

**EMPLOYEE ASSISTANCE PROGRAM
UPHS, GSPP, AND U OF P BENEFIT COVERAGE
GUIDELINES FOR PROVIDERS, GROUPS AND FACILITIES**

REFERRAL PROCEDURE EAP/ UPHS, GSPP, and U of P BENEFIT COVERAGE:

1. The intake staff will contact your office via telephone and advise of the prospective client referral. You will be faxed or mailed the client's identifying data, the nature of their presenting problem, any special case instructions, the number of EAP and/or MH/SA benefit sessions and the name of the designated intake staff. You always have the opportunity to determine the appropriateness and feasibility of accepting a referral.

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

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

3. Should you accept the referral, an Intake Form which details vital client related information and the clinical paperwork will be mailed to you.

4. **Please contact the intake department at 888-321-4433 to receive an authorization and schedule the initial appointment.** If you leave a voice mail, please provide the following information:
 - a. Spelling of Client's Name
 - b. Client's Social Security Number
 - c. Date Initial Assessment is Scheduled to Occur
 - d. Clinician's Name

The scheduling of all subsequent sessions will be coordinated between you and the client.

5. The intake staff should be informed if the client fails to keep the initial session within 24 hours for routine, and 1 hour for urgent or emergent after initial referral.

At no time should a client be required to wait longer than ten (10) minutes beyond their scheduled appointment time without contact being made to indicate the reason for the delay.

EAP CLIENT EDUCATION:

1. It is essential that you clearly educate the client regarding the EAP provider's role of assessment, brief counseling, and if indicated, referral. Short term EAP intervention (early identification and preventive services for problem identification and assessment) should be viewed as appropriate for problems that can be successfully resolved within a relatively small number of sessions. Clients with primary presenting problems of an acute nature (i.e., Chemical Dependency, Major Depression, etc.) are more appropriate for assessment and referral for longer-term treatment. Therefore, the EAP model should not be seen as a substitute for their mental health insurance benefit.
2. If it is necessary for long term treatment and you are a provider for the EAP benefit and the mental health benefit it is important to educate client with referral options. This means that you provide them with the option to go to another therapist for a best match when clinically appropriate.
3. You should inform the client that you are the designated provider of PENN Behavioral Health EAP. In this capacity, your involvement with them will be limited to the parameters of the EAP relationship (unless their mental health benefit allows them to continue). Therefore, if your assessment determines the need for ongoing treatment, you will be assisting them with linkage to their mental health benefit.
4. The client should be reminded that twenty-four (24) hours notice is required for any cancellation.
5. All clients should be reassured that their relationship with the EAP is confidential except where a specific "Release of Information" is signed by the client, or as provided by federal regulations. The specific content, reason for, and person to whom the information should be released should be specified on the release provided. Clients should also be informed about the exceptions to confidentiality as mandated by federal regulation. These are outlined in the Statement of Understanding.

CONFIDENTIALITY/RELEASE OF INFORMATION:

1. All providers are required to adhere to Federal and State regulations and laws that pertain to the maintenance of confidential information/records. Your provider agreement forbids the discussion of participants outside the EAP. Anyone who divulges or releases confidential information or records concerning any participant without proper authorization in accordance with PENN Behavioral Health policies and Federal and State law may be terminated from the Provider network or subject to other remediation per our peer review process.
2. Your provider contract makes you an authorized agent of the PENN Behavioral Health. Therefore, you do not need to obtain a written release to communicate with any EAP staff member, either verbally or in writing.
3. You must have a signed Release of Information before providing communication to any party other than PENN Behavioral Health EAP staff. An EAP staff member will facilitate all communication with the workplace. If a contact with someone at client's workplace is indicated, call the EAP Manager to discuss the situation.

4. **PLEASE NOTE:** Under no circumstances should you provide any written documentation, including letters to the workplace, court, or to any party. In order to ensure the utmost confidentiality of client records PENN Behavioral Health EAP requires a court order for the release of all written documentation. Please direct any inquiries to PENN Behavioral Health EAP staff.

