State of Michigan

Mental Health & Substance Abuse Information Guide

Magellan BEHAVIORAL OF MICHIGAN℠

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Magellan Behavioral of Michigan, Inc. (hereinafter "Magellan") is dedicated to providing the resources you and your covered dependents need should you require mental health or substance abuse services. This program is designed to help you maintain a balanced, functioning work and personal life. It focuses on early intervention and the appropriate use of your benefits. Your privacy is important to us.

Introduction

Welcome to your mental health and substance abuse program for participants and their dependents covered by the State of Michigan under the State Health Plan.

Many people may be uncertain about how to obtain help or services they need for a mental health or substance abuse problem. If you or a covered dependent has a need, Magellan is here to help. Our easy to use, confidential program addresses personal and workplace issues as well as mental health and substance abuse problems. Our provider network has a broad range of experienced professionals, programs and facilities to meet your needs.

It's important to seek help when you first need it, when problems are easier to resolve. Timely care can help you resume a healthy and productive life.

Magellan's professional staff is dedicated to providing you with easy access to quality, compassionate, and confidential services when you need it most.

How to Use Your Information Guide

This guide explains and describes available services, provides information on how to access and use these services, and explains special procedures.

If you have any questions or concerns you can call us at any time day or night. Call our toll-free help line at 1-866-503-3158.

If you need language assistance, please call this toll-free number, and we will arrange for an interpreter. Persons with hearing impairments may call Magellan using the FCC Telecommunications Relay Services (711).

How to Use Magellan's Toll-Free Help Line

Our toll-free Help Line is your connection to services. All mental health and substance abuse services may be accessed through the Magellan Help Line. You can call when you need help or information on any of the following:

- Referral to a mental health or substance abuse provider to obtain maximum benefit coverage and lower out-of-pocket costs;
- Preauthorization of mental health and substance abuse care;
- Emergency assistance anytime, day or night or
- General information about the program, eligibility, benefits, and specific services.

We're available 24 hours a day

Call toll-free at 1-866-503-3158

Steps for How to Obtain Services

Access is Quick and Easy

Step 1. When you call 1-866-503-3158, a Magellan customer service representative will answer and ask you some general questions to determine what level of service or care is needed and to verify your identity.

Step 2. Depending on your need, the Magellan representative will direct your call to an appropriate care manager for a referral, pre-authorization, or emergency services.

Step 3. Magellan care managers are experienced mental health and substance abuse professionals who help to assess your situation and ensure you or your eligible dependent receive the right type of assistance or care.

Step 4. Using Magellan's referral system, the care manager will match your needs with an experienced mental health and substance abuse provider and coordinate your care.

Step 5. Should your care manager assess your problem and determine that mental health or substance abuse services is necessary, you will be referred to a provider that is matched to your specific needs. The care manager will coordinate and guide all of your in-patient and out-patient, mental health and substance abuse care.

Step 6. Should you need emergency services, your care manager will make appropriate and effective arrangements to address your needs.

Mental Health, and Substance Abuse Program

Matching the right provider to your needs makes all the difference.

Member seeks advice
1-866-503-3158

Magellan client service representative routes call

Assessment by Magellan care manager

Referral to mental health/ substance abuse provider

Provider Network

Why It's Important to Match Members and Providers

One of Magellan's features is our ability to refer you to a mental health or substance abuse provider who is experienced with addressing your specific problem. Our referral system gathers comprehensive information on counselors and providers including their area of specialty, experience and interest. This allows us to better assist you in accessing an appropriate mental health and substance abuse provider which is important to the success of your care.

About our Provider Network

To receive full benefits for inpatient treatment, all services must be authorized by the facility at the time of admission.

To receive a referral to a mental health and substance abuse provider near you, call the Magellan 24-hour Help Line at 1-866-503-3158.

Magellan's network counselors and providers are experienced professionals who hold the proper credentials to offer and deliver a full range of specialty services. Providers and counselors participate in Magellan's continuous quality management program and are monitored for the quality of care they deliver to you.

The provider network consists of psychiatrists, psychologists, social workers, and specialized addiction counselors who specialize in crisis intervention, evaluation, brief treatment and traditional therapies.

The facility network includes psychiatric hospitals, alcohol and drug rehabilitation facilities, partial hospitalization programs, and intensive outpatient programs.

