



UNIVERSITY OF PENNSYLVANIA HEALTH SYSTEM (UPHS) AND  
UNIVERSITY OF PENNSYLVANIA BEHAVIORAL HEALTH SERVICES AND EAP BENEFITS COVERAGE  
GUIDELINES FOR PROVIDERS AND PROVIDER GROUPS

**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.

The EAP sessions are on a prescription model – what is needed **up to** the number of sessions granted under the agreement with the employer. Therefore, not all sessions may be needed to accomplish the short term directive counseling and possible referral to their mental health/substance abuse benefit or community resources. Clients with EAP coverage may utilize their EAP benefit when the care they need warrants the use of short-term, brief and directive counseling to resolve minor life issues. The EAP benefit may occasionally be used for an initial assessment 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 the use of the EAP for ability to use benefits) function in determining use of the inpatient or outpatient benefits.

## **SERVICE DESCRIPTIONS**

PENN Behavioral Health provides and/or manages the following services:

- ASO Benefits {mental health and substance abuse benefits}
- EAP Services {short term directive counseling to identify and resolve minor life issues}
- Autism Services {for diagnosis & treatment of Autism Spectrum Disorders- University Employees & Dependents Only}

ASO 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, outpatient treatment for mental health or substance abuse issues is considered a Specialist Office visit. *Benefits for these services will be provided in an office visit by a provider other than a Primary Care Physician.* For the purposes of these plans, "in the office" includes outpatient mental health or substance abuse care visits to a provider's office.

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 under the mental health/substance abuse and medical/surgical plans. In this plan, outpatient care (i.e., psychotherapy, medication management) on the mental health/substance abuse benefits side are classified with outpatient care on the medical/surgical benefits side.

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.

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

### PBH REFERRAL PROCEDURE FOR MENTAL HEALTH/ SUBSTANCE ABUSE (MH/SA) BEHAVIORAL HEALTH SERVICES:

PBH will contact the provider or provider group 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 provider or provider group will always have the opportunity to determine the appropriateness and feasibility of accepting the referral. Should the referral be accepted, the provider or provider group should contact the patient to schedule the initial appointment.

All referrals will be categorized according to the urgency of scheduling an initial session and should be scheduled within the following time frames:

I.	Emergent:	Within twenty-four (24) hours
II.	Urgent:	Within forty-eight (48) hours
III.	Routine:	Within five (5) business days

### SELF- REFERRAL PROCEDURE FOR MH/SA BEHAVIORAL HEALTH SERVICES BENEFITS COVERAGE:

Precertification is not required for Routine Outpatient Mental Health/Substance Abuse services but all MH/SA outpatient services must be medically necessary as outlined above (see Page Two (2)).

When a PENN Behavioral Health (PBH) covered person attempts to make a self-referral for Outpatient Behavioral Health treatment, the member is not responsible for obtaining pre-certification. The provider or provider group is also not required to obtain pre-certification prior to rendering services. However, PBH requests that the provider or group call PBH prior to delivery of services to verify eligibility and register the general information with PBH. **The Provider or Provider Group should call the PBH Contact Center at 888-321-4433 and select Option # 3 to verify eligibility and register the general information with PENN Behavioral Health Services prior to seeing the patient.**

If the provider or provider group fails to obtain verification of eligibility and the person is not covered for services, the covered person will be held harmless for any financial liability and/or 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 Provider or Provider Group with the exception of any applicable co-payments or co-insurance.**

### GENERAL PROCEDURES FOR PROVIDERS AND PROVIDER GROUPS:

- ◆ Should the provider or provider group accept the referral, relevant demographic and clinical information will be provided.
- ◆ If the client fails to report for sessions, PBH should be informed for follow-up.
- ◆ Should a client with PBH Coverage present to the provider or provider group without a referral, the provider or group should contact PBH to verify eligibility and register the case information. Please call PBH Access Services at 888-321-4433 and select Option # 3.
- ◆ For all clinical procedural questions regarding Behavioral Health Services, please refer to the Summary Plan Description (SPD) on the PENN Behavioral Health Website at: [www.pennbehavioralhealth.org/services-behavioral.htm](http://www.pennbehavioralhealth.org/services-behavioral.htm) .

## **PAYMENT PROCESS FOR MENTAL HEALTH/SUBSTANCE ABUSE BENEFITS:**

- ◆ As noted above, when **Behavioral Health covered persons** seek treatment for outpatient care they **are not required to obtain pre-authorization** or a pre-service claim determination from PBH. We do ask that the provider notify PBH to verify the client's eligibility for services.
- ◆ Providers or provider groups will bill PBH as per the pre-negotiated rates for the outpatient treatment services.
- ◆ Payments will be dependent upon submission of correct and complete claims as outlined in the Claims Submission section of this agreement.
- ◆ **Under no circumstances should the covered person be billed for services provided by an In-Network Provider or Provider Group with the exception of any applicable co-payments or co-insurance.**
- ◆ It is up to the provider or provider group to determine if the services are covered prior to delivery of the treatment. The Provider or Provider Group should contact the Administrator for clarification of whether a given service is covered or medically necessary.
- ◆ If the services requested are 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.

A Summary Plan Description which defines medical necessity as well as the excluded and included Behavioral Health services may be viewed on the PBH Website at: <http://www.pennbehavioralhealth.org/services-behavioral.htm>.

The Contract Administrator is authorized to make payments directly to In-Network providers or provider groups furnishing covered services. PBH In-Network providers and provider groups have agreed to accept the rate of reimbursement determined by contract as payment in full for covered services. In-Network providers or provider groups will make no additional charge to covered persons for covered services except in the case of certain co-payments or co-insurance as defined by the plans (which are attached to this document). 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 PBH In-Network provider or provider group.

