Penn Medicine
Lancaster General Health

MENTAL HEALTH, CHEMICAL DEPENDENCY, AUTISM AND BEHAVIORAL HEALTH SERVICES

SUMMARY PLAN DESCRIPTION

prepared exclusively for
PENN MEDICINE LG HEALTH

by

QUEST
BEHAVIORAL HEALTH

Effective July 1, 2021

QUEST
BEHAVIORAL HEALTH

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INTRODUCTION
PENN MEDICINE LG HEALTH
BEHAVIORAL HEALTH BENEFITS

This Summary Plan Description ("SPD") summarizes the main terms of the Behavioral Health Benefits provided to eligible employees of Penn Medicine Lancaster General Health ("LG Health") and their dependents. Behavioral Health Benefits are administered by Quest Behavioral Health (Quest).

Behavioral Health Benefits are offered, pursuant to a self-funded, Administrative Services Only ("ASO") arrangement, under which LG Health assumes responsibility for the payment of benefits while receiving administrative services from Quest. Administrative services include the preparation of an administration manual, communication with employees, determination and payment of benefits, preparation of government reports, preparation of a Summary Plan Description and accounting. LG Health is liable for the financial (claims and related expenses) and legal aspects of Behavioral Health Benefits.

Quest will provide coverage for various Medically Necessary levels of care and *without the need of referrals from a primary care physician.* Please use this Summary Plan Description as a reference guide to familiarize yourself with all aspects of your Behavioral Health Benefits. For other important information relating to Behavioral Health Benefits, please refer to the "General Information" section of this handbook.

Important: If you are facing an emergency and must go to an emergency room, you do not need a referral from Quest. However, you (or your representative or your physician) must call Quest within 24 hours after Emergency care is given or as soon as possible.

About Quest Behavioral Health
Quest administers mental health and chemical dependency benefits to employees and their family members. Quest provides mental health and chemical dependency services that include inpatient, partial hospitalization, intensive outpatient, and traditional outpatient with licensed providers.

Quest Care Managers are available 24 hours a day / 7 days a week for urgent or emergent concerns. Services are available for employees, their families, and providers, to assist in determining the appropriate level of care and what resources are available.

Quest Care Managers can assist with referrals to a wide range of services, provide guidance on how to access treatment, and determine what is needed for authorization.

Eligibility
If you elect Medical Plan coverage under the available LG Health Medical Plans, you are eligible to receive the Behavioral Health Benefits described under this summary plan description for the LG Health Consumer and Select Plans. More specifically, Behavioral Health Benefits are available to eligible employees and their eligible dependents and COBRA members ("Covered Persons") who have properly enrolled in a LG Health Medical Plan.

For a more complete description of the Medical Plan's eligibility rules, you should refer to the LG Employee Health Benefit Program.

To inquire about eligibility and to review how your Behavioral Health Benefits work, call Quest Behavioral Health at 1-800-364-6352.

QUEST BEHAVIORAL HEALTH

LG Consumer Plan

July 1, 2021 – June 30, 2022

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	Tier 1	**Tier 2**	**Tier 3**
Deductible per Plan Year Deductibles accumulate across all Tiers. Deductible includes coinsurance (copays do not contribute to the deductible).			
Employee Only	$2,000		
Family (Aggregate)	$4,000 If family enrolled, family deductible must be met for family member to receive benefits		
Total Out of Pocket Maximum per Plan Year Out-of-Pocket maximums accumulate across all Tiers. Maximum includes Medical and Behavioral Health deductibles, co-payments and coinsurance. Non-covered services, precertification penalties, amounts over the *UCR*, etc. do not count toward the out-of-pocket maximum.			
Individual (Per Person)	$4,000		$6,000
Family (Embedded)	$8,000		$12,000
Covered Expense	**Tier 1**	**Tier 2**	**Out of Network**
Mental Health (MH) & Chemical Dependency (CD) Higher Levels of Care			
Ambulance Services Refer to SPD for coverage details	10% coinsurance after deductible		
Emergency Department/ Crisis Evaluation >Deductible waived if admitted >Non-emergency care excluded	20% coinsurance after deductible		
Mental Health Acute Inpatient **Chemical Dependency Detox & Short Term Residential (Rehab)** **Short Term Eating Disorder Residential** >Emergency Services - Notification required within 48 hours or next business day, whichever is later (Pre-Certification not required) > Non-Emergency Services - Precertification required - Failure to obtain prior authorization for non-emergent services will result in a $500 penalty >Eating Disorder (short-term and long-term) is limited to 180 days maximum benefit per enrolled individual, per plan year	10% coinsurance after deductible		40% coinsurance after deductible
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Professional Fees (Inpatient)	10% coinsurance after deductible		40% coinsurance after deductible
Outpatient and Telemedicine			
Outpatient >Pre-Certification is NOT required for standard OP visits. >Includes School-based counseling - In-Network ONLY	20% copay after deductible		40% coinsurance after deductible
Telemedicine Visit – PHP, IOP, Outpatient **Valid 7/1/2021 - 3/31/2022 ONLY** >Must submit claim with telemedicine modifier or POS code >Provider must be screened and approved by Quest for this modality (beginning 9/30/21)	20% copay after deductible		N/A
Specialized Treatment and Diagnostic Services			
Autism Spectrum Disorders >Authorization required	10% co-insurance after deductible		40% coinsurance after deductible
Electroconvulsive Therapy (ECT) >Pre-Certification required >Failure to obtain prior authorization will result in $500 penalty	10% co-insurance after deductible		40% coinsurance after deductible
Psychological Testing >Authorization required >Excludes educational, vocational, and learning disability testing	100% after deductible		40% coinsurance after deductible
Transcranial Magnetic Stimulation (TMS) >Authorization required	100%, after deductible **(Lancaster General Health and UPHS facilities ONLY)**	N/A	N/A

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Emergency inpatient admissions (through an ED): If the Tier 1 facility (within the NCQA travel distance of 60 minutes or 45 miles) has no available beds and the member is therefore diverted to a Quest Network facility, then that admission will be covered at the Tier 1 cost-sharing level. Care Management will assist in making this determination.

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HOW THE BENEFITS WORK

LG Health has entered into an agreement to allow Quest to manage and provide Behavioral Health Benefits through a broad network of licensed providers and hospitals affiliated with Penn Medicine or contracted third parties that are part of the Quest Network known as In-Network Providers.

The benefit period begins July 1 of each year and Covered Persons have the option of selecting either In-Network Providers or Out-of-Network Providers to access their Behavioral Health Benefits.

IMPORTANT

It is the Member's responsibility to ***verify the network status*** of Providers and Facilities ***before receiving treatment*** and to inquire with Quest about the need for ***Preauthorization before receiving treatment.***

In-Network Provider and Facility
In-Network Providers work directly with Quest to provide high quality and cost-effective services to LG Health Members. Utilizing In-Network Providers for your Behavioral Health needs allows you to lower your out-of-pocket costs and eliminates the need to submit Out-of-Network Claim forms. Note that some Covered Services still require Preauthorization.