EAP TREATMENT REFERRALS:

1. If your assessment determines that a referral to another level of care is required, your assistance with the selection of the specific referral source is considered a crucial element of your role as an EAP provider. Your role in this regard is to ensure a smooth transition to the referral source. Follow-up sessions or contacts may be indicated after you make the referral to another resource if it will help ensure a successful outcome.
2. It is imperative that you provide relevant clinical information to all appropriate referral sources. If a referral for clinical services is required, it is your responsibility to request that the client sign a release of information and verbally communicate any relevant information. Documentation of the linkage to the referral is required on the Closing Summary Form.
3. Your role also includes case management (e.g., follow-up and tracking of your clients' progress in the program to which they were referred). As appropriate, you may see your client while they are in a level of care higher than outpatient (including intensive outpatient, partial, and inpatient) but no more frequently than every two weeks. Exceptions may be requested through the EAP Manager.
4. As an EAP provider you are encouraged to consider linking the client to community and company resources, self-help programs (and the like) during or subsequent to EAP Services. For example, you may encourage your client to attend a company sponsored work/life program concurrent with the EAP sessions. We encourage you to be creative with the scheduling of the EAP sessions for the best possible outcome. For example, you could elongate the duration of the EAP contact by alternating EAP sessions every other week with a community resource.

EAP DOCUMENTATION:

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

psychosocial history, risk assessment, medications, and diagnosis. The original form is to be submitted to PENN Behavioral Health, and copy is to go in the chart.

B. Closing Summary This form serves as the documentation for all subsequent sessions. The original Form is to be submitted to PENN Behavioral Health and copy is to go into chart.

3. The closing summary serves as your final session reimbursement.
4. Your documentation will be initially reviewed upon receipt to determine if all required forms are submitted and if requirements related to timeliness are met. Incomplete documentation will be returned to you for completion.

MH/SA BENEFIT EDUCATION:

1. It is essential that you clearly educate the client regarding the MH/SA Benefit provider's role of assessment, treatment, care determination, and if indicated, referral. MH/SA Benefit intervention should be viewed as appropriate for problems that can be successfully resolved within the context of outpatient sessions determined by their benefit plan. Clients with primary presenting problems of an acute nature (i.e., Chemical Dependency, Major Depression, etc.) may be more appropriate for assessment and referral for in-patient treatment. Therefore, the MH/SA Benefit model should not be seen as a substitute for higher levels of in-patient care when appropriate.
2. If it is necessary for inpatient treatment and you are a provider for the EAP benefit or the MH/SA Benefit it is important to educate client with referral options. This means that you provide them with the option to go to another therapist or a treatment facility for a best match when clinically appropriate.
3. You should inform the client that you are the designated provider of PENN Behavioral Health MH/SA Benefit. In this capacity, your involvement with them will be limited to the parameters of the MH/SA Benefit relationship. Therefore, if your assessment determines the need for inpatient treatment, you will be assisting them with linkage to their inpatient MH/SA Benefits.
4. The client should be reminded that twenty-four (24) hours notice is required for any cancellation.
5. All clients should be reassured that their relationship with the MH/SA benefit is confidential except where a specific "Release of Information" is signed by the client, or as provided by federal regulations. The specific content, reason for, and person to whom the information should be released should be specified on the release provided. Clients should also be informed about the exceptions to confidentiality as mandated by federal regulation. These are outlined in the Statement of Understanding which will be mailed to you along with the clinical paperwork when you accept the referral.

MH/SA BENEFIT TREATMENT REFERRALS:

1. If your assessment determines that a referral to another level of care is required, your assistance with the selection of the specific referral source is considered a crucial element of your role as a MH/SA Benefit provider. Your role in this regard is to ensure a smooth transition to the referral source. It must be noted that any change in the treatment plan

or the level of care requires the notification and authorization of PENN Behavioral Health Staff at 1-888-321-4433.

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

MH/SA DOCUMENTATION:

There are two types of clinical paperwork, EAP forms and MH/SA Benefit Healthcare forms. Therefore, the appropriate referral paperwork will be mailed out to you when you accept the referral. If you do not receive paperwork, please call the access center to request more at 1-888-321-4433. Clinical paperwork should be returned in a timely manner, either as it is completed or at the end of the sessions.

The initial clinical summary (mailed out) will no longer be required. Only complete this clinical summary when requesting additional sessions.

