



**MENTAL HEALTH, CHEMICAL
DEPENDENCY , AUTISM AND BEHAVIORAL
HEALTH SERVICES
SUMMARY PLAN DESCRIPTION**

Prepared exclusively for the

UNIVERSITY OF PENNSYLVANIA

by



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I. INTRODUCTION TO THE UNIVERSITY OF PENNSYLVANIA BEHAVIORAL HEALTH BENEFITS

This Summary Plan Description (SPD) has been prepared so that participants in The University of Pennsylvania Health and Welfare Program's (Program) Personal Choice PennCare PPO Plan (PennCare PPO Plan) may become acquainted with their Behavioral Health Benefits provided by the Contract Administrator (Quest Behavioral Health or Quest) under the Behavioral Health Benefits Plan (Plan). Covered Services under the Plan are available to eligible employees and eligible retirees (Primary Covered Persons) and their eligible dependents (as defined by the Program) 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 4) of this SPD. The Covered Services described in this booklet are subject to the terms and conditions of the Group Contract.

Behavioral Health 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 Quest Behavioral Health. The amount of benefits for any Covered Service will not exceed the amount charged by the mental health or chemical dependency Professional Provider and will not be greater than any Maximum amount determined by or limit described or referred to in this SPD.

For the purposes of this Plan, your Outpatient treatment for mental health or chemical dependency issues are considered on the same level as a primary care office visit. Behavioral Health Benefits for these services will be provided in an office visit by a Professional Provider other than a Primary Care Physician. For the purposes of this Plan, "in the office" includes Outpatient mental health or chemical dependency care visits to a Professional 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.

The Plan's mental health and chemical dependency benefits are designed to be classified similarly to your medical/surgical benefits from the PennCare PPO Plan. This allows for equal benefits on the mental health/chemical dependency and medical/surgical side. In this Plan, Outpatient care (i.e., psychotherapy, medication management) on the mental health /chemical dependency benefits side are classified with outpatient care on the medical/surgical benefits. All other levels of care for mental health and chemical dependency (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.

About Quest Behavioral Health

Quest Behavioral Health is owned and operated by four of Pennsylvania's premier health systems, Penn Medicine LG Health, Tower Health, UPMC Pinnacle and WellSpan Health. Quest Behavioral Health was created in 1997 to administer mental health and chemical dependency benefits to employees and their family members of the owner health systems. Currently we provide services to over 200,000 covered members in 62 counties of Pennsylvania

and 13 states outside of Pennsylvania with a provider network of over 3,200 mental health and chemical dependency Professional Providers including inpatient, Partial Hospitalization, intensive Outpatient and group and individual licensed practitioners. For the convenience of the employees and their family members to access services, Quest operates a 24/7 call center with licensed Doctorate level clinicians available around the clock to assist in determining the appropriate level of services and Professional Providers to meet the members' needs.

Quest Care Managers are Licensed Doctorate Level Clinicians available 24/7 through the Quest Call Center. Care Managers assist with referrals to a wide range of services with Professional Providers and facilities and provide guidance to accessing treatment and authorization to non-routine services.

Important Notices:

If you are facing an Emergency and must go to an emergency room, you do not need a referral from Quest Behavioral Health. However, you (or your representative or your physician) must call Quest 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:

Quest Behavioral Health 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, Quest Behavioral Health 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 Quest Behavioral Health 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 4) of this SPD.

Regarding Treatment which is not Medically Appropriate/Medically Necessary:

Quest Behavioral Health only covers treatment which it determines Medically Appropriate/Medically Necessary. An In-Network Professional Provider accepts Quest's decision and contractually is not permitted to bill the Covered Person for treatment which Quest Behavioral Health 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 Quest Behavioral Health, and that the Covered Person will be financially responsible for such services. An Out-of-Network Professional Provider, however, is not obligated to accept Quest's determination and the Covered

Person may not be reimbursed for treatment which Quest determines is not Medically Appropriate/Medically Necessary. The Covered Person is responsible for these charges when treatment is received by an Out-of-Network Professional Provider. You can avoid these charges by choosing an In-Network Professional Provider for your care. The term “Medically Appropriate/Medically Necessary” is defined in the “DEFINED TERMS” section (Section II., page 4) of this SPD.

Regarding Coverage for Emerging Technology:

While Quest Behavioral Health 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.

Quest 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, Quest Behavioral Health researches all scientific information available from these expert sources. Following this analysis, Quest 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 Professional Provider should contact the Quest at 800-364-6352 to determine whether a proposed treatment is considered “emerging technology.”

REMEMBER: When a Professional 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 Professional Provider, should contact Quest Behavioral Health at 800-364-6352 for a coverage determination so that the Covered Person and the Professional Provider will know in advance if the treatment will be covered by Quest.

In the event the treatment is not covered by Quest Behavioral Health, 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 Quest for coverage determinations, please see the “MANAGED CARE PROCEDURES” section (Section IX., page 41) of this SPD.

II. DEFINED TERMS

The terms below have the following meaning when describing the benefits within this SPD. 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 Professional Provider, acting on the Covered Person's behalf upon written consent, to change a previous decision made by Quest Behavioral Health.

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 Quest Behavioral Health 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 Quest Behavioral Health 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 Plan. A charge shall be considered incurred on the date the service was provided to a Covered Person.

CARF – The Commission on Accreditation of Rehabilitation Facilities, CARF International is an independent, nonprofit accreditor of health and human services. The CARF International group of companies currently accredits more than 50,000 programs and services at 23,000 locations. For more information, go to <http://www.carf.org/home/>.

CLINICALLY MANAGED HIGH-INTENSITY RESIDENTIAL TREATMENT – Level 3.5 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) after the deductible has been satisfied.

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

CO-PAYMENT – A charge or an amount authorized under the PennCare PPO Plan which may be collected directly by Professional 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 \$20.00 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 Plan to the Professional Provider(s). Under the Plans’ contracts, the Quest Behavioral Health pays the Facility Providers using bulk purchasing arrangements that permit it to pay less for services. The amount the Plan pays 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 Quest Behavioral Health’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 Plan, “Covered Expense” means the lesser of the (i) Facility Provider’s charges, or (ii) Quest’s Usual 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 Quest’s contract for In-Network Services.
 - 2 For services rendered by an Out-of-Network Professional Provider that has no contractual arrangement with the Plan, “Covered Expense” means the lesser of the (i) Provider’s charges, or (ii) Quest’s Usual 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 SPD referred to as “Member”).

COVERED SERVICE – Any medical, hospital or other services related to mental health or chemical dependency rendered by a Professional Provider, the administration of which is provided by Quest Behavioral Health and the expense is paid pursuant to the terms of the Plan.

DEDUCTIBLE – The annual amount of charges which a Covered Person is required to pay prior to receiving any benefit payment under the Plan. This amount is a combined deductible with your medical benefits and either the behavioral health services or medical services or a combination of both will satisfy the deductible.

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

ELECTROCONVULSIVE THERAPY (ECT): A treatment technique delivered in inpatient or outpatient settings, administered by a psychiatrist privileged to perform ECT and an anesthesiologist that provokes a therapeutic response by applying an electrical current to the brain to induce a controlled seizure. The initial phase of ECT may be followed by a maintenance phase of treatment when clinically indicated.

EMERGENCY – Quest Behavioral Health follows the “prudent layperson” 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 layperson, 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 – Any procedure, device or service that may potentially be considered Experimental or Investigative include new emerging technology/procedures, as well as existing technology and procedures applied for new uses and treatments.

Or:

Any healthcare services, supplies, procedures, therapies or devices whose effectiveness is unproven. These services are generally excluded from coverage.

These exclusions include:

- 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 chemical dependency care. Such facilities include:

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

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, most commonly The Joint Commission or CARF.

GROUP or (ENROLLED GROUP) – A group of Employees (and their dependents) which has been accepted by the Plan, 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 Plan and identified to Quest Behavioral Health.

GROUP CONTRACT – An administrative services agreement executed by and between the Quest Behavioral Health and the University of Pennsylvania setting forth the services Quest Behavioral Health will provide on behalf of the Plan.

HOSPITAL: With regard to a behavioral health facility, a health care institution that provides continuous treatment of an individual experiencing a behavioral health issue that causes the individual to:

- a. Have a limited or reduced ability to meet the individual's basic physical needs;
- b. Suffer harm that significantly impairs the individual's judgment, reason, behavior, or capacity to recognize reality;
- c. Be a danger to self;
- d. Be a danger to others;
- e. Be persistently or acutely disabled; or
- f. Be gravely disabled.

IN-NETWORK – A Facility Provider, provider group, Professional Provider or other treatment providers who belong to the Quest Behavioral Health Network. The Facility Provider, provider group, Professional Provider, or other treatment providers have a contractual relationship with Quest Behavioral Health the provision of Covered Services to Covered Persons.

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

IN-NETWORK: A facility, individual provider and group provider, who belong to the Quest Network and have a contractual relationship with Quest for the provision of Covered Services to Covered Persons.