In-network Providers

If you are seeking care with a Magellan network provider, your provider will submit the claim directly to Magellan on your behalf. You do not need to submit a claim or call for outpatient authorization.

When you receive care from an in-network Magellan provider, you will receive maximum coverage for your care. This means your out-of-pocket costs will be lower than if you obtain services from a provider who is not in the Magellan network (an out-of-network provider).

Out-of-network Providers

If you are seeking care with an out-of-network provider, the out-of-network provider will be reimbursed at 50% of the usual customary and reasonable rate unless circumstances require you to see an out-of-network provider. To determine if out-of-network services can be handled as an exception and reimbursed at the higher rate, either you or your provider can call the toll-free number and discuss your clinical needs and circumstances with a Magellan Care Manager. When you call the toll-free number, a Care Manager can look up the provider and determine if the provider is an in-network or out-of-network provider. The Care Manager can also search for and refer you to an in-network provider. You may also search the State of Michigan customized website www.MagellanHealth.com/member for a listing of network providers.

If at any time you are unsatisfied with your provider, you can call the toll free number and request a new in-network provider. We will discuss your concerns with your existing provider and refer you to another provider if needed.

If You are already Receiving Care

If you are already receiving mental health or substance abuse care, you or your current provider should call Magellan at 1-866-503-3158. We will work with you and your provider to see that you continue to receive the care that you need. Whenever possible, your care will be completed with your existing provider.

Emergency

What do I do in an Emergency

In the event of an emergency, your program is available 24 hours a day to assist you or your covered family members. To access services, call our toll-free number at: 1-866-503-3158.

In any life-threatening emergency, you or your covered dependents should immediately seek treatment at the nearest emergency facility.

You or your provider must call Magellan within 24 hours of the emergency admission to pre-certify your care. If you or the provider does not call within 24 hours to pre-certify, and care is not authorized, you will not be eligible for maximum benefits and benefits may be denied entirely.

If you are uncertain whether you have an emergency, you can call Magellan and a care manager will help you and assess the seriousness of the situation. If it's determined that your need is not an emergency that requires an inpatient admission, you will be scheduled for an urgent care appointment. If the decision is made not to admit you, a care manager will discuss this with you and your physician. Together, we will determine the most appropriate care and setting.

Emergency Services Outside of the State of Michigan

If you need care outside of Michigan, please call the toll-free help line number for assistance in locating a provider.

Privacy Practices

Uses and Releases of Protected Health Information

Magellan takes the privacy and confidentiality of your protected health information (PHI) seriously and does not use or disclose PHI for purposes other than payment, treatment or health care operations, or as required by law, without obtaining your authorization in accordance with all applicable state and federal privacy laws and regulations. A member must provide written consent for such release, except when disclosure is otherwise required or permitted by law. The type of information that may be disclosed must be specified in your written consent, and only this information may be released to the person(s) or entities that you have identified. Release of records related to drug or alcohol treatment must not only follow appropriate written authorization by the member but also appropriate federal regulations.

Furthermore, Magellan's systems are designed to limit access to specific personnel and will ensure complete confidentiality. Clinical documentation related to mental health or substance abuse services is reviewed by a staff of professionals who are bound by Magellan's confidentiality policy.

Except when disclosure is required by law, no confidential information can be released to your supervisor, employer, or family without your written permission and no one will be notified if and when you access mental health or substance abuse services.

Complaints, Appeals and Claims

Complaints

You can call the Magellan toll free number if you have a complaint about our services. A customer service representative will explain the complaint process. We are interested in hearing any complaints and we are committed to a timely response and resolution of your concerns.

You may file a verbal complaint directly with a client service representative, who will complete the appropriate documentation and forward it for resolution and response. We will respond verbally within 5 days of receipt of your complaint. If you decide to file a written complaint, we will respond in writing within 10 days of receipt of your complaint.

Formal complaints submitted by an agency or organization on behalf of a member will be responded to in writing within 10 days of receipt.

If the outcome of your complaint is not favorable, you may appeal the outcome of your complaint by calling Magellan at 1-866-503-3158.

