous treatment from all MHN staff and providers.
- Discuss appropriate or medically necessary treatment options, regardless of cost or benefit coverage, and obtain a clear explanation of MHN’s criteria for determining medical necessity.
• Rely on MHN to maintain the confidentiality of your medical records (to the extent protected by state and federal laws).
• Obtain an explanation regarding legally required exceptions to confidentiality.
• Receive a clear explanation from your MHN network provider about the recommended treatment plan and length of treatment.
• Participate in decision-making regarding your treatment.
• Refuse or terminate treatment at any time.
• Be treated with respect and recognition of your dignity and need for privacy.
• Receive an explanation from your provider of any consequences that may result from refusing treatment.
• Obtain a clear explanation of MHN’s reasons for determining that care is not medically necessary.
• Appeal a denial.
• File complaints with MHN, or the California Department of Managed Health Care or applicable State Department of Insurance, if you experience problems with MHN or your practitioner.
• Receive a complete explanation of your fees and charges.
• Suggest ways to improve MHN’s member rights and responsibilities policies and procedures.
• Receive a clear explanation of your financial responsibility when you use out-of-network providers.

As a member, it is your responsibility to:
• Share or give your provider permission to share medical information that may help MHN and/or your provider make informed treatment decisions.
• Actively participate in developing treatment goals and strategies for achieving them.
• Follow the treatment plans you have agreed upon with your provider.
• Cancel appointments within the guidelines described by MHN or your provider.
• Read the official plan documents outlining your behavioral health benefits.
• Ask questions to ensure your understanding of covered services, limitations and authorization procedures, and comply with the rules and conditions as stated.
• Pay any copayments at the time of service.
• Demonstrate courtesy and respect to your provider, the provider’s staff and MHN employees, and expect similar treatment in return.

We speak your language!
When you call MHN, free interpretation services are available in over 170 languages. We also contract with a vendor who can physically attend appointments with you, at no cost, if you need help communicating with doctors or other providers.
¡Hablamos su idioma!

Cuando llame a MHN, podrá usar nuestros servicios de interpretación gratuitos en más de 170 idiomas. Además, contamos con proveedores contratados que pueden asistir en persona a las citas con usted, sin cargo alguno, en caso de que necesite ayuda para comunicarse con los médicos u otros proveedores.

我們說您的語言！

您致電 MHN 時，我們可提供 170 多種語言的免費傳譯服務。我們還聘用了翻譯人員，如果您需要翻譯人員幫助您與醫生或其他醫療服務提供者進行交流，該翻譯人員可以與您一道參加約診，該服務為免費提供。

Appeals and grievances

Please contact MHN at the number listed in this brochure or at 1-888-327-0010 if you:

• Are not satisfied with the service, system or clinical care provided by MHN or its network providers.
• Wish to appeal a decision by MHN to deny a claim you filed.

You can also file an appeal or make a complaint online on MHN’s member website. To submit a complaint in writing, send your complaint to:

MHN
Appeals & Grievances
PO Box 10697
San Rafael, CA 94912

Within five business days of receiving your complaint, we will let you know (in writing) that we have received it and submit it for resolution to the appropriate department.

If you lose your health insurance

If you lose your insurance because you’ve lost your job or had your hours reduced, make sure you explore your options for continuation coverage. For example:

• Federal COBRA – Federal COBRA is a U.S. law that applies to employers and group health plans that cover 20 or more employees. It lets you keep your group health insurance when your job ends or your hours are cut. You have to pay the premium but you can keep your insurance for at least 18 months. To learn more about COBRA, contact your employer or visit the U.S. Department of Labor website.
• California plan members, please see below for information about Cal-COBRA.

Additional information for California plan members

MHN is a licensed California specialized health care service plan. The Department of Managed Health Care (“the Department”) is responsible for regulating health care service plans in California. The following information applies for California plan members only:

Evidence of Coverage and Disclosure

For a detailed description of your behavioral health benefits, please review your behavioral health care services Combined Evidence of Coverage and Disclosure Form (EOC), available through MHN or your benefits department. (If there is ever a discrepancy between this brochure or other member materials and the EOC, the terms of the EOC prevail.)
Cal-COBRA

Cal-COBRA is a California law that is like Federal COBRA (see above). Cal-COBRA applies to employers and group health plans that cover from 2 to 19 employees. It lets you keep your insurance for up to a total of 36 months.

Cal-COBRA is also for people who use up their Federal COBRA. When your 18 months of Federal COBRA ends, you can buy 18 more months of health insurance under Cal-COBRA.

To qualify, you must not be eligible for other group medical coverage or entitled to Medicare. If you think you may be eligible for Cal-COBRA, please contact MHN or your former employer. Or, visit MHN’s member website (www.members.mhn.com), complete the Cal-COBRA enrollment request form under “Benefit Overview,” and mail it to:

MHN
Attn: Membership Accounting – Cal-COBRA
PO Box 550
Rancho Cordova, CA 95741

Appeals and grievances

If you have a grievance against MHN, you should first call MHN at the number listed on your ID card or at 1-888-327-0010, and use MHN’s grievance process (described above).

You are encouraged to contact the Department for help if:

• You need help with a grievance involving an emergency.

• Your grievance remains unresolved for more than 30 days, and you have not been notified that additional time is required and informed of the reason for the delay.

• You are dissatisfied with the resolution you got through MHN’s grievance process.

The Department has a toll-free number (1-888-HMO-2219; 1-888-466-2219) to receive complaints, and a TDD line (1-877-688-9891) for the hearing and speech impaired. You may also be eligible for an Independent Medical Review or “IMR.” An IMR provides an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature, and payment disputes for emergency or urgent medical services.

Using the Department’s grievance process does not limit your legal rights or prohibit any legal remedies that may be available to you.

For online instructions, grievance forms and IMR application forms, visit the Department’s website at www.hmohelp.ca.gov.