BENEFITS EXPLANATION FOR

MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES

PROVIDED BY

PENN BEHAVIORAL HEALTH
(Hereafter called "the Contract Administrator")

FOR

THE UNIVERSITY OF PENNSYLVANIA

January 1, 2011

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I. INTRODUCTION TO THE UNIVERSITY OF PENNSYLVANIA BEHAVIORAL HEALTH BENEFITS

This booklet has been prepared so that participants may become acquainted with the PENN Behavioral Health (sometimes referred to as PBH in this document) option offered under the Plans. Covered Services under the Plans are available to eligible employees (Primary Covered Persons) and their eligible dependents (as defined by the Plans) that have properly enrolled for Covered Services. For definitions of Group or (Enrolled Group), Covered Persons, Employees, or Family Coverage, see the "DEFINED TERMS" section (Section II., page 7.) of this booklet. The Covered Services described in this booklet are subject to the terms and conditions of the Group Contract.

Benefits will not be available for services to a greater extent or for a longer period than is Medically Appropriate/Medically Necessary, as determined by the Contract Administrator. The amount of benefits for any Covered service will not exceed the amount by the mental health or substance abuse care provider, and will not be greater than any maximum amount determined by or limit described or referred to in this booklet.

For the purposes of this Plan, your Outpatient treatment for mental health or substance abuse issues is considered a Specialist Office visit. *Benefits for these services will be provided in an office visit by a provider other than a Primary Care Physician.* For the purposes of this plan, "in the office" includes Outpatient mental health or substance abuse care visits to a Provider's office. For the purpose of this plan, "Facility Care" includes Intensive Outpatient care, Consultation care, Emergency care, Partial Hospitalization, Detoxification, and Inpatient care.

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

Important Notices:

If you are facing an emergency and must go to an emergency room, you do not need a referral from PENN Behavioral Health. However, you (or your representative or your physician) must call PBH within 48 hours after Emergency Care is given. If this is not reasonably possible, the call must be made as soon as reasonably possible.

Regarding Experimental or Investigative Treatment:
The Contract Administrator does not cover treatment 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 "DEFINED TERMS" section (Section II., page 7) of this booklet.

Regarding Treatment which is not Medically Appropriate/Medically Necessary:
The Contract Administrator only covers treatment which it determines Medically Appropriate/Medically Necessary. A In-Network Provider accepts the Contract Administrator's decision and contractually is not permitted to bill the Covered Person for treatment which the Contract Administrator determines is not Medically Appropriate/Medically Necessary unless the Contracting Provider specifically advises the Covered Person in writing, and the Covered Person agrees in writing that such services are not covered by the Contract Administrator, and that the Covered Person will be financially responsible for such services. An Out-of-Network Provider, however, is not obligated to accept the Contract Administrator's determination 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 an Out-of-Network Provider. You can avoid these charges simply by choosing an In-Network Provider for your care. The term "Medically Appropriate/Medically Necessary" is defined in the "DEFINED TERMS" section (Section II., page 7) of this booklet.

Regarding Coverage for Emerging Technology
While the Contract Administrator does not cover treatment it determines to be Experimental/Investigational, it routinely performs technology assessments in order to determine when new treatment modalities are safe and effective. A technology assessment is the review and evaluation of available clinical and scientific information from expert sources. These sources include but are not limited to articles published by governmental agencies, national peer review journals, national experts, clinical trials, and manufacturer's literature. The Contract Administrator uses the technology assessment process to assure that new drugs, procedures or devices ("emerging technology") are safe and effective before approving them as Covered Services. When new technology becomes available or at the request of a practitioner or Covered Person, the Contract Administrator researches all scientific information available from these expert sources. Following this analysis, the Contract Administrator makes a decision about when a new drug, procedure, or device has been proven to be safe and effective and uses this information to determine when an item becomes a Covered Service for the condition being treated or not approved as required by federal or governmental agencies. A Covered Person or his or her Provider should contact the Contract Administrator to determine whether a proposed treatment is considered "emerging technology."

REMEMBER: When a provider suggests a new treatment option that may fall under the category of “Experimental/Investigational,” or “emerging technology,” the Covered Person, or his or her Provider, should contact the Contract Administrator for a coverage determination. That way the Covered Person and the Provider will know in advance if the treatment will be covered by the Contract Administrator.

In the event the treatment is not covered by the Contract Administrator, the Covered Person can make an informed decision about whether to pursue alternative treatment options or be financially responsible for the non-covered service.

For more information on when to contact the Contract Administrator for coverage determinations, please see the “MANAGED CARE PROCEDURES” section (Section IX., page 44) of this document.

II. 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.

ALCOHOL OR DRUG ABUSE - 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.

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.

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.

CLINICALLY MANAGED HIGH-INTENSITY RESIDENTIAL TREATMENT - Level 111.5 ASAM Criteria for Adults and Adolescents with substance related disorders. See ASAM Patient Placement Criteria for the Treatment of Substance-Related Disorders, (Second Edition – Revised) (ASAM PPC-2R) for detailed description.

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 $25.00 or $30.00 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 an In-Network Professional Facility Provider – the rate of reimbursement for Covered Services will be made in accordance with Contract Administrator's contract for In-Network Services.

2 For services rendered by an Out-of-Network, 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) Contract Administrator's reasonable and customary rates, for the Covered Services.

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

1 For an In-Network Professional Provider – the rate of reimbursement for Covered Services will be made in accordance with Contract Administrator's contract for In-Network Services.

2 For services rendered by an Out-of-Network Professional Provider that has no contractual arrangement with the Plans, "Covered Expense" means the lesser of the (i) Provider's charges, or (ii) Contract Administrator's reasonable and customary rates, 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.

EARLY INTERVENTION - Level 0.5 ASAM Criteria for Adults and Adolescents with substance related disorders. See ASAM Patient Placement Criteria for the Treatment of Substance-Related Disorders, (Second Edition – Revised) (ASAM PPC-2R) for detailed description.

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

EMERGENCY –The Contract Administrator follows the "prudent lay person" emergency room policy as set forth in the Balanced Budget Act of 1997. Under this Act, an emergency is defined as: One manifesting itself by acute symptoms of sufficient severity such that a prudent lay person, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in serious jeopardy to the person's health.

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 which meets any of the following criteria:

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.