Appeals

You have the right to request Magellan to review the non-authorization of services or denial or payment of any claim. You have two levels of internal appeal available. If your physician substantiates orally or in writing that adhering to the timeframe for the standard internal appeal process would seriously jeopardize your life or health, or would jeopardize your ability to regain maximum function, you are entitled to an expedited appeal.

The standard appeal process is as follows:

1. Within 180 days of receipt of our initial non-authorization decision, you or your authorized representative may call or write to Magellan, explaining why you disagree with our determination on your request for benefits or payment. This is your first level appeal.
2. Mail your written statement to: State of Michigan Appeal Coordinator, Magellan Behavioral of Michigan, 34705 W. Twelve Mile Road, Suite 148, Farmington Hills, MI 48331
3. We will respond to your appeal in writing. If you agree with our response, the appeal process ends.
4. If you disagree with our response, you may request a second level appeal, which you have the right to appear before a designated committee. Mail your written request within 30 days of receipt of our first level appeal decision, along with your medical record, to: State of Michigan Appeal Coordinator, Magellan Behavioral of Michigan, 34705 W. Twelve Mile Road, Suite 148, Farmington Hills, MI 48331

If you wish to participate in the designated committee, you may ask that the designated committee be conducted in person or over the telephone. If in person, the designated committee can be held at our office in Farmington Hills, Michigan. Our written resolution following the meeting of the designated committee will be our final determination regarding your appeal.

If you disagree with our second level appeal decision, you may request an external review. You should also know that you may use an Authorized Representative form, which is included in non-authorization letters or may be requested from Magellan, to authorize in writing another person, including, but not limited to, a physician, to act on your behalf at any stage in the standard internal appeal processes.

Once you have exhausted our standard internal appeal process or if we failed to provide our final determination to you within 30 days, you or your authorized representative have the right to request an external review from the Michigan Department of Insurance and Financial Services (DIFS). There are no fees or costs to you for the external review.

Within 60 days of the date you received our final determination or should have received it, send a written request for an external review to DIFS.

A DIFS Health Care Request for External Review form is enclosed with non-authorization letters. You may call DIFS toll free at 1-877-999-6442 if you have questions concerning the form.

Expedited Internal Appeal Process

You may file a request for an expedited internal appeal if a physician substantiates orally or in writing that adhering to the timeframe for the standard internal appeal process would seriously jeopardize your life or health, or would jeopardize your ability to regain maximum function.

You may submit your expedited internal appeal request by telephone. The required physician's substantiation that your condition qualifies for an expedited internal appeal can also be submitted by telephone. The toll free number to call is: 1-866-503-3158.

We must provide you with our decision within 72 hours of receiving both your appeal and the physician's substantiation. If you disagree with our final determination after this review, you may request an external review, or you may request a first level standard appeal from Magellan. Once you file a request for expedited external review, Magellan's internal appeal process ends.

If you have filed a request for an expedited internal appeal with Magellan, you may request an expedited external review from the Michigan Department of Insurance and Financial Services (DIFS). There are no fees or costs to you for the external review.

Within 10 days of your receipt of our expedited internal appeal non-authorization decision, you or your authorized representative may request an expedited external review from DIFS. A DIFS Health Care Request for External Review form is enclosed with non-authorization letters, or you may call DIFS toll free at 1-877-999-6442 to obtain a copy of the form.

If a physician substantiates orally or in writing that waiting for Magellan's decision on your expedited internal appeal request would seriously jeopardize your life or health, or would jeopardize your ability to regain maximum function, you may complete and mail the Expedited External Review section of the enclosed Health Care Request for External Review form, including the documents identified on the form, or call DIFS toll free at 1-877-999-6442 at the same time that you request an expedited internal appeal review by Magellan.

Additional Information

The consumer ombudsman is also available to provide assistance. The Michigan Health Insurance Consumer Assistance Program (HICAP) is run by the Michigan Department of Insurance and Financial Services (DIFS). You can contact the ombudsman at:

Michigan Health Insurance Consumer Assistance Program (HICAP)
Michigan Department of Insurance and Financial Services
P.O. Box 30220
Lansing, MI 48909-7720
877- 999-6442
http://michigan.gov/HICAP
DIFS-hicap@michigan.gov

Claims

Mental Health and Substance Abuse

If you receive a Magellan referral, your provider will complete and submit the appropriate claim form to be reimbursed for your care.

