



**UNIVERSITY OF PENNSYLVANIA HEALTH SYSTEM (UPHS) AND  
UNIVERSITY OF PENNSYLVANIA BEHAVIORAL HEALTH SERVICES BENEFITS COVERAGE  
GUIDELINES FOR FACILITIES**

**BACKGROUND**

**PENN Behavioral Health has been established as an Administrative Services Organization (ASO)** in part (i) to develop and administer a network of qualified facilities for the purpose of delivering comprehensive mental health and substance abuse treatment services (hereinafter defined as behavioral health services) in a high quality and cost effective manner; and (ii) to act as Plan Administrator (hereinafter defined as Administrator) for payors and employers to arrange for the delivery of comprehensive mental health and substance abuse treatment services to covered persons.

PENN Behavioral Health also acts as an Administrator of Employee Assistance Program (EAP) services for various regional employers including the University of Pennsylvania Health System and the University of Pennsylvania.

Benefits will not be available for Behavioral Health services to a greater extent or for a longer period than is Medically Appropriate/Medically Necessary as determined by the Contract Administrator. The definition of Medically Appropriate/Medically Necessary as determined by the Contract Administrator is as follows: Health care services which are determined by PBH to:

- a] be consistent with generally accepted practice parameters as recognized by health care providers in the same or similar general specialty as typically treats or manages the diagnosis or condition;
- b] help restore or maintain the person's health;
- c] prevent deterioration of or palliate the person's condition; or
- d] prevent the reasonably likely onset of a health problem or detect an incipient problem.

Behavioral Health care services shall also include diagnostic testing, preventive services, and aftercare appropriate in terms of type, amount, frequency, level, setting, and duration to the person's diagnosis or condition.

The amount of benefits for any Covered service will not exceed the amount contracted for with the mental health or substance abuse care provider, and will not be greater than any maximum amount determined by or limit described or referred to in the plans (which are attached to this document).

For the purposes of these Plans, "Facility Care" includes Intensive Outpatient Care, Consultation Care, Emergency Care, Detoxification, Partial Hospitalization, and Inpatient Hospitalization.

The PENN Behavioral Health Plans for mental health and substance abuse are designed to be classified similarly to the medical/surgical plan. This allows for equal benefits on the mental health/substance abuse and medical/surgical side. In these plans, outpatient care (i.e., psychotherapy, medication management) on the mental health/substance abuse benefits side are classified with outpatient care in the medical/surgical benefits plans. All other levels of care for mental health and substance abuse (i.e., Intensive Outpatient Care, Consultation Care, Emergency Care, Detoxification, Partial Hospitalization, and Inpatient Hospitalization) are considered "Facility Care" which is classified with the inpatient medical/surgical benefit.

On occasion, for clients with EAP Coverage, the EAP benefit may be used for an initial assessment at a facility to determine referral options for the most appropriate level of care and/or coordination of care from EAP services to facility services. The EAP can never be used as a substitute, fail first (using lower levels of care first), or gatekeeper (requiring use of the EAP for ability to use benefits) function in determining use of the inpatient or outpatient benefits.

## **MENTAL HEALTH/SUBSTANCE ABUSE (MH/SA)BEHAVIORAL HEALTH SERVICES:**

### **1. PBH REFERRAL PROCEDURE FOR MH/SA BEHAVIORAL HEALTH BENEFITS COVERAGE:**

PBH will contact the facility to advise of a prospective MH/SA Behavioral Health referral. Member demographic data, the nature of the presenting problem, the name of the intake staff member, and any special case instructions will be provided. The facility will always have the opportunity to determine the appropriateness and feasibility of accepting the referral. Should the referral be accepted, relevant demographic and insurance information paperwork will be given verbally by phone or sent to the facility via mail or facsimile.