INPATIENT DETOXIFICATION: A structured hospital-based program and stable living environment which provides 24-hour/7-day nursing care, medical monitoring, physician availability, assessment, diagnostic services, and active behavioral health treatment to complete a medically safe withdrawal from alcohol or drugs. Inpatient Detoxification is

typically indicated when the factors that precipitated the admission suggest that the Member is at risk of severe withdrawal symptoms or serious medical complications including seizures.

INPATIENT MENTAL HEALTH: A structured hospital-based program and stable living environment which provides 24-hour/7-day nursing care, medical monitoring, and physician availability; assessment and diagnostic services, active behavioral health treatment, and specialty medical consultation with an immediacy needed to avoid serious jeopardy to the health of the Member or others.

INPATIENT REHABILITATION: A structured hospital-based program and stable living environment which provides 24-hour/7-day nursing care, medical monitoring, physician availability; assessment, diagnostic services, and active behavioral health treatment for the purpose of initiating the process of assisting a Member with gaining the knowledge and skills needed to prevent recurrence of a substance-related disorder.

INTENSIVE OUTPATIENT: A structured program that maintains 6-9 hours of treatment per week without exceeding 19 hours of treatment per week for Members who are experiencing moderate signs and symptoms that result in significant distress and/or significant psychosocial and environmental issues. Members receive assessment, diagnostic services, and active behavioral health treatment for the purpose of monitoring and maintaining stability, decreasing moderate signs and symptoms, increasing functioning, helping Members integrate into community life, and helping the Member gain knowledge, practice skills, and make changes in behavior that support recovery while living in his/her natural environment. Intensive Outpatient Programs can be used to treat substance-related disorders, mental health conditions, or co-occurring mental health and substance-related disorders.

MEDICAL NECESSITY (OR MEDICALLY NECESSARY): Behavioral Health care services meet the applicable criteria for coverage when they are:

- Medically appropriate and necessary to help prevent the onset and deterioration of a Behavioral Health Condition, or to restore and maintain basic health needs
- Consistent with the diagnosis and condition of national medical practice guidelines regarding type, frequency and duration of treatment
- Rendered in a cost-effective manner

NON-COVERED SERVICES: Specific conditions or circumstances excluded under the Member's benefit plan for which there is not coverage reimbursement under any circumstances; a denial resulting from utilization review, the Experimental or Investigative nature of the service, or the lack of Medical Necessity or appropriateness of treatment.

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.

NEUROPSYCHOLOGICAL TESTS - specifically designed tasks used to measure a psychological function known to be linked to a particular brain structure or pathway. Tests are used for research into brain function and in a clinical setting for the diagnosis of deficits. They usually involve the systematic administration of clearly defined procedures in a formal environment.

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

OUT-OF-POCKET MAXIMUM – The most you have to pay out of your own pocket during the benefit year in deductibles, copays and coinsurance, as long as your providers accept your plan's Usual and Customary charges for services. Once you reach the Out-of-Pocket Maximum, the plan pays 100% of Usual and Customary charges. Each Covered Person will not pay more than the individual Out-of-Pocket Maximum. If multiple dependents are covered, the aggregate total of the out-of-pocket costs paid by all Covered Persons will not exceed the family maximum.

OUTPATIENT - Assessment, diagnosis and active behavioral health treatment for mental health and substance abuse provided in an ambulatory setting; in Outpatient level of care, one or more clinicians see patients as individuals, part of their families, or part of a group.

OUTPATIENT DETOXIFICATION is an outpatient intervention in a case of physical dependence to a drug; the process and experience of a withdrawal syndrome; and any of various treatments for acute drug overdose. A detoxification program for physical dependence does not necessarily address the precedents of addiction, social factors, psychological addiction, or the often-complex behavioral issues that intermingle with addiction.

PARTIAL HOSPITAL: A structured program that maintains at least 20 hours of service per week during which assessment, diagnostic services, and active behavioral health treatment are provided to Members who are experiencing serious signs and symptoms that result in significant personal distress and/or significant psychosocial and environmental issues. The purpose of the services is to stabilize and reduce acute signs and symptoms, increase functioning, and assist a Member with integrating into community life. A Partial Hospital Program can be used to treat mental health conditions, substance related disorders, or the treatment of co-occurring mental health and substance-related disorders.

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 Quest Behavioral Health Care Management staff that proposed services, such as hospitalization, Partial Hospital, Intensive Outpatient Services and other specific outpatient services designated in the plan are Medically Appropriate/Medically Necessary for a particular patient and covered by the Plan.

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.

OTHER TRAINED CLINICIAN – Any other qualified clinician authorized to provide Inpatient or Outpatient treatment for behavioral health conditions, who is either licensed or certified, to provide services and is acting within the scope of that licensure or certification and training (includes TSS, RBT, or other qualified technicians treating members for Autism Spectrum Disorders, certified addictions counselors treating members for substance abuse diagnoses).

PSYCHIATRIC HOSPITAL – A Facility Provider, approved by Quest Behavioral Health, 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.

USUAL AND CUSTOMARY - the amount that is the usual or customary charge for the service or supply as determined by Quest Behavioral Health primarily used for out of network provides or single case agreements. The methodology begins with “Fair Health” market basket rates and if not available, 120% of Medicare and if not available, 50% of charges.

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: A structured sub-acute facility-based program and stable living environment that delivers 24-hour/7-day assessment, diagnostic services, and active behavioral health treatment to Members who do not require the intensity of nursing care, medical monitoring and physician availability offered in Inpatient Mental Health level of care.

THE JOINT COMMISSION – An independent, not-for-profit organization, The Joint Commission accredits and certifies nearly 21,000 health care organizations and programs in the United States. Joint Commission accreditation and certification is recognized nationwide as a symbol of quality that reflects an organization’s commitment to meeting certain performance standards. For more information, go to <https://www.jointcommission.org/>

TRANSCRANIAL MAGNETIC STIMULATION (TMS): A non-invasive technique used to apply brief magnetic pulses to the brain by an FDA approved device in the treatment of Major Depressive Disorder. The pulses are administered by passing high currents through an electromagnetic coil placed adjacent to the patient's scalp. The pulses induce an electrical field in the brain tissue activating neurons in the targeted brain structure. The goal is to lessen the duration or severity of depressive episodes. This service requires preauthorization by Quest Behavioral Health Care Management staff.

III. YOUR BEHAVIORAL HEALTH PLAN

What services are provided by Quest Behavioral Health?

Quest Behavioral Health is the provider of certain administrative services for the University of Pennsylvania. These services include (i) arranging for a network of mental health and chemical dependency 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, Quest Behavioral Health, provides administrative services for the mental health and chemical dependency benefits offered under the University of Pennsylvania Health and Welfare Program's PennCare PPO Plan. The PennCare PPO Plan has an In-Network group of providers who work directly with Quest Behavioral Health. You may use any qualified provider you wish, but your out-of-pocket expense will be minimized when you utilize the In-Network Professional 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 Quest Behavioral Health mental health and chemical dependency benefits program allows you to maximize your mental health and chemical dependency benefits by utilizing Quest Behavioral Health In-Network Professional Providers. Quest In-Network Professional Providers include Penn Medicine Behavioral Health staff as well as members of the regional network. In-Network Professional 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 Penn Medicine Behavioral Health staff or regional network. In-Network Professional Provider benefits are delivered through a specially selected, highly managed network of cost-effective Professional Providers to ensure quality of care.

When you receive mental health or chemical dependency care through an In-Network Professional Provider, you minimize your out-of-pocket expenses. There are no claim forms to fill out, and pre-service claim determination is done by the Professional Provider or facility. Refer to the Quest Behavioral Health Benefit Grid to determine your out-of-pocket expenses for In-Network Professional Providers.

Benefits are also provided if you choose to receive mental health and chemical dependency treatment through a Professional Provider that is not an In-Network Professional Provider but rather an Out-of-Network Professional Provider. However, you will be responsible for a greater share of out-of-pocket expenses. Refer to your Quest Behavioral Health Benefit Grid to determine your out-of-pocket expenses for Out-of-Network Professional Providers. If you choose to receive services from an Out-of-Network Professional Provider, it is your responsibility to submit an invoice (sometimes referred to as a “superbill”) from the Professional Provider showing the following:

- Name of Primary Covered Member
- Name of Member or Dependent for whom services were provided
- Member Address
- Member Phone Number
- Date of birth for Member or Dependent receiving services
- Employee/Primary Covered Member ID number
- Plan Name

In addition to the above information regarding the member, provides the following:

- The Out-of-Network Professional Provider’s (Qualified Professional or Facility Provider) Name
- The license number/degree of the Out-of-Network Professional Provider
- Tax I.D. Number of the Out-of-Network Professional Provider
- Out-of-Network Professional Provider Address
- Out-of-Network Professional Provider Phone Number
- Dates of Service
- Diagnosis codes or description
- CPT codes for services performed with associated itemized charges

You will be required to file a claim form (found online) for an out of network claim. All Out-of-Network claims must be submitted through an “Out-of-Network Claim form” – found at www.questbh.com website.