## **MENTAL HEALTH/SUBSTANCE ABUSE BEHAVIORAL HEALTH SERVICES:**

### **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 outpatient sessions determined by their benefit plan.

- ◆ Clients with primary presenting problems of an acute nature (i.e., Chemical Dependency, Major Depression, etc.) may be more appropriate for assessment and referral for in-patient treatment. Therefore, the MH/SA Benefit model should not be seen as a substitute for higher levels of in-patient care when appropriate.
- ◆ If it is necessary for inpatient treatment and you are a provider for the outpatient MH/SA Benefit it is important to educate clients regarding referral options. This means that you provide them with the option to go to a treatment facility and/or another therapist for a best match when clinically appropriate.
- ◆ 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 your assessment determines that a referral to another level of care is required, assistance with the selection of the specific referral source is considered a crucial element of your role as a Mental Health/Substance Abuse Benefit provider. Your role 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 level of care requires the notification of and authorization by PENN Behavioral Health Staff who may be contacted by calling 1-888-321-4433 and selecting Option # 3.
- ◆ It is imperative that you provide relevant clinical information to all appropriate referral sources. If a referral for clinical services is required, it is your responsibility to request that the client sign the PBH Release of Information Form and to verbally communicate any relevant information. The Release of Information Form can be requested by calling 1-888-321-4433 and selecting Option #3.
- ◆ The role of the provider also includes case management (e.g., follow-up and tracking of the clients' progress in the program to which they were referred). As appropriate, clients may be seen while they are in a level of care higher than outpatient (including intensive outpatient, partial, and inpatient) but no more frequently than every two weeks. Exceptions may be requested through the PENN Behavioral Health Staff who may be contacted by calling 1-888-321-4433, and selecting Option # 3.
- ◆ As an MH/SA Benefit provider you are encouraged to consider linking the client to community and company resources, self-help programs (and the like) during or subsequent to MH/SA Benefit Services. For example, you may encourage your client to attend an AA sponsored support program concurrent with the MH/SA Benefit sessions. We encourage you to be clinically sensitive with the scheduling of the MH/SA sessions for the best possible outcome. For example, you could elongate the duration of the MH/SA Benefit contact by alternating sessions every other week with a community resource.

### CONFIDENTIALITY/RELEASE OF INFORMATION:

- ◆ All providers and provider groups are required to adhere to Federal and State regulations and laws that pertain to the maintenance of confidential information/records. The provider 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 PBH 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.
- ◆ This provider/provider group contract designates 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.**

- ◆ Providers must have a signed Release of Information before providing communication to 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 provider or staff member contact or converse with anyone from a client's workplace without the express 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 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 express 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 by calling 1-888-321-4433, and selecting Option # 3.

### EAP SERVICES:

#### **RATIONALE FOR EMPLOYEE ASSISTANCE PROGRAM (EAP) SERVICES**

PENN Behavioral Health maintains EAP contracts with local and regional clients to provide EAP Services to employees. The goal of this program is to encourage managers and employees to take action as soon as a problem is identified by providing short term assistance to help employees with less serious issues identify and solve problems, and to develop coping skills quickly and efficiently.

The EAP is distinct in its workplace focus and is designed to help employees restore high levels of productivity while helping employers reduce absenteeism and address issues that impact performance. EAP Services help managers recognize problems that impact productivity by identifying issues such as substance abuse and providing them with a resource for early intervention. The EAP also provides a means for employees and their families to access help in times of crisis or when personal problems interfere with workplace performance and/or quality of life.

#### **GENERAL GUIDELINES FOR EAP SERVICES:**

- EAP Services typically include assessment, problem solving, short term intervention, and referral when necessary.
- EAP services should always begin with a thorough assessment of the presenting problem to determine if EAP intervention is appropriate or if more intensive services are needed.
- The assessment should result in the formulation of an EAP Service plan. Service goals should be objective and measurable.
- For employees in crisis, the typical goal is the restoration of the employee's satisfactory level of functioning through rapid linkage to appropriate service and appropriate follow up, including coordination of benefits when necessary.
- **EAP services are not psychotherapy sessions.** EAP Counseling is typically present centered, short term assistance that does not seek extensive exploration or attempted resolution of long term issues.
- A DSM-IV-TR/ICD-9 diagnosis is not a requirement to obtain services, but such a diagnosis does not preclude treatment through EAP Services. Severity and intensity of symptoms and/or presenting problems, combined with the available number of EAP sessions under the employer contract may be a better indicator of the appropriateness of EAP Services.
- EAP Services should not be considered as a substitute for psychotherapy when the initial assessment indicates a more serious problem.
- EAP services may be classified as general services (typically 3 to 5 sessions), SAP Services (typically 2 sessions) and Doctorate Level Evaluations (typically 1 session for determination of problem and referral if appropriate)

- PENN Behavioral Health Care Managers will handle all communications with supervisors and employers in the event of management based referrals. EAP Providers should never communicate directly with employers or any persons other than PENN Behavioral Health staff.
- EAP Providers should report all adverse incidents and/or cases which are potentially harmful or threatening to the patient, the employer, or the EAP provider directly to PBH by calling 888-321-4433 and selecting **Option # 2 to speak** with a Care Manager.

## COMPONENTS OF EAP SERVICES:

EAP Services is the work organization's resource that utilizes specific core technologies to enhance employee and workplace effectiveness through prevention, identification, and resolution of personal and productivity issues. The EAP is a workplace sponsored program designed to assist work organizations in addressing productivity issues and to assist employees and/or family members in identifying and resolving personal concerns that may affect job performance. These concerns may include but are not limited to:

- Marital and/or family issues
- Financial and/or legal problems
- Child and/or elder care concerns
- Substance Abuse
- Emotional well being
- Stress
- Health Issues
- Work related concerns
- Clinical problems related to:
  - Anxiety
  - Depression
  - Mood Disorders
  - Phobias
  - Gambling
  - Eating Disorders
  - Hyperactivity and/or inattention
  - Learning Disabilities
  - Substance Abuse

These types of concerns may be adversely affecting an employee's job performance, attendance, and/or safety.