### **2. SELF- REFERRAL PROCEDURE FOR MH/SA BENEFITS COVERAGE:**

Should a member attempt to make a self-referral without precertification for Intensive Outpatient Care, Consultation Care, Emergency Care, Detoxification, Partial Hospitalization, or Inpatient Hospitalization, it is the responsibility of the facility to obtain pre-certification before treatment is rendered. **The facility should immediately contact PENN Behavioral Health at 888-321-4433 and select Option # 3 to request precertification.**

When covered persons seek treatment that requires pre-service claim determination, they are not responsible for obtaining precertification if the treatment is provided by an In-Network Facility. The facility must contact PBH to request pre-certification. If the Facility fails to obtain the required pre-service claim determination, the covered person will be held harmless for any associated financial penalties assessed by PBH as a result. **Under no circumstances should the covered person be billed for services provided by an In-Network Facility with the exception of any applicable co-payments, co-insurance, or other cost sharing features (such as admission charges).**

### **3. EMERGENCY SELF-REFERRAL PROCEDURE FOR MH/SA BENEFITS COVERAGE:**

Members facing an emergency do not need a referral from PENN Behavioral Health. However, the facility, the member, the member's physician, or the member's representative must call PBH within 48 hours after Emergency Care is given. If this is not reasonably possible, the call must be made as soon thereafter as reasonably possible.

### **4. GENERAL PROCEDURES FOR FACILITIES:**

- ◆ Should the facility accept the referral, relevant demographic and insurance information will be given verbally by phone or sent to the facility via mail or facsimile.
- ◆ If the client fails to report for admission, PBH should be informed within one hour for urgent or emergent admissions or within 24 hours for routine admissions.

- ◆ Should a client with PBH Coverage present to the facility without a referral, the facility must obtain a pre-service authorization. Please call PBH Access Services at 888-321-4433 and select Option # 3.
- ◆ For all clinical procedural questions, please call PBH Access Services at 888-321-4433 and select Option # 3.

## 5. PAYMENT PROCESS

- ◆ As noted above, when covered persons seek treatment that requires pre-service claim determination, they are not responsible for obtaining precertification if the treatment is provided by an In-Network Facility. The Facility must contact PBH to request pre-certification. If the In-Network Facility fails to obtain the required pre-service claim determination, the covered person will be held harmless from any associated financial penalties assessed by PBH as a result. **Under no circumstances should the covered person be billed for services provided by an In-Network Facility with the exception of any applicable co-payment, co-insurance or other cost sharing features (such as admission charges).**
- ◆ If the request for precertification is denied, the covered person will be notified in writing that the admission/service will not be paid because it is considered to be medically inappropriate, not medically necessary, or a non-covered service. If that person decides to continue treatment or care that has not been approved, they will be asked to do the following:
  1. Acknowledge this in writing
  2. Request to have services provided
  3. State their willingness to assume financial liability.
  4. Sign the written statement.

The Contract Administrator is authorized to make payments directly to In-Network Facilities furnishing covered services. PENN Behavioral Health In-Network Facilities have agreed to accept the rate of reimbursement determined by contract as payment in full for covered services. In-Network Facilities will make no additional charge to covered persons for covered services except in the case of certain co-payments, co-insurance, or other cost sharing features (such as admission charges) as specified under the member's benefit plan. The Covered Person is responsible within sixty (60) days of the date in which the Contract Administrator finalizes such services to pay, or make arrangements to pay, such amounts to the PENN Behavioral Health In-Network Facility.

### MH/SA BENEFIT EDUCATION:

- ◆ It is essential to clearly educate the client regarding the MH/SA Benefit provider's role of assessment, treatment, care determination, and, if indicated, referral. MH/SA Benefit intervention should be viewed as appropriate for problems that can be successfully resolved within the context of services/treatments determined by their benefit plan.
- ◆ The client should be reminded that twenty-four (24) hours notice is required for any cancellation.
- ◆ All clients should be reassured that use of their MH/SA benefit is confidential except where a specific "Release of Information" is signed by the client, or as provided by federal regulations. The specific content, reason for, and person to whom the information may be released should be specified on the release provided. Clients should also be informed about exceptions to confidentiality as mandated by federal regulation. Release of Information forms can be requested by calling 1-888-321-4433 and selecting Option #3.

