Managed Behavioral Health in PPO100 and Keystone

Benefit Plan Summary for PPO100

Service	IBH Network	Non-Network	Pre-Certification
Inpatient Psychiatric Care	**100%**	▪ 80% of IBH allowable after $500 deductible (combined MH, CD, and medical) .	**Required through IBH for both network and non-network** 50% penalty for services provided by non-network providers w/o pre-authorization.
Mental Health (MH)- Outpatient Office Visits –Individual, Family, Group Counseling	**$20 co-pay**	▪ 80% of IBH allowable after $500 deductible (combined MH, CD, and medical) .	**Some services require Pre-Certification.**
Inpatient Chemical Dependence (CD)/Substance Abuse	**100%**	▪ 80% of IBH allowable after $500 deductible (combined MH, CD, and medical) .	**Required through IBH for both network and non-network** 50% penalty for services provided by non-network providers w/o pre-authorization.
Chemical Dependence (CD)/ Substance Abuse - Outpatient Office Visits – Individual, Family, Group Counseling	**$20 co-pay**	▪ 80% of IBH allowable after $500 deductible (combined MH, CD, and medical) .	**Some services require Pre-Certification.**

- **Treatment must be provided by a psychiatrist, psychologist, therapist or clinical social worker who is licensed to practice independently at the master's level or above.**
- **Laboratory work must be prescribed by a psychiatrist.**
- **Treatment must be delivered in a goal-oriented manner that produces observable and measurable improvement in the patient's condition.**

Benefit Plan Summary for Keystone Health Plan

Service	IBH Network	Non-Network	Pre-Certification
Inpatient Psychiatric Care	**100%**	No benefit	**Required through IBH**
Mental Health (MH)- Outpatient Office Visits –Individual, Family, Group Counseling	**$20 co-pay**	No benefit	**Some services require Pre-Certification.**
Inpatient Chemical Dependence (CD)/Substance Abuse	**100%**	No benefit	**Required through IBH**
Chemical Dependence (CD)/Substance Abuse - Outpatient Office Visits – Individual, Family, Group Counseling	**$20 co-pay**	No benefit	**Some services require Pre-Certification.**

- **Only inpatient services pre-certified by IBH and provided by network providers are covered. There is no benefit for non-network providers or for services not pre-certified.**
- **Treatment must be provided by a psychiatrist, psychologist, therapist or clinical social worker who is licensed to practice independently at the master's level or above.**
- **Laboratory work must be prescribed by a psychiatrist.**
- **Treatment must be delivered in a goal-oriented manner that produces observable and measurable improvement in the patient's condition.**

A Managed Behavioral Health Plan includes mental health and substance abuse treatment benefits. The behavioral health benefit included for this plan is provided by Integrated Behavioral Health (IBH). This plan is compliant with the Mental Health Parity and Equity Act of 2008 (MHPAEA) and Final Rules of 2013.

Plan features include:

- Use of IBH network providers results in lower copays, coinsurance and patient financial responsibility.
- National network of quality providers and facilities selected and credentialed by IBH.
- No need for patient submission of claim forms when IBH network providers are used.
- IBH network providers accept the plan payment as payment in full after the applicable copayment or deductible.
- All mental health services are subject to evidentiary standards of care and medical necessity.
- Some services require prior authorization, call IBH for care coordination.
- If treatment is needed call 800-395-1616 and IBH will provide referrals, case management, care coordination, and benefit questions for your behavioral health plan.

Certain services are still required to be pre-authorized; contact IBH with any questions.

Pre-authorization of all behavioral health services including initial outpatient care with a psychiatrist, psychologist or therapist is highly recommended. Pre-authorization of behavioral health services will insure medical necessity criteria are met and retrospective review will be limited. All care is subject to eligibility, plan definitions, limitations, exclusions, and are payable when determined by IBH as medically necessary and appropriate.

Inpatient and Program based Mental Health Benefits:

To find an in-network facility, contact Integrated Behavioral Health at 800-395-1616. The benefit may allow you to choose services through an out-of-network facility, but you may have to pay a larger portion of the costs, and subject to prior authorization and concurrent review.

Pre-authorization is required for all inpatient, partial hospitalization, residential, and any program based care. You or your provider may call an IBH care manager at 800-395-1616 to obtain preauthorization prior to starting any intensive treatment program.

Outpatient Mental Health Benefits:

All outpatient care falling within outlier categories, requires the provider to submit documentation for review of medical necessity, evidentiary based treatment, and appropriateness of care.