The specific core activities of EAP services include assessment, brief focused consultation, or referral for appropriate diagnosis, treatment, and assistance. Additionally, EAP may assist in linking employees and their families with available community resources that can provide necessary services and follow up for a wide range of employee support services.

EAP services are, by design, broad in scope but time limited and focused on problem resolution within the specified session model.

The purpose of EAP intervention is assessment, referral, and education in the process of coordinating alternative levels of sustained care when needed.

EAP services may be classified as follows:

- General Services - typically 3 to 5 sessions
- SAP Services – typically 2 sessions
- Evaluations (doctorate level) - typically 1 session for diagnosis and referral if needed

Clients with EAP coverage may utilize their EAP benefit when the care they need warrants the use of short term, brief and directive counseling to resolve minor life issues, The EAP benefit may occasionally be used for an initial assessment 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.

- ◆ **Pre-Authorization is required for EAP Services. Generally, PBH will provide referrals directly to the provider or provider group.**
- ◆ **When EAP covered persons seek EAP services for outpatient care directly, they are required to obtain preauthorization from PBH. Providers or provider groups must have their EAP eligible clients contact PBH prior to delivery of services.**
- ◆ When authorization for EAP services is given, the providers or provider groups will bill PBH as per the authorized sessions and pre-negotiated rates for EAP services.
- ◆ If the provider or provider group fails to ensure that the client has obtained the required pre-service authorization for EAP services, 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 EAP services provided by an In-Network Provider or Provider Group in cases where eligibility was not verified and/or pre-authorization was not obtained.**

#### EAP CLIENT EDUCATION:

- ◆ It is essential that the client be clearly educated regarding the EAP provider's role of assessment, brief counseling, and, if indicated, referral. Short term EAP intervention (early identification and preventive services for problem identification and assessment) should be viewed as appropriate for problems that can be successfully resolved within a relatively small number of sessions. Clients with primary presenting problems of an acute nature (i.e., Chemical Dependency, Major Depression, etc.) are more appropriate for assessment and referral for longer-term treatment. Therefore, the EAP model should not be seen as a substitute for their mental health insurance benefit. The EAP Sessions are based on a prescription model, i.e., what is needed **up to** the number of sessions granted under the agreement with their employer. Therefore, not all sessions may be needed to accomplish the short term directive counseling or possible referral to their benefit or community resources.
- ◆ The EAP can never be used as a fail first (using lower levels of care first) or gatekeeper (requiring the use of the EAP for ability to use the benefits) function in determining use of the inpatient or outpatient benefits.
- ◆ Mental Health Parity mandates a clear distinction between EAP and Mental Health/**Substance Abuse** Benefits. Therefore, providers will need to determine if it is necessary for long term treatment during the initial evaluations. It is important to educate clients regarding referral options, especially if the provider or provider group **handles** both EAP and MH/SA benefits. This means that you may need to provide clients with the option to go to a facility and/or another therapist for a best match when clinically appropriate.

- ◆ The provider should inform the client that he or she is a designated provider of PENN Behavioral Health EAP Services. In this capacity, the provider's involvement will be limited to the parameters of the EAP relationship (unless the client's mental health benefit allows them to continue). Therefore, if the assessment determines the need for ongoing treatment, the provider will be assisting the client with linkage to their mental health benefit.
- ◆ 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 EAP 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 should be released must be specified on the release provided. Clients should also be informed about the exceptions to confidentiality as mandated by federal regulation. These are outlined in the Statement of Understanding.

**PBH REFERRALS FOR EAP SHORT TERM ASSESSMENT/ BRIEF COUNSELING:**

PBH will contact the provider or provider group to advise of a prospective EAP 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 provider or provider group will always have the opportunity to determine the appropriateness and feasibility of accepting the referral. Should the referral be accepted, all relevant demographic and clinical paperwork will be sent to the provider or provider group via mail or facsimile. The provider or provider group should contact the patient to schedule the initial appointment .

- ◆ All referrals will be categorized according to the urgency of scheduling an initial session and should be scheduled within the following time frames:

I.	<b>Emergent:</b>	<b>Within twenty-four (24) hours</b>
II.	<b>Urgent:</b>	<b>Within forty-eight (48) hours</b>
III.	<b>Routine:</b>	<b>Within five (5) business days</b>

- ◆ PBH makes every effort to ensure continuity of care by sending clients who call for EAP services to providers in the PBH network who also accept their Mental Health Insurance in the event that there is a need to transition from EAP to Behavioral Health Benefits.
- ◆ **Please Note:** If a provider constantly sends all EAP Clients into their benefits, it raises a question regarding the provider's current understanding of the difference between EAP (Short term directive counseling to provide the client with coping skills and techniques to resolve minor issues) and Benefits (traditional longer term therapy to resolve or improve personality issues or disorders, major depressive or anxiety conditions, adjustment disorders, or family systems therapy. There will be times where the EAP is used to assess these issues and uncovers the need for long term therapy, but EAP is not therapy or a pre-benefit for therapy with no co-pay. EAP was originally designed (at the beginning of the development of EAPs's) as a way of improving employee performance at work, hence, employee assistance programs are sponsored and paid by the employer.
- ◆ There will be times where EAP Services may assess and uncover the need for long term therapy, but EAP is not a therapy or a pre-benefit for therapy with no co-pay. If the assessment determine that referral to another level of care is required, assistance with the selection of a specific referral source is considered a crucial element of the role of EAP provider. The role of an EAP provider or provider group in this regard is to ensure a smooth transition to benefit or other referral source. Follow up sessions may be indicated after referral to another resource if it will ensure a successful outcome.