In addition to the above criterion that pertains strictly to the use of a drug, biological product or device, any drug, device, mental health or substance abuse treatment or procedure is not considered Experimental/Investigational if it meets all of the criteria listed below:

A. Reliable Evidence exists that the drug, device, mental health or substance abuse treatment or procedure has a definite positive effect on health outcomes.
B. Reliable Evidence exists that over time the drug, device, mental health treatment or procedure leads to improvement in health outcomes; i.e., the beneficial effects outweigh any harmful effects.
C. Reliable Evidence clearly demonstrates that the drug, device, mental health or substance abuse treatment or procedure is at least as effective in improving health outcomes as established technology, or is usable in appropriate clinical contexts in which established technology is not employable.
D. Reliable Evidence clearly demonstrates that improvement in mental health and substance abuse outcomes, as defined above in paragraph C, is possible in standard conditions of mental health and substance abuse practice, outside clinical investigatory settings.
E. Reliable Evidence shows that the prevailing opinion among experts regarding the drug, device, mental health or substance abuse treatment or procedure is that studies or clinical trials have determined its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with standard means of treatment for a particular diagnosis.

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.

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 Employees (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 as 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.

IN-NETWORK – A Facility Provider, provider group, professional provider or other treatment providers who belong to the PENN Behavioral Health Network. The Facility provider, provider group, professional provider, or other treatment providers have a contractual relationship with the PBH for the provision of covered services to Covered Persons.

I**NCURRED -** 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.

INTENSIVE OUTPATIENT - Level 11.1 ASAM Criteria for Adults and Adolescents with substance related disorders. See ASAM Patient Placement Criteria for the Treatment of Substance-Related Disorders, (Second Edition – Revised) (ASAM PPC-2R) for detailed description. For mental health treatment, the APA defines intensive outpatient treatment as a structured program that includes combinations of individual and group process therapy, meeting at least three times per week, and delivering at least four hours of treatment per week.

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. Maximums in this PBH plan apply only to Out-of-Network care.

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

MEDICALLY APPROPRIATE/MEDICALLY NECESSARY – Health care services which are determined by PBH to: a) be consistent with generally accepted practice parameters as recognized by health care providers in the same or similar general specialty as typically treats or manages the diagnosis or condition; (b) help restore or maintain the person's health; (c) prevent deterioration of or palliate the person's condition; or (d) prevent the reasonably likely onset of a health problem or detect an incipient problem. Health care services shall also include diagnostic testing, preventive services and aftercare appropriate in terms of type, amount, frequency, level, setting, and duration to the person's diagnosis or condition.

MEDICALLY MONITORED INTENSIVE INPATIENT TREATMENT - Level 111.7 ASAM Criteria for Adults and Adolescents with substance related disorders. See ASAM Patient Placement Criteria for the Treatment of Substance-Related Disorders, (Second Edition – Revised) (ASAM PPC-2R) for detailed description.

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.

OPIOID MAINTENANCE THERAPY – A level of care criteria for Adults with substance related disorders. See ASAM Patient Placement Criteria for the Treatment of Substance-Related Disorders, (Second Edition – Revised) (ASAM PPC-2R) for detailed description.

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

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. For Substance related disorders, Outpatient Treatment is Level I ASAM criteria Adults and Adolescents. See ASAM Patient Placement Criteria for the Treatment of Substance-Related Disorders, (Second Edition – Revised) (ASAM PPC-2R) for detailed description. For mental health treatment, the APA defines Outpatient as a

level of care in which patients are seen by one or more clinicians as individuals, part of their families, or part of a group.

PARTIAL HOSPITALIZATION– For Substance related disorders, Partial Hospitalization is Level II.5 ASAM criteria for Adults and Adolescents. See ASAM Patient Placement Criteria for the Treatment of Substance-Related Disorders, (Second Edition – Revised) (ASAM PPC-2R) for detailed description. For mental health treatment, the APA defines acute partial hospitalization as treatment that includes daily nursing and active treatment in a structured treatment program lasting 5-7 days per week and delivering at least 20 hours of active treatment per week, with patients going home each evening and/or weekend.

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.

PRECERTIFICATION – 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.

PROFESSIONAL PROVIDER - A person including a psychiatrist, psychologist, psychiatric nurse or social worker, therapist, or other clinician with at least a master's degree, who provides inpatient or outpatient treatment for behavioral health conditions, who is licensed in the state of practice and who is acting within the scope of that license.

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.

PSYCHOLOGICAL TESTING - 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.

REASONABLE AND CUSTOMARY – the amount that is the usual or customary charge for the service or supply as determined by the Contract Administrator. The chosen standard base rate is 110 % of Medicare reimbursement rate, or RVRBS (Resource Based Relative

Value Studies. If no Medicare reimbursement rate exists, the Contract Administrator determines what is reasonable by the severity and/or complexity of the patient's condition for which the service or supply is provided.

RELIABLE EVIDENCE – only published reports and articles in the authoritative medical and scientific literature; the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, biological product, device, mental health treatment or procedure; or the written informed consent used by the treating facility studying substantially the same drug, biological product, device, mental health treatment or procedure.

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

SOMATIC THERAPY – The biological treatment of mental disorders (i.e., Electroconvulsive therapy, psychopharmacological treatment).

III. YOUR PENN BEHAVIORAL HEALTH PLAN

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 mental health and substance abuse benefits of 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 are: The PENN/CARE PPO, the UPHS POS (which includes Keystone, administered in Pennsylvania and AmeriHealth, administered in New Jersey) and the Pre-65 Retiree PPO. The Plans each have an In-Network group of 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 In-Network 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 mental health and substance abuse benefits program allows you to maximize your mental health and substance abuse benefits by utilizing PBH In-Network Providers. PBH In-Network Providers include UPHS staff as well as members of the regional network. In-Network providers are psychiatrists, psychologists, psychiatric nurses or social workers, therapists, or other clinicians with at least a master's degree, who provide Inpatient or Outpatient treatment for a behavioral health conditions, who is licensed in the state of practice and who is acting within the scope of that license (if applicable) and licensed treatment facilities that are part of the PBH staff or regional network. In-Network provider benefits are delivered through a specially selected, highly managed network of cost-effective providers to ensure quality of care.

When you receive mental health or substance abuse care through an In-Network Provider, you are assured of lower out-of-pocket expenses. There is no annual deductible to meet and you are not financially liable for coinsurance. When you receive mental health and substance abuse care through an In-Network Provider, the Plan pays 100% (after applicable co-pays) and has annual out-of-pocket maximums of $1,000 per individual and $2,000 per family for most services. There are no claim forms to fill out, and pre-service claim determination is done by the provider or facility.