When you are ready to access your benefits, you may call the Quest 24-hour toll free number at 800-364-6352 to obtain a referral list. You may also access the website for a list of In-Network Professional Providers at www.questbh.com. Your In-Network Professional Provider will be responsible for sending claims to Quest Behavioral Health. Any information collected by Quest about your care is private and confidential and will not be disclosed except when required by court order, and/or when mandated by law to report child abuse/neglect, and/or when the member is considered at imminent risk of harming themselves or others.

Some of the services you receive through Quest Behavioral Health require authorization before you receive them. All services excluding Emergency Care and Outpatient treatment require authorization (some Outpatient Treatment requires authorization and refer to page 18 for your table of benefits and requirements). Authorizations are used to determine Medical

Appropriate/Medically Necessary treatment, and to make a level of care determination. If you seek In-Network care, the Professional Provider is responsible to authorize the service. If you seek Out-of-Network care, obtaining an authorization is the members' responsibility. (In the case of Autism there must be an authorization made by the Quest Behavioral Health Care Management prior to the authorization of any services. This determination which is made by Quest Behavioral Health to authorize care is based on the reviewed medical necessity of the care prescribed in the treatment plan created through an assessment performed by a licensed Physician, Psychologist, or clinician).

When a Covered Person seeks treatment that requires authorization, they are not responsible for obtaining the authorization if the treatment is provided by an In-Network Professional Provider. In addition, if the In-Network Professional Provider fails to obtain a required authorization, the Covered Person will be held harmless from any associated financial penalties assessed by Quest Behavioral Health as a result. If the request for authorization 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 Professional Provider, they are responsible for initiating the authorization process. They or their Professional Provider should call the Quest Behavioral Health number listed on the back of their Identification Card (800-364-6352) and give their full name, treating Professional Provider or Facility Provider's name, diagnosis, and procedure or reason for admission.

The Behavioral Health Benefit Options:

- In-Network Professional Providers – Use physicians, Hospitals, and other health care providers who are part of the Quest Behavioral Health provider network. For In-Network services there are no claim forms to be filed for the Plan.
- Out-of-Network Providers - Use physicians, Hospitals, and other health care qualified providers who are not a part of the Quest Behavioral Health provider network. When you use this level of benefits, note that the payment for services is based on a percentage of the Usual and Customary rates as determined by the Plan and you must file claim forms and are considered all-inclusive. All additional charges of the provider for Out-of-Network services are your responsibility. All Out-of- Network claims must be submitted through an “Out-of-Network Claim form” – found on at www.questbh.com.

As a participant in the Covered Services of the Plan, 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 Quest Behavioral Health participating provider, call 800-364-6352 or visit the website at www.questbh.com.

Mental health and chemical dependency treatment includes services and supplies which are:

- Covered Services, for mental health and chemical dependency treatment;
- given while the Covered Person is covered under this Plan;
- provided by a Professional Provider or Other Trained licensed or certified Clinician

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.

Other Trained Clinicians refers to any other qualified clinician authorized to provide Inpatient or Outpatient treatment for behavioral health conditions, who is either certified, or otherwise qualified, to provide services and is acting within the scope of that certification or training (includes TSS, RBT, or other qualified technicians treating members for Autism Spectrum Disorders, certified addictions counselors treating members for chemical dependency diagnoses).

Mental health and chemical dependency 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 Quest Behavioral Health. However, you (or your representative or your physician) must call Quest Behavioral Health within 48 hours after Emergency Care is given. If this is not possible, the call must be made as soon as reasonably possible. See "YOUR BEHAVIORAL HEALTH BENEFITS", Part D section (Section V., page 23) for details on Emergency care.

IV. BENEFITS ELIGIBILITY

Quest Behavioral Health certifies that Eligible Employees and Dependents enrolled in the PennCare PPO Plan are entitled to the Covered Services described in this SPD subject to the eligibility and Effective Date requirements of the Group Contract.

This SPD replaces any and all SPDs or communications previously issued by the University of Pennsylvania or Quest Behavioral Health explaining the behavioral health services.

This SPD 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.

V. YOUR 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, then carefully choose a provider that you feel is right for you. To verify that the provider you select is a Quest Behavioral Health In-Network provider, call 800-364-6352, or visit the website at www.questbh.com.

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 Quest Behavioral Health. For definitions of Medically Appropriate/Medically Necessary see the “DEFINED TERMS” section (Section II., page 4) of this SPD. 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 Quest Behavioral Health.

Subject to the exclusions, conditions and limitations of the Plan as set forth in this SPD, 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 (See Section V “YOUR BEHAVIORAL HEALTH BENEFITS”, page 18 for the table graph of benefits).

The percentages shown for the Coinsurance and Covered Services on in the Schedule of Benefits in this SPD 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 4) of this SPD.

Authorizations:

All services above the Outpatient level (i.e., Intensive Outpatient, Partial Hospitalization, Inpatient mental health admissions, Inpatient chemical dependency admissions) require notification and authorization of the admission. Some Outpatient services (Psychological Testing, Neuropsychological Testing, Electroconvulsive Therapy, TMS, psychiatric home care services, Outpatient Detoxification) also require authorization and notification under the Plan before services are rendered to determine if they are Medically Appropriate/Medically Necessary and fully covered according to the Plan benefit design. This authorization of services is a vital program feature that reviews medical and benefit appropriateness of certain procedures/admissions according to the Plan. In certain cases, authorizations help determine

whether a different treatment may be available that is equally effective. Authorizations also help determine the most appropriate setting for certain services.

When a Covered Person seeks mental health or chemical dependency treatment that requires an authorization from an In-Network Provider, the provider is responsible for obtaining the authorization prior to treatment or possibly forfeits the Maximum Plan reimbursements. See “YOURBEHAVIORAL HEALTH PLAN” (Section III., page 12) of this SPD for a detailed explanation of this process.

(See Benefit Tables of the Plans on next page)



1-800-364-6352

University of Pennsylvania

Personal Choice PennCare PPO Behavioral Health Benefits Plan (FY2020 – Effective 7/1/19)

Benefit	In-Network (Quest Preferred)	In-Network (Quest Regional)	Out-of-Network
Overall Annual Deductibles ¹	\$150.00 Individual \$450.00 Family	\$350.00 Individual \$1,050.00 Family	\$500.00 Individual \$1,500.00 Family
Overall Annual Out of Pocket Maximum ^{1,2} Includes deductible, co-insurance and co-payments	\$1,000.00 Individual \$3,000.00 Family	\$2,500.00 Individual \$7,200.00 Family	\$3,500.00 Individual \$10,500.00 Family
MENTAL HEALTH	ALL SERVICE REQUIRE PREAUTHORIZATION EXCEPT FOR OUTPATIENT OFFICE VISITS		
Acute Inpatient ³	10% ⁴ coinsurance after deductible	20% ⁴ coinsurance after deductible Prof Services: 20% ⁴ coinsurance after deductible	40% ⁴ coinsurance after deductible
Partial Hospitalization ³	10% ⁴ coinsurance after deductible	20% ⁴ coinsurance after deductible Prof Services: 20% ⁴ coinsurance after deductible	40% ⁴ coinsurance after deductible
Intensive Outpatient ³	10% ⁴ coinsurance after deductible	20% ⁴ coinsurance after deductible Prof Services: 20% ⁴ coinsurance after deductible	40% ⁴ coinsurance after deductible
Outpatient Office Visit	\$20.00 co-pay per session	\$25.00 co-pay per session	40% ⁴ coinsurance after deductible
Emergency Room	\$100.00 co-pay (waived if admitted)		
CHEMICAL DEPENDENCY	ALL SERVICE REQUIRE PREAUTHORIZATION EXCEPT FOR OUTPATIENT OFFICE VISITS		
Detoxification ³ and Rehabilitation ³	10% ⁴ coinsurance after deductible	20% ⁴ coinsurance after deductible Prof Services: 20% ⁴ coinsurance after deductible	40% ⁴ coinsurance after deductible
Partial Hospitalization ³	10% ⁴ coinsurance after deductible	20% ⁴ coinsurance after deductible Prof Services: 20% ⁴ coinsurance after deductible	40% ⁴ coinsurance after deductible
Intensive Outpatient ³	10% ⁴ coinsurance after deductible	20% ⁴ coinsurance after deductible Prof Services: 20% ⁴ coinsurance after deductible	40% ⁴ coinsurance after deductible
Outpatient Office Visit	\$20.00 co-pay per session	\$25.00 co-pay per session	40% ⁴ coinsurance after deductible
Emergency Room	\$100.00 co-pay (waived if admitted)		
SPECIALIZED TREATMENT	ALL SERVICES REQUIRE PREAUTHORIZATION		
Psychological Testing ³ , ECT ³ , TMS ³	100%	20% ⁴ coinsurance	40% ⁴ coinsurance after deductible
Autism Outpatient Services ³ including Applied Behavioral Analysis (ABA) and selected Behavioral Health Rehabilitative Services (BHRS)	Treatment Delivered by Quest Network Providers 100% Covered		