Out-of-Network Provider and Facility
Out-of-Network Providers do not have a contract with Quest and, therefore, quality of cost-effective services cannot be monitored. Utilizing Out-of-Network Providers for your Behavioral Health Benefits will considerably increase your out-of-pocket costs and necessitate completion and submission of Out-of-Network Claim forms and supporting documents for reimbursement of Covered Services, some of which may need Preauthorization.

COVERED SERVICES

Covered Services are included in the Behavioral Health Benefit and delivered by Quest Network Providers and Facilities contracted to ensure appropriate, time-effective clinical treatment in a manner that is consistent with professional and ethical standards. National certification and state licensing boards, and applicable laws and/or regulations set standards for the performance of services regardless of a Member's benefit plan or terms of coverage.

Routine Services
Routine Behavioral Health Services *do not require Authorization* and include:

- Individual and Group Outpatient Therapy
- Medication Management by a Psychiatrist, Registered Nurse Practitioner, or Physician Assistant – Certified (PA-C)

Non-Routine Services
Authorization must be obtained from Quest for all non-routine Mental Health ("MH") or Chemical Dependency ("CD") higher level of care services within 24 hours from admission (or sooner) in order to assure Medical Necessity and benefit coverage of the proposed treatment. If not reasonably possible, Quest must be contacted by the Facility and, if appropriate, Quest will retroactively authorize coverage for the MH/CD Inpatient services covered by the benefit plan. Non-routine Behavioral Health Services include all treatment and services *that require authorization*, including:

Non-Routine Mental Health Services

1. Inpatient Mental Health
2. Short-term Eating Disorder Residential
3. Residential Treatment (e.g., eating disorder, mental health, autism). Limitation: 180 days *maximum* benefit per enrolled individual, per plan year.
4. Partial Hospitalization Programs
5. Intensive Outpatient Programs

Non-Routine Chemical Dependency Services

1. Inpatient Detoxification
2. Short-term Residential Rehabilitation
3. Residential Treatment. Limitation: 180 days *maximum* benefit per enrolled individual, per plan year.
4. Partial Hospitalization Programs
5. Intensive Outpatient Programs

Authorization for the above-listed non-routine covered services is obtained through contact between the Facility and a Quest Care Manager.

Crisis Evaluations and Emergency Admissions

Circumstances that warrant an emergency admission are those in which there is a clear and immediate risk to the safety of the Member or another person as a direct result of mental illness or substance use disorder.

Medically Necessary inpatient admissions following stabilization in an emergency room are subject to pre-certification. Failure to obtain a pre-certification may result in a reduction of benefits. If appropriate, Quest will retroactively authorize coverage for the emergency services. Refer to the Utilization Review Process section for proper procedure requesting preauthorization. Depending on the specific circumstances of each individual case, Quest reserves the right to deny coverage for all or part of an admission. All requests for retrospective reviews must be received by Quest within one year of the date services were provided to the member unless applicable law mandates otherwise.

Quest Care Managers process all requests for non-routine services and authorizations of coverage are based upon Quest Medical Necessity Criteria, organizational clinical guidelines and sound clinical judgment of the clinician processing the request.

Ambulance Services

Travel and/or transportation expenses when required for an emergency or for circumstances in which Quest has requested and arranged for you to be transferred by ambulance from one facility to another, whether or not it has been recommended or required to receive treatment out of area.

Specialized Services

Preauthorization must be obtained from Quest for all specialized services to assure Medical Necessity and benefit coverage of the proposed treatment. Quest has established specific administrative and coverage criteria for delivery of specialized services considered only after completion of a face-to-face or, when appropriate, a telemental health clinical assessment.

Preauthorization requests for specialized services can be initiated through telephone contact between the Member or Provider/Facility and a Quest Care Manager. In addition, the treating Provider must submit, when necessary, the appropriate clinical data with clear clinical documentation prior to provision of services.

All requests are carefully evaluated for Medical Necessity and reviewed by the Quest Care Manager and when necessary the Quest Clinical Director prior to generating authorizations for:

Inpatient and/or Outpatient Electroconvulsive Therapy (ECT)

ECT can be administered while a Member is hospitalized and can continue after discharge at the outpatient level of care. The process is initiated by contacting a Quest Care Manager for authorization. The referring Provider and/or the Provider administering treatment shall preauthorize the services with Quest Care Management. Requests are reviewed by the Quest Clinical Director if the Quest Care Manager requests review. Quest Care Managers, under the supervision of the Quest Director of Care Management and/or the Medical Director will communicate approval or denial of the request to the Provider via a telephone call and letter. If approved, authorization is generated for a portion of the treatment.

The provider administering ECT will then provide clinical updates to obtain ongoing required authorizations during the entire treatment. This process is valid for both In- Network and Out-of-Network Providers. Quest requires two in-network psychiatrists or one psychiatrist in conjunction with the Quest Medical Director to recommend ECT. If any of the psychiatrists are out of network, then they must meet Quest's credentialing criteria.

Psychological Testing

The process is initiated by completing the Quest Psychological Testing request form

(www.questbh.com). The referring provider and/or the provider administering the testing shall complete the form and submit it to Quest for approval. The request is reviewed by a Quest Care Manager in consultation with the Quest Clinical Director if needed. Doctoral-level staff, which includes a licensed psychologist, a school psychologist, as well as the Director of Care Management, may be utilized for approval. The approval or denial of the request is communicated to the Provider and Member via a telephone call and letter. This process is valid for both In-Network and Out-of-Network Providers.

School-based Counseling

School-based counseling performed by a network licensed provider, who meet Quest's credentialing requirements, may be covered according to in-network standard outpatient benefits.

Transcranial Magnetic Stimulation (TMS)

The approval process is initiated through the referring Provider and/or the treating Provider contacting Quest to request an authorization. The request is reviewed by Quest Care Management under the supervision of the Quest Director of Quest Care Management in consultation with the Quest Medical Director, if needed. The approval or denial of the request is communicated to the Provider and member via a telephone call and letter. If approved, authorization is generated for a portion of the treatment. When appropriate, the provider administering TMS will then submit a Midpoint Treatment Verification form to obtain authorization for the second portion of the treatment. This process may be applicable only to the LGH / UPHS network providers.

Autism Spectrum Disorder (ASD) Treatment

Autism services are continuing and ongoing. The process is initiated with Diagnostic Testing which is pre-authorized by Quest. Once diagnosed, the child is assessed, and a Treatment Plan is developed. The Treatment Plan must also be approved by Quest. Once the Treatment Plan is implemented, the child's progress is continually monitored by Quest Care Management.

It is critical for both In-Network and Out-of-Network Providers to obtain preauthorization from Quest to ensure the services requested are deemed Medically Necessary and appropriate and meet criteria and requirements set forth by Quest.

