

**BENEFITS EXPLANATION FOR
MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES
PROVIDED BY
PENN BEHAVIORAL HEALTH
(Hereafter called “the Contract Administrator”)
FOR
THE UNIVERSITY OF PENNSYLVANIA**

June 2008



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I. INTRODUCTION TO THE UNIVERSITY OF PENNSYLVANIA BEHAVIORAL HEALTH BENEFITS

What services are provided by the Contract Administrator?

The Contract Administrator is the provider of certain administrative services for the University of Pennsylvania. These services include (i) arranging for a network of mental health and substance abuse providers and facilities to provide Covered Services, (ii) conducting a utilization management program related to the Covered Services, and (iii) processing claims and appeals relating to the Covered Services.

Introduction to Your Benefits:

The Contract Administrator provides administrative services for the medical plan options offered under the University of Pennsylvania Health and Welfare Program. The three plans, which include behavioral health benefits administered by PENN Behavioral Health, include the PENNCare/Personal Choice (PPO) Plan, the UPHS Point of Service (POS) Plan and the AmeriHealth Point of Services (POS) Plan. Both the POS and the PPO options have an In-Network group of preferred providers who work directly with the Contract Administrator. You may use any qualified provider you wish, but your out-of-pocket expense will be less when you utilize the preferred providers. You do not have to choose a primary care physician or obtain referrals from a primary care physician to utilize the behavioral health benefits.

The PENN Behavioral Health (PBH) Benefit Options:

The PBH option has two parts:

- Preferred Providers – Use physicians, hospitals, and other health care providers who are part of the PENN Behavioral Health provider network. When you use a provider in this network, you do not have to meet a deductible, the Plans pay 100% (after applicable co-payments and admission fees) for the services which are covered, and there are no claim forms to be filed.
- Non-Preferred Providers - Use physicians, hospitals, and other health care qualified providers who are not a part of the PENN Behavioral Health provider network. When you use this level of benefits, note that the payment for services is based on a percentage of the Plans' Usual, Customary, and Reasonable (UCR) Rates and you must file claim forms. While each of the Plans pays a percentage (based on the Plan you choose) for the services which are covered, all additional charges of the provider for Out-of-Network services are your responsibility.

As a participant in the Covered Services of the Plans, you have a unique opportunity for increased savings on health care costs when you choose an In-Network provider. To verify that the provider you select is a PENN Behavioral Health participating provider, call 1-888-321-4433.

II. BENEFITS ELIGIBILITY

The Contract Administrator certifies that Eligible Faculty and Staff and their Dependents enrolled in the POS and the PPO plans are entitled to the Covered Services described in this booklet subject to the eligibility and Effective Date requirements of the Group Contract.

This booklet replaces any and all booklets or communications previously issued by the University of Pennsylvania or the Contract Administrator explaining the behavioral health services.

This booklet is a summary of the Group Contract provisions that affect the Covered Services. All benefits and exclusions are subject to the terms of the Group Contract.

ATTEST:

BY

III. INTRODUCTION

This booklet has been prepared so that participants may become acquainted with the PBH option offered under the Plans. Covered Services under the Plans are available to eligible Faculty and Staff (Primary Covered Persons) and their eligible dependents as defined by the Plans who have properly enrolled for Covered Services. For definitions of Group or (Enrolled Group), Covered Persons, Employees, or Family Coverage see the “GLOSSARY OF DEFINED TERMS” section (Section XVII) of this booklet. The Covered Services described in this booklet are subject to the terms and conditions of the Group Contract.

Limits to the Benefit:

Benefits will not be available for Covered Services to a greater extent or for a longer period than is Medically Appropriate/Medically Necessary, as required by the Plans and as determined by the Contract Administrator. For definitions of Medically Appropriate and/or Medically Necessary see the “GLOSSARY OF DEFINED TERMS” section (Section XVII) of this booklet. The amount of benefits for any Covered Services will not exceed the amount charged by the behavioral health care provider, and will not be greater than any maximum amount or limit described or referred to in this booklet.

Regarding Experimental or Investigative Treatment:

The Contract Administrator will not approve the coverage of treatment that it determines to be Experimental or Investigative in nature because that treatment is not accepted by the general medical community for the condition being treated or not approved as required by federal or governmental agencies. However, the Contract Administrator acknowledges that situations exist when a Covered Person or his or her Physician agree to utilize Experimental or Investigative treatment. If a Covered Person receives Experimental or Investigative treatment, the Covered Person shall be responsible for the cost of the treatment. A Covered Person or his or her Physician may contact the Contract Administrator to determine whether a treatment is considered Experimental or Investigative. The term “Experimental or Investigative” is defined in the “GLOSSARY OF DEFINED TERMS” section (Section XVII) of this booklet.

Regarding Treatment which is not Medically Appropriate/Medically Necessary:

The Contract Administrator only approves the coverage of treatment which it determines to be Medically Appropriate/Medically Necessary as defined by the Plans. A PENN Behavioral Health Preferred (In-Network) Provider accepts the Contract Administrator’s decision regarding benefit determination of Covered Services and will not bill the Covered Person for treatment which the Contract Administrator determines is not Medically Appropriate/Medically Necessary without that person’s consent. A Non-Preferred (Out-of-Network) Provider, however, is not obligated to accept the Contract Administrator’s determination of the Covered Services and the Covered Person may not be reimbursed for treatment which the Contract Administrator determines is not Medically Appropriate/Medically Necessary. The Covered Person is responsible for these charges when treatment is received by a Non-Preferred (Out-of-Network) Provider. A person may avoid these charges simply by choosing a Preferred (In-Network) Provider for their care. A Covered Person can, however, always choose to pay out of pocket for any services provided by either a Non-Preferred or a Preferred Provider if the services have been deemed by the Contract Administrator to be either not Medically Appropriate/Medically Necessary or not covered by the Plans.

IV. SCHEDULE OF BENEFITS

FY2009 UPHS POS and PENNCare Personal Choice PPO plans			
All services must be pre-certified*	In-Network (PBH Staff)	In-Network (PBH Regional Network)	Out-of-Network
Mental Health	Combined Benefit for Staff or Regional or Out-of-Network Benefits		
Inpatient	100% after \$150 copay per admission Up to 30 days per year (inclusive of all other days)	100% after \$150 copay per admission Up to 30 days per year (inclusive of all other days)	80% of UCR** Up to 30 days per year (inclusive of all other days)
Outpatient	\$15 copay Unlimited visits per year	\$25 copay Up to 60 visits per year (inclusive of all other visits)	70% of UCR** Up to 30 visits per year (inclusive of all other visits)
Lifetime Maximum	None		
Exchange of Benefits (For members diagnosed with a “Serious Mental Illness”, or other cases as might be indicated for clinical consideration, that requires additional outpatient care that is authorized)	Up to 30 inpatient days for up to 60 additional outpatient The definition of SMI used will be that of the PA Mental Health Parity Act of 1998. SMI means any of the following mental illnesses as defined by the American Psychiatric Association in the most recent edition of the Diagnostic and Statistical Manual: schizophrenia, bipolar disorder, obsessive-compulsive disorder, major depressive disorder, panic disorder, anorexia nervosa, bulimia nervosa, schizo-affective disorder and delusional disorder.		
Total Visits with Exchange	Unlimited	120 visits per year	90 visits per year
Authorization for Additional Care (Possible for Individuals with “Serious Mental Illness” or other cases as might be indicated for clinical consideration).	When benefit usage approaches exhaustion in cases with authorized diagnosis of “serious mental illness” (according to Pennsylvania State Parity Diagnostic Categories) or such other cases as might be indicated for clinical consideration, process of benefit extension review for treatment plan evaluation will be initiated for possible extension of benefit eligibility.		

	FY2009 UPHS POS and PENNCare Personal Choice PPO plans		
All services must be pre-certified*	In-Network (PBH Staff)	In-Network (PBH Regional Network)	Out-of-Network
Chemical Dependency	Combined Benefit for Staff or Regional or Out-of-Network Benefits		
Detox and Medically Managed Intensive Rehab: Inpatient	100% after \$150 copay Up to 7 days per admission for detox and 30 days for rehabilitation per year (inclusive of all other days)	100% after \$150 copay Up to 7 days per admission for detox and 30 days for rehabilitation per year (inclusive of all other days)	80% of UCR** Up to 7 days per admission for detox and 30 days for rehabilitation per year (inclusive of all other days)
Inpatient Residential Care	100% after \$150 copay Up to 30 days per year (inclusive of all other days)	100% after \$150 copay Up to 30 days per year (inclusive of all other days)	80% of UCR** Up to 30 days per year (inclusive of all other days)
Outpatient and Acute Intensive Outpatient	\$15 copay Unlimited visits per year	\$25 copay Up to 60 visits per year (inclusive of all other visits)	70% of UCR** Up to 30 visits per year (inclusive of all visits)
Lifetime Maximum	None		
Exchange of Benefits (For members diagnosed with the need for additional outpatient care that is authorized)	Up to 30 of the inpatient days for up to 60 additional outpatient visits		
Total Days with Exchange	Unlimited outpatient visits	120 outpatient visit	90 outpatient visit

* Exception - Covered Persons (or designees) are responsible for notifying the designated agent of an emergency admission or visit for themselves or a Dependent within two (2) business days of the admission or visit, or as soon as reasonably possible as determined by the contract administrator

** The participant is responsible for payment of charges beyond Usual, Customary and Reasonable (UCR) or Negotiated rates for all Out-of-Network services.

Subject to the exclusions, conditions and limitations of the Plans as set forth in the booklet, a Covered Person is entitled to benefits for the Covered Services described in this section during a Benefit Period, in the amounts as specified in this Schedule

of Benefits. The term “Preferred” means “In-Network” and the term “Non-Preferred” means “Out-of-Network”.

The percentages shown for the Coinsurance and Covered Services on page 5 are not always calculated on actual charges. For an explanation of how the Coinsurance is calculated, see the “Covered Expense” definition in the “GLOSSARY OF DEFINED TERMS” section (Section XVII) of this booklet.

Pre-Service Claim Determinations:

All services provided under the Plans must have a pre-service claim determination before they are delivered, to determine if they are medically appropriate and fully covered according to the plan benefit design and the amount of service coverage remaining under that person’s specific benefits. Failure to obtain a pre-service claim determination for Non-Preferred Provider services, when required, may also result in a reduction of benefits. This pre-service claim determination of services is a vital program feature that reviews medical and benefit appropriateness of certain procedures/admissions according to the Plans. In certain cases, pre-service claim determinations help determine whether a different treatment may be available that is equally effective and yet less traumatic. Pre-service claim determinations also help determine the most appropriate setting for certain services.

When a Covered Person seeks medical treatment that requires a pre-service claim determination from a Preferred (In-Network) Provider, they are still responsible for obtaining the pre-service claim determination prior to treatment or possibly forfeit the maximum plan reimbursements. If the preferred (In-Network) provider fails to obtain the required pre-service claim determination of services, the individual will not be responsible for any associated financial penalties assessed by the Plans as a result. If the request for a pre-service claim determination is denied, the person will be notified in writing that the admission/service will not be paid because it is considered to be medically inappropriate or not a covered benefit under the Plan. The purpose of the program is to determine what is payable by the Plan. This program is not designed to be the practice of medicine or to be a substitute for the medical judgment of the attending Physician or other health care provider.

Explanation of Benefits for UPHS Point of Service Plan and AmeriHealth Point of Service Plan

Exchange (Conversion) of Benefits:

The Contract Administrator recognizes that there are specific cases that may require additional benefits in excess of the benefits allotted within the benefit year to ensure that needed clinical care can occur.

For those identified cases, the Contract Administrator will review the clinical needs of the patient and provide conversion of benefits. In all cases (Mental Health benefits) the conversion will occur **only** for members who have been diagnosed with a Serious Mental Illness. Members in this case without a Serious Mental Illness will not be entitled to an exchange of benefits when they exhaust their normal allotment of yearly sessions. See the “Serious Mental Illness” definition in the “GLOSSARY OF DEFINED TERMS” section (Section XVII) of this booklet.

For Chemical Dependency benefits there are no Serious Mental Illness requirements for the exchange of benefits

For a treatment of Mental Illness, the Covered Person may exchange: on a one (1) for two (2) basis, Inpatient days for additional Outpatient visits per year. The maximum number of additional Outpatient visits (in exchange for Inpatient days) will be sixty (60) visits. This applies for both In-Network and Out-of-Network treatment (according to the provisions above) but is a combined benefit for both.

Also, for the treatment of Substance Abuse, the Covered Person may exchange: on a one (1) for two (2) basis, Inpatient days for additional Outpatient visits per year. The maximum number of additional Outpatient visits (in exchange for Inpatient days) will be sixty (60) visits. This applies for both In-Network and Out-of-Network treatment (according to the provisions above) but is a combined benefit for both.

Also for the treatment of Substance Abuse, the Covered Person may exchange: on a two (2) for one (1) basis, Full Out-Patient sessions or Partial Hospital visits for additional inpatient Non-Hospital Residential Care days. Up to fifteen (15) Inpatient Chemical Dependency days are available to exchange for an additional thirty (30) separate sessions of Outpatient or Partial Hospitalization services per year. This applies for both In-Network and Out-of-Network treatment but is a combined benefit for both.

Providers must complete a University specific exchange of benefits form which may be obtained from the Contract Administrator prior to authorization for conversion of benefits. Forms can be obtained by calling a Penn Behavioral Health utilization review Contract Administrator at 1-888-321-4433 or going on line at www.pennbehavioralhealth.org.

See Schedule of Benefits for Exchange of Benefits amounts on page 5.