¹Annual deductible and out-of-pocket maximum shared between mental health, chemical dependency, and medical benefits

²It is the responsibility of the member to demonstrate that the annual out-of-pocket maximum (medical, mental health and chemical dependency) has been reached for reimbursement

³Preauthorization is required

⁴It is important to note that all percentages for services represent the plan allowance and not the provider's actual charge

University of Pennsylvania

Personal Choice PennCare PPO Behavioral Health Benefits Plan for Retirees pre-65 (CY2019 – Effective 1/1/19)

Benefit	In-Network (Quest Preferred)	In-Network (Quest Regional)	Out-of-Network
Overall Annual Deductibles ¹	\$150.00 Individual \$450.00 Family	\$350.00 Individual \$1,050.00 Family	\$500.00 Individual \$1,500.00 Family
Overall Annual Out of Pocket Maximum ^{1, 2} <small>Includes deductible, co-insurance and co-payments</small>	\$1,000.00 Individual \$3,000.00 Family	\$2,500.00 Individual \$7,200.00 Family	\$3,500.00 Individual \$10,500.00 Family
MENTAL HEALTH	ALL SERVICE REQUIRE PREAUTHORIZATION EXCEPT FOR OUTPATIENT OFFICE VISITS		
Acute Inpatient ³	10% ⁴ coinsurance after deductible	20% ⁴ coinsurance after deductible <small>Prof Services: 20%⁴ coinsurance after deductible</small>	40% ⁴ coinsurance after deductible
Partial Hospitalization ³	10% ⁴ coinsurance after deductible	20% ⁴ coinsurance after deductible <small>Prof Services: 20%⁴ coinsurance after deductible</small>	40% ⁴ coinsurance after deductible
Intensive Outpatient ³	10% ⁴ coinsurance after deductible	20% ⁴ coinsurance after deductible <small>Prof Services: 20%⁴ coinsurance after deductible</small>	40% ⁴ coinsurance after deductible
Outpatient Office Visit	\$20.00 co-pay per session	\$25.00 co-pay per session	40% ⁴ coinsurance after deductible
Emergency Room	\$100.00 co-pay (waived if admitted)		
CHEMICAL DEPENDENCY	ALL SERVICE REQUIRE PREAUTHORIZATION EXCEPT FOR OUTPATIENT OFFICE VISITS		
Detoxification ³ and Rehabilitation ³	10% ⁴ coinsurance after deductible	20% ⁴ coinsurance after deductible <small>Prof Services: 20%⁴ coinsurance after deductible</small>	40% ⁴ coinsurance after deductible
Partial Hospitalization ³	10% ⁴ coinsurance after deductible	20% ⁴ coinsurance after deductible <small>Prof Services: 20%⁴ coinsurance after deductible</small>	40% ⁴ coinsurance after deductible
Intensive Outpatient ³	10% ⁴ coinsurance after deductible	20% ⁴ coinsurance after deductible <small>Prof Services: 20%⁴ coinsurance after deductible</small>	40% ⁴ coinsurance after deductible
Outpatient Office Visit	\$20.00 co-pay per session	\$25.00 co-pay per session	40% ⁴ coinsurance after deductible
Emergency Room	\$100.00 co-pay (waived if admitted)		
SPECIALIZED TREATMENT	ALL SERVICES REQUIRE PREAUTHORIZATION		
Psychological Testing ³ , ECT ³ , TMS ³	100%	20% ⁴ coinsurance	40% ⁴ coinsurance after deductible
Autism Outpatient Services ³ including Applied Behavioral Analysis (ABA) and selected Behavioral Health Rehabilitative Services (BHRS)	Treatment Delivered by Quest Network Providers 100% Covered		

¹Annual deductible and out-of-pocket maximum shared between mental health, chemical dependency, and medical benefits

²It is the responsibility of the member to demonstrate that the annual out-of-pocket maximum (medical, mental health and chemical dependency) has been reached for reimbursement

³Preauthorization is required

⁴It is important to note that all percentages for services represent the plan allowance and not the provider's actual charge

B. 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 Plan. 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 available under the medical plan portion of the PennCare PPO Plan and will not be subject to the mental health/psychiatric limitations of this Plan. (See the “MIXED SERVICES GUIDELINES” section (Section VIII., page 37).

Benefits are payable for Mental Health or Chemical Dependency Treatment by a Hospital or Provider, subject to the Coinsurance and Out-of-Network 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. Authorization information must be submitted by the Provider to Quest Behavioral Health for review and evaluation, so a Plan of Treatment may be authorized for the Covered Person. An authorization must be obtained for all treatment, other than Emergency Care and Outpatient care (subject to some Outpatient services requiring authorization as previously stated), 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, as long as the member has signed a release of information, because he/she is most familiar with the patient’s condition. Quest Behavioral Health 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 IX., page 41) of this SPD and the Emergency Care subsection of the YOUR BEHAVIORAL HEALTH BENEFITS section (Section V., page 23) must be followed. Emergency Care is exempt from the requirements for authorization and will be considered In-Network care as In-Network Providers and will be paid at 100%.

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 Quest Behavioral Health 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 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.

C. 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 PennCare PPO Plan available and will not be subject to the Alcohol and Drug Abuse and Dependence Care Limitations of this program. (See the MIXED SERVICES GUIDELINES section (Section VIII., page 37) of this SPD)

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.

Authorization information must be submitted by the provider to Quest Behavioral Health for review and evaluation, so a Plan of Treatment may be authorized for the Covered Person. Authorization 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, as long as the member has signed a release of information, because he/she is most familiar with the patient's condition. Quest 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 41) of this SPD must be followed. Emergency Care is exempt from the authorization requirements and will be considered In-Network care as In-Network Providers and will be paid at 100%.

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.

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;
- d) Psychiatric, psychological and medical laboratory testing;

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

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.

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;
- d) Psychiatric and Psychological Testing;

D. EMERGENCY CARE

EMERGENCY –Quest Behavioral Health follows the “prudent layperson” 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 layperson, 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 Quest Behavioral Health. However, you (or your representative or your physician) must call Quest Behavioral Health 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 Quest Behavioral Health to get a referral to receive any additional services covered in the In-Network level. All services other than Outpatient treatment require authorization. If you are admitted to the Hospital, your copay 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 chemical dependency Emergency Care while traveling. For out-of-area emergencies, go immediately to the nearest emergency room. If you are admitted to the Hospital, contact Quest Behavioral Health or have an agency representative contact Quest Behavioral Health within 48 hours of your admission or as soon as possible for Precertification of treatment.

E. TESTING / DIAGNOSTIC SERVICES

Authorization is required for all diagnostic / testing related services. It is critical to authorize 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 chemical dependency 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 Quest Behavioral Health. The following subsections describe the Psychological Testing authorization process and criteria used by Quest. Before testing is administered, the testing psychologist must call the Quest Behavioral Health at 800-364-6352 and submit a Request for Psychological Testing Authorization form. The Request for Psychological Testing Authorization form can also be found online at www.questbh.com.

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 Quest Behavioral Health 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 Quest Behavioral Health network provider and certified by Quest. Out-of-Network testing must be requested by the provider and certified by Quest. 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:

- Testing is primarily for educational/vocational purposes.
- Testing is primarily for the purpose of determining if a Covered Person is a candidate for a specific type or dosage of psychotropic medication.
- Testing is primarily for the purpose of determining if a Covered Person is a candidate for a medical or surgical procedure.
- Testing results may be invalid due to the active influence of a substance, chemical dependency withdrawal, or similar cause.
- Two or more tests are requested that essentially measure the same functional domain.
- Testing is primarily for legal purposes including custody evaluations, parenting assessments, or other court/government ordered or requested testing.
- Tests requested are Experimental or Investigative, antiquated, or not validated.
- 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 Plan covers this service for the Covered Person.
- Testing is primarily to determine the extent or type of neurological impairment, unless allowed under the Plan.
- The type of testing falls into the category within this SPD which are not covered.

F. LIFETIME MAXIMUMS

Lifetime Maximums:

There is no lifetime Maximum for mental health and chemical dependency Out-of-Network care. There is also no lifetime Maximum for Preferred or Regional In-Network care.

VI. COVERAGE EXCLUSIONS OF THIS PLAN

Listing of the Items Not Covered by the Plan:

Except as specifically defined by Quest Behavioral Health, no benefits will be provided for services, supplies or charges:

- Which are not deemed Medically Appropriate/Medically Necessary (as determined by Quest Behavioral Health) for the diagnosis, care, or treatment of illness, trauma, or restoration of mental health/chemical dependency 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 5* criteria
 - services that are not in connection with a behavioral disorder, psychological injury, or chemical dependency
 - 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 Quest Behavioral Health level of care guidelines or best practices as modified periodically
-
- Which are not deemed by Quest Behavioral Health to be benefit covered (as determined by the individual mental health/ chemical dependency Plan option) for the diagnosis, care, or treatment of illness, trauma, or restoration of mental health/chemical dependency 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 BEHAVIORAL HEALTH BENEFITS” section (Section V., page 16) of this SPD;

 - 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 Plan’s Usual 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 5* diagnoses as related to children: 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 5* 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, 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 U.S.
- Availability of a service, device or treatment does not imply a Covered Service under the 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 5* 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/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 “Authorization Requirements for other than Inpatient Hospitalization” in the MANAGED CARE PROCEDURES section (Section IX., page 41) of this SPD;
- 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 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 despite 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 Plan, 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 Quest Behavioral Health;
- 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 Quest Behavioral Health 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 5 IV TR is mentioned throughout this SPD, it does not indicate that all diagnoses present in the DSM 5 are covered for services. Quest Behavioral Health reserves the right to apply treatment limitations to some DSM 5 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 Quest Behavioral Health, 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 PROCEDURES section (Section IX., page 41) of this SPD. 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 contacting Quest Behavioral Health at 800-364-6352.