Authorizations are specific to the clinician/facility and payment for any specific CPT and/or HCPCS code is subject to ongoing medical necessity review.

Failure to obtain or otherwise follow the required administrative procedures for preauthorization may result in Quest, in accordance with applicable law, applying a reduction of payment to the Network Provider.

Payment reductions for failure to obtain preauthorization are solely the Network Provider's liability. Under no circumstances should a Member be billed for services provided by a Provider/Facility with the exception of any applicable deductible, co-payment, and co-insurance.

For all clinical procedural questions, contact Quest Behavioral Health at 1-800-364-6352. Coverage is subject to all terms, policies and procedures outlined in this booklet. Not all expenses are covered under the plan. Exclusions and limitations apply to certain services. The lack of a specific exclusion, that excludes coverage for a service, does not imply that the service is covered.

Exceptions

- Lancaster General Health BEHAVIORAL HEALTH employees (not spouses/dependents) may seek treatment with a Quest network provider and receive Tier 1 coverage due to privacy. This is for all levels of care. Quest must be informed that the member is a Behavioral Health employee.

- Emergency inpatient admissions (through an Emergency Department): If the Tier 1 facility (within the NCQA travel distance of 60 minutes or 45 miles) has no available beds and the member is therefore diverted to a Quest Network facility, then that admission will be covered at the Tier 1 cost-sharing level.

- Emergency inpatient admissions (through an Emergency Department) to an out of network facility may be treated at the Quest Network (i.e. Tier 2) level up to UCR with balance billing.

- If a specialized service or treatment is not available in-network but is available through an out-of-network provider, then that service can be treated at the Quest Network (i.e. Tier 2) level up to UCR with balance billing.

QUEST
BEHAVIORAL HEALTH

TREATMENT GUIDELINES

Treatment Guidelines are a set of objective and evidence-based behavioral health guidelines used to standardize coverage determinations, promote evidence-based practices, optimize clinical outcomes, and support Members' recovery and consistency in the authorization of benefits.

Treatment Guidelines are used to make Medical Necessity determinations and serve as guidance when providing referral assistance. Services are Medically Necessary when they are provided for the purpose of preventing, evaluating, diagnosing or treating a mental illness or substance use disorders, or their symptoms. Medically Necessary standards are based on credible scientific evidence published in peer-reviewed medical literature relying primarily on controlled clinical trials.

Treatment Guidelines utilized by Quest and the Quest Medical Necessity Criteria are based on the industry standard for admissions, continued stay and discharges to support the determination of facility-based treatments; and supplement, but not replace sound clinical judgment of the care management team. These criteria are revised from time to time and customized for Quest to address updated and most current standards to better assist the needs of the LG Health enrolled members.

Quest Medical Necessity criteria are available by calling 1-800-364-6352. Printed copies are provided upon request.

The Treatment Guidelines reflect Quest's understanding of current best practices of care, but they do not constitute medical advice. Quest reserves the right, in its sole discretion, to update and modify the Treatment Guidelines as necessary in accordance with industry standards.

Care Managers use Treatment Guidelines while considering the members presenting symptoms, clinical history, biopsychosocial factors, as well as the Member's benefit plan and availability of services. Services authorized reflect the treatment needs and support the Member's recovery and goals.

Quest also consults with experts in the field to determine whether health care services are Medically Necessary**.** The decision to apply expert provider recommendations, the selection of an expert and the determination of when to use any such expert opinion shall be within Quest's sole discretion.

Quest does not dictate treatment. Determinations of Medical Necessity support whether the benefit plan will pay for the cost of the behavioral health service, and so decisions are for payment purposes only. The Member and the Provider/Facility make decisions about the actual treatment the Member will receive. When making determinations about Medical Necessity, the information used is provided by the Network Provider/Facility to establish whether services are in accordance with standards of practice if they are clinically appropriate; and whether services are cost-effective and provided in the least restrictive environment.

Exceptions may be made when the Member's condition has not responded to treatment as anticipated. Exceptions are carefully evaluated, documented, and approved by the Quest Director of Care Management and/or the Medical Director. It is also expected that an effort will be made to work with the Provider to identify an appropriate level of care and forms of treatment that are most likely to be effective.

Clinical guidelines apply to each facility-based level of care and specialized services.

Clinical Assessment and Treatment Planning
Optimal treatment is attained when delivered in the setting that is both the least restrictive and the one with the greatest potential for a favorable outcome; a thorough clinical assessment is essential to treatment planning and must include:

1. The mental status exam including an evaluation of suicidal or homicidal risk;
2. A chemical dependency screening, noting any past and present substances abused and treatment interventions.
3. A biopsychosocial history including previous medical and behavioral health conditions, interventions, outcomes, and current and previous medical and behavioral health providers;
4. Developmental history;
5. Unique cultural and spiritual needs of the Member;
6. Education;
7. Legal issues;
8. Social support;
9. The reason the Member is seeking treatment at the requested level of care at this time;
10. Service options to meet the Member's immediate needs and preferences; and
11. The Member's broader recovery, resiliency and wellbeing goals.
12. The assessment helps to identify symptoms, conditions and co-morbidities that may be important to address in a comprehensive treatment plan based on the Member's presenting condition and is used to document realistic and measurable treatment goals as well as the evidence-based treatments that will be used to achieve the goals of treatment.

Effective treatment planning should take into account significant variables such as age and level of development, the history of treatment, whether the proposed services are covered in the Member's benefit plan and are available in the community. The Provider should also take into account the Member's preferences as might be directly expressed or documented in an advance directive or crisis plan. For some Members, treatment is part of a broader recovery and resiliency effort, so the recovery and resiliency goals which may be documented in a recovery plan should also be considered.

Reassessment
A change in the Member's condition should prompt a reassessment of the treatment plan and selection of level of care. The reassessment should determine whether the condition has improved, and if a less restrictive level of care may be adequate to continue treatment or whether treatment is no longer required. When a Member's condition has not improved, or it has worsened, the reassessment should determine whether the diagnosis is accurate, the treatment plan should be modified, and/or the condition should be treated at a different level of care.

Discharge Planning and Coordination of Care
Discharge planning begins at the onset of treatment when the Provider anticipates the discharge date and forms an initial impression of the Member's post-discharge needs. In-Network Providers and Facilities are required to pursue coordination of care with the Member's treating medical or behavioral health clinicians. A signed release of information must be obtained, and in the event that a Member declines consent to the release of information, the refusal and the reason should be documented, as well as information provided regarding the benefits of coordinated care, and the risks thereof.

Effective discharge planning enables the Member's safe and timely transition to the subsequent level of care and documents the services the Member will receive after discharge. The initial discharge plan may evolve in response to changes in the Member's condition. The final discharge plan should document:

- discharge date;
- service recommendations post-discharge;
- care coordination with the Provider at the next level of care;
- plan to reduce the risk of relapse, ***and***
- Member commitment to follow up with the discharge plan.