Lifetime Maximums:

There are no Lifetime Maximums for Mental Health or Chemical Dependency In-Network and Out-of-Network treatment or either inpatient or outpatient care.

See Schedule of Benefits for Lifetime Maximum amounts on page 5.

Authorization for Additional Care

(Possible for Individuals with “Serious Mental Illness” or other cases as might be indicated for clinical consideration).

When benefit usage approaches exhaustion in cases with authorized diagnosis of “serious mental illness” (according to Pennsylvania State Parity Diagnostic Categories) or such other cases as might be indicated for clinical consideration, process of benefit extension review for treatment plan evaluation will be initiated for possible extension of benefit eligibility.

To initiate the process for review for treatment plan evaluation for possible extension of benefit eligibility, members can contact the Penn Behavioral Health utilization review Contract Administrator at 1-888-321-4433 or go on line at www.pennbehavioralhealth.org. to find contact addresses and e-mail boxes.

See Schedule of Benefits for Authorization for Additional Care requirements on page 5.

Explanation of Benefits for PENNCare/Personal Choice Plan

Exchange (Conversion) of Benefits:

The Contract Administrator recognizes that there are specific cases that may require additional benefits in excess of the benefits allotted within the benefit year to ensure that needed clinical care can occur.

For those identified cases, the Contract Administrator will review the clinical needs of the patient and provide conversion of benefits. In all cases (Mental Health benefits) the conversion will occur **only** for members who have been diagnosed with a Serious Mental Illness. Members in this case without a Serious Mental Illness will not be entitled to an exchange of benefits when they exhaust their normal allotment of yearly sessions. See the “Serious Mental Illness” definition in the “GLOSSARY OF DEFINED TERMS” section (Section XVII) of this booklet.

For Chemical Dependency benefits there are no Serious Mental Illness requirements for the exchange of benefits

For a treatment of Mental Illness, the Covered Person may exchange: on a one (1) for two (2) basis, Inpatient days for additional Outpatient visits per year. The maximum number of additional Outpatient visits (in exchange for Inpatient days) will be sixty (60) visits. This applies for both In-Network and Out-of-Network treatment (according to the provisions above) but is a combined benefit for both.

Also, for the treatment of Substance Abuse, the Covered Person may exchange: on a one (1) for two (2) basis, Inpatient days for additional Outpatient visits per year. The maximum number of additional Outpatient visits (in exchange for Inpatient days) will be sixty (60) visits. This applies for both In-Network and Out-of-Network treatment (according to the provisions above) but is a combined benefit for both.

Also for the treatment of Substance Abuse, the Covered Person may exchange: on a two (2) for one (1) basis, Full Out-Patient sessions or Partial Hospital visits for additional inpatient Non-Hospital Residential Care days. Up to fifteen (15) Inpatient Chemical Dependency days are available to exchange for an additional thirty (30) separate sessions of Outpatient or Partial Hospitalization services per year. This applies for both In-Network and Out-of-Network treatment but is a combined benefit for both.

Providers must complete a University specific exchange of benefits form which may be obtained from the Contract Administrator prior to authorization for conversion of benefits. Forms can be obtained by calling a Penn Behavioral Health utilization review Contract Administrator at 1-888-321-4433 or going on line at www.pennbehavioralhealth.org.

See Schedule of Benefits for Exchange of Benefits amounts on page 5.

Lifetime Maximums:

There are no Lifetime Maximums for Mental Health or Chemical Dependency In-Network and Out-of-Network treatment or either inpatient or outpatient care.

See Schedule of Benefits for Lifetime Maximum amounts on page 5.

Authorization for Additional Care:

(Possible for Individuals with “Serious Mental Illness” or other cases as might be indicated for clinical consideration).

When benefit usage approaches exhaustion in cases with authorized diagnosis of “serious mental illness” (according to Pennsylvania State Parity Diagnostic Categories) or such other cases as might be indicated for clinical consideration, process of benefit extension review for treatment plan evaluation will be initiated for possible extension of benefit eligibility.

To initiate the process for review for treatment plan evaluation for possible extension of benefit eligibility, members can contact the Penn Behavioral Health utilization review Contract Administrator at 1-888-321-4433 or go on line at www.pennbehavioralhealth.org. to find contact addresses and e-mail boxes.

See Schedule of Benefits for Authorization for Additional Care requirements on page 5.

V. THE MENTAL HEALTH CARE / SUBSTANCE ABUSE BENEFITS

I. MENTAL HEALTH/PSYCHIATRIC CARE

The Process for Accessing the Mental Health/Psychiatric Care:

Benefits for the treatment of Mental Health Related Problems are based on the services provided and reported by the Provider. Those services provided by and reported by the Provider as Mental Health/Psychiatric Services are subject specifically to the Mental Health/Psychiatric limitations in this program. When a Provider renders medical care, other than Mental Health/Psychiatric Care, for a Covered Person with Mental Health Problems, payment for such care will be based on the medical benefits under the medical plan portion of the Plans available and will not be subject to the Mental Health/Psychiatric Limitations of this program. (See the “MIXED SERVICES GUIDELINES” section of this booklet-Section VIII)

Benefits are payable for the care and treatment of Mental Health Psychiatric Care by a Hospital or Provider, subject to the Maximums shown in the Schedule of Benefits, according to the provisions outlined below. For maximum benefits, treatment must be received from a Preferred Provider.

Pre-service claim determination information must be submitted by the Provider to the Contract Administrator for review and evaluation so a Plan of Treatment may be authorized for the Covered Person. A pre-service claim determination must be obtained for all treatment, other than Emergency Care, in order to assure the Medical Appropriateness or Medical Necessity and benefit coverage of the proposed treatment based on the nature and severity of the Covered Person’s condition.

If a Covered Person is facing a crisis and is currently in treatment, the patient’s therapist must be contacted because he/she is most familiar with the patient’s condition. The Contract Administrator’s providers maintain 24-hour coverage to coordinate all service requests. If there is an Emergency or the Covered Person is having particularly severe symptoms, the same procedures outlined for the Emergency Care services in the “MANAGED CARE PROCEDURES FOR INPATIENT AND PARTIAL HOSPITALIZATION” section (Section XI) of this booklet must be followed. Emergency Care is exempt from the requirements for pre-service claim determination and will be considered Preferred Care for In-Network providers and will be paid at 100% of the Plan’s Usual, Customary, and Reasonable (UCR) Rate for Out-of-Network Providers. However, Emergency admissions or services must be reviewed and authorized within 2 business days of the admission or services, or as soon as possible as determined by the Contract Administrator.

Inpatient Treatment Coverage:

Benefits are provided, subject to the Benefit Period limitations stated in the Schedule of Benefits, for an Inpatient Admission for the treatment of Mental Illness. Inpatient visits for the treatment of Mental Illness are covered when performed by a qualified Facility Provider or Professional Provider.

Covered Services include treatments such as: psychiatric visits, psychiatric consultations, individual and group psychotherapy, electroconvulsive therapy, psychological testing

and psychopharmacologic management.

Note: For Non-Preferred (Out-of-Network) Facility Services, the above services are to be included in an “all inclusive” rate per day, not as separate charges for individual services.

Benefits are not payable for the following services:

- a) vocational or religious counseling
- b) activities that are primarily of an educational nature
- c) treatment modalities that have not been incorporated into the commonly accepted therapeutic repertoire as determined by broad-based professional consensus, such as primal therapy, Rolfing or structural integration, bioenergetic therapy and obesity control therapy.

Outpatient Treatment Coverage:

Benefits are provided, subject to the Benefit Period limitations stated in the Schedule of Benefits, for Outpatient treatment of Mental Illness. Outpatient visits for the treatment of Mental Illness are covered when performed by a qualified Facility Provider or Professional Provider.

Covered Services include treatments such as: psychiatric visits, psychiatric consultations, individual and group psychotherapy, electroconvulsive therapy, psychological testing and psychopharmacologic management.

Benefits are not payable for the following services:

- a) vocational or religious counseling
- b) activities that are primarily of an educational nature
- c) treatment modalities that have not been incorporated into the commonly accepted therapeutic repertoire as determined by broad-based professional consensus, such as primal therapy, Rolfing or structural integration, bioenergetic therapy and obesity control therapy.

For a treatment of Mental Illness, the Covered Person with a **Serious Mental Illness** may exchange: One a one (1) for two (2) basis, Inpatient days for additional Outpatient visits. The maximum number of additional Outpatient visits (In exchange for Inpatient days will be 60 visits. See the “Serious Mental Illness” definition in the GLOSSARY OF DEFINED TERMS” section (Section XVII) of this booklet.

II. ALCOHOL OR DRUG ABUSE AND DEPENDENCY CARE

The Process for Accessing the Alcohol or Drug Abuse and Dependency Care:

Benefits for the treatment of Alcohol or Drug Abuse and Dependency Related Problems are based on the services provided and reported by the Provider. Those services provided by and reported by the Provider as Alcohol and Drug Abuse and Dependency Services are subject specifically to the Alcohol and Drug Abuse and Dependency Services limitations in this program. When a Provider renders medical care, other than Alcohol and Drug Abuse and Dependency Services, for a Covered Person with Chemical Dependency Problems, payment for such care will be based on the medical benefits under the medical plan portion of the Plans available and will not be subject to the Alcohol and Drug Abuse and Dependency Care Limitations of this program. (See the “MIXED SERVICES GUIDELINES” section of this booklet-Section VIII)

Benefits are payable for the care and treatment of Alcohol or Drug Abuse and Dependency provided by a Hospital or Provider, subject to the Maximums shown in the Schedule of Benefits, according to the provisions outlined below. For maximum benefits, treatment must be received from a Preferred Provider.

Pre-authorization information must be submitted by the provider to the Contract Administrator for review and evaluation so a Plan of Treatment may be pre-certified for the Covered Person. Pre-Certification must be obtained for all treatment, other than Emergency Care, in order to assure the Medical Appropriateness or Medical Necessity and benefit coverage of the proposed treatment based on the nature and severity of the Covered Person's condition.

If a Covered Person is facing a crisis and is currently in treatment, the patient's therapist must be contacted because he/she is most familiar with the patient's condition. PENN Behavioral Health providers maintain 24-hour coverage to coordinate all service requests. If there is an Emergency or the Covered Person is having particularly severe symptoms, the same procedures outlined in the Emergency Care services in the "MANAGED CARE PROCEDURES FOR INPATIENT AND PARTIAL HOSPITALIZATION" section (Section XI) of this booklet must be followed. Emergency Care is exempt from the requirements for pre-service claim determination and will be considered Preferred Care for In-Network providers and will be paid at 100% of the Plan's Usual, Customary, and Reasonable (UCR) Rate for Out-of-Network Providers. However, Emergency admissions or services must be reviewed and authorized within 2 business days of the admission or services, or as soon as possible as determined by the Contract Administrator.

Inpatient Detoxification Coverage:

Benefits are provided, subject to the Benefit Period limitations stated in the Schedule of Benefits, for Inpatient Detoxification Treatment of Chemical Dependency. Inpatient Detoxification Treatment days for the treatment of Chemical Dependency are covered when performed by a qualified Facility Provider or Professional Provider.

Covered Services include:

- a) Lodging and dietary services;
- b) Physician, psychologist, nurse, certified addictions counselor and trained staff services;
- c) Diagnostic x-rays;
- d) Psychiatric, psychological and medical laboratory testing;
- e) Drugs, medicines, use of equipment and supplies

Note: For Non-Preferred (Out-of-Network) Facility Services, the above services are to be included in an "all inclusive" rate per day, not as separate charges for individual services.

Hospital and Non-Hospital Residential Treatment Coverage:

Benefits are provided, subject to the Benefit Period limitations stated in the Schedule of Benefits, for Hospital and Non-Hospital Residential Treatment of Chemical Dependency. Hospital and Non-Hospital Residential days for the treatment of Chemical Dependency are covered when performed by a qualified Facility Provider or Professional Provider.

Covered Services include:

- a) Lodging and dietary services;
- b) Physician, psychologist, nurse, certified addictions counselor and trained staff services;
- c) Rehabilitation therapy and counseling;
- d) Family counseling and intervention;
- e) Psychiatric, psychological and medical laboratory testing;
- f) Drugs, medicines, use of equipment and supplies

Note: For Non-Preferred (Out-of-Network) Facility Services, the above services are to be included in an “all inclusive” rate per day, not as separate charges for individual services.

Outpatient Alcohol or Drug Services Coverage:

Benefits are provided, subject to the Benefit Period limitations stated in the Schedule of Benefits, for Outpatient treatment of Chemical Dependency. Outpatient visits for the treatment of Chemical Dependency are covered when performed by a qualified Facility Provider or Professional Provider.

Covered Services include:

- a) Physician, psychologist, nurse, certified addictions counselor and trained staff services;
- b) Rehabilitation therapy and counseling;
- c) Family counseling and intervention;
- d) Psychiatric, psychological and medical laboratory testing;
- e) Drugs, medicines, use of equipment and supplies.

All Preferred (In-Network) Outpatient services must have a pre-service claim determination by the Contract Administrator.

For a treatment of Substance Abuse, the Covered Person diagnosed with the need for additional outpatient care that is authorized may exchange: One a one (1) for two (2) basis, Inpatient days for additional Outpatient visits. The maximum number of additional Outpatient visits (In exchange for Inpatient days will be 60 visits.

VI. PSYCHOLOGICAL TESTING AUTHORIZATION PROCESS AND CRITERIA

The Process of Accessing the Psychological Testing:

While there are a number of valid reasons for administering psychological testing (e.g., school placement or vocational planning), the primary reason that health insurance benefits cover psychological testing is to facilitate the assessment and treatment of mental health and substance abuse disorders. This section is designed to explain when psychological testing benefits will be eligible for authorization. For testing to be eligible for authorization, specific administrative procedures must be followed and specific criteria must be met. The following subsections describe the psychological testing authorization process and criteria used by the Contract Administrator.