Benefits are also provided if you choose to receive mental health and substance abuse care through a Provider that is not an In-Network Provider. However, you will be responsible for a greater share of out-of-pocket expenses. For Actives and Pre-65 Retirees seeing an Out-of-Network Provider, the Plan pays 65% of reasonable and customary rates after annual

deductible of $500 per individual and $1,500 per family. Your out-of-pocket maximum will be $3,500 per individual and $10,500 per family. You will be required to file a claim form. The Pre-65 retiree benefit has the same out-of-pocket maximum and out-of-network deductible as the Active members during calendar year 2011.

Some of the services you receive through the Contract Administrator must have a pre-service claim determination before you receive them. All services excluding Emergency Care and Outpatient treatment require a pre-service claim determination. Pre-service claim determination is used to determine Medical Appropriate/Medically Necessary treatment, and to make a level of care determination. If you seek In-Network care, the provider is responsible for the precertification. If you seek Out-of-Network care, precertification is the members' responsibility.

When you are ready to access your benefits, you may call the 24-hour toll free number at 1-888-321-4433 to obtain a referral list. You may also access the website at www.pennbehavioralhealth.org for a list of In-Network Providers and their areas of treatment. Your In-Network provider will be responsible for sending claims to PENN Behavioral Health. Any information collected by the Contract Administrator about your care is private and confidential, and will not be disclosed except when required by court order.

When a Covered Person seeks treatment that requires pre-service claim determination, they are not responsible for obtaining the precertification if the treatment is provided by an In-Network Provider. In addition, if the In-Network Provider fails to obtain a required pre-service claim determination of services, the Covered person will be held harmless from any associated financial penalties assessed by PBH as a result. If the request for precertification is denied, the Covered Person will be notified in writing that the admission/service will not be paid because it is considered to be medically inappropriate or a Non-Covered service. If that person decides to continue treatment or care that has not been approved, they will be asked to do the following:

1. Acknowledge this in writing.
2. Request to have services provided.
3. State their willingness to assume financial liability.

When a person seeks treatment from an 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, diagnosis, and procedure or reason for admission.

The PENN Behavioral Health (PBH) Benefit Options:
The PBH option has two parts:

- In-Network 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, admission fees and deductibles) for the services which are covered, and there are no claim forms to be filed.

- Out-of-Network 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 reasonable and customary rates as determined by the plan 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 or visit the website at www.pennbehavioralhealth.org.

Mental Health and Substance Abuse Care includes services and supplies which are:
- covered services, for mental health and substance abuse treatment;
- given while the Covered Person is covered under this plan;
- provided by a Professional Provider. A Professional Provider is a person including a psychiatrist, psychologist, psychiatric nurse or social worker, therapist, or other clinician with at least a master's degree, who provides Inpatient or Outpatient treatment for a behavioral health conditions, who is licensed in the state of practice and who is acting within the scope of that license (if applicable). provided at the office of a Professional Provider, or at a hospital or licensed treatment center

Mental Health and Substance Abuse Services includes but is not limited to the following:
- Assessment
- Diagnosis
- Treatment Planning
- Medication Management
- Individual, family and group psychotherapy
- Psychological testing

Services and supplies will not automatically be considered Covered Health Services solely because they were prescribed by a Professional Provider.

If you are facing an emergency and must go to an emergency room, you do not need a referral from PENN Behavioral Health. However, you (or your representative or your physician) must call PBH within 48 hours after Emergency Care is given. If this is not reasonably possible, the call must be made as soon as reasonably possible. See "YOUR PENN BEHAVIORAL HEALTH BENEFITS", Part D section (Section V., page 20) for details on Emergency Care.

IV. BENEFITS ELIGIBILITY

The Contract Administrator certifies that Eligible Employees and 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

V. YOUR PENN BEHAVIORAL HEALTH BENEFITS

As an employee of the University of Pennsylvania you have a unique opportunity for increased savings on health care costs. Consider your options, than carefully choose a provider that you feel is right for you. To verify that the provider you select is a PENN Behavioral Health In-Network provider, call 1-888-321-4433, or visit the website at www.pennbehavioralhealth.org

Limits of the Benefit:
Benefits will not be available for services to a greater extent or for a longer period than is Medically Appropriate/Medically Necessary, as determined by the Contract Administrator. For definitions of Medically Appropriate and/or Medically Necessary see the "DEFINED TERMS" section (Section II., page 7) 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 defined by the Contract Administrator.

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 percentages shown for the Coinsurance and Covered Services on in the Schedule of Benefits in this booklet are not always calculated on actual charges. For an explanation of how the Coinsurance is calculated, see the "Covered Expense" definition in the "DEFINED TERMS" section (Section II., page 7) of this booklet.

Pre-Service Claim Determinations:
All services above the Outpatient level (i.e., Intensive Outpatient, Partial Hospitalization, Inpatient mental health admissions, Inpatient substance abuse admissions, Psychological Testing, Neuropsychological Testing, Electroconvulsive Therapy, psychiatric home care services, Outpatient Detoxification) provided under the Plans must have a pre-service claim determination before they are delivered, to determine if they are Medically Appropriate/Medically Necessary and fully covered according to the plan benefit design and the amount of service coverage remaining under that person's specific 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 mental health or substance abuse treatment that requires a pre-service claim determination from an In-Network Provider, the provider is responsible for obtaining the pre-service claim determination prior to treatment or possibly forfeits the maximum plan reimbursements. See "YOUR PENN BEHAVIORAL HEALTH PLAN" (Section III., page 16) of this document for a detailed explanation of this process.

A. SCHEDULE OF BENEFITS FOR ACTIVES

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

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

1 Copay Maximum

B. SCHEDULE OF BENEFITS FOR PRE-65 RETIREES

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

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

1 Copay Maximum

C. 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 (Section VIII., page 40).

Benefits are payable for the care and treatment of Mental Health Psychiatric Care by a Hospital or Provider, subject to the Out-of-Pocket and Out-of-Network Lifetime Maximums shown in the Schedule of Benefits, according to the provisions outlined below. For maximum benefits, treatment must be received from an In-Network 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 precertification must be obtained for all treatment, other than Emergency Care and outpatient 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 section (Section IX., page 44) of this booklet and the Emergency Care subsection of the YOUR PENN BEHAVIORAL HEALTH BENEFITS section (Section III., page 16) must be followed. Emergency Care is exempt from the requirements for pre-service claim determination and will be considered in-network care as In-Network Providers and will be paid at 100% .