- ◆ It is imperative that relevant clinical information is provided to all appropriate referral sources. If a referral for clinical services is required, it is the provider's responsibility to request that the client sign a Release of Information and verbally communicate any relevant information. Documentation of the linkage to the referral is required on the Closing Summary Form.
- ◆ The provider's role also includes case management (e.g., follow-up and tracking of the clients' progress in the program to which they were referred). As appropriate, the client may be seen while they are in a level of care higher than outpatient (including intensive outpatient, partial, and inpatient) but no more frequently than every two weeks. Exceptions may be requested through the PENN Behavioral Health Staff who may be contacted by calling 1-888-321-4433, and selecting Option # 2.
- ◆ As an EAP provider, you are encouraged to consider linking the client to community and company resources, self-help programs (and the like) during or subsequent to EAP Services. For example, you may encourage your client to attend a company sponsored work/life program concurrent with the EAP sessions. We encourage you to be creative with the scheduling of EAP sessions for the best possible outcome. For example, you could elongate the duration of the EAP contact by alternating EAP sessions every other week with a community resource.

#### SELF- REFERRAL PROCEDURE FOR EAP SERVICES:

- ◆ Precertification is required for EAP Services. When an EAP covered person attempts to make a self-referral for EAP services, it is the responsibility of the provider to ensure that the client has obtained pre-certification before EAP services are rendered. The Provider or Provider Group should immediately contact PENN Behavioral Health at 888-321-4433 and select Option # 2 to verify eligibility and appropriateness of EAP brief counseling services. PBH will then send all relevant information and paperwork to the provider or provider group via mail or facsimile.
- ◆ If the provider or provider group fails to obtain verification of eligibility and appropriateness for EAP Services, and the person is not covered or the services are not appropriate for short term EAP therapy, the patient will be held harmless for any financial responsibility and/or associated financial penalties assessed by PBH as a result.
- ◆ **Under no circumstances should a covered person be billed for EAP services provided by an In-Network Provider or Provider Group.**

#### EAP DOCUMENTATION:

- ◆ All clients should be instructed to complete the "EAP Client Packet" at their initial session. Please ensure that your client completes the entire packet. This includes an introduction to the EAP, basic demographics, reason for referral, and the Statement of Understanding. The EAP Client Packet is to go into client's chart. The duplicate copy of the Statement of Understanding is to be given to client.
- ◆ The provider will be responsible for completing the "EAP Provider Packet." The provider packet must be completed and submitted to PENN Behavioral Health EAP within seven (7) days of the final session. This packet includes:
  - A. Intake Assessment This form serves as the documentation of the initial session. It gathers data such as demographic information, employment data, presenting and assessed problems, type of referral and referral source, work, treatment and psychosocial history, risk assessment, medications, and diagnosis. The original form is to be submitted to PENN Behavioral Health, and the copy is to go in the chart.
  - B. Closing Summary This form serves as the documentation for all subsequent sessions (if required). The original Form is to be submitted to PENN Behavioral Health and the copy is to go into the chart.

C. Claim Form: The CMS 1500 Claim Form (formerly HCFA) contains the elements later defined in the claims submission section of this agreement and must be included with the EAP Documentation in order to ensure payment of claims.

- ◆ Documentation will be initially reviewed upon receipt to determine if all required forms are submitted and if requirements related to timeliness are met. Incomplete documentation will be returned to you for completion.

#### CONFIDENTIALITY/RELEASE OF INFORMATION:

- ◆ All providers are required to adhere to Federal and State regulations and laws that pertain to the maintenance of confidential information/records. The provider agreement forbids the discussion of participants outside the EAP. 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 subject to other remediation per our peer review process.
- ◆ This provider contract designates PBH in-network providers as authorized agents of PENN Behavioral Health. **Therefore, you do not need to obtain a written release to communicate with any PBH/EAP staff member, either verbally or in writing.**
- ◆ All Information regarding EAP cases is confidential and may be shared only between the Provider or Provider Group and PENN Behavioral Health staff. If contact with an EAP client's workplace is indicated, the provider should contact PBH by calling 888-321-4433 and selecting Option # 2 to notify a Care Manager of any the situation.
- ◆ **PBH Staff will be responsible for all communications with the client's workplace. Under no circumstances should any provider or provider group, staff member contact an EAP Client's workplace.**

**PLEASE NOTE:** Under no circumstances should a provider submit any written documentation, including letters to the workplace, court, or to any party. In order to ensure the utmost confidentiality of client records PENN Behavioral Health EAP requires a court order for the release of all written documentation. Please direct any inquiries to PENN Behavioral Health EAP staff by calling 1-888-321-4433, and selecting Option # 2. If required, PBH Staff will be responsible for supplying any written documentation.