Definition of Psychological Testing Coverage:

Psychological testing is defined as the use of one or more standardized measurements, instruments or procedures to observe or record human behavior, and requires the application of appropriate normative data for interpretation or classification. Psychological testing may be used to guide differential diagnosis in the treatment of psychiatric disorders and disabilities. Testing may also be used to provide an assessment of cognitive and intellectual abilities, personality and emotional characteristics, and neuropsychological functioning.

Requirements for Authorization and Medical Necessity Determination:

Psychological testing must be performed by (i) a licensed doctoral level psychologist (Ph.D., Psy.D. or Ed.D.) who has been credentialed by the Contract Administrator and who has contracted with the Plan or (ii) any other qualified provider as permitted by applicable State and/or federal law. In addition, for psychological testing to be eligible for authorization, compliance with the following process is required:

- Requested tests must be valid and reliable. The most recent version of the test is to be utilized. The instrument must be age, developmentally, linguistically, and culturally appropriate to the Covered Person.
- Prior to testing, the Covered Person must be assessed by a behavioral health care provider. The rationale for this is that, in many cases, a diagnostic assessment is sufficient for the diagnosis and treatment of behavioral health disorders. Exceptions to this part of the process are stated later in this document.
- A clear rationale for testing must be provided.
- The rationale provided and the results of the testing must be likely to have a positive impact on treatment.

If psychological testing meets the criteria and requirements of Medical Appropriateness or Medical Necessity, the following three (3) criteria must also be met to be eligible to obtain authorization.

1. The reason for the testing must be based on a specific referral question or questions from the treating provider and related directly to the psychiatric or psychological treatment of the Covered Person, and

2. The specific referral question or questions cannot be answered by means of diagnostic assessment and/or behavioral observations, and
3. The specific referral question or questions and testing results will have meaningful impact on the course or outcome of therapy.

The first criterion highlights the need for a specific clinical reason or rationale for psychological testing. Routine or “standard orders” testing does not meet this criterion. Psychological testing must serve a specific purpose for each individual Covered Person.

The second criterion focuses on the specialized need for psychological testing. In most circumstances, a diagnostic assessment is sufficient to determine a Covered Person’s diagnosis and treatment plan. For psychological testing benefits to be eligible for authorization, the provider must clearly delineate why an assessment and/or behavioral observations are not adequate, and how testing is likely to answer the referral question(s).

The third criterion emphasizes the importance of utility for the testing. For example, if a diagnostic assessment is unable to differentiate between several diagnoses, but testing is likely to clarify a specific diagnostic issue and facilitate appropriate treatment, then testing benefits may be authorized.

All three criteria must be met for testing benefits to be eligible for authorization.

Reasons for Non-Authorization:

Testing benefits may not be authorized for the following reasons:

1. Testing is primarily for educational/vocational purposes.
2. Testing is primarily for the purpose of determining if a Covered Person is a candidate for a specific type or dosage of psychotropic medication.
3. Testing is primarily for the purpose of determining if a Covered Person is a candidate for a medical or surgical procedure.
4. Testing results may be invalid due to the active influence of a substance, substance abuse withdrawal, or similar cause.
5. Two or more tests are requested that essentially measure the same functional domain.
6. Testing is primarily for legal purposes including custody evaluations, parenting assessments, or other court/government ordered or requested testing.
7. Tests requested are Experimental or Investigative, antiquated, or not validated.
8. Testing request is made prior to completion of a diagnostic interview by a behavioral health provider. An exception is when a neuropsychological disorder screening/evaluation is necessary to differentially diagnose between a neurological or psychiatric disorder and the Covered Person’s Plan covers this service.
9. Testing is primarily to determine the extent or type of neurological impairment, unless allowed under the Covered Person’s Plan.
10. The type of testing falls into the category within this booklet of benefits which are not covered.

The Authorization Process:

Before testing is administered, the testing psychologist must call the Contract Administrator’s Access Department for pre-service claim benefit determination.

This testing request telephone call must be completed with the Contract Administrator prior to testing. A post-service benefit claim adverse determination, in routine circumstances, will occur if pre-service claim determination certification is not obtained.

In Emergency testing circumstances, post-service benefit claim determinations will follow the same procedures as other provisions for Emergency Care listed in the covered services section of this booklet.

VII. COVERAGE EXCLUSIONS OF THIS PLAN

Listing of the Items Not Covered:

Except as specifically defined by the Contract Administrator, no benefits will be provided for services, supplies or charges:

- Which are not **deemed Medically Appropriate/Medically Necessary** (as determined by the individual Mental Health/ Substance Abuse Plan option) for the diagnosis, care, or treatment of illness, trauma, or restoration of mental health/substance abuse impaired functions; this exclusion does not apply to covered preventive services;
- Which are not **deemed by the Contract Administrator to be benefit covered** (as determined by the individual Mental Health/ Substance Abuse Plan option) for the diagnosis, care, or treatment of illness, trauma, or restoration of mental health/substance abuse impaired functions; this exclusion does not apply to covered preventive services;
- Which are Experimental or Investigative in nature (including testing or developmental, educational, vocational, occupational, mental capacity, or candidacy for specific type or dosage of psychotropic medication or medical/surgical procedures); this exclusion does not apply to covered preventive or testing services other than those specifically defined as reasons for non-authorization in the PSYCHOLOGICAL TESTING AND AUTHORIZATION PROCESS AND CRITERIA section (Section VI) of this booklet;
- Which were incurred after the date of termination of the Covered Person's coverage;
- For any loss sustained or expenses incurred during military service while on active duty; or as a result of enemy action or act of war, whether declared or undeclared;
- For which a Covered Person would have no legal obligation to pay;
- For any charges for care that exceed the Plans' Usual, Customary and Reasonable Rate (UCR) amount for Out-of-Network care;
- For any additional treatment necessitated by lack of Covered Person's cooperation or failure to follow a prescribed plan of treatment;
- For autistic diseases of childhood; behavioral problems; cognitive rehabilitation; hyperkinetic syndromes; learning disabilities, mental retardation treatment that extends beyond traditional mental health and psychiatric treatment or for environmental or social change; or special education, including lessons in sign language to instruct a plan participant whose ability to speak has been lost or impaired;
- For beam neurologic testing;
- For marriage, family, child, career, social adjustment, pastoral, or financial counseling;
- For Outpatient prescription drugs and medications or drugs and medications that may be dispensed without a doctor's prescription;
- For recreational, educational, and sleep therapy, including any related diagnostic testing;
- For research studies;

- For services for which the cost is later recovered through legal action, compromise, or claim settlement;
- For biofeedback;
- For charges made only because there is health coverage;
- For completion of insurance forms;
- For services provided by a member of the participant's Immediate Family;
- For special medical reports including those not directly related to the Covered Person's treatment, such as employment or insurance physicals and reports prepared in connection with litigation;
- For spinal manipulation or acupuncture;
- For therapy or rehabilitation services including but not limited to primal therapy, chelation therapy, Rolfing, psychodrama, megavitamin therapy, purging, bioenergetic therapy, vision perception training, cognitive rehabilitative therapy and music therapy;
- For convenience items, including but not limited to, adjustments made to vehicles, air conditioners, beauty/barber shop services, chairlifts, exercise or physical fitness equipment, guest trays, health club or spa memberships, humidifiers, improvements made to a Covered Person's home or place of business, radios and televisions, stair glides, spa, whirlpool, sauna, hot tub, or equivalent device, or wigs, or any other devices or equipment not deemed Medically Appropriate or Medically Necessary or benefit covered by the Plans whether or not recommended by the Covered Person's provider;
- For court ordered services or those required by court order as a condition of parole or probation, other than medically necessary services provided by participating providers with prior referral by the patient's provider;
- For injuries resulting from the commission of a crime or involving criminal activity;
- For payment made under Medicare when Medicare is primary or would have been made if the Covered Person had enrolled in Medicare and claimed Medicare benefits; however, this exclusion shall not apply when the Group is obligated by law to offer the Covered Person all the benefits of this program and the Covered Person so elects this coverage as primary;
- For any occupational illness or bodily injury which occurs in the course of employment if benefits or compensation are available, in whole or in part, under the provisions of Worker's Compensation Law or any similar Occupational Disease Law or Act. This exclusion applies whether or not the Covered Person claims the benefits or compensation;
- To the extent benefits are provided by the Veterans Administration or by the Department of Defense for members of the armed forces of any nation while on active duty;
- For injuries resulting from the maintenance or use of a motor vehicle if such treatment or service is paid under a plan or policy of motor vehicle insurance, including a certified self-insurance plan, or payable in any manner under the Pennsylvania Motor Vehicle Financial Responsibility Law;
- For drugs or medicines for which the Covered Person has coverage under a free-standing prescription drug program provided through the Enrolled Group;
- Which are not billed and performed by a Provider unless otherwise indicated under the subsections entitled "Pre-certification Requirements for other than Inpatient Hospitalization" in the "MANAGED CARE PROCEDURES FOR INPATIENT AND PARTIAL HOSPITALIZATION" section (Section XI) of

this booklet;

- For telephone consultations, charges for failures to keep a scheduled visit, or charges for completion of a claim form;
- For custodial care, domiciliary care or rest care;
- For equipment costs related to services performed on high cost technological equipment as defined by the Plans, such as, but not limited to, computer tomography (CT) scanners, magnetic resonance imagers (MRI) and linear accelerators, unless the acquisition of such equipment by a Professional Provider was approved through a Certificate of Need (CON) process and/or by the Contract Administrator;
- For maintenance of chronic conditions, injuries or illness when response to treatment has reached the maximum therapeutic level, no additional functional improvement can be demonstrated or anticipated, and continuation of the service will be of no therapeutic value to the Covered Person;
- For any other service or treatment except as provided under the coverage.

VIII. MIXED SERVICE GUIDELINES

Description of Mixed Services:

The **Mixed Services Guidelines** in the proceeding section are intended to delineate financial and utilization management responsibilities of Medical/Surgical and Psychiatric/Chemical Dependency Services. The purpose of this section is to provide guidelines for distinguishing between behavioral health/mental health/chemical dependency and medical/surgical services and to assign responsibility for financial payment and Case Management of those services. These protocols are intended to provide clarification for cases which fall into the gray area between behavioral health and medical/surgical and to provide clarity in determining benefit coverage in the management of cases receiving concurrent treatment.

Determination of mixed services accountabilities within this section follows several general principles. Financial responsibility for mixed services is determined by review of the three (3) factors described below. If a Covered Person presents to a medical/surgical setting with a behavioral health problem, the Case Management and financial responsibility, (e.g. for medical clearance and evaluation), is covered under the medical/surgical benefits of the Plans. After the Contract Administrator is notified of the behavioral health care and a subsequent pre-service claim benefit determination is made, the clinical and financial responsibilities for ongoing necessary mental health/chemical dependency services may be Covered Services depending on the provisions of the Plans.

Payment of Mixed Services:

Financial Responsibility is determined by consideration of:

1. Control of the Service:
 - Is the service on a medical/surgical or psychiatric unit of a general hospital, or is the service in a freestanding psychiatric or chemical dependency Facility Provider
 - Is the attending M.D./D.O. an internist/PCP or a psychiatrist
 - Which professional has ordered the laboratory, procedure or prescription
2. Primary Clinical Condition that is the focus of treatment:
 - Which diagnosis is primary
 - Is the condition amenable to psychiatric/psychological intervention
 - What is the purpose of the assessment, evaluation or test
3. Type of Treating Professional:
 - Is the treating professional a psychiatrist/behavioral health professional or
 - An internist/primary care physician/other medical professional

Coordination of Behavioral and Medical/Surgical Services:

Medical/surgical and behavioral health care managers should work together in a coordinated manner for the well-being of the patient. The care manager initially involved with the case is responsible for initiating coordination of care when mixed services

are necessary. In the case of a hand-off, the initial care manager should not close the case until they are certain that the succeeding care manager has assumed responsibility for the patient and that the attending physician and patient/family are aware of the transfer.

Mixed Service Exclusions:

This mixed service protocol attempts to assign financial and Case Management responsibility for **Covered Services**. Covered Services under the Plans do not include those services that are explicitly excluded for coverage by the relevant certificates of coverage, applicable master contracts or applicable individual provider contracts.

PENN Behavioral Health Mixed Service Matrix:

The following mixed service matrix is intended to clarify the above principles with specific examples. Each clinical situation is evaluated with respect to who controls the service, the primary diagnosis and the attending physician’s area of specialty. For unusual conditions or circumstances which fall outside the realm of this section, successful management will require consultation and coordination between medical/surgical and care managers.