Inpatient Treatment Coverage:
Benefits are provided as 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 and when determined by the Contract Administrator to be Medically Appropriate/Medically Necessary.

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

Note: For 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, as 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.

D. 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 or Dependency services are subject to Alcohol and Drug Abuse or 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 an Dependence Care Limitations of this program. (See the MIXED SERVICES GUIDELINES section (Section VIII., page 40) of this booklet)

Benefits are payable for the care and treatment of Alcohol or Drug Abuse and Dependency provided by a Hospital or Facility Provider, subject to the Maximums shown in the Schedule of Benefits, according to the provisions outlined above. For maximum benefits, treatment must be received from an In-Network 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 and Outpatient Care, in order to assure the Medical Appropriateness/ 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 section (Section IX., page 44) of this booklet must be followed. Emergency Care is exempt from the precertification requirements and will be considered in-network care as In-Network Providers and will be paid at 100%.

<u>Inpatient Detoxification Coverage:</u>
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) Detoxification
b) Physician, psychologist, nurse, certified addictions counselor and trained staff services;
c) Diagnostic x-rays;
d) Psychiatric, psychological and testing;

Note: For 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.

<u>Hospital and Non-Hospital Residential Treatment Coverage:</u>
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 days 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;

Note: For 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. Out-of-Network care will be reimbursed at 65% of the reasonable and customary rates after an annual $500 individual or $1,500 family deductible is met for Out-of-Network treatment for Actives and The Pre-65 Retirees who have the same out of network re-imbursement rate and deductible as Actives starting calendar year 2011.

Outpatient Alcohol or Drug Services Coverage:
Benefits are provided as 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. EMERGENCY CARE

EMERGENCY –The Contract Administrator follows the "prudent lay person" emergency room policy as set forth in the Balanced Budget Act of 1997. Under this Act, an emergency is defined as: One manifesting itself by acute symptoms of sufficient severity such that a prudent lay person, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in serious jeopardy to the person's health.

If you are facing an emergency and must go to an emergency room, you do not need a referral from PENN Behavioral Health. However, you (or your representative or your physician) must call PBH within 48 hours after Emergency Care is given. If this is not reasonably possible, the call must be made as soon as reasonably possible.

Once Emergency Care is ended, call PBH to get a referral to receive any additional services covered in the In-Network level. All services other than outpatient treatment require precertification. Emergency visits are covered at 100% after $75.00 co-pay. If you are admitted to the hospital, your copy will be waived and in-patient charges will be processed based on whether the facility is In-network or Out-of-Network.

You are covered for mental health or substance abuse emergency care while traveling. For out-of-area emergencies, go immediately to the nearest emergency room. If you are admitted to the hospital, contact PBH or have an agency representative contact PBH within 48 hours of your admission or as soon as possible for precertification of treatment.

F. TESTING / DIAGNOSTIC SERVICES

Pre-service claims determination is required for all diagnostic / testing related services. It is critical to pre-certify both In-Network and Out-of-Network testing or diagnostic services to ensure that the service is a Covered Service.

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 as defined by the Contract Administrator. The following subsections describe the psychological testing authorization process and criteria used by the Contract Administrator. Before testing is administered, the testing psychologist must call the Contract Administrator's Access Department for pre-service claim benefit determination.

Requirements for Authorization and Medical Necessity Determination:
Psychological testing must be performed by an In-Network (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 (Out-of-Network) 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:

- In-network Psychological testing must be requested by a PBH network provider and certified by the Contract Administrator. Out-of-Network testing must be requested by the provider and certified by the Contract Administrator. For both In-network and Out-of-Network testing, 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.

- 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.

If psychological testing meets the criteria and requirements of Medical Appropriateness/ 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.

G. LIFETIME MAXIMUMS

Lifetime Maximums:
There is a Lifetime Maximum for Mental Health and Substance Abuse Out-of-Network care of $1,500,000. Benefits for Out-of-Network care will cease after care exceeds the individual Lifetime Maximum. Amounts applied to the Covered Person's Lifetime Maximum are not restorable. There is no lifetime maximum for In-Network care.