If you are obtaining services from an out-of-network provider, please submit the claim on a standard super bill. The requirements can be found on page 15 or on www.MagellanHealth.com/member. If you or your provider needs assistance in obtaining these forms, please call the toll free number. The timely claim filing limitation for the State of Michigan is 12 months. Magellan must receive the claim within 12 months of the date that the service was rendered in order to be considered for payment. Review Out-of-Network Benefits for more information about filing claims for out-of-network services.)

Program Overview

About your Benefit

Benefits for the treatment of mental health conditions and alcohol and/or chemical dependency covered by the State Health Plan are provided by Magellan for eligible State of Michigan employees and retirees.

The following is a brief description of how the program works. Your coverage includes a range of mental health and substance abuse services. Refer to the Benefit Summary for details.

Magellan maintains a network of mental health professionals under contract to provide services to members, including:

- Psychiatrists
- Psychologists
- Social Workers
- Licensed Professional Counselors
- Treatment clinics and hospitals

Accessing your Benefits

Magellan enables you to go directly to your provider without calling first to precertify care. If you have already selected an in-network provider, you do not need to call the toll-free number to register (precertify) care. You may access your provider's services directly. If you need help selecting a provider or would like to receive a clinical assessment, call Magellan at 1-866-503-3158.

How Case Management Works

When you call the toll-free number to access non-emergency care, or to ask a question, you will be guided through our case management process. In the event of an emergency, you will be transferred immediately to a case manager. To access care or receive information, you will be asked for the following information:

- Your name
- Member ID number
- The patient's name if different from yours
- The reason for the call

You will speak to a case manager who will:

- Discuss the nature of your situation
- Determine medical necessity
- Help you select a licensed in-network provider experienced in handling your type of situation

Case managers are licensed mental health professionals experienced in dealing with mental health, alcohol and substance abuse problems. Your case manager will work with you and your provider to determine the appropriate level of care and the right facility for your care. Your case manager will determine the appropriate length of stay and treatment plan based upon your specific needs and situation.

Your coverage includes a range of mental health and substance abuse services. When authorized, these services may include:

- Inpatient care
- Partial Hospitalization
- Intensive outpatient programs
- Outpatient treatment
- Residential substance abuse care
- Detoxification
- Office visits
- Inpatient laboratory/diagnostic tests related to mental health and substance abuse treatment

Magellan's case managers and physician advisors make decisions about authorizing reimbursement for services based on the appropriateness of care and your benefit coverage. They do not receive financial incentives to encourage reducing services or rewards for denying services.

If you or a covered family member is hospitalized, your case manager will work with you, your family, attending therapists, and hospital staff, to ensure your care is coordinated and that you receive a high level of care during your stay.

Other Magellan Programs

Screening Programs

Magellan wants to make sure that all of your behavioral health needs are met and that you get the services that you need. When Magellan's care managers talk with you about your mental health needs, they will also evaluate your need for services to assist with substance use issues. Additionally, you may receive a call from a Magellan care manager to determine whether you may need behavioral health services associated with chronic or complex medical issues. If services or programs are recommended by a Magellan care manager, we encourage you to use the programs and resources recommended.

Complex Case Management Program

Magellan offers a Complex Case Management (CCM) program for individuals with more severe or complex mental health conditions. Magellan's Care Managers work with individuals who are appropriate for this program to coordinate treatment planning with the individual's doctor and other treating providers as needed to improve the individual's behavioral health functioning. If you or your family member are in need of additional case management support or services, contact Magellan at 866-503-3158 and ask for a free assessment for Complex Case Management.

Questions

Magellan's customer service department is available to help you with any questions you may have regarding your benefits or our services. Just call the toll-free number at 1-866-503-3158, 8 a.m. to 5 p.m., EST, Monday through Friday or for more information you can visit www.MagellanHealth.com/member.

Out-of-Network Benefits

If you choose to be treated by a provider that is not in the Magellan network, please be aware that you will be financially responsible to pay all or a portion of the provider fee's. For more information please refer to the Benefit Summary.