SELF-INFLICTED HARM				
<i>Clinical Circumstances</i>	<i>Service</i>	<i>Primary Diagnosis</i>	<i>Attending Provider Type</i>	<i>Clinical/Financial Responsibility</i>
Serious injury or overdose requiring immediate medical attention	Medical services in ER or Med/Surgical unit	Medical trauma	PCP, internist or other medical specialist	Medical Plan
Mild injury not requiring Emergency services	Medical services on a mental health/chemical dependency unit	Medical trauma	Psychiatrist	PBH

SUBSTANCE ABUSE/CHEMICAL DEPENDENCY				
<i>Clinical Circumstances</i>	<i>Service</i>	<i>Primary Diagnosis</i>	<i>Attending Provider Type</i>	<i>Clinical/Financial Responsibility</i>
Medical Detoxification with serious medical complications (end-organ damage with abnormal physiology)	ICU or other specialized Med/Surgical unit	Chemical Dependency (ICD.9 Code – 303 – 305.9)	Addictionologist, Internist or Family Practitioner	Medical Plan
Medical Detoxification without serious medical complications	Detox unit general hospital, floating bed in general hospital, specialized or residential Chemical Dependency facility, ambulatory detox	Chemical Dependency	Addictionologist, Internist, Psychiatrist or Family Practitioner	PBH

COGNITIVE DISORDER (Delirium, Dementia, Amnesia, etc.)				
<i>Clinical Circumstances</i>	<i>Service</i>	<i>Primary Diagnosis</i>	<i>Attending Provider Type</i>	<i>Clinical/Financial Responsibility</i>
Cognitive Disorder due to medical etiology (e.g. AIDS, Alzheimer's, vascular, head trauma)	Inpatient services on Med/Surgical unit, or ambulatory services	Med-Surg and/or Mental Health/Chemical Dependency	Med/Surg provider with Psychiatrist consulting	Medical Plan
Cognitive Disorder due to substance abuse/withdrawal	Inpatient services in psychiatric or residential facility, or ambulatory	Mental Health/Chemical Dependency	Psychiatrist	PBH
Cognitive Disorder due to a primary psychiatric condition	Inpatient services in psychiatric or residential facility, or ambulatory	Mental Health/Chemical Dependency	Psychiatrist, Behavioral Health/Chemical Dependency Provider	PBH

EMERGENCY SERVICES WITHOUT ADMISSION				
<i>Clinical Circumstances</i>	<i>Service</i>	<i>Primary Diagnosis</i>	<i>Attending Provider Type</i>	<i>Clinical/Financial Responsibility</i>
Presentation with symptoms indicative of possible medical crisis (chest pains, shortness of breath, numbness, etc.)	Emergency Room evaluation (Diagnostic assessment, psychiatric consultation)	Med/Surgical and/or Mental Health/Chemical Dependency	PCP, Internist, Family Practitioner, ER Physician	Medical Plan
Presentation with symptoms indicative of possible medical crisis (chest pains, shortness of breath, numbness, etc.)	Emergency Room evaluation (Diagnostic assessment, psychiatric consultation)	Med/Surgical and/or Mental Health/Chemical Dependency	Psychiatrist, Other Medical	Medical Plan

EATING DISORDER				
<i>Clinical Circumstances</i>	<i>Service</i>	<i>Primary Diagnosis</i>	<i>Attending Provider Type</i>	<i>Clinical/Financial Responsibility</i>
Serious medical complications due to eating disorder	Stabilization of medical condition on Med/Surgical unit	Mental Health/Chemical Dependency or both	PCP, Internist	Medical Plan
Compromised weight/nutritional status	Med/Surgical unit, Behavioral Treatment planning	Mental Health/Chemical Dependency or both	PCP, Internist	Medical Plan

Compromised weight/nutritional status	Psychiatric unit Behavioral treatment planning and intervention	Mental Health/Chemical Dependency or both	Psychiatrist	PBH
Compromised weight/nutritional status	Med/Surgical unit, Routine monitoring	Mental Health/Chemical Dependency or both	PCP, Internist	Medical Plan
Compromised weight/nutritional status	Psychiatric unit, Routine monitoring	Mental Health/Chemical Dependency or both	Psychiatrist	PBH

PAIN MANAGEMENT				
<i>Clinical Circumstances</i>	<i>Service</i>	<i>Primary Diagnosis</i>	<i>Attending Provider Type</i>	<i>Clinical/Financial Responsibility</i>
Chronic pain	Structured pain program in an inpatient or ambulatory setting/pain clinic	Med/Surgical	PCP/Internist/ Anesthesiologist/ Addictionologist	Medical Plan
Somatoform Disorder	Behavioral Health/Chemical Dependency services in inpatient or ambulatory setting	Mental Health/Chemical Dependency	Psychiatrist	PBH
Psychogenic pain	Behavioral Health/Chemical Dependency services in inpatient or ambulatory setting	Mental Health/Chemical Dependency	Psychiatrist, Addictionologist or other Behavioral Health Chemical Dependency provider	PBH

HEAD INJURY				
<i>Clinical Circumstances</i>	<i>Service</i>	<i>Primary Diagnosis</i>	<i>Attending Provider Type</i>	<i>Clinical/Financial Responsibility</i>
Head injury resulting in neurological damage	Neurological assessment/Psychiatric consultation	Med/Surgical	Neurologist, Surgeon, Internist	Medical Plan
Head injury resulting in neurological damage	Rehabilitation services in Inpatient or ambulatory setting	Med/Surgical	Neurologist, Surgeon, Internist with supportive Psychiatry	Medical Plan
Mood or personality change due to head injury	Psychiatric services in Inpatient or ambulatory setting	Mental Health/Chemical Dependency	Psychiatrist	Medical Plan PBH collaborates/shapes

MEDICATION MANAGEMENT				
<i>Clinical Circumstances</i>	<i>Service</i>	<i>Primary Diagnosis</i>	<i>Attending Provider Type</i>	<i>Clinical/Financial Responsibility</i>
Psychiatric symptoms necessitating pharmacologic treatment	Inpatient or ambulatory Med/Surgical setting	Med/Surgical Diagnosis with Behavioral Health secondary	PCP, Internist, Surgeon	Medical Plan
Psychiatric symptoms necessitating pharmacologic treatment	Inpatient or ambulatory Med/Surgical setting with Psychiatric Consult	Mental Health /Chemical Dep. Med/Surgical or both	Psychiatrist	Medical Plan PBH collaborates/shapes

ADHD				
<i>Clinical Circumstances</i>	<i>Service</i>	<i>Primary Diagnosis</i>	<i>Attending Provider Type</i>	<i>Clinical/Financial Responsibility</i>
Diagnosis and treatment of ADHD	Inpatient or ambulatory service in Med/Surgical setting	ADHD	Internist, Family Practice, Neurologist, Pediatrician	<i>Medical Plan</i>
Diagnosis and treatment of ADHD	Inpatient or ambulatory service in Mental Health setting	ADHD	Psychiatrist, Psychologist	PBH

INTERFACILITY TRANSPORT				
<i>Clinical Circumstances</i>	<i>Service</i>	<i>Primary Diagnosis</i>	<i>Attending Provider Type</i>	<i>Clinical/Financial Responsibility</i>
Patient's condition requires transport to Mental Health/Chemical Dependency facility	Transportation	Mental Health/Chemical Dependency	Psychiatrist	PBH receiving, in collaboration with Medical Plan
Patient's condition requires transport to Med/Surgical facility	Transportation	Med/Surgical and/or Mental Health/Chemical Dependency	PCP, Internist, Surgeon with Psychiatrist consulting	Medical Plan receiving, in collaboration with PBH

IX. CLINICAL PRACTICE GUIDELINES

Definition and Prescribed Use Design:

The Contract Administrator has adopted a number of clinical practice guidelines to assist providers in the assessment and treatment of disorders commonly occurring among Covered Persons. Prior to the adoption of each guideline, the relevant scientific literature is reviewed by a multi-disciplinary panel that includes Board-certified psychiatrists, with input from providers in the Contract Administrator's provider network and from consumers and community agencies. The Contract Administrator reviews adopted guidelines at least every two (2) years and provides updates as necessary. Providers are encouraged to visit the Contract Administrator's web site www.pennbehavioralhealth.org and click on the Service Provider section to learn about updates. As with clinical guidelines in general, the Contract Administrator's adopted guidelines are intended to augment, not replace, sound clinical judgment.

Criteria for Short Term Treatment of Acute Psychiatric Illness:

Depression

The Contract Administrator has adopted the American Psychiatric Association's (APA) Practice Guideline for the Treatment of Patients with Major Depression, (Second Edition April 2000) to serve as an evidence-based framework for providers' clinical decision making with adult Covered Persons who have major depression. The guideline covers the psychiatric management of patients with this disorder, with content ranging from clinical features and epidemiology to all recognized aspects of treatment approach and planning.

Please Note: The APA guideline is for the treatment of adult patients only and therefore is not applicable to children and adolescents.

Suicidal Behaviors

The Contract Administrator has adopted the American Psychiatric Association (APA) Practice Guideline for the Treatment of Patients with Suicidal Behaviors (November 2003) to serve as an evidence-based framework for providers' clinical decision making with Covered Persons who exhibit suicidal risk. The guideline covers the psychiatric management of patients with this disorder, with content ranging from clinical features and epidemiology to all recognized aspects of treatment approach and planning.

Substance Use Disorders

The Contract Administrator has adopted the American Psychiatric Association (APA) Practice Guideline for the Treatment of Patients with Substance Use Disorders, Alcohol, Cocaine, and Opioids (November 1995) to serve as an evidence-based framework for providers' clinical decision making with Covered Persons who have substance abuse disorders. The guideline covers the psychiatric management of patients with this disorder, with content ranging from clinical features and epidemiology to all recognized aspects of treatment approach and planning.

Schizophrenia

The Contract Administrator has adopted the American Psychiatric Association (APA) Practice Guideline for the Treatment of Patients with Schizophrenia (Second Edition, February 2004) to serve as an evidence-based framework for providers' clinical decision making with Covered Persons who have schizophrenia. The guideline covers the psychiatric management of patients with this disorder, with content ranging from clinical features and epidemiology to all recognized aspects of treatment approach and planning.

Bipolar Disorder

The Contract Administrator has adopted the American Psychiatric Association (APA) Practice Guideline for the Treatment of Patients with Bipolar Disorder (April 2002) to serve as an evidence-based framework for providers' clinical decision making with Covered Persons who have been diagnosed with Bipolar Disorder. The guideline covers the psychiatric management of patients with this disorder, with content ranging from clinical features and epidemiology to all recognized aspects of treatment approach and planning.

Panic Disorder

The Contract Administrator has adopted the American Psychiatric Association (APA) Practice Guideline for the Treatment of Patients with Panic Disorder (May 1998) to serve as an evidence-based framework for providers' clinical decision making with Covered Persons who have been diagnosed with Panic Disorder. The guideline covers the psychiatric management of patients with this disorder, with content ranging from clinical features and epidemiology to all recognized aspects of treatment approach and planning.

Eating Disorders

The Contract Administrator has adopted the American Psychiatric Association (APA) Practice Guideline for the Treatment of Patients with Eating Disorders (Second Edition, January 2000) to serve as an evidence-based framework for providers' clinical decision making with Covered Persons who have been diagnosed with an Eating Disorder. The guideline covers the psychiatric management of patients with this disorder, with content ranging from clinical features and epidemiology to all recognized aspects of treatment approach and planning.

Borderline Personality Disorder

The Contract Administrator has adopted the American Psychiatric Association (APA) Practice Guideline for the Treatment of Patients with Borderline Personality Disorder (October 2001) to serve as an evidence-based framework for providers' clinical decision making with Covered Persons who been diagnosed with Borderline Personality Disorder. The guideline covers the psychiatric management of patients with this disorder, with content ranging from clinical features and epidemiology to all recognized aspects of treatment approach and planning.

Contact Information

APA:

American Psychiatric Association
1000 Wilson Boulevard, Suite 1825
Arlington, VA 22209-3901
(800) 368-5777
www.appi.org

X. SUBSTANCE ABUSE PLACEMENT CRITERIA

Description of Criteria for Adults and Adolescents:

The Contract Administrator has adopted a number of substance abuse placement criteria to assist providers in the assessment and placement of patients with alcohol and other drug problems for treatment of substance use disorders commonly occurring among Covered Persons. Prior to the adoption of each guideline, the relevant scientific literature is reviewed by a multi-disciplinary panel that includes Board-certified psychiatrists, with input from providers in the Contract Administrator's provider network and from consumers and community agencies. The Contract Administrator reviews adopted criteria at least every two (2) years and provides updates as necessary. Providers are encouraged to visit the Contract Administrator's web site at www.pennbehavioralhealth.org and click on the Service Provider section to learn about updates. As with placement criteria in general, the Contract Administrator's adopted guidelines are intended to augment, not replace, sound clinical judgment.

The criteria used by the Contract Administrator are published by The American Society of Addiction Medicine (ASAM). It is called, The ASAM Patient Placement Criteria for the Treatment of Substance-Related Disorders, (Second Edition – Revised) (ASAM PPC-2R) and was released in April, 2001. It contains two sets of guidelines, one for adults and one for adolescents, and five broad levels of care for each group.

Levels of Care Placement for the Treatment of Substance-Related Disorders:

Level 0.5 EARLY INTERVENTION

Level I OUTPATIENT TREATMENT

Level II INTENSIVE OUTPATIENT/PARTIAL HOSPITALIZATION

Level III RESIDENTIAL INPATIENT TREATMENT

Level IV MEDICALLY-MANAGED INTENSIVE INPATIENT TREATMENT

For each level of care, a brief overview of the services available for particular severities of addiction and related problems is presented; as is a structured description of the settings, staff and services, and admission criteria for the following six dimensions: acute intoxication/withdrawal potential; biomedical conditions and complications; emotional, behavioral or cognitive conditions and complications; readiness to change; relapse, continued use or continued problem potential; and recovery environment.