VI. COVERAGE EXCLUSIONS OF THIS PLAN

Listing of the Items Not Covered By the Plan:
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 Contract Administrator) 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.
  This includes, but is not limited to:
  - services performed in connection with conditions that do not fit current DSM IV TR* criteria
  - services that are not in connection with a behavioral disorder, psychological injury, or substance abuse
  - services that are not consistent with prevailing national standards of clinical treatment of such conditions, including but not limited to APA and ASAM standards
  - services that are not consistent with prevailing professional research demonstrating measurable and beneficial outcomes
  - services that demonstrate more effectiveness than less intensive or costly treatment alternatives
  - typically do not result in outcomes demonstrably better than other available treatment alternatives that are less intensive or more cost effective
  - are not consistent with PBH's level of care guidelines or best practices as modified periodically
- 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 "YOUR PENN BEHAVIORAL HEALTH BENEFTS" section (Section V., page 20) of this booklet;
- Which were incurred after the date of termination of the Covered Person's coverage or prior to eligibility or enrollment in the plan;
- For which a Covered Person would have no legal obligation to pay;
- For any charges for care that exceed the Plans' reasonable and customary rates 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 treatment of (except for initial diagnoses) of the following DSM IV TR* diagnoses as related to children: 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 treatment of (except for initial diagnoses) of pervasive developmental disorders as defined by DSM IV TR*, including the design, implementation and evaluation of environmental modifications, using behavioral stimuli and consequence, to produce socially significant improvement in behavior. This includes the use of direct observation, measurement and functional analysis of the relations between environment and behavior;
- For beam neurologic testing; neuropsychological testing when used for the diagnosis of attention deficit disorder;
- For marriage, family, child, career, social adjustment, pastoral, or financial counseling;
- For V-Codes;
- For medically supervised, psychiatric residential treatment (an APA level of care that includes individualized and intensive treatment on a 24-hour basis in a residential setting);
- For Outpatient prescription drugs and medications or drugs and medications that may be dispensed without a doctor's prescription; including herbal medicine, holistic or homeopathic care, herbal drugs, or other forms of alternative treatment as defined by the Office of Alternative Medicine of National Institutes of Health; as well as Aromatherapy, Ayurvedic medicine, guided imagery, herbal medicine, massage therapy, naturopathy, relaxation therapy, transcendental meditation and yoga;
- For sedative action electrostimulation therapy;
- For sensitivity training;
- For twelve step model programs; as sole therapy for problems such as eating disorder and addictive gambling;
- For psychological and/or neuropsychological or neuropsychiatric testing for (1) learning disabilities/problems; (2) school related issues; (3) the purposes of obtaining or maintaining employment; and (4) the purpose of submitting a disability application for a mental or emotional condition;
- For recreational, educational, and sleep therapy, including any related diagnostic testing;
- For research studies, including medical reports;
- 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; by birth or marriage, including spouse, brother, sister, parent or child. This includes services the provider may perform on him or herself;
- For services provided by someone with the same legal residence as the member, or who is currently or has at some point resided with the member;
- For special medical reports including those not directly related to the Covered Person's treatment, such as employment, camp, education, travel, sports or insurance physicals and reports prepared in connection with litigation except as required by law;
- As required to obtain or maintain a license of any type;
- Any treatment/services, including motivational training programs, related to personal or professional growth/development, educational or professional training or certification, or for investigative purposes related to employment;
- 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, Aversion therapy, carbon dioxide therapy, confrontation therapy, crystal healing therapy, cult deprogramming, electrical aversion therapy for alcoholism, narcotherapy, orthomolecular therapy, art and music therapy, hyperbaric or other oxygen therapy, equine assisted therapy; and other services, supplies and treatments that are considered unproven, investigational or experimental due to not meeting generally accepted standards of medical practice in the US. Availability of a service, device or treatment does not imply covered service under the PBH plan. The fact that a service, treatment, or device is the only available treatment for a particular condition will not result in it being a covered service if service, treatment, or device is considered to be unproven, investigational, or experimental.;
- For services performed or billed by residential therapeutic camps (e.g., wilderness camps, outward bound, etc.);
- For acupuncture and acupressure;
- For truancy or disciplinary problems alone;
- For sex therapy, without a DSM IV TR diagnosis and treatment for sexual addiction;
- For convenience items, including but not limited to, adjustments made to vehicles, air conditioners, or purifiers, 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, telephones, stair glides, spa, whirlpool, sauna, hot tub, or equivalent device, or wigs, beauty/barber services 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 light boxes and other equipment, whether associated with a behavioral or non behavioral health condition;
- 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;
- For services 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 section (Section IX., page 44) 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; except for the acute stabilization and return back to your baseline level of individual functioning. Care is determined to be Custodial Care when:
  - it provides a protected, controlled environment for the primary purpose of protective detention and / or providing services necessary to assure competent functioning in activities of daily living; or
  - it is not expected that the care provided or psychiatric treatment alone will reduce this disorder, injury or impairment to the extent necessary to function outside a structured environment. This applies when there is little expectation of improvement in spite of any and all treatment attempts.

- repeated and volitional non-compliance with treatment recommendations resulting a situation in which there can be no reasonable expectation of a successful outcome

- 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 (i.e., personality disorders, dementia), 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;
- For nutritional Counseling, except as prescribed for the treatment of primary eating disorders as part of a comprehensive multimodal treatment plan;
- For weight reduction or control programs (unless there is a diagnosis of Morbid Obesity and the program is under medical supervision), special foods, food supplements, liquid diets, diet plans or any related products or supplies;
- For services or treatment rendered by unlicensed providers, including pastoral counselors, as recognized by the state and federal licensing laws (except as required by law), or which are outside the scope of the providers' licensure;
- For private duty nursing services while confined in a facility;
- For smoking cessation related services and supplies;
- For travel or transportation expenses unless PBH has requested and arranged for you to be transferred by ambulance from one facility to another, whether or not it has been recommended by a Professional Provider or if it is required to receive treatment at an out of area Provider.
- In excess of any specified Plan limitations
- For any charges for missed appointments
- For any charges for record processing except as required by law
- For treatment or services received prior to you being eligible for coverage under the Plan or after the date your coverage under the Plan ends.

Any exclusion above will not apply to the extent that the coverage of charges is required under any law that applies to the coverage. These Excluded Amounts will not be used when figuring Benefits. The law of jurisdiction where a person lives when a claim occurs may prohibit some Benefits. If so, they will not be paid.

* When the DSM IV TR is mentioned throughout this document, it does not indicate that all diagnoses present in the DSM IV TR are covered for services. PENN Behavioral Health reserves the right to apply treatment limitations to some DSM IV TR diagnoses.

VII. GENERAL INFORMATION

Consultations

Consultations are covered services rendered to an Inpatient in a Hospital or individual receiving Partial Hospitalization services by a Professional Provider at the request of the attending Professional Provider. Consultations do not include staff consultations which are required by the Facility Provider's rules and regulations.

Ambulance

Ambulance services, which are Medically Appropriate/Medically Necessary as determined by the Contract Administrator, for local transportation in a specially designed and equipped vehicle used only to transport the afflicted are a Covered Expense. All Out-of-Network, non-emergency ambulance services must have a pre-service claim determination in accordance with the provisions set forth in the MANAGED CARE section (Section IX., page 44) of this booklet. The Ambulance must be transporting the Covered Person:

a. from a Covered Person's home or the scene of an incident or emergency to the nearest Hospital;
b. If there is no Hospital in the local area that can provide services Medically Appropriate/Medically Necessary for the Covered Person's condition, then ambulance service means transportation to the closest Hospital outside the local area that can provide the necessary service.
c. If a Covered Person presents in an emergency at an Out-of-Network facility and fits Medically Appropriate/Medically Necessary criteria for admission and chooses to be admitted at an In-Network facility to maximize coverage benefits, Ambulance transportation can be arranged by the facility after completing a pre-service claims determination with PBH.

Assignment of Benefits to Providers

The right of the Covered Person to receive benefit payments under this coverage is personal to the Covered Person and is not assignable in whole or in part to any person, Hospital, or other entity nor may benefits of this coverage be transferred, either before of after Covered Services are rendered. However, a Covered Person can assign benefit payments to the custodial parent of a Dependent covered under the Group Contract, as required by law.

Release of Information

Each covered person agrees that any person or entity having information relating to an illness or injury for which benefits are claimed under this PBH may furnish to the Contract Administrator, upon its request, any information (including copies of records relating to the care).

In addition, the Contract Administrator may furnish similar information to other entities providing similar benefits at their request.

The Contract Administrator shall provide to the Group at the Group's request certain information regarding claims and charges submitted to the Contract Administrator. The parties understand that any information provided to the Group will be adjusted by the Contract Administrator to prevent the disclosure of any information that is protected by applicable state or federal laws of any Employee or other patient treated by said Providers. The Group shall reimburse the Contract Administrator for the actual costs of preparing and providing said information.