The following outpatient evaluations or treatments require authorization before commencing:

- Psychological testing
- Group therapy

- Outpatient Electroconvulsive Therapy (ECT)
- Transcranial Magnetic Stimulation (TMS)
- Or any service determined as an outlier.

The benefit may allow you to choose services through either an IBH network provider or a non-network provider. Non-network providers must be independently licensed and still must follow plan requirements of submitting documentation of evidentiary standards and medically necessary care. Call IBH to determine if a non-network provider is eligible for coverage under your plan.

While there are no treatment visit or hospital day limits in the benefit plan, all claims for treatment (including those delivered before any pre-authorization) are subject to review for medical necessity and appropriateness of care by IBH.

All claims are subject to benefit eligibility as well as plan exclusions and limitations at time of service.

Services Not Included in the Managed Behavioral Health Plan in PPO100 or Keystone HMO:

1. Services performed by the patient on him/herself or performed by immediate family, or an individual residing in the same household, including but not limited to a spouse, child, brother, sister, parent, or the spouse's parent, even if that individual is a qualified provider.
2. Services provided by someone not licensed by the state to treat the condition for which the claim is made and to independently bill fee for service and/or not trained or experienced to treat a specific condition under review.
3. Extended hospital, residential or program related stays that are unrelated to medically necessary and approved treatment.
4. Services furnished by or for the U.S. government, Federal and state funded agency or foreign government, unless payment is legally required.
5. Treatment that is of an experimental or educational nature. Procedures which are experimental, investigational, or unproven. Therapies and technologies whose long-term efficacy or effect is undetermined, or whose efficacy is no greater than that of traditionally accepted standard treatment.
6. Services applied under any government or publicly funded program or law under which the individual is covered.
7. Services for which a third-party is liable.
8. New procedures, services, and medication until they are reviewed for safety and efficacy, through accepted evidentiary review.
9. Services that are primarily to assess or address neurodevelopmental disorders are to be considered as medical conditions and as such not covered under the mental health benefits. With the exception of Attention Deficit/ Hyperactivity disorder, and Tic disorders which are covered by the mental health portion of the plan.
10. Custodial care or supportive counseling, including care for conditions not typically resolved by treatment.
11. Alternative treatment methods that do not meet national standards for behavioral

health practice, including but not limited to: regressive therapy, aversion therapy, neurofeedback or neuro-biofeedback, hypnotherapy, acupuncture, acupressure, aromatherapy, massage therapy, reiki, thought-field energy, art or dance therapy.

12. Services not medically necessary. All services must be medically necessary. The fact that a physician or other provider may prescribe, order, recommended, or approve a service or supply does not, in itself, make it medically necessary, even though it is not specifically listed as an exclusion or limitation.

13. Court-ordered treatment. If a participant is currently in a course of treatment that is confirmed as being required by a court, the treatment may be considered only as long as it is medically necessary.

14. Psychological or neuropsychological testing, unless specifically pre-certified by IBH.

15. Inpatient treatment for co-dependency, gambling and sexual addiction.

16. Treatment primarily for chronic pain management or neuropsychological rehabilitation.

17. Treatment primarily for the convenience of the patient or provider.

18. Treatment provided primarily for medical or other research.

19. Charges for services, supplies or treatments which are primarily educational in nature; charges for services for educational or vocational testing or training and work hardening programs regardless of diagnosis or symptoms; charges for self-help training or other forms of non-medical self-care.

20. Charges primarily for marriage, career, or legal counseling, mediation, or custody related services.

21. Treatment of sexual dysfunction not related to organic disease. Sex therapy.

22. Services provided if covered individual would not legally have to pay for them if the covered individual were not covered by the Plan or any other medical plan, to the extent that exclusion of charges for such services is not prohibited by law or regulation.

23. Assessment or treatment related to sex change procedures.

24. Evaluation or services not required for health reasons, including but not limited to employment, insurance or government licenses, and court ordered, forensic, or custodial evaluations.

25. Charges for obtaining medical records or completing a treatment report, and late payment charges.

26. Methadone maintenance.

27. Speech and language evaluations or speech therapy.

28. Charges for failure to keep a scheduled visit, charges for completion of a claim form.

29. Therapy or treatment intended primarily to improve or maintain general physical condition or for the purpose of enhancing job, school, athletic or recreational performance.

30. Expenses for pastoral counseling, marriage therapy, music or art therapy, assertiveness training, social skills training, recreational therapy, stress management, or other supportive therapies.