Contact Information

ASAM:

American Society of Addiction Medicine
4601 N. Park Avenue
Upper Arcade #101
Chevy Chase, MD 20815
Phone: 301-656-3920
Fax: 301-656-3815
www.asam.org

XI. MANAGED CARE PROCEDURES FOR INPATIENT AND PARTIAL HOSPITALIZATION

Inpatient Pre-Admission Review

Preferred Inpatient Admissions:

All Preferred Inpatient Admissions must meet the requirements of the Contract Administrator's utilization management program and policies. Under the program as described below, any Inpatient Admission, other than an Emergency admission, must go through a pre-service claim benefit determination in accordance with the standards of the Contract Administrator as to the Medical Appropriateness of the admission and the available benefit coverage. The pre-service claim benefit determination requirements for Emergency admissions are set forth in the "MENTAL HEALTH CARE/SUBSTANCE ABUSE BENEFITS" (Section V) and "COST MANAGEMENT SERVICES" sections (Section XII) of this booklet. Preferred Hospitals or other Facility Providers in the network will verify the pre-service claim determination certification at or before the time of admission. However, the Covered Person is also responsible to procure a pre-service claim benefit determination for an Inpatient Admission under the program. The Contract Administrator will not authorize the Hospital or other Facility Provider admission if pre-service claim determination is required and is not obtained in advance. The Covered Person will not be financially responsible for admissions to Hospitals or other Facility Providers in the Network which fail to conform to the pre-service claim benefit determination requirements unless (1) the Hospital or other Facility Provider provides prior written notice that the admission will not be paid by the Plans; and (2) the Covered Person acknowledges this fact in writing together with a request to be admitted which states that he/she will assume financial liability for such Hospital or other Facility Provider admission.

Non-Preferred Inpatient Admissions:

For a Non-Preferred (Out-of-Network) Inpatient Admission, the Covered Person is responsible to have the admission registered through a pre-service claim benefit determination in advance as an approved admission.

- To obtain a pre-service claim benefit determination certification, the Covered Person is responsible to contact, or have the admitting Physician or Hospital, or other Facility Provider contact, the Contract Administrator prior to admission to the Hospital or other Facility Provider. The Contract Administrator will notify the Covered Person, admitting Physician and Hospital, or other Facility Provider of the determination. The Covered Person is eligible for Inpatient benefits coverage at the Non-Preferred Provider level shown in the Schedule of Benefits if, and only if, prior approval of such benefits has been through a pre-service claim benefit determination certification in accordance with the Group Contract.
- If such approval for a Medically Appropriate Inpatient Admission has not been pre-service claim benefit determination certified as required under the Group Contract, the Covered Person may jeopardize any and all coverage for such services if the benefit coverage does not match the services being delivered. Such adverse claim determinations and any difference in what is covered by the Plans and the Covered Person's obligations to the Provider will

be the sole responsibility of, and payable by, the Covered Person.

If a Covered Person elects to be admitted to the Hospital or other Facility Provider after pre-service claim benefit determination review and notification that the reason for admission is not approved for an Inpatient level of care, Inpatient benefits will not be provided and the Covered Person will be financially liable for non-covered Inpatient charges.

- If pre-service claim benefit determination for admission certification is denied, the Covered Person, the Physicians, the Hospital or other Facility Provider may appeal the determination and submit information in support of the claim for Inpatient benefits. A final determination concerning eligibility for Inpatient benefits will be made and the Covered Person, Physician, Hospital or other Facility Provider will be so notified.

Emergency Admissions Review:

1. Covered Persons are responsible for notifying the designated agent of a Non-Preferred Emergency admission for themselves or a Dependent within two (2) business days of the admission, or as soon as reasonably possible, as determined by the Contract Administrator.
2. Failure to initiate Emergency admission pre-service claim review may result in the Covered Person jeopardizing any and all coverage for such services if the benefit coverage does not match the services being delivered. Such adverse claim determinations and any difference in what is covered by the Plans and the Covered Person's obligations to the Provider will be the sole responsibility of, and payable by, the Covered Person.
3. If the Covered Person elects to remain hospitalized after the designated agent and the attending physician have determined that an Inpatient level of care is not Medically Appropriate, the Covered Person will be financially liable for the non-covered Inpatient charges from the date of notification.

Concurrent Review

The Contract Administrator assigns an estimated length of stay for all approved Inpatient Hospital admissions based on Medical Appropriateness or Medical Necessity, benefit coverage and eligibility. It also approves admissions to other types of care provided by other Facility Providers and Professional Providers as provided for in the "MENTAL HEALTH CARE/SUBSTANCE ABUSE BENEFITS" section (Section V) of this booklet. Concurrent review of an approved admission or plan of treatment may result in an approval of a request for an extension of approved care. The Contract Administrator will verbally inform the Provider of the approval of any additional care as a result of the concurrent review. It will also continue to monitor extensions of care to determine when further Covered Services are no longer covered under the terms of the benefit coverage. The written determination by both the Contract Administrator and the attending physician that Covered Services are no longer Medically Appropriate/Medically Necessary or benefit eligible will result in the termination of benefits payable for the treatment of the illness.

Pre-Certification Requirements for other than Inpatient Hospitalization:

Pre-service claim benefit determination certification is required by the Contract Administrator in advance of Partial and Outpatient Therapy services which are identified below and Emergency and non-Emergency ambulance services. When a Covered Person plans to receive any of these procedures, the Contract Administrator must review the Medical Necessity or Medical Appropriateness for the procedure to determine the benefit eligibility for the services being provided and grant prior approval of benefits.

Partial Hospitalization

Residential Care

Intensive Outpatient Therapy

Outpatient Detox

Psychological Testing

XII. COST MANAGEMENT SERVICES

How to Access the Cost Management Services

The Cost Management Services Telephone Number is:

PENN Behavioral Health – Access Department
1-888-321-4433

The Covered Person or family member must call this number to receive certification of certain Cost Management Services. This call must be made at least in advance of services being rendered or within 48 hours after an Emergency.

Utilization Review Process:

Utilization review is a program designed to help ensure that all Covered Persons receive necessary and appropriate health care while avoiding unnecessary expenses.

The program is as follows:

- a Urgent Care Claim determination of the benefit coverage of the listed services is provided on an Emergency basis;
- b Pre-certification of the Medical Appropriateness or Medical Necessity is required for Hospitalizations before services are provided;
- c Retrospective review of the Medical Appropriateness or Medical Necessity of the listed services is provided on an Emergency basis;
- d Concurrent review, based on the admitting diagnosis, of the listed services requested by the attending Physician is provided; and
- e Certification of services and planning for discharge from a Facility Provider or cessation of treatment is provided.

The purpose of the program is to determine what is payable by the Plans. The program is not designed to be the practice of medicine or to be a substitute for the judgment of a Physician or other Professional Provider.

If a particular course of treatment is not certified, it means the Plans will not consider that course of treatment as appropriate for the maximum reimbursement under the Plans.

In order to maximize Plan reimbursements, please read the following provisions carefully:

Pre-certification: Before a Covered Person enters a Facility Provider on a non-Emergency basis, the utilization review Contract Administrator will, in conjunction with the attending Physician, certify the care as appropriate for Plan reimbursement. A non-Emergency stay in a Facility Provider is one that can be scheduled in advance.

The utilization review program is set in motion by a telephone call from the Covered Person. Contact the utilization review Contract Administrator, PENN Behavioral Health

1-888-321-4433, **at least before** services are scheduled to be rendered with the following information:

- The name of the Covered Person and relationship to the Employee (Primary Covered Member)-
- The name, Social Security number and address of the Employee (Primary Covered Member)
- The name of the Employer
- The name and telephone number of the attending Physician
- The name of Facility Provider, proposed admission date, and proposed length of stay
- The diagnosis or reason for admission

If there is an **Emergency** admission to the Facility Provider, the Covered Person, the Covered Person's family member, Facility Provider or Physician must contact the Contract Administrator **within 48 hours** of the first business day after the admission.

The utilization review Contract Administrator will determine the number of days of stay at the Facility Provider authorized for payment. **Failure to follow the procedure may reduce reimbursement received from the Plans.**

Concurrent Review and Discharge Planning:

Concurrent review of a course of treatment and discharge planning from a Facility Provider are parts of the utilization review program. The utilization review Contract Administrator will monitor the Covered Person's Facility Provider stay or use of services and coordinate with the Physician, Facility Provider and Covered Person for either the scheduled release or an extension of the Facility Provider stay or extension of the use of other services.

If the Physician feels that it is Medically Appropriate or Medically Necessary for a Covered Person to receive additional services or to stay in the Facility Provider for a greater length of time than has been pre-certified, the Physician must request the additional services or days.

XIII. THE PENN BEHAVIORAL HEALTH NETWORK PROVIDERS

Who are the Preferred (In-Network) Providers?:

Covered Persons can maximize their health care benefits by utilizing PENN Behavioral Health (PBH) Providers. These providers are called “Preferred Providers” in this booklet. They are often referred to as “In-Network Providers”. Preferred Providers are doctors, hospitals and other behavioral health care professionals and institutions that are part of the entire PENN Behavioral Health Network. There are many UPHS Providers who are qualified health care providers who also belong to the Penn Behavioral Health Network. They are referred to in the schedule of benefits (page 5) as PBH Staff. All Preferred Provider benefits are delivered through a specially selected network of cost-effective providers to ensure quality care. The PBH Network includes hospitals, facilities, ambulance services, physicians, psychologists and therapists.

Services Provided by Preferred (In-Network – PBH Staff) Providers:

When a Covered Person receives behavioral health care through a PENN Behavioral Health Staff Provider, they will receive the highest level of benefits, with the fewest out-of-pocket expenses. There is no Deductible involved and the participant is not financially liable for coinsurance. The Plan pays 100% (after applicable co-payments) for most services. There are no claim forms to complete.

Services Provided by Preferred (In-Network- PBH Regional Network) Providers:

When a Covered Person receives behavioral health care through a PENN Behavioral Health Provider, they will receive a higher level of benefits, with fewer out-of-pocket expenses. There is no Deductible involved and the participant is not financially liable for coinsurance. The Plan pays 100% (after applicable co-payments) for most services. There are no claim forms to complete.

Services Provided by Non-Preferred (Out-of-Network) Providers:

Benefits are also provided if the Covered Person chooses to receive Covered Services through a provider that is not a Preferred Provider. However, the level of benefits will be reduced, and the Covered Person will be responsible for a greater share of the Co-insurance expenses. They will also be required to submit the claim or have their provider submit the claim.

All participants in the Plans will be notified of a web based directory that lists the PENN Behavioral Health Providers who belong to the University of Pennsylvania Health System and Preferred Providers that belong to the general PENN Behavioral Health Network. Individuals may also go to the Human Resources website and link to the PBH directory on-line.

Services which are Medically Appropriate/Medically Necessary and Benefit Eligible:

The Plans cover only care that is Medically Appropriate/Medically Necessary as described in the Plans. Medically Appropriate/Medically Necessary care is care that is required for the Covered Person’s particular condition in order that they may receive care at the most appropriate levels of service. Examples of different levels of service are Hospital Inpatient care, Partial Hospitalization and Outpatient services.

Some of the services received under the Plans must go through a pre-service claim benefit determination before they are received, to determine whether they are Medically Appropriate/ Medically Necessary and benefit eligible. Failure to obtain a “pre-service claim benefit determination” for Non-Preferred (Out-of-Network) services, when required, may result in a loss of benefit coverage for that particular service. Pre-service claim benefit determination certification of services is a vital program feature that reviews Medical Appropriateness of certain procedures/admissions and reviews benefit coverage for the services. In certain cases, pre-service claim benefit certification helps to locate alternative treatments that may be available and are as equally effective. Pre-service claims benefit determination certification also helps determine the most appropriate setting for certain services.

When a Covered Person seeks treatment that requires pre-service claims benefit determination certification, they are responsible for obtaining the pre-service claims benefit determination even if the treatment is provided by a Preferred (In-Network) Provider. In addition, if the Preferred (In-Network) Provider fails to obtain a required pre-service claims benefit determination certification of services, the person receiving care will not be responsible for any associated financial penalties assessed by the Plans as a result. If the request for pre-service claims benefit determination certification is denied, the Covered Person will be notified in writing that the admission/service will not be paid because it is not considered to be Medically Appropriate/Medically Necessary and is not benefit eligible. 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.

When a person seeks treatment from a Non-Preferred (Out-of-Network) Provider, they are responsible for initiating the pre-service claims benefit determination process. They or their provider should call the pre-service claims benefit determination number listed on the back of their Identification Card, 1-888-321-4433, and give their full name, treating provider or Facility Provider’s name, and procedure or reason for admission. Failure to obtain the pre-service claims benefit determination of the required services may result in a denial of benefits payable to that participant.

For Facility Provider pre-service claims, contact the utilization review Contract Administrator, PENN Behavioral Health 1-888-321-4433, with the following information:

- The name of the Covered Person and relationship to the Employee (Primary Covered Member)-
- The name, Social Security number and address of the Employee (Primary Covered Member)
- The name of the Employer
- The name and telephone number of the attending Physician
- The name of Facility Provider, proposed admission date, and proposed length of stay
- The diagnosis or reason for admission

If there is an **Emergency** admission to the Facility Provider, the Covered Person, the Covered Person's family member, Facility Provider or Physician must contact PENN Behavioral Health **within 48 hours** of the first business day after the admission.

The utilization review Contract Administrator will determine the number of days of stay at the Facility Provider authorized for payment. **Failure to follow the procedure may reduce reimbursement received from the Plans.**

XIV. THE PAYMENT PROCESS

Provider Reimbursement:

The Plans intend to encourage the provision of quality, cost-effective care for Covered Persons through the use of Preferred Providers. Set forth below is a general description of the reimbursement programs by type of provider.

Please note that these programs may change from time to time, and the arrangements with particular providers may be modified as new contracts are negotiated. If a Covered Person has any questions about how their provider is compensated, they can speak with their provider directly or contact PBH Access Services at 1-888-321-4433.

PENN Behavioral Health Preferred (In-Network) Facility and Individual Providers will need to receive pre-service claims authorization (for other than Emergency services) and then directly bill Penn Behavioral Health for the authorized services rendered.