Reasonable and Customary Rates

The amount that is the usual or customary charge for the service or supply as determined by the Contract Administrator. The chosen standard base rate is 110 % of Medicare reimbursement rate, or RVRBS (Resource Based Relative Value Studies. If no Medicare reimbursement rate exists, the Contract Administrator determines what is reasonable by the severity and/or complexity of the patient's condition for which the service or supply is provided.

Out of Area Care for Dependent Students

If an unmarried dependent child is a full-time student in an Accredited Educational Institution located outside the area served by the PENN Behavioral Health network, the student may be eligible to received Out-of-Network care at the In-Network level of benefits. Charges for treatment will be paid at the In-Network level of benefits when the Dependent student receives care from Providers or Facilities that accept the In-Network rates and who are already In-Network with Blue Cross or Aetna. The Contract Administrator will employ the standard credentialing process in order to approve care with the out of area Out-of-Network provider and to negotiate rates. Nothing in this provision will act to continue coverage of a Dependent child past the date when such child's coverage would otherwise be terminated under the group contract.

Annual Out of Pocket Maximum (Medical and Mental Health/Substance Abuse)

Participant Copayments and Coinsurance/deductibles are listed on the Schedule of Benefits. For in-network care, the Out-of-Pocket Maximum for copayment is $1,000 per individual and $2,000 per family and there is no deductible. For out-of-network care, the Out-of-Pocket Maximum is $3,500 per individual and $10,500 per family and the deductible is $500 individual and $1,500 family. To be eligible for reimbursement under this provision, contact PENN Behavioral Health. You will be asked to supply information in order to demonstrate that the Annual Out-of-Pocket Maximum has been reached.*

*This information is applicable for both Actives and Pre-65 Retirees.

Coordination of Benefits

PBH's Coordination of Benefits provision is designed to conserve funds associated with mental health and substance abuse care. The following provisions do not apply to prescription drug coverage when provided through the medical plan.

1. Definitions

In addition to the Definitions of this Plan for purposes of Provisions only: "PBH Plan" shall mean this group arrangement providing mental health care benefits or Covered Services through:

a) Individual, group, (except hospital indemnity plans of less than $200), blanket (except student accident) or franchise insurance coverage:
b) The PBH Plan, mental health and substance abuse maintenance organization and other prepayment coverage;
c) Coverage under labor management trusted plans, union welfare plans, Employer organization plans, or Employee benefit organization plans; and
d) Coverage under any tax supported or government program to the extent permitted by law.

2. Determination of Benefits

Coordination of Benefits (COB) applies when an Employee has mental health or substance abuse coverage under and other group health care plan for services covered under the PBH plan, or when the Employee has coverage under any tax-supported or governmental program unless such program's benefits are, to the extent permitted by law, excess to those of any private insurance coverage. When COB applies, payments may be coordinated between the other Plan and the PBH Plan in order to avoid duplication of benefits.

Benefits under this PBH Plan will be provided in full when the PBH benefits are primary, that is, when PBH determines benefits first. If another Plan is primary, PBH will provide benefits as described below

When an Employee has group mental heath and substance abuse coverage under this Plan and another Plan, the following will apply to determine which coverage is primary:

a) If the other Plan does not include rules for coordinating benefits, such other Plan will be primary.
b) If the other Plan includes rules for coordinating benefits:
    1. The Plan covering the patient other than as a Dependent shall be primary.
    2. The Plan covering the patient as a Dependent of the parent whose date of birth, excluding year of birth, occurs earlier in the calendar year shall be primary, unless the child's parents are separated or divorced and there is no joint custody agreement. If both parents have the same birthday, the Plan which covered the parent longer shall be primary. However, if the other Plan does not have birthday rule as described herein, but instead has a rule based on the gender of the parent, and if as a result, the Plans do not agree on the order of benefits, the rule in the other Plan shall control unless the child's parents are separated or divorced.
    3. Except as provided in subparagraph (4) below, if the child's parents are separated or divorced and there is no joint custody agreement, benefits for the child are determined as follows:
        i) First, the Plan covering the child as a Dependent of the parent with custody;
        ii) Then, the Plan of the spouse of the parent with custody of the child
        iii) Finally, the Plan of the parent not having custody of the child

4. When there is a court decree which establishes financial responsibility for the health care expenses of the Dependent child and the Plan covering the parent with such financial responsibility has actual knowledge of the court decreed, benefits of that plan are determined first.
5. If the specific terms of the court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the Plans covering the child shall follow the order of benefit determination rules outlined above in 2(b)(2)

c) The Plan covering the patient as an Employee who is neither laid off nor retired (or as that Employee's dependent) is primary to a Plan which covers the patient as a laid off or retired Employee (or as that Employee's dependent). However, if the other Plan does not have the rule described immediately above and if, as a result, the Plans do not agree on the order of benefits, this rule does not apply.

d) If none of the above rules apply, the Plan which covered the Employee longer shall be primary.

3. Effect on Benefits

When the other Plan is secondary, the benefits under this PBH plan will be reduced so that PBH will pay no more than the difference, if any, between the benefits provided under the other Plan for service covered under this Plan and the total Covered Services provide to the Employee. Benefits payable under another Plan will include benefits that would have been payable had the claim been duly made therefore. In no event will a PBH payment exceed the amount that would have been payable under the Plan if PBH were primary.

Right of Recovery

Whenever payments which should be made under this PBH Plan in accordance with this provision have been made under any other Plan, PBH shall have the right, exercisable alone and in its sole discretion, to pay over to any organization making such other payments any amounts it shall determine to be warranted in order to satisfy the intent of this provision. Amounts so paid shall be deemed to be benefits provided under this Plan and, to the extent of such payments, PBH shall be fully discharged from liability under this Plan.

Whenever payments have been made by PBH in a total amount, at any time, in excess of the maximum amount of payment necessary at that time to satisfy the intent of this provision, irrespective of to whom paid, PBH shall have the right to recover such payments to the extent of such excess from among one or more of the following, as PBH shall determine:

1. the person PBH has paid or for whom the have paid
2. insurance companies; or
3. any other organizations.

You, on your own behalf and on behalf of your Dependents, shall, upon request, execute and deliver such instruments and papers, as may be required and do whatever else is reasonably necessary to secure such rights to PBH.