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 or 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 the PennCare PPO Plan's behavioral health benefits may furnish to Quest Behavioral Health, upon its request, any information (including copies of records relating to the care).

In addition, Quest Behavioral Health may furnish similar information to other entities providing similar benefits at their request as long as a signed Release of Information is in place.

Quest Behavioral Health shall provide to the Group at the Group's request certain information regarding claims and charges submitted to Quest Behavioral Health. The parties understand that any information provided to the Group will be adjusted by Quest Behavioral Health 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 Quest Behavioral Health for the actual costs of preparing and providing said information.

Usual and Customary Rates

The amount that is the usual or customary charge for the service or supply as determined by Quest Behavioral Health primarily used for out of network provides or single case agreements. The methodology begins with "Fair Health" market basket rates and if not available, 120% of Medicare and if not available, 50% of charges)

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 Quest Behavioral Health network, the student may be eligible to receive 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 which may be negotiated under a single case agreement. If the treatment may be long-term and the provider is interested, Quest Behavioral Health will employ the standard credentialing process in order to approve care with the out of area Out-of-Network Provider and to negotiate rates. If a provider is unwilling to negotiate rates, then Quest will reimburse the provider at the Usual and Customary Rate (UCR) established for that geographical area. Enrollees may be responsible for the balance billing if charges are greater than the established UCR. 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/Chemical dependency)

Participant Copayments and Coinsurance/Deductibles are listed on the Schedule of Benefits. To be eligible for reimbursement under this provision, contact Quest Behavioral Health at 800-364-6352. 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 to Actives only.

Coordination of Benefits

Quest Behavioral Health's Coordination of Benefits provision is designed to conserve funds associated with mental health and chemical dependency treatment. 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: The Behavioral Plan" shall mean this group arrangement providing mental health and chemical dependency 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 Behavioral Health Plan, mental health and chemical dependency 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 other group health care plan for services covered under the Behavioral Health 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 this Behavioral Health Plan in order to avoid duplication of benefits.

Benefits under this Behavioral Health Plan will be provided in full when the Quest benefits are primary, that is, when Quest determines benefits first. If another plan is primary, Quest will provide benefits as described below. When an Employee has group mental health and chemical dependency 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:
 - i. The plan covering the patient other than as a Dependent shall be primary.
 - ii. 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.
- c. 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
- d. 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.

- e. 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)(ii)
- f. 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.
- g. 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 Plan will be reduced so that Quest Behavioral Health 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 Quest Behavioral Health payment exceed the amount that would have been payable under this Plan if Quest were primary.

Right of Recovery

Whenever payments which should be made under this Plan in accordance with this provision have been made under any other plan, Quest Behavioral Health 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, Quest shall be fully discharged from liability under this Plan.

Whenever payments have been made by Quest Behavioral Health 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, Quest Behavioral Health shall have the right to recover such payments to the extent of such excess from among one or more of the following, as Quest shall determine:

1. the person Quest has paid or for whom they 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 Quest Behavioral Health.

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 Quest Behavioral Health at 800-364-6352.

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 PennCare PPO Plan. After the Quest Behavioral Health 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 Plan.

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 this Plan does not include those services that are explicitly excluded for coverage by the relevant certificates of coverage, applicable master contracts or applicable individual provider contracts.

Quest 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	Independence Blue Cross
Mild injury not requiring Emergency Services	Medical services on a mental health/chemical dependency unit	Medical trauma	Psychiatrist	Quest

CHEMICAL DEPENDENCY				
Clinical Circumstances	Service	Primary Diagnosis	Attending Provider Type	Clinical/Financial Responsibility
Medical Detoxification with serious complications (end-organ damage with abnormal physiology)	ICU or other specialized Med/Surgical unit	Chemical Dependency (ICD 10 Code – 303-305.9)	Addictionologist, Internist, or Family Practitioner	Medical Plan Independence Blue Cross
Medical Detoxification without serious 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	Quest

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/Surgical and/or Mental Health/Chemical Dependency	Med/Surgical provider with Psychiatrist consulting	Medical Plan Independence Blue Cross
Cognitive Disorder due to chemical dependency withdrawal	Inpatient services in psychiatric or residential facility or ambulatory services	Mental Health/Chemical Dependency	Psychiatrist	Quest
Cognitive Disorder due to a primary psychiatric condition	Inpatient services in psychiatric or residential facility or ambulatory services	Mental Health/Chemical Dependency	Psychiatrist, Behavioral Health/Chemical Dependency Provider	Quest

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 Independence Blue Cross
Presentation with symptoms indicative of possible medical crisis (chest pains, shortness of breath, numbness, etc.)	Emergency Room evaluation (Diagnostic assessment, psychiatric consultation)	Med/Surgical and/or Mental Health/Chemical Dependency	Psychiatrist, Other Medical	Medical Plan Independence Blue Cross

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 Independence Blue Cross
Compromised weight/nutritional status	Stabilization of medical condition on Med/Surgical unit	Mental Health/Chemical Dependency or both	PCP, Internist	Medical Plan Independence Blue Cross
Compromised weight/nutritional status	Psychiatric unit Behavioral treatment planning and intervention	Mental Health/Chemical Dependency or both	Psychiatrist	Quest
Compromised weight/nutritional status	Med/Surgical unit, Routine monitoring	Mental Health/Chemical Dependency or both	PCP, Internist	Medical Plan Independence Blue Cross
Compromised weight/nutritional status	Psychiatric unit, Routine monitoring	Mental Health/Chemical Dependency or both	Psychiatrist	Quest

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 Independence Blue Cross
Somatoform Disorder	Behavioral Health/Chemical Dependency services in Inpatient or ambulatory setting	Mental Health/ Chemical Dependency	Psychiatrist	Quest
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	Quest

IX. MANAGED CARE PROCEDURES

Inpatient Pre-Admission Review:

In-Network Inpatient Admissions:

All In-Network Inpatient Admissions must meet the requirements of the Quest Behavioral Health utilization management program and policies. Under the program as described below, any Inpatient Admission, other than an Emergency admission, requires an authorization in accordance with the standards of Quest Behavioral Health as to the Medical Appropriateness/Medical Necessity of the admission and the available benefit coverage. The authorization requirements for Emergency admissions are set forth in the “YOUR BEHAVIORAL HEALTH BENEFITS” section (Section V., page 16) of this SPD. In-Network Hospitals or other Facility Providers in the network will verify the authorization at or before the time of admission. Quest will not authorize the Hospital or other Facility Provider admission if authorization 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 authorization requirements unless (1) the Hospital or other Facility Provider provides prior written notice that the admission will not be paid by the Plan; 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 authorized in advance as an approved admission.

- a. To obtain an authorization, the Covered Person is responsible to contact, or have the admitting physician or Hospital, or other Facility Provider contact, Quest Behavioral Health prior to admission to the Hospital or other Facility Provider. Quest Behavioral Health 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 authorized in accordance with the Group Contract.
- b. If a Covered Person elects to be admitted to the Hospital or other Facility Provider after authorization 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 Plan and the Covered Person’s obligations to the Provider will be the sole responsibility of, and payable by, the Covered Person.

- c. If authorization 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 Quest Behavioral Health of the In-Network Emergency Admission.

Out-of-Network Admissions:

- a. Covered Persons are responsible for notifying the designated agent of an Out-of-Network Emergency admission for themselves or a Dependent within two (2) business days of the admission, or as soon as reasonably possible.
- b. 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/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:

Quest Behavioral Health will verbally inform the Provider of the approval of any additional care as a result of the concurrent review. The written and verbal determination by both Quest Behavioral Health 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 assesses 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 Quest Behavioral Health not being notified of a Covered Person's admission until after discharge or where medical charts are unavailable at the time of concurrent review. Requests for retro-review and related claims must be submitted to Quest within 1 year from the date of services.

Pre-Certification Requirements for other than Inpatient Hospitalization:

Authorization is required by Quest Behavioral Health 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, Quest Behavioral Health 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.

- Inpatient
- Partial Hospitalization
- Residential Care
- Intensive Outpatient Therapy
- Outpatient Detox
- Psychological Testing
- Electroconvulsive Therapy
- Transcranial Magnetic Stimulation

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. Authorization of the Medical Appropriateness or Medical Necessity is required for Hospitalizations (Detoxification, Intensive Outpatient, Partial Hospitalization, Inpatient 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 Plan. 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 Plan will not consider that course of treatment as appropriate for the Maximum reimbursement under the Plan.