A timely first appointment post-discharge lessens the risk of relapse, therefore, when Members transition to the next level of care, their first appointment should be scheduled prior to discharge and based on clinical needs. This timeframe is in accordance with the HEDIS® standard for follow-up treatment after discharge from inpatient care. Quest assesses the compliance of its Network Facilities in meeting this standard on an annual basis and the compliance of its Members and Outpatient Providers about kept appointments.

Quest's Care Managers monitor discharge plans and are available to assist with identifying and facilitating access to available treatment services. Coordination of care, with a member's signed release of information, may improve the quality of care to Members in a number of ways. For example: -

1. allows behavioral health and medical providers to create a comprehensive care plan;
2. allows a primary care physician to know that his or her patient followed through on a behavioral health referral;
3. minimizes potential adverse medication interactions for Members who are being treated with psychotropic and non-psychotropic medication;
4. allows for better management of treatment and follow-up for Members with coexisting behavioral and medical disorders;
5. promotes a safe and effective transition from one level of care to another; and / or
6. reduces the risk of relapse.

QUEST
BEHAVIORAL HEALTH

UTILIZATION REVIEW PROCESS

Utilization Review is a program designed to help ensure that all Members receive necessary and appropriate behavioral health care while avoiding unnecessary expenses. The process is used to monitor utilization and quality of services a patient is receiving throughout the continuum of care.

Authorization
Facilities obtain Authorization on behalf of the Member upon admission, and Quest uses its admission Medical Necessity Criteria to make a determination.

Concurrent Reviews
A concurrent review at specific time intervals is intended to ensure and authorize appropriate treatment based on Medical Necessity

Retrospective Reviews
A retrospective review occurs when an initial request for Authorization or Preauthorization is made after services have already been delivered but no claim has been filed.

Retrospective review requests must be submitted up to a year from the date(s) of service unless otherwise mandated by applicable law. Requests for retrospective review must include information regarding the reason or circumstances preventing required Preauthorization and will be processed at Quest's sole discretion.

For all retrospective reviews, Quest will issue a determination within 30 calendar days of receipt of the request, unless otherwise required by applicable law. Any retrospective review requests received outside the established time frame may not be processed by Quest.

Verbal Preauthorization
This review concerns documenting the date and time Authorization and Preauthorization occurred, as well as the Quest Care Manager who spoke directly with the practitioner. This is usually provided to Facilities at the time of a concurrent review for Non-routine MH/CD facility-based Levels of Care.

Written Notice of Authorization of Coverage Determination
This Written notice is a confirmation of coverage based upon Medical Necessity and is available upon request. The approval letter may include:
1. the specific clinical rationale for the determination,
2. a description of the Member's presenting symptoms or condition, diagnosis, and treatment interventions,
3. a reference number,
4. the appropriate dates, and
5. the number of days/units of services authorized for pre-service claims or concurrent service claims.

Written Notice of Denial of Coverage Determination
This Written notice is a denial of coverage based upon Medical Necessity. The denial letter normally includes –
1. the specific clinical rationale for the determination,
2. a description of the Member's presenting symptoms or condition, diagnosis, and treatment interventions,
3. alternative treatment options/services covered under the Member's plan, if any, and
4. a description of the Member's appeal rights and how to initiate an appeal.

Written Notice of Denial of Payment

This Written notice outlines the reasons for payment denial and the instructions on how to initiate a provider appeal.

QUEST
BEHAVIORAL HEALTH

NON-COVERED SERVICES

Non-Covered Services not deemed Medically Necessary for the diagnosis, treatment of illness trauma, or restoration of mental health/chemical dependency impaired functions. Exclusions do not apply to covered preventive services or testing services other than specifically defined as reasons for non-authorization by Quest. Non-covered services include, but are not limited to:

- Services that are not in connection with a behavioral disorder, psychological injury, or substance use disorder;
- Services performed in connection with conditions that do not fit current DSM V criteria;
- Services that are not consistent with prevailing national standards of clinical treatment of such conditions, including but not limited to Quest standards;
- Services that are not consistent with prevailing professional research demonstrating measurable and beneficial outcomes, demonstrate less effectiveness than less intense or costly treatment alternatives, and/or do not result in outcomes demonstrably better than other available treatment alternatives that are less intense or more cost effective;
- Treatment that is Experimental or Investigative in nature, including testing or developmental, educational, vocational, employment, or occupational counseling, or candidacy for specific type or dosage of psychotropic medication;
- Treatment/services related to personal or professional growth/development, educational or professional training or certification, or treatment services required for Investigative purposes related to employment;
- Psychoanalysis;
- Treatment incurred after the date of termination of the Covered Person's coverage or prior to eligibility or enrollment in the plan;
- Services for which a Covered Person would have no legal obligation to pay
- Charges for any treatment that exceed Quest's reasonable and customary rates for Out-of-Network care;
- Additional treatment necessitated by lack of Covered Person's cooperation or failure to follow a prescribed plan of treatment;
- Treatment, except for initial diagnosis, of selected DSM V behavioral problems:
    a) cognitive rehabilitation,
    b) learning disabilities**,**
    c) mental retardation treatment that extends beyond traditional mental health and psychiatric treatment or for environmental or social change,
    d) special education including lessons in sign language to instruct a plan participant whose ability to speak has been lost or impaired;
- BEAM testing and neuropsychological testing when used for the diagnosis of Attention-Deficit/Hyperactivity Disorder;
- Psychological and/or neuropsychological or neuropsychiatric testing for
    a) learning disabilities/problems**,**
    b) school-related issues,
    c) the purposes of obtaining or maintaining employment;
    d) the purpose of submitting a disability application for a mental or emotional condition;
- Services not performed by a Provider;
- Career and financial counseling;
- 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;
- V-Codes;
- Prescription and non-prescription drugs;
- Forms of alternative treatment as defined by the Office of Alternative Medicine of National Institutes of

Health;

a) Herbal medicine,
b) Holistic or Homeopathic care,
c) Aromatherapy,
d) Ayurvedic medicine,
e) Guided Imagery (except when performed by a licensed provider during the course of treatment),
f) Massage therapy,
g) Naturopathy,
h) Relaxation therapy (except when performed by a licensed provider during the course of treatment),
i) Transcendental meditation and Yoga**;**
j) Acupuncture and Acupressure.