## MH/SA BENEFIT TREATMENT REFERRALS:

- ◆ If assessment determines that referral to another level of care is required, assistance with the selection of the specific referral source is considered a crucial element of service of the In-network facility. The role of the facility in this regard is to ensure a smooth transition to the referral source. It must be noted that any change in the treatment plan or the level of care requires the notification of and authorization by PENN Behavioral Health Staff who may be contacted by calling 1-888-321-4433, Option # 3.
- ◆ It is imperative that the facility provide relevant clinical information to all appropriate referral sources. If a referral for clinical services is required, it is the facility's responsibility to request that the client sign the PBH Release of Information Form (which can be requested by calling 1-888-321-4433 and selecting Option #3) and verbally communicate any relevant information.
- ◆ The role of the facility also includes case management (e.g., follow-up and tracking of the client's progress in the program to which they were referred).
- ◆ All In-Network Facilities are encouraged to consider linking the client to community, regional, and company resources, self-help programs (and the like) during or subsequent to MH/SA Benefit Services.

## CONFIDENTIALITY/RELEASE OF INFORMATION:

- ◆ All facility providers and staff are required to adhere to Federal and State regulations and laws that pertain to the maintenance of confidential information/records. The facility agreement forbids the discussion of patient information under HIPAA privacy guidelines. Anyone who divulges or releases confidential information or records concerning any participant without proper authorization in accordance with PENN Behavioral Health policies and Federal and State law may be terminated from the Provider network and/or may be subject to other remediation per the PBH Peer Review process.
- ◆ The facility contract designates facility providers as authorized agents of PENN Behavioral Health. **Therefore, a written release is not required in order to communicate with any PBH staff member, either verbally or in writing.**
- ◆ Facilities must have a signed Release of Information before communicating with any party or parties other than PENN Behavioral Health. A PBH staff member will facilitate all communication with the workplace. **Under no circumstances should a facility provider or staff member contact or converse with anyone from a client's workplace without the expressed written permission of PBH.**
- ◆ **PLEASE NOTE:** If contact with someone at a client's workplace is indicated, please call PBH to discuss the situation. **Under no circumstances should a facility provider or staff member submit any written documentation, including letters to the workplace, court, or to any party or parties other than PBH.** In order to ensure the utmost confidentiality of client records PENN Behavioral Health requires a court order for the release of all written documentation. Any dissemination of information that is legally required will be provided only by PENN Behavioral Health or with the expressed written permission of PENN Behavioral Health and the appropriate signed Release of Information form. Please request the form or direct any inquiries to PENN Behavioral Health staff.

## **COMPLAINT/GRIEVANCE PROCEDURE:**

PENN Behavioral Health is committed to member and customer service and has established a process for facilities to register complaints in a timely manner.

### **DEFINITIONS:**

- ◆ Complaints are criticisms received by PENN Behavioral Health which should be resolved within 30 days
- ◆ Grievances are formal written complaints or complaints of a serious nature.
- ◆ Inquiries are contacts directed to PENN Behavioral Health, such as concerns or questions. Not all inquiries are considered complaints or criticisms.

### **PROCESS:**

- ◆ All complaints should first be addressed to the individual or department directly involved in the action in question (e.g., first attempt to call the care manager to see if he/she can correct problem).
- ◆ Complaints that can not be addressed satisfactorily with the individual or department may be registered by submitting a written complaint to PENN Behavioral Health, 3535 Market Street, 4<sup>th</sup> Floor, Philadelphia, PA 19104, Attention: Provider Relations Department.
- ◆ All complaints will be logged and tracked by PENN Behavioral Health and every effort will be made to rectify the problem in a timely manner.
- ◆ If the complaint is *not* resolved to the satisfaction of the complainant, within a reasonable time frame (usually 30 days), a grievance may be registered.
- ◆ If a complaint involves an emergent clinical situation, PENN Behavioral Health will respond within 24 hours or as soon as the clinical situation warrants. For urgent situations, PENN Behavioral Health will respond within 48 hours, or as soon as the clinical situation warrants.

## **COMPLAINT LEVELS AND RESOLUTION PROCEDURE:**

The nature and seriousness of complaints are deemed to fall into one of the four categories listed. While all initial complaints are resolved by the Committee on Quality Improvement, any uncertainty about the level of response will be reviewed by the Executive Medical Director. The Level of response may also be altered at any time based on additional information.