BENEFIT COVERAGE DOCUMENTATION:

There are two types of clinical paperwork, EAP forms and Behavioral Healthcare MH/SA forms. PENN Behavioral Health provides the behavioral health benefit for the University of Pennsylvania Health System (UPHS) plan (PENNCare), the Good Shepherd Penn Partners (GSPP) plan (PENNCare), and for two of the plans (UPHS POS and Personal Choice) of the University of Pennsylvania. Therefore, the appropriate referral paperwork will be mailed out to you. If you do not receive paperwork, please call the access center to request more. Clinical paperwork should be returned in a timely manner, either as it is completed or at the end of the sessions.

TRANSFERRING (UPHS, GGPP, AND U OF P) EAP CLIENTS TO THE BENEFIT PLANS:

Authorizations under the benefit plans must be requested by the outpatient provider by calling our access number at 888-321-4433. A review will be completed with the Intake Staff. Additional benefit sessions will be authorized based on medical necessity and within the constraints of the member's benefit.

PRECERTIFICATION/CONCURRENT REVIEW FOR OUTPATIENT THERAPISTS OF BENEFIT COVERED MEMBERS:

For individual/family therapy, once we are informed of the initial evaluation appointment, an authorization for 1 evaluation and 9 therapy sessions will be mailed out to the provider. If more sessions are needed, the provider should mail or fax the Clinical Summary/Primary Care Physician Report after the 8th session (including evaluation). A care manager will conduct a concurrent review. Additional sessions will be authorized based upon medical necessity and within the constraints of the member's benefit. Providers will receive a written confirmation of the authorization. The *Clinical Summary/Primary Care Physician Report* must be submitted for authorization of treatment beyond the 9th therapy session.

PRECERTIFICATION/CONCURRENT REVIEW FOR OUTPATIENT PSYCHIATRISTS OF BENEFIT COVERED MEMBERS:

For medication management, once we are informed of the initial psychiatric evaluation appointment, an authorization of 1 evaluation and 4 medication management sessions will be mailed out to the provider. If more sessions are needed, the provider should mail or fax *the Clinical Summary/Primary Care Physician Report* after the fourth session (including psychiatric evaluation). A care manager will conduct a concurrent review. Additional sessions will be authorized based on medical necessity and within the constraints of the member's benefit. Providers will receive a written confirmation of the authorization. Continued authorization beyond 4 medication management sessions is contingent upon the receipt of the Clinical Summary/Primary Care Physician Report and the concurrent review.

OUTPATIENT PROVIDERS REQUEST FOR HIGHER LEVELS OF CARE FOR OF BENEFIT COVERED MEMBERS:

Authorizations for higher levels of care under the benefits should be requested by the outpatient provider by calling our access number at 888-321-5533. A review will be completed with the care manager. Treatment will be authorized based on medical necessity and within the constraints of the member's benefit.

CONVERSION OF BENEFITS:

Providers who are requesting conversion of benefits according the descriptions of the plan designs (see attached charts at the end of this document for the specific plan requirements) must fill out the appropriate conversion of benefit forms for the specific conversion types (non serious mental illness and serious mental illness) and specific plans (UPHS, GSPP, or U of P). These forms can be found on-line at www.pennbehavioralhealth.org or requested by phone at 1-888-321-4433.

COMPLAINT/GRIEVANCE PROCEDURE:

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

Definitions:

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

If you have a complaint, or wish to register a complaint on a client's behalf, report it to a PENN Behavioral Health/ EAP Staff person. They will log the concern or complaint with the Quality Improvement division. If you would like to file a formal grievance, please write to the, PENN Behavioral Health/EAP, attention: Paul Rusch, 3535 Market Street, 4th Floor, Philadelphia, PA 19104.

- A. If a complaint is registered, every attempt will be made to immediately rectify the problem (e.g., a provider who complains about not receiving referral information soon enough will be provided the information in a timely manner). All complaints should first be addressed to the individual or department supervisor directly involved in the action in question (e.g., first attempt to call the care manager to see if he/she can correct problem).
- B. All complaints will be logged and tracked by PENN Behavioral Health. The log will contain the caller's name, date, nature of the complaint, and the resolution.
- C. If the complaint is *not* resolved to the satisfaction of the complainant within 30 days, a grievance may be registered.
- D. If a complaint involves an emergent clinical situation, PENN Behavioral Health will respond within 24 hours or as soon as the clinical situation warrants. For urgent situations, PENN Behavioral Health will respond within 48 hours, or as soon as the clinical situation warrants.
- E. Complaint Levels and Resolution Procedure:

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

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

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

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

for further consideration by peer review process where the plan for resolution will be determined.