Consumer Rights

Each Covered Person has the right to access, review, and copy their own health and membership records and request amendments to their records. This includes information pertaining to claim payments, payment methodology, reduction or denial, medical information secured from other agents, plans or providers.

For more information about accessing, reviewing or copying records, call the Access line at 1-888-321-4433.

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				
Clinical Circumstances	***Service***	***Primary Diagnosis***	***Attending Provider Type***	***Clinical/Financial Responsibility***
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				
Clinical Circumstances	***Service***	***Primary Diagnosis***	***Attending Provider Type***	***Clinical/Financial Responsibility***
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 service	Chemical Dependency	Addictionologist, Internist, Psychiatrist or Family Practitioner	PBH
COGNITIVE DISORDER (Delirium, Dementia, Amnesia, etc.)				
Clinical Circumstances	***Service***	***Primary Diagnosis***	***Attending Provider Type***	***Clinical/Financial Responsibility***
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/	Inpatient services in psychiatric or residential	Mental Health/Chemical	Psychiatrist	PBH

withdrawal	facility, or ambulatory	Dependency		
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				
Clinical Circumstances	***Service***	***Primary Diagnosis***	***Attending Provider Type***	***Clinical/Financial Responsibility***
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 evaluatio (Diagnostic assessment, psychiatric consultation)	Med/Surgical and/or Mental Health/ Chemical Dependency	Psychiatrist, Other Medical	Medical Plan
EATING DISORDER				
Clinical Circumstances	***Service***	***Primary Diagnosis***	***Attending Provider Type***	***Clinical/Financial Responsibility***
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				
Clinical Circumstances	***Service***	***Primary Diagnosis***	***Attending Provider Type***	***Clinical/Financial Responsibility***
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				
Clinical Circumstances	***Service***	***Primary Diagnosis***	***Attending Provider Type***	***Clinical/Financial Responsibility***
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				
Clinical Circumstances	***Service***	***Primary Diagnosis***	***Attending Provider Type***	***Clinical/Financial Responsibility***
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				
Clinical Circumstances	***Service***	***Primary Diagnosis***	***Attending Provider Type***	***Clinical/Financial Responsibility***
Diagnosis and treatment of ADHD	Inpatient or ambulatory service in Med/Surgical setting	ADHD	Internist, Family Practice, Neurologist, Pediatrician	*Medical Plan*
Diagnosis and treatment of ADHD	Inpatient or ambulatory service in Mental Health setting	ADHD	Psychiatrist, Psychologist	PBH

INTERFACILITY TRANSPORT				
Clinical Circumstances	***Service***	***Primary Diagnosis***	***Attending Provider Type***	***Clinical/Financial Responsibility***
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. MANAGED CARE PROCEDURES

Inpatient Pre-Admission Review:

In-Network Inpatient Admissions:

All In-Network 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/Medical Necessity of the admission and the available benefit coverage. The pre-service claim benefit determination requirements for Emergency admissions are set forth in the "YOUR PENN BEHAVIORAL HEALTH BENEFITS" section (Section V., page 20) of this booklet. In-Network Hospitals or other Facility Providers in the network will verify the pre-service claim determination certification at or before the time of admission. 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 In-Network Hospitals or other Facility Providers 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.

Out-of-Network Inpatient Admissions:

For an 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.

a. 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 Out-of-Network 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.

b. 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. 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.

c. 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:

In-Network Admissions:
It is the responsibility of the Provider or Facility representative to notify the Contract administrator of the In-Network Emergency Admission.

Out-of-Network Admissions:

1. Covered Persons are responsible for notifying the designated agent of a Out-of Network Emergency admission for themselves or a Dependent within two (2) business days of the admission, or as soon as reasonably possible, as determined by
2. 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 or Medically Necessary, the Covered Person will be financially liable for the non-covered Inpatient charges from the date of notification.

Concurrent Review and Retrospective Review:
The Contract Administrator will verbally inform the Provider of the approval of any additional care as a result of the concurrent review. The written determination by both the Contract Administrator and the Attending Physician that Covered Services are no longer Medically Appropriate/Medically Necessary will result in the termination of benefits payable for the treatment of the illness.

Concurrent review is performed while services are being performed. This may occur during an inpatient stay. The review evaluates the expected and current length of stay to determine if continued hospitalization is Medically Appropriate/Medically Necessary. The review assess the level of care provided to the Covered Person and coordinates discharge planning. Concurrent review continues until the patient is discharged.

Retrospective/Post-service review occurs after services have been provided. This may be for a variety of reasons, including the Contract Administrator not being notified of a Covered Person's admission until after discharge or where medical charts are unavailable at the time of concurrent review.

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 Intensive 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

Electroconvulsive Therapy

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 (Detoxification, Intensive Outpatient, Partial Hospitalization, In-patient hospitalization) 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 and Retrospective 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 Licensed Behavioral Health Professional, certify the care as appropriate for Plan

reimbursement. A non-Emergency stay in an In-Network Facility Provider is one that can be scheduled in advance. Precertification is required for In-Network care other than Emergency and Outpatient care.

The utilization review program is set in motion by a telephone call from the Provider. 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.

Concurrent Review and Discharge Planning:
Concurrent review of a course of treatment and discharge planning from an In-Network 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.

Emergency services and Outpatient treatment are the only services covered in the plan that do not require precertification. When seeking Outpatient services, you may want to confirm that your chosen provider is a PBH In-Network provider in order to get the highest level of benefit.

A. CRITERIA FOR SHORT TERM TREATMENT OF ACUTE PSYCHIATRIC ILLNESS

Definition and Prescribed Use Design:
The Contract Administrator has adopted a set of treatment criteria to assist providers in the assessment and treatment of disorders commonly occurring among Covered Persons. The criteria are also used to make level of care determinations when conducing pre-service claims determination. Prior to the adoption the criteria, 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 review adopted criteria at least every two (2) years and provides updates as necessary. As with clinical criteria in general, the Contract Administrator's adopted criteria are intended to augment, not replace, sound clinical judgment.

Covered APA levels of care for mental health treatment settings:
1. Acute inpatient hospitalization
3. Acute Partial Hospitalization
4. Intensive Outpatient treatment
5. Outpatient treatment (general)

The problem that brings an individual to treatment, as well as the following factors are incorporated into the level of care decision making process:
1. Co-morbid psychiatric conditions
2. Co-morbid substance abuse conditions
3. Co-morbid biomedical conditions
4. The patient's acceptance or resistance to treatment
5. The level of support from the family and other environmental factors; and
6. The persistence of the disease process and the likelihood for relapse.