#### PAYMENT PROCESS FOR EAP SERVICES:

- ◆ As noted above, pre-authorization is required for EAP Services. An EAP Authorization Number must be included when submitting claims for EAP Sessions.
- ◆ In the event of an EAP Self-referral, it is the responsibility of the provider or provider group to verify that the client has obtained pre-authorization. The provider should call 888-321-4433 and select Option #2 to obtain the EAP authorization number.
- ◆ Providers or provider groups will bill PBH as per the pre-negotiated rates for EAP services. There are no co-payments required for EAP Sessions.
- ◆ Payments will be dependent upon submission of correct and complete claims as outlined in the Claims Submission section of this agreement.
- ◆ **Under no circumstances should a covered person be billed for EAP services provided by an In-Network Provider or Provider Group.**

## AUTISM SPECTRUM DISORDERS:

- ◆ The University of Pennsylvania (not UPHS) has elected in FY 2012 to cover services for Autism Spectrum Disorders for two of their active member plans. The plans which cover Autism Spectrum Disorders are the University PPO and POS Plans listed in the Benefit Schedules A and B.
- ◆ The guidelines and standards being followed for Autism Spectrum Disorder Services will match those enumerated in PA Act 62 with the exception of the maximum allowance which has been deleted from the plan in deference to a non-limited benefit.
- ◆ Benefits are based on medical necessity and are covered for enrollees 21 years of age or younger.
- ◆ There are no lifetime limits and there will not be a yearly cap on coverage dollars. All medical and behavioral health co-payments, co-insurance, deductibles, out of pocket maximums, and other general exclusions and limitations will apply.
- ◆ Autism services covered by PBH must be specified in an approved Treatment Plan as defined in the Autism Spectrum Disorders Provider Guidelines which will be supplied to all providers and provider groups who treat Autism Spectrum Disorders. These documents can also be viewed on the PBH Website at <http://www.pennbehavioralhealth.org/autism.htm>.
- ◆ It is the responsibility of the provider to verify that an approved treatment plan is on file and to obtain authorization prior to providing autism services. Providers may call the Contact Center at 888-321-4433 and select Option #3 to obtain verification and authorization.
- ◆ Services not included in the treatment plan will not be covered.
- ◆ Other exclusions include treatment medications and services covered by medical plans. These include blood level tests and therapies provided by speech/language pathologists, occupational therapists, and physical therapists.
- ◆ Autism Spectrum Services provided in a school setting or available through a school district are not covered.
- ◆ PENN Behavioral Health will not provide payment for cancellations or no-shows. The provider maintains responsibility to collect all amounts related to co-payments, deductibles, and co-insurance. Payments, as set forth above, will be reduced by the applicable amount due from the patient whether collected or not.
- ◆ All claims for authorized services rendered under the approved treatment plan must be submitted on a CMS 1500 Form within sixty (60) days of service date. All claims must include patient identification data, certification numbers for each encounter, date(s) of service, and CPT code(s). PENN Behavioral Health reserves the right to reject and/or deny any claims for services which are incomplete, illegible, or submitted beyond this deadline.
- ◆ Claims should be mailed to:

PENN Behavioral Health  
3535 Market Street, 4<sup>th</sup> Floor,  
Philadelphia, PA 19104  
ATTENTION: Claims Department.

## COMPLAINT/GRIEVANCE PROCEDURE:

PENN Behavioral Health is committed to member and customer service and has established a process for providers and provider groups 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 written 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.

### Questions:

Please contact PENN Behavioral Health with any questions, concerns, problems, or suggestions that you might have.

Please have members or employees and/or their dependents contact PENN Behavioral Health with any questions, concerns, problems, or suggestions that they might have.

## 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.

## **PAYMENTS AND REIMBURSEMENTS:**

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

- ◆ The rate of reimbursement as stipulated in the provider contract constitutes payment in full with the exception of applicable co-payment or co-insurance amounts under Mental Health Benefits.
- ◆ **PENN Behavioral Health Clients will be held harmless for any payment with the exception of any applicable co-payments or co-insurance.**
- ◆ Do not discuss your fees with clients or have them fill out any financial screening forms.
- ◆ Do not discuss fees with other providers, provider groups, or facilities.
- ◆ 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 and selecting, Option # 3.

## FILING CLAIMS FOR BEHAVIORAL HEALTH AND EAP SERVICES

### CLAIMS FILING PROCEDURES:

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

Preferred (In-Network) Providers or Provider Groups 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) Providers 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) providers with the exception of any applicable co-payments or co-insurance **under mental health benefits**.

PENN Behavioral Health EAP clients will at all times be held harmless for payment of services rendered by Preferred (In-Network) providers without exception.

### IT IS THE PROVIDER'S RESPONSIBILITY TO:

- ◆ Collect applicable co-payments from Covered Persons and submit "clean claims" for the services provided;
- ◆ Submit "clean claims" for provider based services on an accurately completed paper CMS-1500 claim form for provider based services and programs;

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) 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 EAP 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 provider or provider group 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 is 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 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 not, more information may be requested from the claimant. The Plan reserves the right to have a Plan Participant seek a second medical opinion.