Out-of-network providers are not required to process claims on your behalf – in such cases you must submit the claim yourself. Send the out-of-network provider's itemized bill and the HCFA 1500 form (available from your provider or on the Magellan State of Michigan website), along with your name, address, and social security number to:

Magellan Claims

Attn: State of Michigan–Claims Unit
P.O. Box 2278
Maryland Heights, MO 63043

Claims should be received by Magellan within 60 days of the date you or a covered dependent received services. Remember, in order for your claim to be paid, you must continue to be eligible for coverage on the date you receive care. All claims will be processed in accordance with confidential procedures.

Services obtained without Magellan precertification will not be eligible to receive the maximum benefit covered by the plan and may not be covered at all.

Coordination of Benefits

When you call the toll-free number we will verify your other health insurance coverage. Magellan will work with your other insurance carrier to ensure that claims are paid appropriately. If you have any questions concerning coordination of benefits, contact the toll-free number at 1-866-503-3158.

Exclusions

The following exclusions apply to mental health and substance abuse services. This is not an all-inclusive list of exclusions. Please call Magellan's toll-free number to determine whether services are covered under your benefit.

- Services provided by practitioners not designated as eligible providers
- Hypnotherapy
- Guided imagery
- Marital counseling
- Methadone Maintenance
- Psychodrama
- Sex therapy, including therapy for sexual dysfunction or therapy related in any way to gender identity disorders or intersex surgery
- Art therapy
- Recreation therapy
- Behavior modification, including for habitual behaviors such as compulsive gambling
- Counseling for vocational, academic, or education purposes
- Court-ordered psychotherapy, including substance abuse
- Services received at private residences
- Phone consultations or therapeutic phone sessions
- Music therapy
- Repetitive transcranial magnetic stimulation (rTMS)
- Telehealth
- Residential Mental Health

Limitations

The Plan's BASIC Hospital Benefit will not provide BASIC benefits for any expenses you may incur during an inpatient or outpatient hospital confinement due to a mental or nervous condition (including the treatment of alcoholism or substance abuse) after it has been determined that such a condition is not subject to a favorable modification.

Benefits Summary

Mental Health Benefits

	IN-NETWORK	OUT-OF-NETWORK
Inpatient	100% Up to 365 days per year	50% of the Usual, Customary and Reasonable (UCR) Health Insurance Association of America (HIAA) rate Up to 365 days per year
Partial Hospitalization (PHP)	100% Authorized at a 2:1 ratio**	50% of the UCR (HIAA) rate Authorized at a 2:1 ratio**
Outpatient	As necessary 90% of network rates	As necessary 50% benefit of the UCR (HIAA) rate Subject to 10% co-pay
Autism Coverage Applied Behavioral Analysis (ABA)	State of Michigan Mandated Coverage 90% of daily charges after deductible	80% of the UCR (HIAA) rate after deductible

Substance Abuse Benefits

	IN-NETWORK	OUT-OF-NETWORK
Acute Detox	Managed and authorized by your medical carrier, BCBSM.	
Inpatient	100% **Up to two 28-day admissions per year. There must be at least 60 days between admissions. Inpatient days may be utilized for intensive outpatient treatment (IOP) at 2:1 ratio. One inpatient day equals two IOP days. Halfway House 100%	50% of the UCR (HIAA) rate **Up to two 28-day admissions per year. There must be at least 60 days between admissions. Inpatient days may be utilized for intensive outpatient treatment (IOP) at 2:1 ratio. One inpatient day equals two IOP days. Halfway House 50% of the UCR rate
Outpatient	$3,500 per calendar year.* 90% of network rates	$3,500 per calendar year.* 50% benefit of the UCR rate Subject to 10% co-pay

* *$3,500 per calendar year limitation pertains to services for chemical dependency only.*

** *Inpatient days may be utilized for partial day hospitalization (PHP) at 2:1 ratio. One inpatient day equals two PHP days.*

Online Resources

Magellan's member website is available for State of Michigan employees and retirees covered under the State Health Plan. Please visit this site at the following address: www.MagellanHealth.com/member.

You can register for the site by clicking on the "New or Unregistered Users" box and entering your Magellan toll-free number: (866-503-3158).

This website provides tools and resources to support you and your family. You will be able to search for a provider, inquire about your claims, access screening and assessment tools and educational materials regarding your mental health and substance abuse benefits provided by Magellan, as well as self-management tools to assist you with health and wellness.