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, Quest Behavioral Health 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 Quest Behavioral Health at 800-364-6352, 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 Quest Behavioral Health within 48 hours of the first business day after the admission.

Quest Behavioral Health 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. Quest Behavioral Health 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/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 authorized, 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 authorization. When seeking Outpatient services, you may want to confirm that your chosen provider is a Quest 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:

Quest Behavioral Health 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 conducting authorizations. 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 Quest Behavioral Health provider network and from consumers and community agencies. Quest Behavioral Health reviews adopted criteria at least every two (2) years and provides updates as necessary. As with clinical criteria in general, the Quest Behavioral Health 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
2. Acute Partial Hospitalization
3. Intensive Outpatient Program
4. 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 chemical dependency 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.

Quest Behavioral Health 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 is available online at the American Psychiatric Association website, www.psychiatry.org. 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.

Quest Behavioral Health 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 is 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-5 is mentioned throughout this SPD, it does not indicate that all diagnoses present in the DSM-5 are covered for services. Quest Behavioral Health reserves the right to apply treatment limitations to some DSM-5 diagnoses.

Contact Information for APA:

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

Contact Information for AACAP:

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

B. CHEMICAL DEPENDENCY PLACEMENT CRITERIA

Description of Criteria for Adults and Adolescents:

Quest Behavioral Health has adopted a number of chemical dependency placement criteria to assist providers in the assessment and placement of patients with alcohol and other drug problems for treatment of chemical 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 Quest Behavioral Health provider network and from consumers and community agencies. Quest Behavioral Health reviews adopted criteria at least every two years and provide updates as necessary. Providers are encouraged to visit the Quest Behavioral Health web site at www.questbh.com and click on the Service Provider section to learn about updates. As with placement criteria in general, the Quest Behavioral Health adopted guidelines are intended to augment, not replace, sound clinical judgment.

The criteria used by Quest Behavioral Health 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 1 | OUTPATIENT TREATMENT
See ASAM Patient Placement Criteria for the Treatment of Substance- Related Disorders, (Second Edition – Revised) (ASAM PPC-2R) |
| Level 2.1 | INTENSIVE OUTPATIENT
See ASAM Patient Placement Criteria for the Treatment of Substance- Related Disorders, (Second Edition – Revised) (ASAM PPC-2R) |
| Level 2.5 | PARTIAL HOSPITALIZATION
See ASAM Patient Placement Criteria for the Treatment of Substance- Related Disorders, (Second Edition – Revised) (ASAM PPC-2R) |

- Level 3.5 **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 3.7 **MEDICALLY MONITORED INTENSIVE INPATIENT TREATMENT**
See ASAM Patient Placement Criteria for the Treatment of Substance- Related Disorders, (Second Edition – Revised) (ASAM PPC-2R)
- Level 4 **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 for 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 Plan intends 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.

Quest Behavioral Health In-Network Facility and Individual Providers will need to receive authorization from Quest Care Managers (for services other than Emergency and Outpatient) and then directly bill Quest Behavioral Health for the authorized services rendered. Quest 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 and made payment to an Out-of-Network Provider, you will need to file a claim to receive benefits. If you do not have a claim form, call Quest Behavioral Health at 800-364-6352 to contact the Claims Department or go to the Quest website (www.questbh.com) for further instructions and forms to submit claims. Fill out the claim form and please return it with your itemized superbills to Quest 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 Quest Behavioral Health 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 one year after the end of the Benefit Period in which the Covered Services are rendered.

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.

Professional Providers

In-Network Professional Providers are paid on a fee-for-service basis, meaning that payment is being made according to Quest Behavioral Health’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 Quest Behavioral Health, 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 4) of this SPD.

Payment for In-Network Professional and Facility Providers

Quest Behavioral Health is authorized by the Covered Person to make payments directly to In-Network Facility and In-Network Professional Providers furnishing Covered Services for which benefits are provided under this coverage. In-Network Providers have agreed to accept the rate of reimbursement determined by a contract as payment in full for Covered Services. 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 BEHAVIORAL HEALTH BENEFITS section (Section V., page 16) of this SPD.

Benefit amounts, as specified in the YOUR BEHAVIORAL HEALTH BENEFITS section (Section V., page 16) of this SPD, 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 In-Network Provider and a Covered Person with respect to balance billing shall be submitted to Quest Behavioral Health for determination. The decision of Quest shall be final.

The Plan will provide benefits for the Covered Expenses Incurred for certain mental health/chemical dependency 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 Plan. The Plan also provides benefits for the Covered Expenses for Outpatient care.

Once Covered Services are rendered by an In-Network Provider, the Plan will not honor a Covered person's request not to pay for claims submitted by the In-Network Facility Provider. The Plan 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 Quest Network, nor do they have a contract with the Plan. The Plan will provide benefits to the Covered Person for use of such Out-of-Network as specified in the YOUR BEHAVIORAL HEALTH BENEFITS (Section V., page 16) of this SPD. Accordingly, when a Covered Person seeks care from Out-of-Network care, any difference between the Out-of-Network charge and the Plan's payment shall be the personal responsibility of the Covered Person

If Quest Behavioral Health 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 Quest Behavioral Health.

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 Quest Behavioral Health at 800-364-6352.

XI. FILING CLAIMS FOR SERVICES

How to File a Claim:

You are never required to file a claim when Covered Services are provided by In-Network Providers. If you choose to receive services from an Out-of-Network Provider, it is your responsibility to submit an invoice (sometimes referred to as a “superbill”) from the provider within 90 days of completion of the Covered Services, showing the following:

- Name of Primary Covered Member
- Name of Member or Dependent for whom services were provided
- Member Address
- Member Phone Number
- Date of birth for Member or Dependent receiving services
- Employee/Primary Covered Member ID number
- Plan Name

In addition to the above information regarding the member, provides the following:

- The Out-of-Network Provider’s (Qualified Professional or Facility Provider) Name
- The license number/degree of the Out-of-Network Provider
- Tax I.D. Number of the Out-of-Network Provider
- Out-of-Network Provider Address
- Out-of-Network Provider Phone Number
- Dates of Service
- Diagnosis codes or description
- CPT codes for services performed with associated itemized charges

The Covered Person (or their designated legal guardian/custodian) should submit the above pertinent information and return it with any itemized bills to:

Quest Behavioral Health
PO Box 1032
York, PA 17405

When Claims Should Be Filed:

Claims should be filed with the Quest Claims Department within the 90 days of the date charges for the services were Incurred. Benefits are based on the Plan’s provisions at the time the charges were Incurred. Claims filed later than that date may be declined or reduced unless:

- (a) it’s not reasonably possible to submit the claim in that time; and

- (b) the claim is submitted by the end of the one (1) year deadline from the time when the claim was Incurred. This period will not apply when the person is not legally capable of submitting the claim.

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

Claims Procedure:

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

Pre-Service Claim - A "pre-service claim" is a claim that requires approval before Covered Services are provided.

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 claim must contain the information requested on a claim form provided by the applicable provider.

Concurrent Care Claim - A "post-service claim" is a claim where the Plan has previously approved a course of treatment over a period of time or for a specific number of treatments, and the Plan later reduces or terminates coverage for those treatments.

Urgent Care Claim - A "claim" is considered an "urgent care claim" if not making a claim urgent could seriously jeopardize the life, or health, or ability to regain maximum function or, in the opinion of a Provider with knowledge of your condition, would lead to worsening of the condition if not receiving treatment, which is the subject of the claim. Quest Behavioral Health will defer to the treating Provider to determine the urgency of a claim.

In general, any Covered Person or his/her duly authorized representative (the "claimant") may file a written claim for benefits using the proper form and procedure.

If the Plan does not fully agree with your claim, you will receive an "adverse benefit determination" - a denial, reduction, or termination of a benefit, or failure to provide or pay for (in whole or in part) a benefit. An adverse benefit determination includes a rescission of coverage (generally a retroactive cancellation of coverage) under the Plan, whether or not in connection with the rescission there is an adverse effect on any particular benefit at that time. However, the Plan will not rescind coverage for a Covered Person unless they perform an act, practice, or omission that constitutes fraud (as defined by the Plan) or intentionally misrepresents a material fact with respect to Plan coverage.

Time Periods for Responding to Initial Benefit Determinations: If you bring a claim for benefits under the Plan, Quest Behavioral Health will respond to your claim within the following time periods:

Pre-Service Claim - Quest Behavioral Health, the Claims Administrator, shall respond to you of its determination, whether adverse or not, within a reasonable period of time, but not later than 15 days after receipt of the pre-service claim. This period may be extended by 15 days, provided the Claims Administrator determines that an extension is necessary due to matters beyond the control of the Plan and notifies you, within the initial period of the circumstances requiring the extension and the date by which the Plan expects to render a decision. If such an extension is necessary due to your failure to submit the information necessary to decide the claim, the notice of extension will specifically describe the required information. If the claim is improperly filed, the Claims Administrator will notify you as soon as possible, but not later than 5 days after receipt of the claim by the Plan, of the specific information necessary to complete the claim. Notification of the improper filing may be made orally unless you request written notification. You will be afforded at least 45 days from receipt of the notice within which to provide the specified information.