SAMPLE

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

### Details of Coverage for Active PENNCare PPO Plan for FY2012

BENEFIT COVERAGE	In-Network PBH Staff	In-Network PBH Regional Network	Out-of-Network
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>	<b>COMBINED BENEFIT IN-NETWORK AND OUT-OF-NETWORK</b>		
• Acute Inpatient*	• Deductible, 90%, Unlimited Days	• Deductible, 90%, Unlimited Days	• Deductible, 60% , Unlimited days
• Acute Partial Hospitalization*	• Deductible, 90%, Unlimited Days	• Deductible, 90%, Unlimited Days	• Deductible, 60% , Unlimited days
• Acute Intensive Outpatient*	• Deductible, 90%, Unlimited Days	• Deductible, 90%, Unlimited Days	• Deductible, 60% , Unlimited days
• Outpatient Non-Office Visit (Diagnostic Testing)*	• 100% , Unlimited Visits per year	• 100%, Unlimited Visits per year	• Deductible, 60%, Unlimited Visits per year
NOTE: * INDICATES SERVICES REQUIRING PRECERTIFICATION. It is the responsibility of the provider to pre-certify the services listed above.			
• Outpatient Office Visit	• 100% after \$20 co-pay, Unlimited Visits per year	• 100% after \$20 co-pay, Unlimited Visits per year	• Deductible, 60%, Unlimited Visits per year
• Emergency Room	• \$100 copay (waived if admitted)		
• Out of Pocket Maximum (Medical and Mental Health/ Substance Abuse) †	• \$1,000 Individual, \$3,000 Family	• \$1,000 Individual, \$3,000 Family	• \$3,500 Individual, \$10,500 Family
• Annual Deductible¥	• \$100 Individual/\$300 Family	• 100 Individual/\$300 Family	• \$500 Individual/\$1,500 Family
• Lifetime Maximum	• None		
<b>CHEMICAL DEPENDENCE BENEFITS</b>	<b>COMBINED BENEFIT FOR IN-NETWORK AND OUT-OF-NETWORK</b>		
• Detoxification*	• Deductible, 90%, Unlimited Days	• Deductible, 90%, Unlimited Days	• Deductible, 60% , Unlimited days
• Acute Inpatient Residential Rehab*	• Deductible, 90%, Unlimited Days	• Deductible, 90%, Unlimited Days	• Deductible, 60% , Unlimited days
• Acute Partial Hospitalization*	• Deductible, 90%, Unlimited Days	• Deductible, 90%, Unlimited Days	• Deductible, 60% , Unlimited days
• Acute Intensive Outpatient*	• Deductible, 90%, Unlimited Days	• Deductible, 90%, Unlimited Days	• Deductible, 60% , Unlimited days
• Outpatient Non-Office Visit (Diagnostic Testing)*	• 100% , Unlimited Visits per year	• 100%, Unlimited Visits per year	• Deductible, 60%, Unlimited Visits per year
NOTE: * INDICATES SERVICES REQUIRING PRECERTIFICATION. It is the responsibility of the provider to pre-certify the services listed above.			
• Outpatient Office Visit	• 100% after \$20 co-pay, Unlimited Visits per year	• 100% after \$20 co-pay, Unlimited Visits per year	• Deductible, 60%, Unlimited Visits per year
• Emergency Room	• \$100 copay (waived if admitted)		
• Out of Pocket Maximum (Medical and Mental Health/ Substance Abuse) †	• \$1,000 Individual, \$3,000 Family	• \$1,000 Individual, \$3,000 Family	• \$3,500 Individual, \$10,500 Family

• Annual Deductible ¥	• \$100 Individual/\$300 Family	• 100 Individual/\$300 Family	• \$500 Individual/\$1,500 Family
<b>CHEMICAL DEPENDENCE BENEFITS (CONTINUED)</b>	<b>COMBINED BENEFIT FOR IN-NETWORK AND OUT-OF-NETWORK (CONTINUED)</b>		
• Lifetime Maximum	• None		
<b>AUTISM BENEFITS</b>	<b>COMBINED BENEFIT FOR IN-NETWORK AND OUT-OF-NETWORK</b>		
• <b>Acute Inpatient *</b>	• Deductible, 90%, Unlimited Days	• Deductible, 90%, Unlimited Days	• Deductible, 60% , Unlimited days
• <b>Acute Partial Hospitalization*</b>	• Deductible, 90%, Unlimited Days	• Deductible, 90%, Unlimited Days	• Deductible, 60% , Unlimited days
• <b>Acute Intensive Outpatient*</b>	• Deductible, 90%, Unlimited Days	• Deductible, 90%, Unlimited Days	• Deductible, 60% , Unlimited days
• <b>Outpatient Non-Office Visit * for Diagnostic and Psychological Testing, and Treatment Plan</b>  • <b>Also ABA and Other Rehabilitative Services*</b>  PRECERTIFICATION REQUIRED	• 100% , Unlimited Visits per year	• 100%, Unlimited Visits per year	• Deductible, 60%, Unlimited Visits per year
<b>NOTE: * INDICATES SERVICES REQUIRING PRECERTIFICATION. It is the responsibility of the provider to pre-certify the services listed above.</b>			
• <b>Outpatient Office Visit</b>	• 100% after \$20 co-pay, Unlimited Visits per year	• 100% after \$20 co-pay, Unlimited Visits per year	• Deductible, 60%, Unlimited Visits per year
• <b>Emergency Room</b>	• \$100 copay (waived if admitted)		
• <b>Out of Pocket Maximum (Medical and Mental Health/ Substance Abuse) †</b>	• \$1,000 Individual, \$3,000 Family †	• \$1,000 Individual, \$3,000 Family †	• \$3,500 Individual, \$10,500 Family †
• Annual Deductible ¥	• \$100 Individual/\$300 Family	• 100 Individual/\$300 Family	• \$500 Individual/\$1,500 Family
• Lifetime Maximum	• None		

\* = Precertification Required

† = Out of Pocket Maximum includes the medical benefit

¥ = Annual Deductible maximum includes the medical benefit

*It is the responsibility of the member to demonstrate that the Annual Out of Pocket Maximum and Annual Deductible levels have been reached in order to be eligible for reimbursement.*

**B. SCHEDULE OF BENEFITS FOR UNIVERSITY OF PENNSYLVANIA ACTIVES**  
***Details of Coverage for Active Aetna Point of Service POS CHOICE II Plan for FY 2012***