The Contract Administrator has adopted the American Psychiatric Association's (APA) Practice Guidelines of evidence based recommendations for the assessment and treatment of psychiatric disorders. Full access to practice guidelines are available online at the American Psychiatric Association website, www.psychiatryonline.com. The practice guidelines are also published in the American Journal of Psychiatry in their referenced published years. Full access to the APA Criteria for Short-Term Treatment of Acute Psychiatric Illness (1996, 1995) is available from the APA as well.

The Contract Administrator has adopted the American Academy of Child and Adolescent Psychiatry's Practice Parameters that are designed to assist clinicians in providing high quality assessment and treatment for children and adolescents that is consistent with the best available scientific evidence and clinical consensus. Full access to the practice parameters are available online at www.aacap.org. The APA Criteria for Short-Term Treatment of Acute Psychiatric Illness (1996, 1995) referenced in the above paragraph were developed as collaboration between APA and AACAP and both organizations have adapted the guidelines.

* When the DSM IV TR is mentioned throughout this document, it does not indicate that all diagnoses present in the DSM IV TR are covered for services. The Contract Administrator reserves the right to apply treatment limitations to some DSM IV TR diagnoses.

Contact Information

APA:

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

AACAP:

American Academy of Child and Adolescent Psychiatry
3615 Wisconsin Ave., N.W.
Washington, D.C. 20016-3007
www.aacap.org

B. 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 provide 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.

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

Level 0.5 EARLY INTERVENTION
See ASAM Patient Placement Criteria for the Treatment of Substance-Related Disorders, (Second Edition – Revised) (ASAM PPC-2R)

Opioid Maintenance Therapy (for Adults only)

See ASAM Patient Placement Criteria for the Treatment of Substance-Related Disorders, (Second Edition – Revised) (ASAM PPC-2R)

Level I OUTPATIENT TREATMENT

See ASAM Patient Placement Criteria for the Treatment of Substance-Related Disorders, (Second Edition – Revised) (ASAM PPC-2R)

Level II.I INTENSIVE OUTPATIENT

See ASAM Patient Placement Criteria for the Treatment of Substance-Related Disorders, (Second Edition – Revised) (ASAM PPC-2R)

Level II.5 PARTIAL HOSPITALIZATION

See ASAM Patient Placement Criteria for the Treatment of Substance-Related Disorders, (Second Edition – Revised) (ASAM PPC-2R)

Level III.5 CLINICALLY MANAGED HIGH-INTENSITY RESIDENTIAL TREATMENT

See ASAM Patient Placement Criteria for the Treatment of Substance-Related Disorders, (Second Edition – Revised) (ASAM PPC-2R)

Level III.7 MEDICALLY MONITORED INTENSIVE INPATIENT TREATMENT

See ASAM Patient Placement Criteria for the Treatment of Substance-Related Disorders, (Second Edition – Revised) (ASAM PPC-2R)

Level IV MEDICALLY-MANAGED INTENSIVE INPATIENT TREATMENT

See ASAM Patient Placement Criteria for the Treatment of Substance-Related Disorders, (Second Edition – Revised) (ASAM PPC-2R)

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

X. THE PAYMENT PROCESS

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

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

You are never required to file a claim when Covered Services are provided by In-Network Providers. When you receive care from an Out-of-Network Provider, you will need to file a claim to receive benefits. If you do not have a claim form, call the Access number at 1-888-321-4433, or visit the website at www.pennbehavioralhealth.org. Fill out the claim form and please return it with your itemized bills to PBH at the address listed no later than 90 days after 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 incurred on the date the service or supply was rendered.

If it was not possible to file the claim within the 90-day period, your benefits will not be reduced, but in no event will the plan be required to accept the claim from more than two years after the end of the Benefit Period in which the Covered Services are rendered.

Although not mandatory, it will benefit you to notify PBH of Out-of-Network Outpatient Care in order to expedite payment of your Out-of-Network claims. You can call 1-888-321-4433 to begin this process.

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.

Professional Providers
In-Network Professional Providers 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 provider 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 Provider 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 DEFINED TERMS section (Section II., page 7) of this booklet.

Payment for In-Network Professional and Facility Providers

The Contract Administrator is authorized by the Covered Person to make payments directly to PENN Behavioral Health, In-Network Facility and In-Network Professional Providers furnishing Covered Services for which benefits are provided under this coverage. PENN Behavioral Health, In-Network Providers have agreed to accept the rate of reimbursement determined by a contract as payment in full for Covered Services. PENN Behavioral Health, In-Network 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 YOUR PENN BEHAVIORAL HEALTH BENEFITS section (Section V., page 20) 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 In-Network Provider.

Benefit amounts, as specified in the YOUR PENN BEHAVIORAL HEALTH BENEFITS section (Section V., page 20) of this booklet, refer to Covered Services rendered by an 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 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 an In-Network Facility Provider, payment shall be made to such Facility Provider subject to any existing agreement between the Facility Provider and the Plans. The Plans also provide benefits for the Covered Expenses for Outpatient Care.

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

Payment for Out-of-Network Professional and Facility Providers

An Out-of-Network Qualified Provider is a Facility Provider or Professional which does not belong to the PBH Network, nor do they have a contract with the Plans. The Plans will provide benefits to the Covered Person for use of such Out-of-Network as specified in the YOUR PENN BEHAVIORAL HEALTH BENEFITS (Section V., page 20) of this booklet. Accordingly, when a Covered Person seeks care from Out-of-Network care, any difference between the Out-of-Network 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 Out-of-Network services. Emergency admissions must have 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 Out-of-Network Qualified Facility Provider's charge and the Plans' payment for Emergency services shall be the personal responsibility of the Covered Person.

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.

XI. FILING CLAIMS FOR SERVICES AND APPEALS

How to File a Claim:

You are never required to file a claim when Covered Services are provided by In-Network Providers. When you receive care from an Out-of-Network Provider, you will need to file a claim to receive benefits. If you do not have a claim form, call the Access number at 1-888-321-4433, or visit the website at www.pennbehavioralhealth.org. Fill out the claim form and please return it with your itemized bills to PBH at the address listed no later than 90 days after 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 incurred on the date the service or supply was rendered.

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 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 two (2) years 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 two (2) 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:
<u>Types of Claims</u>: 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 calendar 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 calendar 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 exclusions because they are **not deemed the Contract Administrator to be benefit covered.**

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 calendar 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.

XII. 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 538A
Philadelphia, PA 19104
215-898-6884

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