- Sedative action electro stimulation therapy;
- Sensitivity training;
- Twelve step model programs as sole therapy for eating disorder and addictive gambling;
- Recreational**,** educational, and sleep therapy, including any related diagnostic testing;
- Research studies;
- 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;
- Services for which the cost is later recovered through legal action, compromise, or claim settlement;
- Biofeedback;
- Charges made only because there is health coverage (e.g. School billing the health plan for behavioral health services rendered in the school setting not authorized).
- Completion of insurance forms;
- 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 for him or herself;
- 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;
- 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;
- Therapy or rehabilitation services including but not limited to

(a) primal therapy,

(b) chelation therapy

(c) Rolfing,

(d) psychodrama

(e) megavitamin therapy**,**

(f) purging**,**

(g) bioenergetic therapy,

(h) vision perception training,

(i) cognitive rehabilitative therapy,

(j) carbon dioxide therapy,

(k) confrontation therapy,

(l) crystal healing therapy,

(m) cult deprogramming,

(n) electrical aversion therapy for alcoholism,

(o) narcotherapy,

(p) orthomolecular therapy,

(q) music therapy,

(r) hyperbaric or other oxygen therapy,

(s) equine assisted therapy;
(t) aversion therapy;
(u) hypnosis, unless deemed medically necessary;
(v) diversional therapy or recreational therapy;
(w) holistic and/or naturopathic;

- Services**,** supplies and treatments for speech therapy due to developmental delay, school-related problems, apraxic disorders unless caused by an accident or episodic illness, stuttering, speech delay, articulation disorder, functional dysphonia, or speech problems resulting from psychoneurotic or personality disorders;
- Services, supplies and treatments that are considered unproven, Investigational or Experimental due to not meeting generally accepted standards of medical practice in the US. Availability of a service, device or treatment does not imply covered service under the Quest 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;
- Services performed or billed by residential therapeutic camps (e.g., wilderness camps, outward bound, halfway houses, boot camps, etc.);
- Treatment for truancy or disciplinary problems alone;
- Sex therapy without a DSM V diagnosis;
- Light boxes, wigs, beauty/barber services, or any other equipment, whether associated with a behavioral or non-behavioral health condition;
- Court ordered services or those required by as a condition of parole or probation, unless medical necessity criteria are met;
- Telephone consultations, unless due to a declared national or local emergency, quarantine or other public health safety mandate;
- Charges for missed appointments, completion of a claim form, for record processing; Custodial care, domiciliary care or rest care, except for the acute stabilization and return to baseline level of individual functioning.

  Care is determined to be Custodial Care when (a) it provides a protected, controlled environment for the primary purpose of protective detention, (b) it provides services necessary to assure competent functioning in activities of daily living, (c) the care provided or psychiatric treatment alone is not expected to reduce 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 non-compliance with treatment recommendations resulting in a situation in which there can be no reasonable expectation of a successful outcome;
- Genetic counseling and genetics studies not required for diagnosis that are not required for diagnosis or treatment of genetic abnormalities;
- Marriage or relationship counseling, unless patient has a covered diagnosis and conjoint or family therapy would help in the treatment of that diagnosis;
- Sex therapy unless associated with a behavioral health diagnosis;
- Nutritional counseling;
- 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;

- Gastric bypass psychological evaluation;
- Private duty nursing services while confined in a facility;
- Smoking cessation related services and supplies;
- Travel or transportation expenses unless otherwise specified;
- Treatment or services received prior to you being eligible for coverage under the Plan or after the date your coverage under the Plan ends;
- 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;
- Instances where benefits are provided to Members of the armed forces of any nation while on active duty by the Veterans Administration or by the Department of Defense;
- 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;
- Equipment costs related to services performed on high cost technological equipment as defined by the benefit plans, such as, but not limited to, computed 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**;**
- Charges for room and board in a facility for days on which the **Member** is permitted to leave (e.g., weekend pass)

Exclusions above will not apply when law requires the coverage of charges. 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.

Mentioning of the DSM V in this document does not indicate that all diagnoses present in the DSM V are covered services. Quest reserves the right to apply treatment limitations to some DSM V diagnoses.

QUEST
BEHAVIORAL HEALTH

COORDINATION OF BENEFITS

Members may be covered by more than one health care plan and Coordination of Benefits (COB) helps ensure delivery of Covered Services while avoiding overpayment by either plan.

If you are covered by more than one health plan, for example, you are covered under your employer plan as well as your spouse's health plan, the former is considered the primary insurance, while the latter is considered the secondary insurance. The primary insurance covers the major portion of the bill according to the plan allowances, while the secondary insurance covers any remaining allowable expenses. The benefits are thus "coordinated" among all of the health plans, and payments do not exceed 100% of charges for the covered services.

Quest processes claims using industry-wide COB standards and in accordance with benefit contracts and applicable state laws. If the Behavioral Health Benefit plan managed by Quest is determined to be primary, payment will be provided based on the benefit plan allowances. If the other plan is determined to be primary, Quest will cover any amount not covered by the other plan, up to Quest UCR, not to exceed the amount billed for the services rendered after all co-pays, co-insurance, and deductibles have been applied. Under no circumstances will a payment from Quest exceed the amount payable under the Behavioral Health Benefit plan managed by Quest if it were primary.

In order to determine which plan is primary, Quest follows the guidelines below:

1. If your other plan does not include rules for coordinating benefits, the other plan will be primary;
2. If your other plan does include rules for coordinating benefits:
   a) The plan covering the patient, other than as a dependent, shall be primary;
   b) When a covered dependent is a patient, the parent whose date of birth, excluding the year, occurs earlier in the calendar year shall be primary carrier, unless the parents are separated or divorced and there is no joint custody. In this instance, see 3, below;
   c) When a covered dependent is a patient, and the parents have the same date of birth, the plan which covered the parent longer shall be primary. However, if the other plan does not have the birthday rule, but a gender rule, and as a result, the plans do not agree on the order of benefits, then the rule in the other plan shall control which plan is primary, unless the child's parents are separated or divorced. In this instance, see 3, below.
3. Except as allowed in paragraph 4, below, if a dependent's parents are separated or divorced and there is no joint custody arrangement, the dependent's benefits are determined in the order as follows:
   a) First: If the parent with custody of the dependent has a plan, that parent's plan will provide the benefits.
   b) Second: If the parent with custody does not have a plan, then the plan of the spouse of the parent with custody will cover the dependent.
   c) Third: If (a) or (b) do not apply, then the plan of the parent not having custody of the child will cover the dependent.
4. When there is a court decree that establishes which parent shall be financially responsible for health care expenses of a dependent, and the plan covering the parent with such financially responsibility is aware of the court decree, then benefits of that plan are determined to be primary.
5. If divorced parents share joint custody, and the court decree does not state who is responsible for health care expenses, the Plan covering the dependent shall follow the order of benefit determination in 2, above.

6. The Plan covering a patient who is actively employed (one who is not laid off or retired) and the active employee's dependents, becomes the primary plan as opposed to a Plan that is covering a laid off or retired employee. However, if the other plan does not have the rule described above, and the Plans do not agree on the order of benefits, this rule does not apply.

ELIGIBLE SPOUSE RULE

LGH's plan will pay on a primary basis (pays first) when an employee enrolls his or her spouse and:

- that spouse has not been offered group health insurance by his or her employer; or
- that spouse has been offered group health insurance by his or her employer and the spouse's contribution is 50% or more of the total cost of the employer's single premium.