Provider Search App for Mobile Devices

Magellan has an app for Apple products which include the iPhone® and iPad®. This app can immediately locate a provider in your area that is part of our network. The My Provider app can be found via the iTunes store and is available to anyone at no cost.

Employee Services Program (ESP)

The State of Michigan, Employee Service Program (ESP) provides confidential assistance to classified state employees and eligible family members to promote wellness and to prevent or resolve personal or organizational issues that may interfere with work productivity, home life or behavioral health. ESP's licensed masters social workers (LMSW) are available to provide professional confidential services to identify strategies for resolving concerns affecting personal or work life.

Lansing Office
517-373-7630 or 800-521-1377
Capitol Common Center
400 South Pine, Suite 103
Lansing, MI 48909

Detroit Office
313-456-4020
Cadillac Place
3068 West Grand Blvd.
Suite 4-300
Detroit, MI 48202

The Employee Services Program (ESP) also provides an online confidential Interactive Screening Program available 24 hours a day, 7 days per week for screenings on depression, anxiety, alcohol, post-traumatic stress, eating disorders, and adolescent depression. The screenings are not professional diagnoses, but highlight possible symptoms of these treatable medical conditions, and are provided free of charge. To take an online screening for any of these conditions, go to www.mentalhealthscreening.org/screening/espmi.

Your Rights and Responsibilities

Magellan is committed to protecting your rights and responsibilities to ensure that you are treated with dignity and respect in the delivery of services, and that your privacy is protected. Your rights and responsibilities are described below.

Statement of Members' Rights

Members have the right to:

- Be treated with dignity and respect.
- Be treated fairly, regardless of their race, religion, gender, ethnicity, age, disability, or source of payment.
- Have their treatment and other member information kept confidential. Only where permitted by law may records be released without the member's permission.
- Easily access care in a timely fashion.
- Know about their treatment choices. This is regardless of cost or coverage by their benefit plan.
- Share in developing their plan of care.
- Receive information in a language they can understand, and free of charge.
- Receive a clear explanation of their condition and treatment options.
- Receive information about Magellan, its providers, programs, services and role in the treatment process.
- Receive information about clinical guidelines used in providing and managing their care.
- Ask their provider about their work history and training.
- Give input on the Members' Rights and Responsibilities policy.
- Know about advocacy and community groups and prevention services.
- Freely file a complaint or appeal and learn how to do so.
- Know of their rights and responsibilities in the treatment process.
- Request certain preferences in a provider.
- Have provider decisions about their care made on the basis of treatment needs.

Statement of Members' Responsibilities

Members have the responsibility to:

- Treat those giving them care with dignity and respect.
- Give providers and Magellan information that they need. This is so providers can deliver quality care and Magellan can deliver appropriate services.
- Ask questions about their care. This is to help them understand their care.
- Follow the treatment plan. The plan of care is to be agreed upon by the member and provider.
- Follow the agreed upon medication plan.
- Tell their provider and primary care physician about medication changes, including medications given to them by others.
- Keep their appointments. Members should call their provider(s) as soon they know they need to cancel visits.
- Let their provider know when the treatment plan is not working for them.
- Let their provider know about problems with paying fees.
- Report abuse and fraud.
- Openly report concerns about the quality of care they receive.

Glossary of Terms

Authorization—Clinical approval by a Magellan case manager for reimbursement for mental health or substance abuse services for a member.

Case Management—A system of continuing review by a case manager. This process when conducted in a managed care system may include the "Certification" or authorization of the covered individual's medical services by licensed health care reviewers. The reviewers use objective clinical criteria for determining medical necessity and appropriateness of treatment within benefit allowances for a covered diagnostic condition.

Clinical Appeal—A formal request for Magellan to reconsider a clinical denial for authorization, either concurrently or retrospectively, for admissions, continued stays, levels of care, procedures, or services.

Complaint—A verbal or written statement of dissatisfaction arising from a perceived adverse action, decision, or policy on the part of Magellan.

Continuing Review/Concurrent Review—A review of the care being delivered and the proposed treatment plan for future care; conducted at specific intervals by a case manager to determine the appropriateness and authorization of further care.