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

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

REIMBURSEMENT:

1. PENN Behavioral Health is solely responsible for the payment of your services. The only exclusion is the UPHS PENN-Care, Good Shepherd Penn Partners PENN-Care and the University Point of Service and Personal Choice co-pay and admission charges that is the member's responsibility. (see attached charts at the end of this document for the specific plan requirements)

The rate of your reimbursement is stipulated in your provider contract and constitutes payment in full for your professional services.

2. Do not discuss your fees with clients or have them fill out any of your private practice financial screening forms.
3. Under no circumstances should an EAP client receive any billing statements. PENN Behavioral Health is solely responsible for payment of services.
4. Submit claims as per the guidelines below..... Payment for final session will be paid upon receipt

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

FILING CLAIMS FOR BEHAVIORAL HEALTH SERVICES (For Providers and Facilities)

CLAIMS FILING PROCEDURES:

Covered Participants 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) Qualified 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 Carrier, arrangements may be made to have payments made directly to the provider such as in the case of a facility or other hospital setting.

Preferred (In-Network) Providers of PENN Behavioral Health must notify University of Pennsylvania, University of Pennsylvania Health System, and Good Shepherd Penn Partners Covered Participants of their In-Network status prior to billing so Covered Persons will know not to submit claims. Preferred (In-Network) Providers must also notify PENN Behavioral Health for a pre-claims benefit determination to assure their eligibility and benefit coverage. Failure to notify PENN Behavioral Health prior to treatment may result in forfeiture of payment or delay in claim processing.

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

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

It is the Provider’s responsibility to:

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

Required information submitted includes:

- o Name of Covered Person,
- o Name of Patient,
- o Address,
- o Phone Numbers,
- o Date of Birth,
- o Employee ID #, and
- o Plan Name
- o Provider’s (Qualified Professional or Facility Provider) Name (with degree),
- o Address,

- o Phone number,
 - o Dates of Service,
 - o Diagnosis (by listed codes and/or description) and services performed (by codes or rates) with associated itemized charges, and,
 - o Itemized bills (based on negotiated rates for services);
- Use only HIPAA compliant service codes;
 - Submit all claims by mail or “dedicated confidential fax” and not e-mail or phone;
 - Submit all claims in compliance with regulatory and/or contractually required timely filing standards; and
 - Respond to requests for additional information or other corrective action in a timely manner (within 45 days).

It is PENN Behavioral Health’s responsibility to:

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

WHEN CLAIMS SHOULD BE FILED:

Claims should be filed with the Claims Department within the 60 days of the date charges for the services were incurred. Benefits are based on the Plan’s provisions at the time the charges were incurred. Claims filed later than that date may be declined or reduced unless:

- (a) it’s not reasonably possible to submit the claim in that time; and
- (b) the claim is submitted by the end of the 90 day deadline from the time when the claim was incurred.

If it is not possible to file the claim within the 60-day period, the provider must submit in writing the reason for the delinquent claim, but in no event will the Plan be required to accept the claim submitted more than 90 days after the end of the Benefit Period in which the Covered Services are rendered.

Additional Information:

Providers who have questions regarding claims can call PENN Behavioral Health Member Services (Access Services Department) at (1-888-321-4433) and the full process for filing a claim will be described.

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

PENN Behavioral Health
Claims Department
3535 Market Street, 4TH Floor
Philadelphia, PA 19104

Please submit claims no later than 60 days after the completion of the Covered Services. The claim should include the date and information required by the Carrier to determine benefits.

The Claims Administrator will determine if enough information has been submitted to enable proper consideration of the claim. If not, more information may be requested from the claimant. The Plan reserves the right to have a Plan Participant seek a second medical opinion.

BENEFITS FOR UNIVERSITY OF PENNSYLVANIA

Details of Coverage under 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.		
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.