LGH's plan will pay on a secondary basis (pays second) when an employee enrolls his or her spouse and:

- that spouse has been offered group health insurance by his or her employer; and
- that spouse is required to contribute less than 50% or more of the total cost of the employer's single premium.
- When his/her spouse files a claim, he/she must follow the rules of his/her primary plan or risk no payment being made under the Lancaster General Health program.

AUDITS

Quest Behavioral Health representatives may conduct site visits at clinician offices**,** group offices, and facility locations**.** On-site audits are completed to address specific quality of care issues or in response to Member complaints about the quality of the office or facility environment.

PAYMENTS

Members are never to be charged in advance of the delivery of services by an in-network provider with the exception of an applicable copayment. Members should be billed for deductibles and coinsurance after claims processing yields an Explanation of Benefits indicating Member responsibility.

Filing Claims
Members are never required to file a claim when using an in-network provider. In-network providers will bill Quest directly and Quest will pay the provider directly. Members are only responsible for deductibles, co-insurance, and co-payments as they apply to your health benefit plan.

Out-of-Network Providers are not responsible to submit claims. Members are responsible to submit Out-of-Network claims with copies of itemized bills to Quest. Out-of-Network claim forms are available on the Quest website at www.questbh.com or can be obtained by mail or fax by calling 1-800-364-6352.

Quest complies with the Department of Labor's claim procedure regulations. In the event of any conflict between the benefit plan and those regulations, the latter will control. Changes in those regulations shall be deemed to amend the benefit plan, effective from the date of those changes.

Claims should be filed with Quest Claims Department within 90 days of the date charges for services were incurred; Quest will not accept claims filed more than one year from the date of completed services and these claims will be denied. Benefits are based upon your benefit plan at the time the charges were incurred.

Types of Claims
In determining if the claim for benefits should be treated as an urgent care claim, Quest will defer to the determination of treating provider that the claim should be treated as urgent, if timely provided to Quest.

Urgent Care Claims

Benefit Claims are considered "urgent" 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 will defer to the treating Provider to determine the urgency of a claim, if that determination is provided to Quest in a timely manner.

If a claim is considered urgent Quest will notify the Member of the benefit determination (whether adverse or not) no later than 72 hours from the time Quest receives the claim, provided sufficient information is received by Quest to make said determination.

If Quest fails to receive sufficient information to complete the claim determination, a request for additional information will be made no later than 24 hours after Quest receives the Urgent Care Claim. The notice may be verbal unless written notification is requested.

If sufficient information was not supplied, Quest will allow at least 48 hours to submit the specified information.

Upon receipt of all requested information, Quest will inform of its determination as soon as possible, but in no case later than 48 hours after the earlier of either:
(a) the receipt of the requested information
(b) the end of the 48-hour period afforded to provide the specified additional information

Pre -Service Claim

Pre-service claims are requests for approval necessary before obtaining treatment from a behavioral health provider, such as Preauthorization or a decision on whether a treatment or procedure is Medically Necessary.

In the case of a pre-service claim, Quest shall notify the Claimant of the benefit determination, whether adverse or not, within 15 days after receipt of the claim. This period may be extended one time by Quest for up to additional 15 days, provided Quest determines such an extension is necessary, prior to the expiration of the initial 15-day period.

If such an extension is necessary due to a failure of the Claimant to submit the information necessary to decide the claim, the notice of extension should specifically describe the required information, and the Claimant shall be afforded at least 45 days from receipt of the notice within which to provide the specified information. Notification of any adverse benefit determination pursuant to this paragraph shall be made in accordance with the procedure outlined in Section X.B (2), below.

Concurrent Care Claims

Concurrent care claims are requests for approval necessary for ongoing treatment from a behavioral health provider over a period or a number of treatments:

a. Any reduction or termination by Quest of the course of treatment (other than by amendment or termination) before the end of such period of time or number of treatments shall constitute an adverse benefit determination. Quest shall notify the Member, in accordance with Section X, below, of the adverse determination at a time sufficiently in advance of the reduction or termination to allow the Member to appeal and obtain a determination on review of that adverse benefit determination before the benefit is reduced or terminated.
b. Any request a Member makes to extend the course of treatment beyond the period of time or number of treatments that is a claim involving urgent care shall be decided as soon as possible, taking into account the medical exigencies. Quest shall notify the Member of the benefit determination, whether adverse or not, within 24 hours after receipt of the claim, provided that the claim is made to Quest at least 24 hours prior to the expiration of the prescribed period of time or number of treatments. Notification of any adverse benefit determination concerning a request to extend the course of treatment whether involving urgent care or not, shall be made in accordance with Section X.B(2), below.

Post-Service Claims

Post service claims are all other benefit claims after services have been provided, such as requests for reimbursement, or payment of the cost of the services provided.

In accordance with Section X, below, Quest will notify Claimants of adverse benefit determination within 30 days after receipt of the claim. This period may be extended one time by Quest for up to 15 days, provided that such an extension is necessary due to matters beyond the control of Quest and Quest notifies the Member, prior to the expiration of the initial 30-day period, of the circumstances requiring the extension and the date Quest expects to render a decision.

If such an extension is necessary due to failure to submit the information necessary, the notice of extension shall specifically describe the required information, and the Member shall be afforded at least 45 days from receipt of the notice to provide the requested information. The time required for a benefit determination shall begin when a claim is filed, regardless of whether all the information necessary to make a benefit determination accompanies the filing.

If an extension is needed due to a Member's failure to submit information necessary to decide a claim, the period for making the benefit determination shall begin on the date when the Member responds to the request for additional information. If the Member fails 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 benefits determination.

How to File a Claim

Covered Persons are never required to file a claim when In-Network Providers provide covered services. When Out-of-Network Providers provide covered services, Covered Persons will need to file a claim or have their Provider file a claim on their behalf in order to receive reimbursement. In some cases, at the discretion of Quest, arrangements may be made to have payments made directly to the provider such as in the case of a Facility Provider or other hospital setting.

Covered Persons can call the number listed on the back of their identification card, 1-800-364-6352, to receive guidance with filing claims.

The following information is required when completing the **Out-of-Network Claim Form (available at www.questbh.com)**:

a. Name of Subscriber
b. Employee (Primary Covered Member) ID#
c. Plan Name
d. Patient's Name, Date of Birth, Address, Phone Number
e. Out-of-Network Provider's Name, Degree/License, Address, Phone Number
f. Description of Dates and Services Rendered
g. Signatures

The itemized bill or original receipts are required and must include the following information:

a. Out-of-Network Provider's Name, Degree/License, Address, Phone Number
b. Tax I.D. number
c. Patient's Diagnosis (codes and description)
d. Services performed (codes) with associated charges
e. Dates of Service

The employee or covered individual (or their designated legal guardian/custodian) must:

a. Complete the claim form
b. Sign the claim form
c. Include all required information
d. Return the completed claim form with all itemized bills to the address below.

To expedite your claims processing, submit a "Clean Claim" to Quest. A claim is considered "Clean" if it includes all of the above-listed components.