Coordination of Benefits (COB)—An agreement using language developed by the National Association of Insurance Commissioners that prevents double payment for services when a subscriber has coverage from two or more sources. For example, a husband may have traditional coverage through work and the wife may have elected an HMO through her place of employment. The agreement gives the order for which organization has primary responsibility and which organization has secondary responsibility for payment.

Deductible—That portion of a subscriber's (or covered insured's) health care expenses that must be paid out-of-pocket before any insurance coverage applies. Refer to your "Benefit Summary" for the deductible required by your coverage.

Grievance—A written statement of dissatisfaction submitted in response to a decision made by Magellan regarding a previously filed complaint.

Network Providers—The group of mental health care providers, including doctors, hospitals, counselors and treatment facilities, who have agreed to adhere to Magellan's care standards, payment schedules, and procedures.

Out-of-Network Providers—Mental health care providers who do not belong to Magellan's network. These services may be covered at a lower rate under your benefit plan. Refer to your "Benefit Summary" for the benefits provided by your coverage.

Pre-certification—The process of registering for services prior to seeking mental health or substance abuse care. For in-network outpatient care, your in-network provider will register your care. You do not need to call the toll free number to register care. Inpatient care must be pre-certified through the toll free number by your provider.

Please refer to the "Benefit Summary" for complete information on the benefits provided under your plan.

In an effort to provide you with the best in customer service, please be aware that your call to Magellan's Customer Service Department may be monitored by a Magellan supervisor as part of our staff evaluation efforts.

How to file a claim using a Super Bill

When do I have to file a claim?

As part of their provider agreement with us, all Magellan network providers are required to file claims for you, and our payment is sent directly to them. If your plan has out of network (OON) benefits you may have to file the claim yourself. Ask your OON provider if he or she will accept assignment of benefits and submit the claim directly to Magellan. If your OON provider does not accept assignment of benefits, you should file the claim directly with us.

What is my claim filing period?

Your Magellan network provider has ninety days to file a claim for services rendered. If you are filing the claim yourself, please refer to your benefit plan document for claim filing deadlines. If you fail to submit your claim in this timeframe, your claim will not be reimbursable.

How do I file a claim?

- If you are using an OON provider, the provider may ask you to pay the bill at the time you receive services. If this happens, pay the provider and submit a claim and/or an itemized bill from your provider to Magellan for reimbursement. Our payment is then sent directly to you. The claim and/or itemized bill must contain the following elements:
  - Patient's name membership number;
  - Patient's address and phone number;
  - Patient's date of birth;
  - Your employer group number;
  - Your provider's name, address, Tax ID number, NPI number, and license level;
  - The applicable codes for diagnosis and treatment;
  - The charges for each service performed;
  - The date of service;
  - Your signature
  - Your provider's signature
- Mail your completed claim information to Magellan Claims at the address in your benefit plan document or call the customer service number on your insurance card to obtain the specific claims mailing address.
- We send the payment for covered services directly to you. You will also receive an Explanation of Benefits (EOB) anytime we review a claim. An EOB is not a bill; it is documentation of the action we have taken on your claim.

How long does it take to pay my claim?

After we receive a properly completed claim, we usually process the claim within 15 days. There may be instances where we need additional time and information to make a final decision about payment. If this happens, we will send you a notice explaining the reason for the delay. We will make a decision within 30 days of receiving any missing information needed to complete the claim review.

How do I coordinate my benefits with different carriers?

Magellan coordinates benefits with other payers when a member is covered by two or more group health benefit plans. Coordination of Benefits (COB) is the industry standard practice used to share the cost of care between two or more carriers when a member is covered by more than one health benefit plan. It is a contractual provision of a majority of health benefit contracts. Magellan complies with federal and state regulations for COB and follows COB guidelines published by the National Association of Insurance Administrators (NAIC). When you file your claim, include information about any other coverage you have and any payments made by the other payer.

If you have more than one health plan, one of the plans will provide "primary coverage" and the other will provide "secondary coverage." First, the health plan providing primary coverage will reimburse at their normal rate. The plan with secondary coverage will then take into consideration what has already been paid, and pay any difference between what the primary coverage paid and what is normally covered under the secondary coverage.

For more information on our coordination of benefits procedures, please consult your benefits administrator or Magellan's service representatives, at the number on your insurance benefit card.

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