<b>BENEFIT COVERAGE</b>	<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>	<b>COMBINED BENEFIT IN-NETWORK AND OUT-OF-NETWORK</b>		
• Acute Inpatient*	• Deductible, 80%, Unlimited Days	• Deductible, 80%, Unlimited Days	• Deductible, 60% , Unlimited days
• Acute Partial Hospitalization*	• Deductible, 80%, Unlimited Days	• Deductible, 80%, Unlimited Days	• Deductible, 60% , Unlimited days
• Acute Intensive Outpatient*	• Deductible, 80%, Unlimited Days	• Deductible, 80%, Unlimited Days	• Deductible, 60% , Unlimited days
• Outpatient Non-Office Visit * (Diagnostic Testing)	• 100% , Unlimited Visits per year	• 100%, Unlimited Visits per year	• Deductible, 60%, Unlimited Visits per year
<b>NOTE: * INDICATES SERVICES REQUIRING PRECERTIFICATION. It is the responsibility of the provider to pre-certify the services listed above.</b>			
• Outpatient Office Visit	• 100% after \$30 co-pay, Unlimited Visits per year	• 100% after \$30 co-pay, Unlimited Visits per year	• Deductible, 60%, Unlimited Visits per year
• Emergency Room	• \$150 copay (waived if admitted)		
• Out of Pocket Maximum (Medical and Mental Health/ Substance Abuse) †	• \$2,000 Individual, \$6,000 Family	• \$2,000 Individual, \$6,000 Family	• \$3,000 Individual, \$9,000 Family
• Annual Deductible¥	• \$500 Individual/\$1,500 Family	• \$500 Individual/\$1,500 Family	• \$1,000 Individual/\$3,000 Family
• Lifetime Maximum	• None		
<b>CHEMICAL DEPENDENCE BENEFITS</b>	<b>COMBINED BENEFIT FOR IN-NETWORK AND OUT-OF-NETWORK</b>		
• Detoxification*	• Deductible, 80%, Unlimited Days	• Deductible, 80%, Unlimited Days	• Deductible, 60% , Unlimited days
• Acute Inpatient Residential Rehab*	• Deductible, 80%, Unlimited Days	• Deductible, 80%, Unlimited Days	• Deductible, 60% , Unlimited days
• Acute Partial Hospitalization*	• Deductible, 80%, Unlimited Days	• Deductible, 80%, Unlimited Days	• Deductible, 60% , Unlimited days
• Acute Intensive Outpatient*	• 100% , Unlimited Visits per year	• 100%, Unlimited Visits per year	• Deductible, 60%, Unlimited Visits per year
• Outpatient Non-Office Visit * (Diagnostic Testing)	• Deductible, 80%, Unlimited Days	• Deductible, 80%, Unlimited Days	• Deductible, 60% , Unlimited days
<b>NOTE: * INDICATES SERVICES REQUIRING PRECERTIFICATION. It is the responsibility of the provider to pre-certify the services listed above.</b>			
• Outpatient Office Visit	• 100% after \$30 co-pay, Unlimited Visits per year	• 100% after \$30 co-pay, Unlimited Visits per year	• Deductible, 60%, Unlimited Visits per year
• Emergency Room	• \$150 copay (waived if admitted)		
• Out of Pocket Maximum (Medical and Mental Health/ Substance Abuse) †	• \$2,000 Individual, \$6,000 Family	• \$2,000 Individual, \$6,000 Family	• \$3,000 Individual, \$9,000 Family
• Annual Deductible ¥	• \$500 Individual/\$1,500 Family	• \$500 Individual/\$1,500 Family	• \$1,000 Individual/\$3,000 Family

CHEMICAL DEPENDENCE BENEFITS (CONTINUED)	COMBINED BENEFIT FOR IN-NETWORK AND OUT-OF-NETWORK (CONTINUED)		
• Lifetime Maximum	• None		
AUTISM BENEFITS	COMBINED BENEFIT FOR IN-NETWORK AND OUT-OF-NETWORK		
• Acute Inpatient *	• Deductible, 80%, Unlimited Days	• Deductible, 80%, Unlimited Days	• Deductible, 60% , Unlimited days
• Acute Partial Hospitalization*	• Deductible, 80%, Unlimited Days	• Deductible, 80%, Unlimited Days	• Deductible, 60% , Unlimited days
• Acute Intensive Outpatient*	• Deductible, 80%, Unlimited Days	• Deductible, 80%, Unlimited Days	• Deductible, 60% , Unlimited days
• Outpatient Non-Office Visit * for Diagnostic and Psychological Testing, and Treatment Plan  • Also ABA and Other Rehabilitative Services*  PRECERTIFICATION REQUIRED	• 100% , Unlimited Visits per year	• 100%, Unlimited Visits per year	• Deductible, 60%, Unlimited Visits per year
<b>NOTE: * INDICATES SERVICES REQUIRING PRECERTIFICATION. It is the responsibility of the provider to pre-certify the services listed above.</b>			
• Outpatient Office Visit	• 100% after \$30 co-pay, Unlimited Visits per year	• 100% after \$30 co-pay, Unlimited Visits per year	• Deductible, 60%, Unlimited Visits per year
• Emergency Room	• \$100 copay (waived if admitted)		
• Out of Pocket Maximum (Medical and Mental Health/ Substance Abuse) †	• \$2,000 Individual, \$6,000 Family †	• \$2,000 Individual, \$6,000 Family †	• \$3,000 Individual, \$9,000 Family †
• Annual Deductible ¥	• \$500 Individual/\$1,500 Family	• \$500 Individual/\$1,500 Family	• \$1,000 Individual/\$3,000 Family
• Lifetime Maximum	• None		

\* = Precertification Required

† = Out of Pocket Maximum includes the medical benefit

¥ = Annual Deductible maximum includes the medical benefit

*It is the responsibility of the member to demonstrate that the Annual Out of Pocket Maximum and Annual Deductible levels have been reached in order to be eligible for reimbursement.*