Please return the completed Out of Network Claim Form with all itemized bills to:

Quest Behavioral Health
P.O. Box 1032
York, PA 17405

Providers submitting paper claims on behalf of the member can send to:
Quest Behavioral Health
P.O. Box 565
Arnold, MD 21012

APPEALS OF ADVERSE BENEFIT DETERMINATION

Plan 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 and:

1. Provide Claimants at least 180 days from the date of the adverse benefit determination to appeal;
2. Provide for a review that does not rely on the initial adverse benefit determination. The individual will not have been involved in the initial adverse benefit determination or a subordinate of any person previously consulted.
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, drug, 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 and provide for the identification of medical or vocational 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;
4. 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 or facsimile;
5. Give Claimants the right to review their claim file, including access to and copies of documents, records and other information relevant to their claim;
6. 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 Department of Labor guidance;
7. 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
8. 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.

QUEST
BEHAVIORAL HEALTH

Internal Review Timeline

1. Quest will conduct a review by an appropriate named fiduciary of the Plan who did not make the adverse determination that is the subject of the appeal, and who is not a subordinate of the person who made the adverse determination.

2. The fiduciary will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgement before making a decision on review of any adverse determination based in whole or in part on a medical judgment. The health care professional engaged will be an individual who has not been a consultant in connection with the adverse determination that is the subject of the appeal, nor a subordinate of any such individual.

3. Quest will identify any health care professional whose advice is obtained in connection with the review of the adverse determination regardless of whether or not said advice is relied upon when reviewing the adverse determination.
4. If an appeal does not involve a claim for urgent care, or pre-service care, Quest must notify the Claimant of the determination on appeal within a reasonable period of time, but not later than 60 days after receipt of the request for review. If Quest determines that special circumstances require an extension of time for processing the appeal, Written notice must be given to the Claimant prior to the termination of the initial 60-day period. The extension notice must indicate the special circumstances requiring an extension of time and the date by which the Plan expects to render the determination on review. The extension must not exceed a period of 60 days from the end of the initial period.
5. Quest must notify the Claimant of an *urgent care claim* of the Plan's appeal determination 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.
6. If the appeal involves a *pre-service claim*, Quest must notify the Claimant within a reasonable period of time appropriate to the behavioral health circumstance, but no later than 15 days after receipt of the Claimant's request for review.
7. For appeals involving *post-service claims*, Quest must notify the Claimant within 60 days of the receipt of each request for review.

Content of Internal Review Decision Notification

1. The Plan will provide Claimant with written notification of the Plan's decision regarding the Claimant's appeal.
2. If the Plan made an adverse benefit determination, 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

Information regarding available consumer assistance or ombudsmen established pursuant to the Patient Protection and Affordable Care Act (PPACA) 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. 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.

4. 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.
5. If the reviewer overturns the denial, Quest will reimburse for the treatment according to the stipulations set by the reviewer.
6. Requests for review of an initial denied claim must be submitted to:

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

Federal 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.

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 Quest benefit plan.

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.

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
Attn: Appeals Administrator
PO Box 1032
York, PA 17405

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.

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;

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:

a) 48 hours following the date of receipt of the notice for urgent care claims appeals, or
b) Until the end of the 4-month deadline in (C3), above to provide the necessary additional information

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.

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;
b) Based upon any new information received, the Plan may reconsider its final internal adverse determination. Reconsideration by the Plan will not delay the external review process. If the Plan 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 the Plan 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.

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 the Plan'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.

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:

a) 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.

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.

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 Quest as confirmation of the decision within 48 hours after the date of the notice.

Content of Federal External Appeal Decision Notification

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

a) 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;
b) The date the External Review Organization received the assignment to conduct the external review and the date of the External Review Organization's decision;
c) References to the evidence or documentation, including the specific coverage provisions and evidence -based standards, considered in reaching its decision;
    a) 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;
    b) 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;
    c) A statement that judicial review may be available to the Claimant; *and*
    d) 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.

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, the Plan, or an appropriate fiduciary of the Plan, will make a determination based on the information in its possession, which will likely result in an adverse benefit determination.

Failure to Follow Appeal Timeline

If the Plan 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 remedies externally under State or Federal law.

However, if a court deems the Plan's violation is minor and would not likely cause prejudice or harm and the Plan can demonstrate the violation was for good cause or due to matters beyond its control, the Plan 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 the Plan.

External Review Determination

A determination on external review is binding on the Plan 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 the Plan 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 the Plan to provide benefits or payment on a claim, the Plan will provide benefits or payment pursuant to the decision without unreasonable delay regardless of whether the Plan intends to seek judicial review of the decision, unless and until there is a judicial decision that provides otherwise.

Benefit Claims Litigation

A Covered Person must exhaust the Plan's claims and appeals process before commencing a court action pursuant to ERISA § 502(a) (1). However, if the Plan fails to establish or follow claims and appeals 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 the Plan 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).

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 Provider will not constitute appointment of that 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.

Physical Examinations

The Plan 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.

Complaint Process

The Plan has a process for Covered Persons to express Complaints. To register a Complaint, Covered Persons should call Quest at 1-800-364-6352; 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
P.O. 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 fifteen (15) days.

QUEST
BEHAVIORAL HEALTH

DEFINITIONS

ABUSE: Practices that directly or indirectly result in unnecessary costs to health care benefit programs. This includes any practice that results in the provision of services that:

- Are not Medically Necessary;
- Do not meet professional recognized standards for health care;
- Are not fairly priced.

AGREEMENT: A contract describing the terms and conditions of the contractual relationship between Quest and a Provider under which mental health, chemical dependency and Autism services are provided to Members.

ADVERSE DETERMINATION: A denial, reduction, termination, or failure to provide or make payment of services, in whole or in part, based upon:

- Determination of an individual's eligibility to participate in the Benefit Plan;
- Results of a utilization review by Quest Care Manager;
- Determination that the services provided are as Experimental, Investigational, or not Medically Necessary, or a Non-Covered Service

AFFORDABLE CARE ACT: The Patient Protection and Affordable Care Act of 2010 ("ACA"). For additional information, go to http://www.hhs.gov/healthcare/about-the-law/read-the-law/index.html.

APPEAL: A specific request by a Covered Person, or the Covered Person's representative or, in the case of the urgent care claims, a Provider, acting on the Covered Person's behalf upon written consent, to reverse a previous adverse decision or a potential restriction of benefit reimbursement made by Quest or its delegate.

AUTHORIZATION: The number of days/visits/services/units for which benefits have been applied as part of the Member benefit plan for payment. Authorizations are not a guarantee of payment and final determinations are made based on eligibility and the terms and conditions of the benefit plan when the service is delivered.

BEHAVIORAL HEALTH: Assessment and treatment of mental health, chemical dependency, and Autism disorders.

BEHAVIORAL HEALTH BENEFIT: The benefit offered by LG HEALTH to provide coverage for mental health, chemical dependency, and Autism services to its Members. The Behavioral Health Benefit is administered by Quest Behavioral Health on behalf of LG HEALTH.