Post-Service Claim - For non-urgent post-service claims, the Plan has up to 30 days following receipt of the claim to evaluate and respond to claims for benefits. This period may be extended by 15 days provided the Quest Behavioral Health, the Claims Administrator, if they determine that an extension is necessary due to matters beyond the control of the Plan and notifies you, within the initial period, of the circumstances requiring the extension and the date by which the Plan expects to render a decision. In addition, the notice of extension must include the unresolved issues that prevent a decision on the claim and the additional information needed to resolve those issues. You will be afforded at least 45 days from receipt of the notice within which to provide the specified information.

Concurrent Care Claim - Concurrent care claims may fall under any of the other three categories, depending on when the request is made. If you request an extension of ongoing treatment in an urgent care situation, Quest Behavioral Health, the Claims Administrator, the Claims Administrator, will notify you within 24 hours of your request, provided your request is made at least 24 hours before the end of the approved treatment. Non-urgent claims will be treated as either pre-service or post-service claims.

Urgent Care Claim - Quest Behavioral Health, the Claims Administrator, will notify you of the Plan's determination, whether adverse or not, as soon as possible, taking into account medical requirements but, not later than 72 hours after receipt of the urgent care claim unless you fail to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the Plan. In the case of such a failure, the Claims Administrator will notify you as soon as possible, but not later than 24 hours after receipt of the claim by the Plan, of the specific information necessary to complete the claim. Notification of the improper filing may be made orally, unless the claimant requests written notification. You will be afforded a reasonable amount of time, taking into account the circumstances, but not less than 48 hours, to provide the specified information. The Claims Administrator will notify you of the Plan's benefit determination as soon as possible, but no later than 48 hours after the earlier of the Plan's receipt

of the specified information or the end of the period afforded you to provide the specified additional information.

Information Contained in a Notice of Adverse Benefit Determination: In the event of an adverse benefit determination, Quest will provide you with written or oral notice, as applicable, of the determination. This notice will include the following:

- Reason(s) - the specific reason or reasons for the adverse benefit determination;
- Reference to Plan Provisions - reference to the specific Plan provisions on which the determination 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 adverse benefit determination or a statement that such a rule, guideline, protocol, or other criterion was relied upon in making the determination or a statement that a copy of such information will be made available free of charge upon request;
- Description of Medical Necessity or Experimental treatment - a copy of an explanation of the scientific or clinical judgment for any adverse benefit determination based on Medical Necessity or Experimental treatment or similar exclusion or limit, or a statement that such explanation will be provided free of charge upon request;
- 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 benefit determination on appeal and a description of any expedited review process for Urgent Care Claims); and
- Urgent Care - for adverse benefit determinations involving urgent care, a description of the expedited review process for such claims. This notice can be provided in writing or orally within the timeframe for the expedited process, as long as written notice is provided no later than 3 days after the oral notice.

When a claimant receives an adverse benefit determination, the claimant has 180 days following receipt of the notification in which to appeal the determination. A claimant may submit written comments, documents, records, and other information relating to the claim with their appeal request to Quest. The claimant must send the appeal with appropriate documentation to:

Quest Behavioral Health
Appeals Administrator
PO Box 1032
York, PA 17405

The Plan will provide continued coverage pending the outcome of an internal appeal. Further, the Plan will not reduce or terminate an ongoing course of treatment without providing advance notice and an opportunity for advance review. If you don't appeal on time, you lose your right to later object to the decision.

XII. APPEALS OF ADVERSE BENEFIT DETERMINATION

Quest claim procedures will provide a claimant with a reasonable opportunity for a full and fair review of any adverse benefit determination, including rescissions of coverage, regardless of whether the rescission had an adverse effect on any particular benefit, only if the claims procedures:

1. Provide Claimants at least 180 days to appeal following receipt of a notification of an adverse benefit determination within which to appeal the determination;
2. Provide for a review that does not rely on the initial adverse benefit determination and that is conducted by an appropriate named fiduciary of the Plan who is neither the individual who made the adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual;
3. Provide that, in deciding an appeal of any adverse benefit determination that is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment or other item is Experimental, Investigational, or not Medically Necessary or appropriate, the appropriate named fiduciary will consult with a healthcare professional who has appropriate training and experience in the field of behavioral health involved in the judgment;
4. Provide for the identification of behavioral health experts whose advice was obtained on behalf of the Plan in connection with a Claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination;

5. Provide that the behavioral healthcare professional engaged for purposes of a consultation will be an individual who is neither an individual who was consulted in connection with the initial determination, nor the subordinate of any such individual;
6. Provide, in the case of an Urgent Care Claim, for an expedited review process that allows for verbal submission of the request for review and communication by telephone, facsimile, or other available similarly expeditious method;
7. Give Claimants the right to review their claim file, including access to and copies of documents, records and other information relevant to their claim. Whether a document, record or other information is relevant to the claim will be determined in accordance with the applicable Department of Labor guidance;
8. Give Claimants the opportunity to present evidence and testimony as part of the appeals process. The terms “evidence” and “testimony” shall be interpreted in accordance with applicable Department of Labor guidance;
9. In the event the Plan (or a claim reviewer on behalf of the Plan) considers, relies upon or generates new or additional evidence in connection with the claim, or is considering a new or additional rationale for the denial of the claim at the internal claims appeal stage, the Claimant will be advised in advance of the determination of the new evidence or rationale being considered, and will be allowed no less than 60 days to respond to such new evidence or rationale, except with respect to appeals of Urgent Care Claims, in which event the Claimant will be provided no less than two (2) days to respond to the new evidence or rationale; and
10. To the extent Plan personnel are involved in the claims process, the Plan will not consider, in connection with any decision regarding the hiring, compensation, promotion, termination or other similar matters with respect to an individual involved, directly or indirectly, with the evaluation or determination of the claims or appeals of any Claimant, whether or not such individual is likely to support the denial of benefits to a Claimant.

A. First Level Internal Appeal Timeline

1. For Pre-Service Claims, Quest must notify the Claimant of the determination on appeal within a reasonable period of time, but not later than 15 days after receipt of each request for review.
2. For Post-Service Claims, Quest must notify the Claimant of the determination on appeal within a reasonable period of time, but not later than 30 days after receipt of each request for review.

3. For Urgent Care Claims, Quest must notify the Claimant of the determination on appeal as soon as possible taking into account the medical needs, but not later than 72 hours after receipt of the Claimant's request for review.
4. If the appeal involves an authorization, Quest must notify the Claimant within a reasonable period of time appropriate to the behavioral health circumstance; notice for each appeal level must be provided within 30 days of receipt of each request for review.

B. Content of First Level Internal Appeal Decision Notification

1. Quest will provide Claimant with written notification of the Plan's decision regarding the Claimant's appeal.
2. If Quest made an adverse benefit determination on appeal, the notification will include:
 - a. The specific reason(s) for the adverse determination;
 - b. Reference to the specific Plan provisions on which the benefit determination is based;
 - c. A statement that the Claimant is entitled to receive, free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claimant's claim for benefits;
 - d. A statement describing any voluntary appeal procedure offered by Quest and the Claimant's right to obtain the information about such procedures, and a statement of Claimant's right to bring action under ERISA § 502(a);
 - e. Quest will also notify the Claimant of any internal rule, guideline, protocol, or other similar criterion relied upon in making the adverse benefit determination and advise the Claimant that a copy of the internal rule, guideline, or protocol will be provided free of charge upon request;
 - f. Quest will provide an explanation of the scientific or clinical judgment for any adverse determination based on Medical Necessity or Experimental treatment or similar exclusion or limit, or a statement that such explanation will be provided free of charge upon request; and
 - g. Information regarding available consumer assistance or ombudsmen to assist with internal claims and appeals and external review processes.
3. The Claimant will have an opportunity to review all documents, comment in writing and submit additional documentation to the reviewer for consideration in the outcome of the request.
4. Quest will provide any new or additional evidence or rationale considered in connection with the claim in advance of Quest's deadline of notice of its

determination on review to afford the Claimant an opportunity to review and respond prior to such determination.

5. Quest will ensure all claims are adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making the decisions.
6. If the reviewer overturns the denial, Quest will reimburse for the treatment according to the stipulations set by the reviewer.
7. Requests for review of an initial denied claim must be submitted to:

Quest Behavioral Health
Appeal Administrator
PO Box 1032
York, PA 17405

C. Second Level External Appeal Timeline

Upon exhausting the internal appeals process the Claimant may request an external review of Quest's final adverse determination. Quest will provide for an external review process in accordance with Federal law.