In-Network providers can go to the www.pennbehavioralhealth.org website for further instructions and forms regarding submitting claims or contact Claims Assistance (Claims Department) at 1-888-321-4433.

PENN Behavioral Health Non-Preferred (Out-of-Network) Facility and Individual Providers should but will not need to receive pre-service claims authorization and then charge the Covered Person (who will submit the claims) or directly bill Penn Behavioral Health for the pre-service or post-service authorized claims for the services rendered. Emergency Care does not need pre-service authorization.

Non-Preferred (Out-of-Network) Facilities and Individual Providers or Covered Persons 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.

Out-of-Network Providers or Covered Persons can go to www.pennbehavioralhealth.org website for further instructions and forms regarding submitting claims or contact Claims Assistance (Claims Department) at 1-888-321-4433.

Physicians

Network physicians are paid on a fee-for-service basis, meaning that payment is being made according to the Contract Administrator’s fee schedule for the specific services that the physician performs.

Institutional Providers

Hospitals: For most Inpatient medical services, Hospitals are paid per diem rates, which are specific amounts paid for each day a Covered Person is in the Hospital. These rates usually vary according to the intensity of the Covered Services provided. Some Hospitals are also paid as case rates, which are set dollar amounts paid for a complete Hospital stay related to a specific procedure or diagnosis. For most Outpatient and Emergency Services and procedures, most Hospitals are paid specific rates based on the type of Covered Services performed. For a few Covered Services, Hospitals are paid on a percentage of billed charges. Most Hospitals are paid through a combination of the

above payment mechanisms for various services.

Special care facilities: Most special care facilities are paid per diem rates, which specific amounts are paid for each day a Covered Person is in the Facility Provider. These amounts may vary according to the level of Covered Services provided.

Group Practices: Certain group practices employ or contract with individual Physicians and behavioral health care Providers to provide services. These groups are paid as described in the Physician reimbursement section outlined above. These groups may pay their affiliated providers a salary and/or provide incentives based on production, quality, service, or other performance standards.

Payment Methods for All Facility and Professional Providers:

Covered Person or the Provider may submit bills directly to the Contract Administrator, and, to the extent that benefits and indemnity are payable within the terms and conditions of this coverage, reimbursement will be furnished as detailed below. The Covered Person's coinsurance, benefit Maximums and benefits for Covered Services are based on the rate of reimbursement as defined under "Covered Expense" in the "GLOSSARY OF DEFINED TERMS" section (Section XVII) of this booklet. They are also enumerated in the "SCHEDULE OF BENEFITS" section (Section IV) of this booklet.

Payment for Facility Providers

A. Payment for PENN Behavioral Health Preferred (In-Network) Facility Providers:

PENN Behavioral Health Preferred (In-Network) Facility Providers are specific members of the University of Pennsylvania Health System (PBH Staff) as well as members of the PBH Network (PBH Regional Network) and have a contractual arrangement with the Contract Administrator for the provision of services to Covered Persons. Benefits will be provided as specified in the "SCHEDULE OF BENEFITS" section (Section IV) of this booklet for services that have been performed by a UPHS (PBH Staff) or Preferred (PBH Regional Network) In-Network Facility Provider. The Contract Administrator will compensate UPHS (PBH Staff) and Preferred (PBH Regional Network) In-Network Facility Providers in accordance with the contracts entered into between such Providers and the Contract Administrator. No payment will be made directly to the Covered Person for Covered Services rendered by any UPHS (PBH Staff) or Preferred (PBH Regional Network) (In-Network) Facility Provider.

The Contract Administrator is authorized by the Covered Person to make payments directly to PENN Behavioral Health, Preferred (In-Network) Facility Providers furnishing Covered Services for which benefits are provided under this coverage. PENN Behavioral Health, Preferred (In-Network) Facility Providers have agreed to accept the rate of reimbursement determined by a contract as payment in full for Covered Services. PENN Behavioral Health, Preferred (In-Network) Facility Providers will make no additional charge to Covered Persons for Covered Services except in case of certain Co-Payments, coinsurance or other cost sharing features (such as admission charges) as specified under this program in the "SCHEDULE OF BENEFITS" section (Section IV) of this booklet. 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, Preferred (In-Network) Facility Provider.

Benefit amounts, as specified in the “SCHEDULE OF BENEFITS” section (Section IV) of this booklet, refer to Covered Services rendered by a Preferred (In-Network) Facility Provider which is regularly included in such Provider’s charges and are billed by and payable to such Provider. Any dispute between the PENN Behavioral Health or Preferred (In-Network) Provider and a Covered Person with respect to balance billing shall be submitted to the Contract Administrator for determination. The decision of the Contract Administrator shall be final.

The Plans will provide benefits for the Covered Expenses incurred for certain mental health/substance abuse services when rendered incident to hospitalization, as described herein. If charges for such services are included in a bill from a Preferred (In-Network) Facility Provider, payment shall be made to such Facility Provider subject to any existing agreement between the Facility Provider and the Plans.

Once Covered Services are rendered by a Preferred (In-Network) Facility Provider, the Plans will not honor a Covered person’s request not to pay for claims submitted by the Preferred (In-Network) Facility Provider. The Plans will have no liability to any person because of its rejection of the request.

B. Payment for Non-Preferred (Out-of-Network) Facility Providers:

A Non-Preferred (Out-of-Network) Qualified Facility Provider is a Facility Provider which does not belong to the PBH Network, nor does it have a contract with the Plans. The Plans will provide benefits to the Covered Person for use of such Non-Preferred (Out-of-Network) Qualified Facility Provider at the Non-Preferred (Out-of-Network) coinsurance level specified in the “SCHEDULE OF BENEFITS” section (Section IV) of this booklet. Accordingly, when a Covered Person seeks care from Non-Preferred (Out-of-Network) Qualified Facility Providers, any difference between the Non-Preferred (Out-of-Network) Qualified Facility Provider’s charge and the Plans’ payment shall be the personal responsibility of the Covered Person.

If the Contract Administrator determines that Covered Services were for Emergency Care as defined herein, the Covered Person will not be subject to the coinsurance penalties that would ordinarily be applicable to Qualified Non-Preferred (Out-of-Network) services. Emergency admissions must be pre-service claims benefit determination certified within two (2) business days of admission, or as soon as reasonably possible, as determined by the Contract Administrator. Note: any difference between the Non-Preferred Out-of-Network Qualified Facility Provider’s charge and the Plans’ payment for Emergency services shall be the personal responsibility of the Covered Person.

Professional Providers

A. Payment for PENN Behavioral Health Preferred (In-Network) Professional Providers:

PENN Behavioral Health Preferred (In-Network) Professional Providers are specific members of the University of Pennsylvania Health System as well as members of the PBH Network and have a contractual arrangement with the Plans for the provision of services to Covered Persons. Benefits will be provided as specified in the “SCHEDULE OF BENEFITS” section (Section IV) of this booklet for services that have been performed by a UPHS (PBH Staff) or Preferred (PBH Regional Network) In-Network Professional Provider. The Plans will compensate UPHS (PBH Staff) and Preferred

(PBH Regional Network) In-Network Professional Providers in accordance with the contracts entered into between such Providers and the Plans. No payment will be made directly to the Covered Person for Covered Services rendered by any UPHS (PBH Staff) or Preferred (PBH Regional Network) In-Network Professional Provider.

The Contract Administrator is authorized by the Covered Person to make payments directly to PENN Behavioral Health, Preferred (In-Network) Professional Providers furnishing Covered Services for which benefits are provided under this coverage. PENN Behavioral Health, Preferred (In-Network) Professional Providers have agreed to accept the rate of reimbursement determined by a contract as payment in full for Covered Services. PENN Behavioral Health, Preferred (In-Network) Professional Providers will make no additional charge to Covered Persons for Covered Services except in case of certain Co-Payments, Coinsurance or other cost sharing features as specified under this program in the “SCHEDULE OF BENEFITS” section (Section IV) of this booklet. The Covered Person is responsible within 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, Preferred (In-Network) Professional Provider.

Benefit amounts, as specified in the “SCHEDULE OF BENEFITS” (Section IV) of this booklet refer to Covered Services rendered by a Preferred (In-Network) Professional Provider which is regularly included in such provider’s charges and are billed by and payable to such provider. Any dispute between the PENN Behavioral Health or Preferred (In-Network) Professional Provider and a Covered Person with respect to balance billing shall be submitted to the Contract Administrator for determination. The decision of the Contract Administrator shall be final.

The Plans will provide benefits for the Covered Expenses incurred for certain mental health/substance abuse services when rendered incident to hospitalization, as described herein. If charges for such services are included in a bill from a Preferred (In-Network) Facility Provider, payment shall be made to such Professional Provider subject to any existing agreement between the Professional Provider and the Plans.

Once Covered Services are rendered by a Preferred (In-Network) Professional Provider, the Plans will not honor a Covered Person’s request not to pay for claims submitted by the (In-Network) Professional Provider. The Plans will have no liability to any person because of its rejection of the request.

B. Payment for Non-Preferred (Out-of-Network) Professional Provider Reimbursement:

A Non-Preferred (Out-of-Network) Qualified Professional Provider is a Provider which does not belong to the PBH Network, nor does it have a contract with the Plans. The Plans will provide benefits to the Covered Person for use of such Non-Preferred (Out-of-Network) Qualified Professional Provider at the Non-Preferred (Out-of-Network) coinsurance level specified in the “SCHEDULE OF BENEFITS” section (Section IV) of this booklet. Accordingly, when a Covered Person seeks care from Non-Preferred (Out-of-Network) Qualified Professional Providers, any difference between the Non-Preferred (Out-of-Network) Qualified Professional Provider’s charge and the Plans’ payment shall be the personal responsibility of the Covered Person.

If the Contract Administrator determines that Covered Services were for Emergency Care as defined herein, the Covered Person will not be subject to the Coinsurance penalties that would ordinarily be applicable to qualified Non-Preferred (Out-of-Network) services. Emergency admissions must be pre-service claims benefit determination certified within two (2) business days of admission, or as soon as reasonably possible, as determined by the Contract Administrator. Note: any difference between the Non-Preferred Out-of-Network Qualified Professional Provider's charge and the Plans' payment for Emergency services shall be the personal responsibility of the Covered Person.

XV. FILING CLAIMS FOR SERVICES AND APPEALS

How to File a Claim:

Covered Persons are never required to file a claim when Covered Services are provided by Preferred (In-Network) Providers. When they receive care from a Non-Preferred (Out-of-Network) Provider, they will need to file a claim or have their provider file a claim for the covered participant to receive reimbursement. In some cases, at the discretion of the Contract Administrator, arrangements may be made to have payments made directly to the provider such as in the case of a Facility Provider or other hospital setting.

To file a claim, the Covered Person can call Member Services (Access Services Department) at the number listed on the back of their Identification Card, (1-888-321-4433) and the full process for filing a claim will be described. There are two options:

- (a) The individual can fill out a claim form posted in the member section of the www.pennbehavioralhealth.org website or request them to be sent by Claims Services (Claims Department) by calling (1-888-321-4433) or
- (b) By simply sending in the following information:
 - Name of Covered Participant,
 - Name of Patient,
 - Address,
 - Phone Numbers,
 - Date of Birth,
 - Employee (Primary Covered Member) ID #, and
 - Plan Name

along with their itemized bills containing:

- The Non-Preferred (Out-of-Network) Provider's (Qualified Professional or Facility Provider) Name (with degree/license),
- Tax I.D. number,
- Address,
- Phone number,
- Dates of Service, and
- Diagnosis (by listed codes and/or description) and services performed (by codes or rates) with associated itemized charges.

The Covered Person (or their designated legal guardian/custodian) must fill out the claim form or include the above pertinent information and return it with any itemized bills to:

PENN Behavioral Health
Claims Administrator
3535 Market Street, 4th Floor
Philadelphia, PA 19104

Please submit claims no later than 90 days after the completion of the Covered Services. The claim should include the date and information required by the Contract Administrator to determine benefits. An expense will be considered "incurred" on the date the service was rendered.

If it is not possible to file the claim within the 90-day period, the benefits will not be reduced, but in no event will the Plans be required to accept the claim more than one (1) year after the end of the Benefit Period in which the Covered Services are rendered.

When Claims Should Be Filed:

Claims should be filed with the Claims Department within the 90 days of the date charges for the services were incurred. Benefits are based on the Plans' 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 one (1) year deadline from the time when the claim was incurred. This period will not apply when the person is not legally capable of submitting the claim.

The Contract 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 Plans reserve the right to have a Plan Participant seek a second medical opinion.

Claims Procedure:

Types of Claims: There are several different types of claims that you may bring under the Plan. The Plan's procedures for evaluating claims (for example, the time limits for responding to claims and appeals) depend upon the particular type of claim. The types of claims that you generally may bring under the Plan are as follows:

- Pre-Service Claim - A "pre-service claim" is a claim for a particular benefit under the Plan that is conditioned upon you receiving prior approval in advance of receiving the benefit. A pre-service claim must contain, at a minimum, the name of the individual for whom benefits are being claimed, a specific medical condition or symptom, and a specific treatment, service or product for which approval is being requested.
- Post-Service Claim - A "post-service claim" is a claim for payment for a particular benefit or for a particular service after the benefit or service has been provided. A post-service claim must contain the information requested on a claim form provided by the applicable provider.
- Urgent Care Claim - An "urgent care claim" is a claim for benefits or services involving a sudden and urgent need for such benefits or services. A claim will be considered to involve urgent care if the Claims Administrator or a physician with knowledge of your condition determines that the application of the claims review procedures for non-urgent claims (i) could seriously jeopardize your life or your health, or your ability to regain maximum function, or (ii) in your physician's opinion, would subject you to severe pain that cannot adequately be managed without the care or treatment that is the subject of the claim.
- Concurrent Care Review Claim - A "concurrent care review claim" is a claim relating to the continuation/reduction of an ongoing course of treatment.