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

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

BENEFIT COVERAGE	IN-NETWORK	OUT-OF-NETWORK
AVAILABLE PROVIDERS	Must choose PENN Behavioral Health Staff or Regional In-Network providers.	May choose any qualified provider
<b>MENTAL HEALTH BENEFITS</b>	<b>COMBINED BENEFIT FOR IN-NETWORK AND OUT-OF-NETWORK</b>	
● Acute Inpatient *	● 100% coverage after \$250 co-pay per admission Unlimited days per year	● 65% , Unlimited days per year
● Acute Partial Hospitalization *	● 100% coverage after \$250 co-pay per admission Unlimited days per year	● 65% , Unlimited days per year
● Acute Intensive Outpatient *	● 100% coverage after \$30 co-pay per admission Unlimited visits per year	● 65% , Unlimited visits per year
● Outpatient Non-Office Visit * (Diagnostic Testing)	● 100% coverage, Unlimited Visits per year	● 65%, Unlimited visits per year
NOTE: * INDICATES SERVICES REQUIRING PRECERTIFICATION. It is the responsibility of the provider to per-certify the services listed above.		
● Outpatient Office Visit	● 100% coverage after \$30 co-pay Unlimited visits per year	● 65% , Unlimited visits per year
● Out of Pocket Maximums †	● \$1,000 Individual/\$2,000 Family	● \$3,500 Individual, \$10,500 Family
● Lifetime Maximum	● None	● \$1,500,000
● Testing	● 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 DEPENDENCE BENEFITS</b>	<b>COMBINED BENEFIT FOR STAFF AND REGIONAL IN-NETWORK OR OUT-OF-NETWORK</b>	
● Acute Inpatient *	● 100% coverage after \$250 co-pay per admission Unlimited days per year	● 65% , Unlimited days per year
● Acute Partial Hospitalization *	● 100% coverage after \$250 co-pay per admission Unlimited days per year	● 65% , Unlimited days per year
● Acute Intensive Outpatient *	● 100% coverage after \$30 co-pay per admission Unlimited visits per year	● 65% , Unlimited visits per year
● Outpatient Non-Office Visit * (Diagnostic Testing)	● 100% coverage, Unlimited Visits per year	● 65%, Unlimited visits per year
NOTE: * INDICATES SERVICES REQUIRING PRECERTIFICATION. It is the responsibility of the provider to per-certify the services listed above.		
● Outpatient Office Visit	● 100% coverage after \$30 co-pay Unlimited visits per year	● 65% , Unlimited visits per year
● Out of Pocket Maximums †	● \$1,000 Individual/\$2,000 Family	● \$3,500 Individual, \$10,500 Family
● Lifetime Maximum	● None	● \$1,500,000
● Testing	● 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

\* Precertification Required

† Shared deductible and out of pocket maximum includes the medical benefit

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

***Details of Coverage for PENNCare/Personal Choice PPO and PENN Preferred Point of Service POS Plans  
(Aetna OPOS and Keystone POS) Plans for FY 2012***

BENEFIT COVERAGE	In-Network PBH Staff	In-Network PBH Regional Network	Out-of-Network
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>	<b>COMBINED BENEFIT IN-NETWORK AND OUT-OF-NETWORK</b>		
• Acute Inpatient*	• Covered	• Covered	• Deductible, 70% , Unlimited days per year
• Acute Partial Hospitalization*	• Covered	• Covered	• Deductible, 70% , Unlimited days per year
• Acute Intensive Outpatient*	• Covered	• Covered	• Deductible, 70% , Unlimited days per year
• Outpatient Non-Office * Visit (Diagnostic Testing)	• 100% , Unlimited Visits per year	• 100%, Unlimited Visits per year	• Deductible, 70%, Unlimited Visits per year
• Outpatient Office Visit	• \$10 co-pay per session Unlimited Visits per year	• \$10 co-pay per session Unlimited Visits per year	• Deductible, 70% Unlimited Visits per year
• Emergency Room	• \$25.00 copay (waived if admitted)		
• Annual Out of Pocket Maximums For both MH & CD combined	• N/A	• N/A	• \$2,500 Individual/\$5,000 Family
• Annual Deductibles	• None	• None	• \$300 Individual/\$600 Family
• Lifetime Maximum	• No Lifetime Maximum		
<b>CHEMICAL DEPENDENCE BENEFITS</b>	<b>COMBINED BENEFIT FOR IN-NETWORK AND OUT-OF-NETWORK</b>		
• Detoxification & Rehab* A combined benefit for both detox & residential treatment	• Covered	• Covered	• Deductible, 70% , Unlimited days per year
• Acute Partial Hospitalization*	• Covered	• Covered	• Deductible, 70% , Unlimited days per year
• Acute Intensive Outpatient*	• Covered	• Covered	• Deductible, 70% , Unlimited days per year
• Outpatient Non-Office Visit (Diagnostic Testing)*	• 100% , Unlimited Visits per year	• 100%, Unlimited Visits per year	• Deductible, 70%, Unlimited Visits per year
• Outpatient Office Visit	• \$10 co-pay per session Unlimited Visits per year	• \$10 co-pay per session Unlimited Visits per year	• Deductible, 70% Unlimited Visits per year
• Emergency Room	• \$25.00 copay (waived if admitted)		
• Annual Out of Pocket Maximums For both MH & CD combined	• N/A	• N/A	• \$2,500 Individual/\$5,000 Family
• Annual Deductibles	• None	• None	• \$300 Individual/\$600 Family
• Lifetime Maximum	• No Lifetime Maximum		

\* = Precertification Required

Legal Disclaimer: The descriptions in this chart are not intended to be complete, accurate statements of every benefit. There may be differences between these descriptions and the actual plan document. Where details differ, the plan document shall apply. Employees are advised that plans are amended from time to time; it is the employee's responsibility to inquire about the effect of such changes with the plan. For clarity regarding the details of your Mental Health/Chemical Dependence coverage and services requiring precertification, please contact PENN Behavioral Health at 888-321-4433 and select Option # 3.