Level One (1) This level involves complaints related to access and/or payment. Clinical issues are not involved. The Committee on Quality Improvement is responsible for resolution.

Level Two (2) This level involves clinical issues that are deemed not to be of sufficient severity to cause harm to patients or that do not involve a serious breach of ethical conduct. This level of complaint involves investigation by interviewing all parties involved with concomitant review of the clinical documentation if deemed appropriate. The complaint may also be referred to the appropriate Peer Review Committee for further consideration by peer review process. The Committee on Quality Improvement is responsible for resolution.

Level Three (3) This level involves complaints of sufficient clinical severity that they may impact patient safety and/or complaints involving ethical conduct. The Committee on Quality Improvement will immediately notify the Executive Medical Director upon receiving any level three complaints. This level of complaint will also be

referred to the Peer Review Committee for further consideration by peer review process where the plan for resolution will be determined.

**Level Four (4)** This level involves a complaint of such a serious nature that all of the provider's services for PENN Behavioral Health are suspended until a resolution has been determined. The resolution process involves immediate review by the Executive Medical Director and review of the clinical documentation. At the discretion of the Executive Medical Director, clinical records of other members treated by the provider in question may be reviewed. In addition, these cases will be reviewed by the Peer Review Committee who will make recommendations for actions along with the Executive Medical Director.

The Credentialing/Peer Review Committee will meet within 15 days of a Level Three or higher complaint. The complainant will be advised of the resolution in writing and, at times, additionally by phone depending on the urgency of the clinical situation.

### **REIMBURSEMENT:**

PENN Behavioral Health is solely responsible for payment of services with the exception of any applicable co-payments, deductibles, or co-insurance (see attached charts at the end of this document for specific plan requirements).

- ◆ The rate of reimbursement as stipulated in the facility contract constitutes payment in full.
- ◆ **PENN Behavioral Health Clients will be held harmless for any payment with the exception of any co-payments, co-insurance, or other cost sharing features (such as admission charges).**
- ◆ Do not discuss your fees with clients or have them fill out any financial screening forms.
- ◆ Do not discuss fees with other facilities or providers.
- ◆ Submit claims as per the guidelines below.

Compliance with PENN Behavioral Health policies and procedures is required in order to ensure additional referrals. If you have any questions, please contact PBH staff by calling 1-888-321-4433, Option # 3

## **FILING CLAIMS FOR BEHAVIORAL HEALTH SERVICES**

### **CLAIMS FILING PROCEDURES:**

Covered Participants are never required to file a claim when Covered Services are provided by Preferred (In-Network) Facilities.

Preferred (In-Network) Facility Providers of PENN Behavioral Health must notify covered participants of their In-Network status prior to billing so that covered persons will know not to submit claims.

Preferred (In-Network) Facility Providers must notify PENN Behavioral Health for a pre-claims benefit determination to assure the client's eligibility and benefit coverage, and to request authorization prior to treatment. Failure to notify PENN Behavioral Health prior to treatment may result in forfeiture of payment or delay in claims processing. **Facilities may not bill patients for services which have not been pre-certified by PENN Behavioral Health. PENN Behavioral Health clients will at all times be held harmless for payment of claims for services which have not been pre-certified.**

Preferred (In-Network) Facilities are expected to submit “clean claims” for prompt processing and payment. A “clean claim” must contain no defect or impropriety, including a lack of any required substantiating documentation, HIPAA compliant coding, or other particular circumstance requiring special treatment that prevents timely payment from being made.

**PLEASE NOTE:** If at any time PENN Behavioral Health requires additional information from any party external to PENN Behavioral Health, the claim is no longer considered a “clean claim” and may be referred as an “unclean” or contested claim.