Time Periods for Responding to Initial Claims: If you bring a claim for benefits under the Plan, the Claims Administrator will respond to your claim within the following time periods:

- **Post-Service Claim** - In the case of a post-service claim, the Claims Administrator shall respond to you within 30 days after receipt of the claim. If the Claims Administrator determines that an extension is necessary due to matters beyond the control of the Plan, the Claims Administrator will notify you within the initial 30-day period that the Claims Administrator needs up to an additional 15 days to review your claim. If such an extension is necessary because you failed to provide the information necessary to evaluate your claim, the notice of extension will describe the information that you need to provide to the Claims Administrator. You will have no less than 45 days from the date you receive the notice to provide the requested information.
- **Pre-Service Claim** - In the case of a pre-service claim, the Claims Administrator shall respond to you within 15 days after receipt of the claim. If the Claims Administrator determines that an extension is necessary due to matters beyond the control of the Plan, the Claims Administrator will notify you within the initial 15-day period that the Claims Administrator needs up to an additional 15 days to review your claim. If such an extension is because you failed to provide the information necessary to evaluate your claim, the notice of extension will describe the information that you need to provide to the Claims Administrator. You will have no less than 45 days from the date you receive the notice to provide the requested information.
- **Urgent Care Claim** - In the case of an urgent care claim, the Claims Administrator shall respond to you within 72 hours after receipt of the claim. If the Claims Administrator determines that it needs additional information to review your claim, the Claims Administrator will notify you within 24 hours after receipt of the claim and provide you with a description of the additional information that it needs to evaluate your claim. You will have no less than 48 hours from the time you receive this notice to provide the requested information. Once you provide the requested information, the Claims Administrator will evaluate your claim within 48 hours after the earlier of the Claims Administrator's receipt of the requested information, or the end of the extension period given to you to provide the requested information. There is a special time period for responding to a request to extend an ongoing course of treatment if the request is an urgent care claim. For these types of claims, the Claims Administrator must respond to you within 24 hours after receipt of the claim by the Plan (provided, that you make the claim at least 24 hours prior to the expiration of the ongoing course of treatment).
- **Concurrent Care Review Claim** - If the Plan has already approved an ongoing course of treatment for you and contemplates reducing or terminating the treatment, the Claims Administrator will notify you sufficiently in advance of the reduction or termination of treatment to allow you to appeal the Claims Administrator's decision and obtain a determination or review before the treatment is reduced or terminated.

Notice and Information Contained in Notice Denying Initial Claim: If the Claims Administrator denies your claim (in whole or in part), the Claims Administrator will provide you with written notice of the denial (although initial notice of a denied urgent care claim may be provided to you orally). This notice will include the following:

- Reason for the Denial - the specific reason or reasons for the denial;
- Reference to Plan Provisions - reference to the specific Plan provisions on which the denial is based;
- Description of Additional Material - a description of any additional material or information necessary for you to perfect your claim and an explanation as to why such information is necessary;
- Description of Any Internal Rules - a copy of any internal rule, guideline, protocol, or other similar criterion relied upon in making the initial determination or a statement that such a rule, guideline, protocol, or other criterion was relied upon in making the appeal determination and that a copy of such rule will be provided to you free of charge at your request; and
- Description of Claims Appeals Procedures - a description of the Plan's appeals procedures and the time limits applicable for such procedures (such description will include a statement that you are eligible to bring a civil action in Federal court under Section 502 of ERISA to appeal any adverse decision on appeal and a description of any expedited review process for urgent care claims).

Appeals

When a claimant receives an adverse benefit determination, the claimant has 180 days following receipt of the notification in which to appeal the decision. A claimant may submit written comments, documents, records, and other information relating to the Claim.

The member (or their designated legal guardian/custodian) must send the appeal with appropriate documentation (as noted above) to:

PENN Behavioral Health
Appeals Administrator
3535 Market Street, 4th Floor
Philadelphia, PA 19104

Appealing a Denied Claim for Benefits: If your initial claim for benefits is denied by the Claims Administrator, you may appeal the denial by filing a written request (or an oral request in the case of an urgent care claim) with the Appeals Administrator within 180 days after you receive the notice denying your initial claim for benefits. If you decide to appeal a denied claim for benefits, you will be able to submit written comments, documents, records, and other information relating to your claim for benefits (regardless of whether such information was considered in your initial claim for benefits) to the Appeals Administrator for review and consideration. You will also be entitled to receive, upon request and free of charge, access to and copies of, all documents, records and other information that is relevant to your appeal.

Types of Appeals:

Following are the two types of appeals and the issues they address:

Medical Appropriateness/Medical Necessity Appeal Issues – An appeal by or on behalf of a Covered Person that focuses on issues of Medical Appropriateness /Medical Necessity and requests the Contract Administrator to change its decision to deny or limit the provision of a Covered Service. Medical Appropriateness/Medical Necessity appeals include appeals of adverse benefit determinations based on the exclusion for Experimental or Investigative services or other services considered as an exclusion because they are **not deemed**

Medically Appropriate/Medically Necessary (as determined by the individual Mental Health/ Substance Abuse Plan option) for the diagnosis, care, or treatment of illness, trauma, or restoration of mental health/substance abuse impaired functions.

Administrative Appeal Issues – An appeal by or on behalf of a Covered Person that focuses on unresolved disputes or objections regarding a Contract Administrator decision that concerns coverage terms such as contract exclusions and non-covered benefits, exhausted benefits, and claims payment issues. Although an administrative appeal may present issues related to Medical Necessity and Medical Appropriateness, these are not the primary issues that affect the outcome of the appeal. Administrative Appeals include appeals of adverse benefit determinations based on the exclusion of services because they are **not deemed by the Contract Administrator to be benefit covered** (as determined by the individual Mental Health/ Substance Abuse Plan option) for the diagnosis, care, or treatment of illness, trauma, or restoration of mental health/substance abuse impaired functions.

Time Periods for Responding to Appealed Claims: If you appeal a denied claim for benefits, the Appeals Administrator will respond to your claim within the following time periods:

- Post-Service Claim - In the case of an appeal of a denied post-service claim, the Appeals Administrator shall respond to you within 60 days after receipt of the appeal.
- Pre-Service Claim - In the case of an appeal of a denied pre-service claim, the Appeals Administrator shall respond to you within 30 days after receipt of the appeal.
- Urgent Care Claim - In the case of an appeal of a denied urgent care claim, the Appeals Administrator shall respond to you within 72 hours after receipt of the appeal.
- Concurrent Care Review Claim - In the case of an appeal of a denied concurrent care review claim, the Appeals Administrator shall respond to you before the concurrent or ongoing treatment in question is reduced or terminated.

Notice and Information Contained in Notice Denying Appeal: If the Appeals Administrator denies your claim (in whole or in part), the Appeals Administrator will provide you with written notice of the denial (although initial notice of a denied urgent care claim may be provided to you orally or via facsimile or other similarly expeditious means of communication). This notice will include the following:

- Reason for the Denial - the specific reason or reasons for the denial;
- Reference to Plan Provisions - reference to the specific Plan provisions on which the denial is based;
- Statement of Entitlement to Documents - a statement that you are entitled to receive, upon request and free of charge, access to and copies of, all documents, records and other information that is relevant to your claim and/or appeal for benefits;
- Description of Any Internal Rules - a copy of any internal rule, guideline, protocol, or other similar criterion relied upon in making the appeal determination or a statement that such a rule, guideline, protocol, or other criterion was relied upon in making the appeal determination and that a copy of such rule will be provided to you free of charge at your request; and
- Statement of Right to Bring Action - a statement that you are entitled to bring a civil action in Federal court under Section 502 of ERISA to pursue your claim for benefits.

The decision of the Appeals Administrator shall be final and conclusive on all persons claiming benefits under the Plan, subject to applicable law. If you challenge the decision of the Appeals Administrator, a review by a court of law will be limited to the facts, evidence and issues presented during the claims procedure set forth above. The appeal process described herein must be exhausted before you can pursue the claim in federal court. Facts and evidence that become known to you after having exhausted the appeals procedure may be submitted for reconsideration of the appeal in accordance with the time limits established above. Issues not raised during the appeal will be deemed waived.

XVI. RESOLVING PROBLEMS

Complaint Process:

The Contract Administrator has a process for Covered Persons to express Complaints. To register a Complaint, Covered Persons should call the Access Services Department at the telephone number on the back of their identification card or write to the Contract Administrator at the following address:

Member Services
PENN Behavioral Health
3535 Market Street, 4th Floor
Philadelphia, PA 19104

Most Covered Person's concerns are resolved informally at this level. However, if the Contract Administrator is unable to immediately resolve the Covered Person's Complaint, it will be investigated, and the Covered Person will receive a response in writing within thirty (30) days.

If you have any questions about this booklet you should contact the Plan Administrator or PENN Behavioral Health. The University of Pennsylvania has designated the Vice President of Human Resources to act as the Plan Administrator for the Plan. Contact information for the Plan Administrator and PENN Behavioral Health is as follows:

Plan Administrator
Vice President of Human Resources of the
University of Pennsylvania
3401 Walnut Street, Suite 328A
Philadelphia, PA 19104

PENN Behavioral Health
3535 Market Street, 4th Floor
Philadelphia, PA 19104
1-888-321-4433

XVII. GLOSSARY OF DEFINED TERMS

The terms below have the following meaning when describing the benefits within this Booklet. They will be helpful to you in fully understanding your benefits.

ACCESSING – The extent to which a Covered Person can obtain from a Preferred Provider available Covered Services at the time they are needed. Accessing a Preferred Provider refers to both telephone access and ease of scheduling an appointment.

ALCOHOL OR DRUG ABUSE - Means a pattern of pathological use of alcohol or other drugs which causes impairment in social and/or occupational functioning and which results in physiological and/or psychological dependency evidenced by physical tolerance or withdrawal.

ANESTHESIA - Consists of the administration of regional or rectal anesthetic or the administration of a drug or other anesthetic agent by injection or inhalation, the purpose and effect of which is to obtain muscular relaxation, loss of sensation or loss of consciousness.

APPEAL – A request by a Covered Person, or the Covered Person’s representative or Provider, acting on the Covered Person’s behalf upon written consent, to change a previous decision made by the Contract Administrator.

1. **ADMINISTRATIVE APPEAL** – an appeal by or on behalf of a Covered Person that focuses on unresolved disputes or objections regarding coverage terms such as contract exclusions and non-covered benefits. Administrative appeal may present issues related to Medical Necessity or Medical Appropriateness, but these are not the primary issues that affect the outcome of the appeal.
2. **MEDICAL NECESSITY APPEAL** – request for the Contract Administrator to change its decision, based primarily on Medical Necessity or Appropriateness, to deny or limit the provision of a Covered Service.
3. **EXPEDITED APPEAL** - a faster review of a Medical Necessity Appeal, conducted when the Contract Administrator determines that a delay in decision making would seriously jeopardize the Covered Person’s life, health, or ability to regain maximum function.

APPLICANT AND EMPLOYEE/PRIMARY COVERED PARTICIPANT /PRIMARY MEMBER – The Employee (or former employee) who applies for coverage under the Plan.

ATTENTION DEFICIT DISORDER/ ATTENTION DEFICIT HYPERACTIVITY DISORDER – A disease characterized by developmentally inattention, impulsiveness and hyperactivity.

BENEFIT PERIOD – The specified period of time as shown in the Schedule of Benefits during which charges for the Covered Services must be incurred in order to be eligible for payment by the Plans. A charge shall be considered Incurred on the date the service was provided to a Covered Person.

CASE MANAGEMENT – Comprehensive Case Management programs serve individuals who have been diagnosed with a complex, catastrophic, or chronic illness or injury. The objectives of Case Management are to facilitate access by the Covered Person to ensure the efficient use of appropriate health care resources, link the Covered Person with preventative health care services, assist providers in coordinating prescribed services, monitor the quality of services delivered, and improve Covered Person’s outcomes. Case Management supports Covered Persons and providers by locating, coordinating, and/or evaluating services for a Covered Person who has been diagnosed with a complex, catastrophic or chronic illness and/or injury across various levels and sites of care.

COINSURANCE – A type of cost-sharing in which a Covered Person assumes a percentage of the Covered Expense for Covered Services (such as twenty percent).

COMPLAINT – Any expression of dissatisfaction, verbal or written, by a Covered Person.

CO-PAYMENT – A charge or an amount authorized under the applicable Plan which may be collected directly by Providers or Facilities from a Covered Person and which amount is the financial responsibility of the Covered Person. It is a type of cost-sharing in which a Covered Person pays a flat dollar amount each time a Covered Service is provided (such as a \$10.00 or \$15.00 co-payment per office visit).

COVERED EXPENSE – Refers to the basis on which a Covered Person’s Deductibles, Coinsurance, benefit Maximums and benefits are calculated.

- (a) For services rendered by a Facility Provider, the term “Covered Expense” may not refer to the actual amount(s) paid by the Plans to the Provider(s). Under the Plans’ contracts, the Contract Administrator pays the Facility Providers using bulk purchasing arrangements that permit it to pay less for services. The amount the Plans pay at the time of any given claim may be more or it may be less than the amount used to calculate the Covered Person’s liability. Rather, “Covered Expense” means the following:

1 For a Participating Professional Facility Provider – the rate of reimbursement for Covered Services will be made in accordance with PENN Behavioral Health’s contract for In-Network Services.