BENEFITS FOR UNIVERSITY OF PENNSYLVANIA HEALTH SYSTEM

Details of Coverage under the PENNCare PPO and POS (Aetna QPOS and Keystone) Plans

	In-Network	Out-of-Network
Available Providers	Must choose PENN Behavioral Health network providers. Pre-certification needed 1-888-321-4433	May choose any qualified provider All care must be approved by Pre-certification 1-888-321-4433
Mental Health Benefits	Combined benefit for In-Network and Out-of-Network	
• Inpatient	<ul style="list-style-type: none"> 100% coverage for up to thirty-five (35) days per year when medically necessary and pre-certified by PBH (no co-payment). All care not pre-certified will receive 70% of the UCR charge as determined by PBH. * 	<ul style="list-style-type: none"> 70% of the UCR charge as determined by PBH after a \$240 per admission co-payment for up to thirty-five (35) days per year when medically necessary and pre-certified by PBH. All care not pre-certified will receive 50% of the UCR charge, as determined by PBH after a \$240 per admission co-payment for up to thirty-five (35) days per year when medically necessary.*
	Lifetime Maximum 120 days combined benefit for In-Network and Out-of-Network	
Partial Days	Thirty (30) Partial Hospital Days when Medically Necessary and Pre-certified, Available when exchanged two (2) for one (1) Inpatient Days	
Specialized Treatment	<ul style="list-style-type: none"> Members using network providers may receive ECT when requested by PBH Network provider and pre-certified by PBH. The Exchange is one (1) Inpatient day for one (1) ECT session 	<ul style="list-style-type: none"> Not covered
• Outpatient	<ul style="list-style-type: none"> \$15 co-payment for up to twenty (20) visits per year when medically necessary and pre-certified by PBH. All care not pre-certified will receive 50% of the UCR charge as determined by PBH.* 	<ul style="list-style-type: none"> 70% of the UCR charge as determined by PBH, for up to twenty (20) visits per year when medically necessary and pre-certified by PBH. All care not pre-certified will receive 50% of the UCR charge, as determined by PBH for up to twenty (20) visits per year when medically necessary. *
Exchange of Benefits	Members diagnosed with a Serious Mental Illness may exchange one (1) Mental Health Inpatient day for up to four (4) outpatient visits for a maximum of 40 visits	Not Applicable
Specialized Treatment	Members using network providers may receive ECT when requested by PBH Network provider and pre-certified by PBH. The Exchange is one (1) Inpatient day for one (1) ECT session	Not Covered
Testing	Members using network providers may receive psychological testing when requested by PBH Network provider and pre-certified by PBH	Not Covered
Chemical Dependency Benefits	Combined benefit for In-Network and Out-of-Network	
	The thirty (30) days is a combined benefit for both detoxification and residential treatment	
• Inpatient	<ul style="list-style-type: none"> 100% coverage for up to 30 days per year when medically necessary and pre-certified by PBH. All care not pre-certified will receive 50% of the UCR charge as determined by PBH. * 	<ul style="list-style-type: none"> 70% of the UCR charge as determined by PBH after a \$240 per admission co-payment for up to thirty (30) days per year when medically necessary and pre-certified by PBH. All care not pre-certified will receive 50% of the UCR charge, as determined by PBH after a \$240 per admission co-payment for up to thirty (30) days per year when medically necessary. *
	Lifetime Maximum 120 days combined benefit for In-Network and Out-of-Network	
Partial Days	Thirty (30) Partial Hospital Days when Medically Necessary and Pre-certified, Available when exchanged two (2) for one (1) Inpatient Days	
• Outpatient and acute intensive outpatient	<ul style="list-style-type: none"> \$15 co-payment for up to thirty (30) visits per year when medically necessary and pre-certified by PBH. All care not pre-certified will receive 50% of the UCR charge as determined by PBH.* 	<ul style="list-style-type: none"> 70% of the UCR charge as determined by PBH, for up to thirty (30) visits per year when medically necessary and pre-certified by PBH. All care not pre-certified will receive 50% of the UCR charge, as determined by PBH for up to twenty (20) visits per year when medically necessary. *
Exchange of Benefits	Members using network providers may exchange one (1) Substance Abuse Inpatient day for up to two (2) outpatient visits for a maximum of 30 visits	Not Applicable

* The participant is responsible for payment of charges beyond usual, customary and reasonable or negotiated rates for all out-of-network services.