**PENN Behavioral Health clients will at all times be held harmless for payment of services rendered by Preferred (In-Network) Facilities with the exception of any applicable co-payments, co-insurance, or other cost sharing features (such as admission charges).**

**IT IS THE FACILITY’S RESPONSIBILITY TO:**

- ◆ Collect applicable co-payments from Covered Persons and submit “clean claims” for the services provided;
- ◆ Submit “clean claims” for facility based services on an accurately completed paper UB-92 claim form for facility based services and programs;
- ◆ Submit “clean claims” for other professional services which are not part of a structured outpatient program, or when a facility per diem is exclusive of professional charges on an accurately completed paper CMS-1500 claim form (HCFA-1500);

Required information submitted includes:

- Name of Covered Person,
  - Name of Patient,
  - Address,
  - Phone Numbers,
  - Date of Birth,
  - Employee ID #,
  - Plan Name,
  - Provider’s (Qualified Professional or Facility Provider) Name (with degree),
  - Address,
  - Phone number,
  - Dates of Service,
  - Diagnosis (by listed codes and/or description) and services performed (by codes or rates) with associated itemized charges, and,
  - Itemized bills (based on negotiated rates for services);
- ◆ Use only HIPAA compliant service codes;
  - ◆ Submit all claims by mail or “dedicated confidential fax” at 215-716-2695 and not by e-mail or phone;
  - ◆ Submit all claims in compliance with regulatory and/or contractually required timely filing standards; and
  - ◆ Respond to requests for additional information or other corrective action in a timely manner (within 45 days).

## **IT IS PENN BEHAVIORAL HEALTH'S RESPONSIBILITY TO:**

- ◆ Send authorization letters when services are authorized which includes:
  - telephone numbers for clinical and claims questions;
  - an identification number for the Covered Person;
  - the authorized services;
  - the number of units and time period for the authorization;
  - an authorization number for the authorized services; and
  - the payor and address to which the claims must be sent.
- ◆ Review all claims in a timely manner to determine:
  - Benefit eligibility of Covered Person;
  - Benefit coverage of Covered Person;
  - Benefit adjustment (co-payment, co-insurance, or co-benefit) if needed;
  - Claim completeness (cleanliness); and
  - Correct provider information and updated credentialing.
- ◆ Give the facility appropriate notice regarding corrective action or missing information if a claim is determined to be "unclean" or contested. If PENN Behavioral Health does not receive the information requested within 45 days, the claim will be adjudicated based on the information available, which may result in denial for insufficient information, subject to applicable state and federal law.
- ◆ Send an Explanation of Payment (EOP) and other notification for each claim submitted (including procedures for filing an appeal for adverse claim determinations).

## **WHEN CLAIMS SHOULD BE FILED:**

- ◆ Claims should be filed with the Claims Department within 60 days of the date charges for the services were incurred. Benefits are based on the Plan's provisions at the time the charges were incurred. Claims filed later than that date may be declined or reduced unless:
  - (a) it's not reasonably possible to submit the claim in that time; and
  - (b) the claim is submitted by the end of the 60 day deadline from the time when the claim was incurred.

## **Additional Information:**

Questions regarding claims may be addressed to PENN Behavioral Health Member Services (Access Services Department) at 1-888-321-4433 and the full process for filing a claim will be described.

The provider must include the above pertinent information and return it with any itemized bills to:

PENN Behavioral Health Claims Department  
3535 Market Street, 4<sup>TH</sup> Floor  
Philadelphia, PA 19104

Please submit claims no later than 60 days after the completion of the Covered Services. The claim should include the date and information required by the Carrier to determine benefits. The Claims Administrator will determine if enough information has been submitted to enable proper consideration of the claim. If necessary, additional information may be requested from the claimant. The Plan reserves the right to have a Plan Participant seek a second medical opinion.