2 For services rendered by a Non-Preferred, Non-Participating Facility Provider that has no contractual arrangement with the Plans, “Covered Expense” means the lesser of the (i) Facility Provider’s charges, or (ii) PENN Behavioral Health’s Usual, Customary and Reasonable Rate (UCR) for the Covered Services.

(b) For services rendered by a Professional Provider, “Covered Expense” means the following:

1. For a Participating Professional Provider – the rate of reimbursement for Covered Services will be made in accordance with PENN Behavioral Health’s contract for In-Network Services.
2. For services rendered by a Non-Preferred, Non-Participating Professional Provider that has no contractual arrangement with the Plans, “Covered Expense” means the lesser of the (i) Provider’s charges, or (ii) PENN Behavioral Health’s Usual, Customary and Reasonable Rate (UCR) for the Covered Services.

COVERED PERSONS/MEMBERS – An enrolled Employee (Primary Covered Person) or his/her Dependents who have satisfied the criteria for eligibility (also in this booklet referred to as “Member”).

COVERED SERVICE – Any medical, hospital or other services related to mental health or substance abuse rendered by a provider, the administration of which is provided by the Contract Administrator and the expense is paid pursuant to the terms of the Plans.

DEDUCTIBLE – A specified amount of Covered Expenses for the Covered Services that is incurred by the Covered Person before the Plans will assume any liability.

DETOXIFICATION – The process by which an alcohol or drug intoxicated or alcohol or drug dependent person is assisted, in a licensed Facility Provider, through the period of time necessary to eliminate, by metabolic or other means, the intoxicating alcohol or other drug, or alcohol or other drug dependency factors, or alcohol in combination with drugs, as determined by a licensed Physician, while keeping the physiological risk to the Covered Person at a minimum.

EFFECTIVE DATE – The date on which coverage for a Covered Person begins in the Plan.

EMERGENCY – The sudden and unexpected onset of a medical or psychiatric condition manifesting itself in acute symptoms of sufficient severity or severe pain, such that a prudent layperson who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

- A. Imminent risk to self and others;
- B. Suffering which needs to be averted;
- C. Loss of functional safety of the Covered Person;
- D. Imminent risk of acute mental status deterioration;
- E. Significant weight loss;
- F. Acute and serious impairment of psychosocial functioning;

EMERGENCY CARE – Immediate care based on case risk presented (defined by the Emergency situation above) at the time of assessment according to the DSM-IV diagnosis for a condition which requires immediate or rapid intervention to prevent death, serious harm to Covered Person or others, or to prevent deterioration of the Covered Person’s

clinical state, such that gross impairment of functioning exists and is likely to result in compromise of the Covered Person's safety.

EMPLOYEE/PRIMARY COVERED PERSON/PRIMARY MEMBER - An individual of the Group who meets the eligibility requirements for enrollment, who is so specified for enrollment and in whose name the Identification Card is issued.

EXPERIMENTAL OR INVESTIGATIVE – A drug, device, medical treatment or procedure:

- A. If the drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration (FDA) and approval for marketing has not been given at the time the drug or device is furnished; or
- B. If the drug, device, medical treatment or procedure, or the Covered Person informed consent document utilized with the drug, device, treatment or procedure, was reviewed by the treatment Facility Provider's Institutional Review Board or other body serving a similar function, or if federal law requires such review and approval; or
- C. If reliable evidence shows that the drug, device, medical treatment or procedure is the subject of on-going Phase I or Phase II clinical trials, is the research, Experimental or Investigative, study or investigative arm of on-going Phase III clinical trials, or is otherwise under study to determine maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis, or
- D. If reliable evidence shows that the prevailing opinion among experts regarding the drug, device, medical treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with a standard means of treatment or diagnosis, or
- E. Any drug which the FDA has determined to be contraindicated for the specific treatment for which such drug is prescribed.

FACILITY PROVIDER - An institutional or entity licensed provider that offers acute Inpatient treatment, non-hospital treatment or residential treatment to provide mental health or substance abuse care. Such facilities include:

- Hospital
- Free Standing Ambulatory Care Facility
- Non-Hospital Facility
- Psychiatric Hospital
- Residential Treatment Facility
- Psychiatric Hospital

FAMILY COVERAGE – An enrolled employee (Primary Covered Person) and his/her eligible dependents.

FREE STANDING AMBULATORY CARE FACILITY – A Facility Provider, other than a Hospital, which provides treatment or services on an Outpatient or partial basis

and is not, other than incidentally, used as an office or clinic for the private practice of a Physician. This Facility Provider shall be licensed by the state in which it is located and be accredited by the appropriate regulatory body.

GRIEVANCE – A request by a Covered Person, or a Provider with the written consent of the Covered Person, to have the ASO review the denial of service based on benefit determination.

GROUP or (ENROLLED GROUP) – A group of Employees (and their dependents) which has been accepted by the Plans, consisting of all those active Applicants whose charges are remitted by the University of Pennsylvania together with all the Faculty and Staff (and their dependents), listed on the Application Cards or amendments thereof, which have been accepted by the Plans and identified to the Contract Administrator.

GROUP CONTRACT – An administrative services agreement executed by and between the Contract Administrator and the University of Pennsylvania setting forth the services the Contract Administrator will provide on behalf of the Plans.

HOSPITAL – A short-term, acute care, general Hospital which has been approved by the Joint Commission on Accreditation of Healthcare Organizations and/or by the American Osteopathic Hospital Association or by the Contract Administrator and which:

- A. Is a duly licensed institution;
- B. Is primarily engaged in providing Inpatient diagnostic and therapeutic services for the diagnosis, treatment, and care of injured and sick persons by or under the supervision of Physicians;
- C. Has organized departments of medicine;
- D. Provides 24-hour nursing service by or under the supervision of Registered Nurses; and
- E. Is not, other than incidentally a:
 - Skilled Nursing Facility;
 - Nursing Home;
 - Custodial Care Home;
 - Health resort, spa or sanitarium;
 - Place for rest; or
 - Place for the aged.

IDENTIFICATION CARD - The currently effective card issued to Covered Persons by the Plans or the Contract Administrator.

IMMEDIATE FAMILY - The Employee's (Primary Covered Person's) spouse, parent, child, stepchild, brother, sister, mother-in-law, father-in-law, brother-in-law, daughter-in-law, and/or son-in-law.

IN-NETWORK – A Facility Provider, provider group, professional provider or other treatment providers who belong to the PENN Behavioral Health Network of Preferred Providers. They can include UPHS (PBH Staff) Providers and Regional (PBH Regional Network) Providers contracted by PBH for services.

INCURRED - A charge shall be considered incurred on the date a Covered Person receives the service for which the charge is made.

INPATIENT ADMISSION or INPATIENT - The Covered Person's actual entry into a Hospital or Facility Provider to receive Inpatient services as a registered bed patient in such Hospital or Facility Provider and for whom a room and board charge is made; the Inpatient Admission shall continue until such time as the Covered Person is actually discharged from the Hospital or Facility Provider.

MAINTENANCE - Continuation of care and management of the patient when the therapeutic goals of a treatment plan have been achieved, no additional functional improvement is apparent or expected to occur, and the provision of Covered Services for a condition ceases to be of therapeutic value.

MAXIMUM – A limit on the amount of Covered Services that a Covered Person may receive. The Maximum applies to all Covered Services or selected types. When the Maximum is expressed in dollars, the Maximum is measured by the Covered Expenses, less deductibles, coinsurance and co-payment amounts paid by the Covered Persons for the Services to which the Maximum applies. The Maximum may not be measured by the actual amounts paid by the Plans to the Providers. A Maximum may also be expressed in number of days or number of services for a specified period of time.

A. Benefit Maximum – the greatest amount of a specific Covered Service that a Covered Person may receive.

B. Lifetime Maximum – the greatest amount of Covered Services that a Covered Person may receive in his/her lifetime.

MEDICALLY APPROPRIATE or MEDICAL APPROPRIATENESS – Services provided by a Facility Provider that the Contract Administrator determines are:

- A. Ordered by a Professional Provider or other appropriately licensed health care professional; and
- B. Required for the diagnosis, or the direct care and treatment of a condition, illness, disease or injury; and
- C. Appropriate for the symptoms and diagnosis or treatment of a condition, illness, disease or injury; and
- D. In accordance with standards of good medical practice as generally recognized and accepted by the medical community; and
- E. Not primarily for the convenience of the Covered Person's Immediate Family, or the Facility Provider or Professional Provider; and
- F. The most efficient level of service that can be safely provided to the Covered Person. When applied to hospitalization, this further means that the Covered Person requires acute care as a bed patient due to the nature of the services rendered for the condition and the Covered Person cannot receive safe and adequate care in some other setting without adversely affecting the Covered Person's condition or quality of care.

MEDICALLY NECESSARY or MEDICAL NECESSITY – Services provided by a Professional Provider in order to diagnose or treat an illness or condition which meet all of the following criteria:

- A. Appropriate for the symptoms and diagnosis or treatment of the Covered Person's condition disease, or illness that is defined under IICD-9-CM ,

- or DSM IV, or its replacement;
- B. Provided in accordance with generally accepted standards of professional practice for the diagnosis, or the direct care and treatment of the Covered Person's condition, illness, disease or injury;
 - C. Not rendered primarily for the convenience of the Covered Person's convenience, or the convenience of the Professional Provider; and
 - D. The most efficient and economical level of service that can safely be provided. When applied to hospitalization, this further means that the Covered Person requires acute care as a bed patient due to the nature of the services rendered for the condition and the Covered Person cannot receive safe and adequate care in some other setting without adversely affecting the Covered Person's condition or quality of care.

NON-HOSPITAL FACILITY – A Facility Provider, licensed by the Department of Health for the care or treatment of Alcohol or Drug dependent persons, except for transitional living facilities. Non-Hospital Facilities shall include but not be limited to Residential Treatment Facilities and Free Standing Ambulatory Care Facilities for Partial Hospitalization Programs.

NON-HOSPITAL RESIDENTIAL TREATMENT – The provision of medical, nursing, counseling, or therapeutic services to patients suffering from alcohol or drug abuse or dependency in a residential environment, according to individualized treatment plans.

OUT-OF-NETWORK – A Facility Provider, provider group, professional provider or other treatment providers who do not belong to the PENN Behavioral Health Network of Preferred Providers.

OUT-OF-POCKET LIMIT – A specified dollar amount of Coinsurance expense Incurred by a Covered Person for Covered Expenses in a Benefit Period. Such expense does not include any Deductible, penalties, Inpatient or Outpatient services, or Co-payment amounts. When the Out-of-Pocket Limit is reached, the level of benefits is increased as specified in the Schedule of Benefits.

OUTPATIENT – A Covered Person who receives services designated by the Contract Administrator as “Outpatient services”. Specifically, other than Inpatient or Non-Hospital Treatment Services defined above

PARTIAL HOSPITALIZATION – Medical, nursing, counseling or therapeutic services (at least 5 and ½ hours) provided on a planned and regularly scheduled basis in a Hospital or Facility Provider, designed for a patient who would benefit from more intensive services than are offered in Outpatient treatment but who does not require an Inpatient stay.

PHYSICIAN – A person who is a doctor of medicine (M.D.) or a doctor of osteopathy (D.O.), licensed, and legally entitled to practice medicine in all its branches, perform surgery and dispense drugs.

PLAN OF TREATMENT – A plan of care which is prescribed in writing by a Professional Provider for the treatment of injury or illness. The Plan of Treatment should

be limited in scope and extent to that care which is Medically Appropriate/Medically Necessary for the Covered Person's diagnosis and condition.

PRE-CERTIFICATION – Prior assessment by the Contract Administrator or designated agent that proposed services, such as hospitalization, are Medically Appropriate/Medically Necessary for a particular patient and covered by the Covered Person's Plan. Payment for services depends on whether the Covered Person and the category of service are covered under the Covered Person's Plan of coverage.

PREFERRED (IN-NETWORK) FACILITY PROVIDER – A Facility Provider that has a contractual relationship with the Plans for the provision of covered services to Covered Persons.

PREFERRED (IN-NETWORK) PROFESSIONAL PROVIDER – A Professional Provider who has a contractual relationship with the Plans for the provision of covered services to Covered Persons.

PROFESSIONAL PROVIDER - A person or practitioner licensed where required and performing services within the scope of such licensure. The Professional Providers are:

- Licensed Clinical Social Worker (LCSW)
- Licensed Professional Counselor (LPC)
- Physician
- Psychologist

PSYCHIATRIC HOSPITAL – A Facility Provider, approved by the Contract Administrator, which is primarily engaged in providing diagnostic and therapeutic services for the Inpatient treatment of Mental Illness. Such services are provided by or under the supervision of an organized staff of Physicians. Continuous nursing services are provided under the supervision of a Registered Nurse.

PSYCHOLOGIST - A Psychologist who is licensed in the state in which he/she practices; or a Psychologist who is otherwise duly qualified to practice by a state in which there is no Psychologist licensure.

RESIDENTIAL TREATMENT FACILITY – A Facility Provider licensed and approved by the appropriate government agency and approved by the Contract Administrator, which provides treatment for Mental Illness or for substance abuse (Alcohol and Drug) to partial, Outpatient or live-in patients who do not require acute Medical Care.

SERIOUS MENTAL ILLNESS – Is defined as schizophrenia, bipolar disorder, obsessive-compulsive disorder, major depressive disorder, panic disorder, anorexia nervosa, bulimia nervosa, schizo-affective disorder and delusional disorder. This does not apply to the treatment of alcoholism or other drug dependencies.

USUAL, CUSTOMARY AND REASONABLE RATES – Means the rate schedule followed by PENN Behavioral Health in the Plan administration representing the fees paid out for Out-of-Network providers and facilities for covered services rendered to Covered Participants.