1. Exception: A Federal external review process is not available for review of an internal adverse determination that is based upon a determination that a Claimant failed to meet the eligibility requirements under the terms of the Plan.
2. According to the Federal external review process "Qualifying Reasons" for external review are available for:
 - a. An adverse determination that involves medical judgement including, but not limited to, Quest's requirements for Medical Necessity, appropriateness, health care setting, level of care or effectiveness of a covered benefit; or
 - b. Quest's determination that a treatment is Experimental or Investigative; or
 - c. A rescission of coverage.
3. The Claimant has 4 months following receipt of notice from Quest's final internal adverse determination to request an external review. Submit requests to:

Quest Behavioral Health
Appeal Administrator
PO Box 1032
York, PA 17405

4. Within 5 business days of receipt of the notice for an external review, Quest will complete a preliminary review. Quest will notify Claimant within 1 business day after it completes the preliminary review whether you are eligible for an external review process.

5. If the request is complete, but the claim is not eligible, Quest will notify and describe the reasons the claim is not eligible and will provide contact information for the Employee Benefits Security Administration;
 - a. If the request is not complete, the notice will list the information required to make the request complete. The Claimant will have the later of 48 hours following the date of receipt of the notice, or
 - b. Until the end of the 4-month deadline in (C3), above to provide the necessary additional information
6. Following Quest's preliminary review, if the request is eligible for external review, Quest will assign an External Review Organization (ERO) as soon as administratively feasible to make a determination on the request for external review.
7. Within 5 business days following assignment of the External Review Organization, Quest will forward all information and materials relevant to the final internal adverse determination to the External Review Organization:
 - a. Quest will notify the Claimant in writing of the determination of the External Review Organization. The notice will include a statement regarding the Claimant's right to submit any additional information, within ten (10) business days from the date of receipt of the notice
 - b. Based upon any new information received, Quest may reconsider its final internal adverse determination. Reconsideration by Quest will not delay the external review process. If Quest does not reconsider its final internal adverse benefits determination, the External Review Organization will continue to proceed with the external review process;
 - c. Quest will forward on and share with the External Review Organization any additional information received. If Quest does not reverse its initial adverse determination, within 45 days the External Review Organization must provide written notice of its external review determination to the Claimant and Quest.
8. An Expedited External Review is also available to the Claimant if the initial internal adverse determination involves an urgent-care claim, when:
 - a. A medical condition for which the time frame for completion of an expedited internal appeal under Quest's internal claim procedures would seriously jeopardize the Covered Person's life or health or would jeopardize the Covered Person's ability to regain maximum function and you have filed a request for an expedited internal appeal; or
 - b. The final internal adverse determination concerns an admission, availability of care, continued stay or health care item or service for which the Covered Person received Emergency services but has not been discharged from a facility.

9. The following requirements apply to an Expedited External Review:
- a. Quest will complete a preliminary review the date immediately following receipt of the external review request; Quest will notify the Claimant in writing whether the request is eligible for the external review process.
 - b. If the request is complete, but the claim is not eligible for external review, the notice will describe the reasons it is not eligible and will include contact information for the Employee Benefits Security Administration.
 - c. If the request is not complete, the notice will describe any information or materials needed to make the request complete. If the request is not complete and additional information or materials is needed to complete the preliminary review. The Claimant will have either:
 - 48 hours following the date of receipt of the notice, or
 - Until the end of the 4-month deadline in (C3) above, to provide the necessary additional information.
 - d. Following Quest's preliminary review, if the request is eligible for external review, Quest will assign an External Review Organization (ERO) to make a determination on the request for external review. Quest will promptly forward to the External Review Organization, by any available expeditious method (e.g. telephone, facsimile, etc.), all information and materials relevant to the final internal adverse determination.
 - e. Either in writing or verbally, the External Review Organization must provide notice to the Claimant and Quest, as expeditiously as the Claimant's medical condition or circumstance requires and no later than 72 hours after it receives the expedited external review request from Quest. If notice was not provided in writing, the External Review Organization must provide written notice to the Claimant and Quest as confirmation of the decision within 48 hours after the date of the notice.

D. Content of Second Level External Appeal Decision Notification

The External Review Organization's notice is required to contain the following:

1. A general description of the reason for the request for external review, including information sufficient to identify the claim, the diagnosis code and treatment code and the corresponding meaning for each and the reason for the previous denial;
2. The date the External Review Organization received the assignment to conduct the external review and the date of the External Review Organization's decision;
3. References to the evidence or documentation, including the specific coverage provisions and evidence-based standards, considered in reaching its decision;

4. A discussion of the principal reason or reasons for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision;
5. A statement that the determination is binding except to the extent that other remedies may be available under State or Federal law to either Quest or to the Claimant;
6. A statement that judicial review may be available to the Claimant; and
7. Current contact information, including telephone number, for any applicable office of health insurance consumer assistance or ombudsman established under the Public Health Service Act Section 2793.

IMPORTANT: Additional requirements apply with respect to exhausting the claims and appeals procedures. Also, deadlines apply for commencing a claim or action related to benefits, rights, or remedies with respect to the benefit plan or benefit plan fiduciaries. Please see the subsection "Requirement to Exhaust Claims Procedure and Deadline for Bringing a Civil Action" in the "Claims Procedure" section of the SPD for the Health and Welfare Plan for details.

E. Calculating Response Time

The period of time in which Quest is required to respond to an appeal of an adverse determination begins when the request is filed. However, if all the necessary information does not accompany your request, the period of time for making a determination is "frozen" from the date that the request for additional information is sent to you until the date you respond. If you fail to provide the requested information within 45 days, Quest will make a determination based on the information in its possession, which will likely result in an adverse benefit determination.

F. Failure to Follow Appeal Timeline

If Quest fails to follow its appeal procedures and in doing so would yield a decision based on the merits of the claim, the Claimant will have exhausted internal appeal options and be entitled to pursue applicable remedies externally under State or Federal law.

However, if a court deems Quest's violation is minor and would not likely cause prejudice or harm and Quest can demonstrate the violation was for good cause or due to matters beyond its control, Quest Behavioral Health will provide notice of the Claimant's right to resubmit an internal appeal within 10 days of the court's decision. Any applicable time limit for you to re-file your claim will begin when you receive notice from Quest.

G. External Review Determination

A determination on external review is binding on Quest and the Claimant, except to the extent other remedies are available under applicable State or Federal law. However, a decision by the external reviewer does not preclude Quest from making payment or providing benefits on a claim at any time, including after a decision that denies the claim. When an external review decision requires Quest to provide benefits or payment on a claim, Quest will provide benefits or payment pursuant to the decision without unreasonable delay regardless of whether Quest intends to seek judicial review of the decision, unless and until there is a judicial decision that provides otherwise.

H. Benefit Claims Litigation

A Covered Person must exhaust Quest's appeals process before commencing a court action pursuant to ERISA § 502(a) (1). However, if Quest fails to establish or follow claims procedures consistent with the regulations, a Claimant may be deemed to have exhausted the administrative remedies available and be entitled to pursue any available remedies under ERISA § 502(a) on the basis that Quest failed to provide a reasonable claims procedure that would yield a decision on the merits of the claim. 29 C.F.R. § 2560.503-1(l).

I. APPOINTMENT OF AUTHORIZED REPRESENTATIVE

A Covered Person is permitted to appoint an authorized representative to act on his or her behalf with respect to a benefit claim or appeal of a denial. An assignment of benefits by a Covered Person to a Professional Provider will not constitute appointment of that Professional Provider as an authorized representative. To appoint such a representative, the Covered Person must complete an Agent Authorization form which can be obtained from Quest. However, in connection with a claim involving urgent care, Quest will permit a health care professional with knowledge of the Covered Person's medical condition to act as the Covered Person's authorized representative without completion of this form. In the event a Covered Person designates an authorized representative, all future communications from Quest will be with the representative, rather than the Covered Person, unless the Covered Person directs, in writing, to the contrary.

J. PHYSICAL EXAMINATIONS

Quest reserves the right to have a physician of its own choosing examine any Covered Person whose illness or injury is the basis of a claim. All such examinations will be at the expense of Quest. This right may be exercised when and as often as Quest may reasonably require during the pendency of a claim. The Covered Person must comply with this requirement as a necessary condition to coverage.

XIII. COMPLAINT PROCESS

Quest has a process for Covered Persons to express Complaints. To register a Complaint, Covered Persons should call Quest at 800-364-6352; the telephone number is located on the back of the medical health insurance card, or write to Quest at the following address:

Quest Behavioral Health
Quality Management Coordinator
PO Box 1032
York, PA 17405

Most Covered Person's concerns are resolved informally at this level. However, if unable to immediately resolve the Covered Person's Complaint, Quest will initiate an investigation, and the Covered Person will receive a response in writing within thirty (30) days.

If you have any questions about this SPD you should contact the Plan Administrator or Quest 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 Quest Behavioral Health is as follows:

Quest Behavioral Health
PO Box 1032
York, PA 17405
800-364-6352

Vice President of Human Resources
University of Pennsylvania
3451 Walnut Street

600 Franklin Building

Philadelphia, PA 19104-6205
215-898-1334