## A. SCHEDULE OF BENEFITS FOR UNIVERSITY OF PENNSYLVANIA ACTIVES

### Details of Coverage for Active PENNCare/Personal Choice PPO and UPHS Point of Service POS Plans

	<b>In-Network PBH Staff</b>	<b>In-Network PBH Regional Network</b>	<b>Out-of-Network</b>
Available Providers	Must choose PENN Behavioral Health Staff Providers.	Must choose PENN Behavioral Health Network Providers	May choose Any Qualified Provider
<b>Mental Health Benefits</b>	Combined benefit for Staff or Regional In-Network or Out-of-Network		
• <b>Inpatient</b>	• 100% coverage after \$250 co-pay per admission, Unlimited days per year	• 100% coverage after \$250 co-pay per admission, Unlimited days per year	• Deductible, 65% , Unlimited days per year
• <b>Partial Hospitalization /Residential</b>	• 100% coverage after \$250 co-pay per admission, Unlimited days per year	• 100% coverage after \$250 co-pay per admission, Unlimited days per year	• Deductible, 65% , Unlimited days per year
• <b>Intensive Outpatient</b>	• 100% after \$30 co-pay, Unlimited visits per year	• 100% after \$30 co-pay, Unlimited visits per year	• Deductible, 65%, Unlimited visits per year
• <b>Outpatient</b>	• 100% after \$30 co-pay, Unlimited visits per year	• 100% after \$30 co-pay, Unlimited visits per year	• Deductible, 65%, Unlimited visits per year
• <b>Emergency Room</b>	• \$75 co-payment (waived if admitted)		
• <b>Out of Pocket Maximum (Medical and Mental Health/ Substance Abuse)*</b>	• \$1,000 Individual, \$2,000 Family 1	• \$1,000 Individual, \$2,000 Family 1	• \$3,500 Individual, \$10,500 Family
• <b>Annual Deductible</b>	• None	• None	• \$500 Individual, \$1,500 Family
• <b>Lifetime Maximum</b>	• None		• \$1,500,000
• <b>Testing</b>	• Members using network providers may receive psychological testing when requested by PBH Network provider and pre-certified by PBH.	• Members using network providers may receive psychological testing when requested by PBH Network provider and pre-certified by PBH.	• Members using out of network providers may receive psychological testing when requested by out of Network provider and pre-certified by PBH.
<b>Chemical Dependency Benefits</b>	Combined benefit for Staff or Regional In-Network or Out-of-Network		
• <b>Detoxification and Medically Managed Rehabilitation: Inpatient</b>	• 100% coverage after \$250 co-pay per admission, Unlimited days per year	• 100% coverage after \$250 co-pay per admission, Unlimited days per year	• Deductible, 65% , Unlimited days per year
• <b>Inpatient Residential</b>	• 100% coverage after \$250 co-pay per admission, Unlimited days per year	• 100% coverage after \$250 co-pay per admission, Unlimited days per year	• Deductible, 65% , Unlimited days per year
• <b>Outpatient and Acute Intensive Outpatient</b>	• 100% after \$30 co-pay, Unlimited visits per year	• 100% after \$30 co-pay, Unlimited visits per year	• Deductible, 65%, Unlimited visits per year
• <b>Emergency Room</b>	• \$75 co-payment (waived if admitted)		
• <b>Out of Pocket Maximum (Medical and Mental Health/ Substance Abuse)*</b>	• \$1,000 Individual, \$2,000 Family 1	• \$1,000 Individual, \$2,000 Family	• \$3,500 Individual, \$10,500 Family
• <b>Annual Deductible</b>	• None	• None	• \$500 Individual, \$1,500 Family
• <b>Lifetime Maximum</b>	• None		• \$1,500,000