BENEFITS FOR GOOD SHEPHERD PENN PARTNERS

Details of Coverage under the PENNCare PPO and POS (Aetna QPOS and Keystone) Plans

	In-Network	Out-of-Network
Available Providers	Must choose PENN Behavioral Health network providers. Pre-certification needed 1-888-321-4433	May choose any qualified provider with any EAP staff member All care must be approved by Pre-certification 1-888-321-4433
Mental Health Benefits	Combined benefit for In-Network and Out-of-Network	
• Inpatient	• 100% coverage for up to thirty-five (35 days) per year when medically necessary and pre-certified by PBH (no co-payment). All care not pre-certified will receive 70% of the UCR charge as determined by PBH. *	• 70% of the UCR charge as determined by PBH after a \$240 per admission co-payment for up to thirty-five (35) days per year when medically necessary and pre-certified by PBH. All care not pre-certified will receive 50% of the UCR charge, as determined by PBH after a \$240 per admission co-payment for up to thirty-five (35) days per year when medically necessary.*
	Lifetime Maximum 120 days combined benefit for In-Network and Out-of-Network	
Partial Days	Thirty (30) Partial Hospital Days when Medically Necessary and Pre-certified, Available when exchanged two (2) for one (1) Inpatient Days	
Specialized Treatment	• Members using network providers may receive ECT when requested by PBH Network provider and pre-certified by PBH. The Exchange is one (1) Inpatient day for one (1) ECT session	• Not covered
• Outpatient	• \$15 co-payment for up to twenty (20) visits per year when medically necessary and pre-certified by PBH. All care not pre-certified will receive 50% of the UCR charge as determined by PBH.*	• 70% of the UCR charge as determined by PBH, for up to twenty (20) visits per year when medically necessary and pre-certified by PBH. All care not pre-certified will receive 50% of the UCR charge, as determined by PBH for up to twenty (20) visits per year when medically necessary. *
Exchange of Benefits	Members diagnosed with a Serious Mental Illness may exchange one (1) Mental Health Inpatient day for up to four (4) outpatient visits for a maximum of 40 visits	Not Applicable
Specialized Treatment	Members using network providers may receive ECT when requested by PBH Network provider and pre-certified by PBH. The Exchange is one (1) Inpatient day for one (1) ECT session	Not Covered
Testing	Members using network providers may receive psychological testing when requested by PBH Network provider and pre-certified by PBH	Not Covered
Chemical Dependency Benefits	Combined benefit for In-Network and Out-of-Network	
	The thirty (30) days is a combined benefit for both detoxification and residential treatment	
• Inpatient	• 100% coverage for up to 30 days per year when medically necessary and pre-certified by PBH. All care not pre-certified will receive 50% of the UCR charge as determined by PBH. *	• 70% of the UCR charge as determined by PBH after a \$240 per admission co-payment for up to thirty (30) days per year when medically necessary and pre-certified by PBH. All care not pre-certified will receive 50% of the UCR charge, as determined by PBH after a \$240 per admission co-payment for up to thirty (30) days per year when medically necessary. *
	Lifetime Maximum 120 days combined benefit for In-Network and Out-of-Network	
Partial Days	Thirty (30) Partial Hospital Days when Medically Necessary and Pre-certified, Available when exchanged two (2) for one (1) Inpatient Days	
• Outpatient and acute intensive outpatient	• \$15 co-payment for up to thirty (30) visits per year when medically necessary and pre-certified by PBH. All care not pre-certified will receive 50% of the UCR charge as determined by PBH.*	• 70% of the UCR charge as determined by PBH, for up to thirty (30) visits per year when medically necessary and pre-certified by PBH. All care not pre-certified will receive 50% of the UCR charge, as determined by PBH for up to twenty (20) visits per year when medically necessary. *
Exchange of Benefits	Members using network providers may exchange one (1) Substance Abuse Inpatient day for up to two (2) outpatient visits for a maximum of 30 visits	Not Applicable

* The participant is responsible for payment of charges beyond usual, customary and reasonable or negotiated rates for all out-of-network services.