31. Long-term treatment at a residential treatment facility, or long term rehabilitation therapy.

32. Smoking cessation programs not covered under the medical plan.

33. Therapeutic foster care, group home, halfway or three-quarter houses, residential/therapeutic schools, camps.

34. Any treatment or condition excluded by
the medical Plan.

How Managed Behavioral Health Plan Claims Are Paid:
Network services require no claim forms. IBH will pay your provider directly. You are responsible for paying coinsurance, copay, or deductible that may apply.

If you use a non-network provider, either you or the provider must submit a claim form and you are responsible for paying the balance of the provider's outpatient or inpatient mental health or substance abuse charges, after the IBH payment of the non-network benefit based on the IBH allowable rate. The IBH allowable rate is the rate for the IBH fee schedule for specific network services. Remember if you use non-network providers, your financial responsibility, the amount you pay, for non-network mental health or substance abuse care is higher and is based on the IBH allowable rate. Claims may be mailed to:

Integrated Behavioral Health
Claims Department
P.O. 30018
Laguna Niguel, CA 92607-0018

How to File a Managed Behavioral Health Plan Appeal:
For purposes of the appeal procedure, a mental health or substance abuse claim appeal includes any request for benefits or authorization that is denied either in part or in whole. You or your provider may appeal a claim or other adverse benefit decision directly to IBH. The appeal must be submitted to:

Integrated Behavioral Health
Quality Management—Appeals
P.O. Box 30018
Laguna Niguel, CA 92607-0018

Appeals Process:
Policy: Integrated Behavioral Health shall offer an appeals process for both members and providers. Such policy shall include reasonable efforts to resolve concerns and disagreements prior to a formal appeal process through collegial and non-adversarial means. The appeals process is consistent with ERISA guidelines.

Procedures: IBH provides an appeal process for members, providers and employers/health plans hereinafter referred to as claimant. This appeal process is available for any adverse benefit decision and/or when disagreements occur regarding decisions or potential decisions about authorizations for proposed treatment, claims payments, or treatment reviews. When such adverse benefit decisions or disagreements occur, the member, provider or employer/health plan may request reconsideration by phone or mail. A Senior Care Manager or supervisor

responds to this Request for Reconsideration immediately. The response is communicated by phone and mail. Facsimile is used when issues are urgent.

Should this reconsideration process fail to satisfy the issue, the claimant may submit a formal appeal for review. This Level 1 Appeal may be a written request or telephonic. It is responded to within the timeframes outlined below for the particular type of claim. A clinical person, with appropriate expertise, and other than the care manager who effected the denial must conduct the appeal review. Such clinician may not be supervised by the initial reviewer. The response is communicated by phone and mail. Facsimile is used when issues are urgent.

External Review Option: If the appealing party continues to be dissatisfied, a second level appeal can be requested in writing or telephonically and is conducted by an external clinical person with appropriate expertise. This decision is also provided within the timeframes outlined below for the particular type of claim. The providers and members are informed by mail or facsimile, depending on the urgency.

All protected health information shall be managed within HIPAA regulations and within other federal law and regulations specific to confidentiality of behavioral health medical data.

Timeframes: *Expedited/Urgent Care Claims*

Initial Claim Response Timeframe:	48 Hours
Request Missing Info from Claimant:	24 Hours
Claimant to Provide Missing Info:	48 Hours
Claimant to Request Appeal:	180 days
Appeal Response Timeframe:	72 Hours

Pre-Service Health Care Claims

Initial Claim Response Timeframe:	15 Days
Extension (Proper Notice/Delay Beyond Plan Control):	15 Days
Request Missing Info from Claimant:	5 Days
Claimant to Provide Missing Info:	50 Days
Claimant to Request Appeal:	180 Days
Appeal Response Timeframe:	30 Days

Post-Service Health Care Claim

Initial Claim Response Timeframe:	30 Days
Extension (Proper Notice/Delay Beyond Plan Control):	15 Days
Request Missing Info from Claimant:	30 Days
Claimant to Provide Missing Info:	50 Days
Claimant to Request Appeal:	180 Days

Appeal Response Timeframe: 60 Days

<u>Additional Claimant Rights</u>:

The claimant is entitled to receive, free of charge, and have access to all relevant documents and information relied upon in making the claim determination.

Once you have completed all mandatory appeals, you and your plan may have other voluntary alternative dispute resolution options. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency.

Under ERISA Section 502(a)(I)(B), you have the right to bring a civil action. This right can be exercised when all required reviews of your claims, including the appeal process, have been completed, your claim was not approved, in whole or in part, and you disagree with the outcome.

The above-described Appeal Process is subject to all applicable State and Federal laws and regulations.