1 Copay Maximum

**B. SCHEDULE OF BENEFITS FOR UNIVERSITY OF PENNSYLVANIA  
PRE-65 RETIREES**

***Details of Coverage for Pre-65 PENNCare/Personal Choice PPO***

	<b>In-Network</b>	<b>Out-of-Network</b>
<b>Available Providers</b>	Must choose PENN Behavioral Health Staff or Regional In-Network providers.	May choose any qualified provider
<b>Mental Health Benefits</b>	Combined benefit for Staff and Regional In-Network or Out-of-Network	
• <b>Inpatient</b>	• 100% coverage after \$150 co-pay per admission Unlimited days per year	• 70% , Unlimited days per year
• <b>Partial Hospitalization /Residential</b>	• 100% coverage after \$150 co-pay per admission Unlimited days per year	• 70% , Unlimited days per year
• <b>Intensive Outpatient</b>	• 100% coverage after \$25 co-pay Unlimited visits per year	• 70% , Unlimited visits per year
• <b>Outpatient</b>	• 100% coverage after \$25 co-pay Unlimited visits per year	• 70% , Unlimited visits per year
• <b>Out of Pocket Maximums</b>	• None	• \$3,000 Individual, \$9,000 Family
• <b>Lifetime Maximum</b>	• None	• \$1,500,000
• <b>Testing</b>	• Members using network providers may receive psychological testing when requested by PBH Network provider and pre-certified by PBH	• Members using out-of-network providers may receive psychological testing when requested by out-of-network provider and pre-certified by PBH
<b>Chemical Dependency Benefits</b>	Combined benefit for Staff and Regional In-Network or Out-of-Network	
• <b>Detoxification and Medically Managed Rehabilitation: Inpatient</b>	• 100% coverage after \$150 co-pay per admission Unlimited days per year	• 70% , Unlimited days per year
• <b>Inpatient Residential</b>	• 100% coverage after \$150 co-pay per admission Unlimited days per year	• 70% , Unlimited days per year
• <b>Acute Intensive Outpatient</b>	• 100% coverage after \$25 co-pay Unlimited visits per year	• 70% , Unlimited visits per year
• <b>Outpatient</b>	• 100% coverage after \$25 co-pay Unlimited visits per year	• 70% , Unlimited visits per year
• <b>Out of Pocket Maximums</b>	• None	• \$3,000 Individual, \$9,000 Family
• <b>Lifetime Maximum</b>	• None	• \$1,500,000

**C. SCHEDULE OF BENEFITS FOR UNIVERSITY OF PENNSYLVANIA  
HEALTH SYSTEM ACTIVES AND RETIREES**

**Details of Coverage for Active PENNCare/Personal Choice PPO and PENN Preferred Point of Service  
POS Plans (Aetna OPOS and Keystone POS)**

	<b>In-Network PBH Staff</b>	<b>In-Network PBH Regional Network</b>	<b>Out-of-Network</b>
Available Providers	Must choose PENN Behavioral Health Staff Providers.	Must choose PENN Behavioral Health Network Providers	May choose Any Qualified Provider
<b>Mental Health Benefits</b>	Combined benefit for Staff or Regional In-Network or Out-of-Network		
• Inpatient	• Covered	• Covered	• Deductible, 70% , Unlimited days per year
• Partial Hospitalization /Residential	• Covered	• Covered	• Deductible, 70% , Unlimited days per year
• Intensive Outpatient	• Covered	• Covered	• Deductible, 70%, Unlimited visits per year
• Outpatient	• Covered	• Covered	• Deductible, 70%, Unlimited visits per year
• Emergency Room	• \$25 co-payment (waived if admitted)		
• Out of Pocket Maximum (Medical and Mental Health/ Substance Abuse)*	• N/A 1	• N/A	• \$2,500 Individual, \$5,000 Family
• Annual Deductible	• None	• None	• \$300 Individual, \$600 Family
• Lifetime Maximum	• None		• \$2,000,000
• Testing	• Members using network providers may receive psychological testing when requested by PBH Network provider and pre-certified by PBH.	• Members using network providers may receive psychological testing when requested by PBH Network provider and pre-certified by PBH.	• Members using out of network providers may receive psychological testing when requested by out of Network provider and pre-certified by PBH.
<b>Chemical Dependency Benefits</b>	Combined benefit for Staff or Regional In-Network or Out-of-Network		
• Detoxification and Medically Managed Rehabilitation: Inpatient	• Covered	• Covered	• Deductible, 70% , Unlimited days per year
• Inpatient Residential	• Covered	• Covered	• Deductible, 70% , Unlimited days per year
• Outpatient and Acute Intensive Outpatient	• Covered	• Covered	• Deductible, 70%, Unlimited visits per year
• Emergency Room	• \$25 co-payment (waived if admitted)		
• Out of Pocket Maximum (Medical and Mental Health/ Substance Abuse)*	• N/A	• N/A	• \$2,500 Individual, \$5,000 Family
• Annual Deductible	• None	• None	• \$300 Individual, \$600 Family
• Lifetime Maximum	• None		• \$2,000,000