BENEFIT PERIOD: The specified time as shown in the Schedule of Benefits during which charges for Covered Services must be incurred in order to be eligible for payment by Quest. 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/.

CARE MANAGER: A Quest employee who is a licensed clinical professional, such as a social worker or professional counselor, who works with Members, health care professionals, and physicians to maximize benefits available under a Member's benefit plan.

CHEMICAL DEPENDENCY INPATIENT DETOXIFICATION: A structured 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.

CHEMICAL DEPENDENCY SHORT-TERM RESIDENTIAL REHABILITATION: A short-term structured 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.

CHEMICAL DEPENDENCY RESIDENTIAL: A structured long-term sub-acute facility-based program which provides 24-hour/7-day assessment, diagnostic services, and active behavioral health treatment to Members for initiating the process of assisting a Member with gaining the knowledge and skills, needed to prevent recurrence of a substance-related disorder.

CLAIMANT: A Member or their representative who files a claim or formal request for payment to Quest for treatment services under the LG HEALTH's Behavioral Health Benefit plan.

CLAIMS:
Clean Claim**:** UB-04 or HCFA-1500 claim form submitted by a facility or clinician for health services rendered to a Covered Person which accurately contains all the following information:
Covered Person**'s** identifying information (name, date of birth, subscriber ID); Facility or clinician information (name, address, tax ID, NPI); date(s) and place of service; Valid ICD-9 code or its successor code; procedure narrative; Valid CPT-4 or revenue; Services and supplies provided; Facility charges.

Urgent Care Claims: A claim for benefits is considered "urgent" if not making a claim urgent could seriously jeopardize your life or health or your ability to regain maximum function or, in the opinion of a Provider with knowledge of your condition, would lead to worsening of your condition if you were not to receive the treatment which is the subject of the claim. Quest will defer to the attending provider to determine the urgency of a claim if that determination is provided to Quest in a timely manner.

Concurrent Care Review Claim: A claim relating to the continuation/reduction of an ongoing course of treatment.

Pre-service Claims: A claim for benefits is considered a pre-service claim if the claim requires approval in advance of obtaining the care in question.

Post-service Claims: A claim for benefits is considered a post-service claim if it is a request for payment for services or other benefits that you already received.

COINSURANCE: Applied after meeting the Deductible requirement, is the cost of covered behavioral health services the Member is financially responsible for, according to a fixed percentage of the approved amount.

CONTRACT ADMINIS TRATOR: A Quest professional dedicated to managing contractual relationships with hospitals, freestanding facilities and services, and Providers.

CO-PAYMENT: A specific charge the Member pays and is collected by providers and facilities at the time the behavioral health services are rendered. The Co-payment can be a flat dollar amount or a percentage of the cost of the approved behavioral health service.

COVERED PERSON: An enrolled Employee (also called Primary Covered Person or Subscriber) or his/her Dependents who have satisfied the criteria for eligibility.

COVERED SERVICES: Behavioral Health Care related hospitalization and services rendered by a licensed Behavioral Health Provider, the administration of which is provided by Quest and the expense is paid pursuant to the terms of the benefit plan.

CREDENTIALING: The process a provider must follow for approval to the network.

CRISIS CENTERS: Freestanding or co-located with another facility-based program that employ behavioral health professionals to deliver a range of 24-hour services in a less intensive level of care, including safe crisis stabilization with or without medication management, treatment recommendations, information about community resources, and assisted access to the next appropriate level when a Member's condition requires more intensive treatment.

DEDUCTIBLE: The annual amount of charges for behavioral health care services, as provided under your benefit plan, which a Covered Person is required to pay prior to receiving any benefit payment under the Covered Person's plan.

DIAGNOSTIC ASSESSMENT: Medically necessary evaluation that may include tests performed by a licensed physician or psychologist. Diagnostic Assessments includes initial assessments and re-assessments to determine or confirm diagnosis, review current or past treatment and to develop a treatment plan.

DSM V: Diagnostic and Statistical Manual of Mental Disorders is the standard classification of mental disorders used by mental health professionals in the United States.

ELECTROCONVULSIVE THERAPY (ECT): A treatment technique delivered in inpatient or outpatient settings, administered by a psychiatrist to perform ECT and an anesthesiologist that initiates 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: A clinical situation requiring an immediate response/evaluation due to safety threats to self and/or others, acute decompensation, chemical dependency with potential medical risk, or change in mental status. Quest follows the *"prudent layperson" emergency room policy* 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.

EMERGENCY, LIFE THREATENING: A critical condition requiring immediate intervention to prevent death or serious harm to the Member or others characterized by sudden onset, rapid deterioration of cognition, judgment, or behavior, and time limited in intensity and duration. The situation is so critical that the Member may not be able to access the needed intervention without assistance to transport. Situations requiring the

initiation of involuntary commitment proceedings are considered critical or life-threatening emergencies.

EMERGENCY, NON-LIFE THREATENING: A condition requiring rapid intervention to prevent acute deterioration of the patient's clinical state, such that gross impairment of functioning exists and is likely to result in a compromise of the patient's safety. Patients presenting with non-life-threatening emergencies can be triaged face-to-face within six (6) hours and the evaluation does not immediately require a secure environment.

ERROR: Mistakes, inaccuracies or misunderstandings that can usually be identified and fixed quickly.

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:

1. 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

2. 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
3. If reliable evidence shows that the drug, device, medical treatment or procedure is the subject of ongoing 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

4. 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

5. Any drug which the FDA has determined to be contraindicated for the specific treatment for which such drug is prescribed.

6. 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 chemical dependency treatment or procedure is not considered Experimental / Investigative if it meets all of the criteria listed below:
    a) Reliable Evidence exists that the drug, device, mental health, or chemical dependency 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 chemical dependency 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 chemical dependency outcomes, as defined above in paragraph C, is possible in standard conditions of mental health, and chemical dependency practice, outside clinical investigatory settings.

e) Reliable Evidence shows that the prevailing opinion among experts regarding the drug, device, mental health, or chemical dependency 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.

EXTERNAL REVIEW: An independent entity/individual retained by Quest to review adverse determinations based on Medical Necessity that has been appealed by, or on behalf of, a Member.

FACILITY: A licensed institution that provides inpatient, residential, or ambulatory services and has contracted to deliver behavioral health care services to Members (also known as a network facility). Such facilities include:

- Hospital
- Free Standing Ambulatory Care Facility
- Non-Hospital Facility
- Psychiatric Hospital
- Residential Treatment Facility (short-term)

FREE STANDING FACILITY: A facility that provides treatment other than a Hospital. The Free-Standing Care Facility shall be licensed by the state in which it is located for the level of care requesting payment and be accredited by the appropriate regulatory body, most commonly The Joint Commission or CARF.

FRAUD: Intentional misrepresentation or concealing facts to obtain something of value. The complete definition has three primary components:

- Intentional dishonest action or misrepresentation of fact;
- Committed by a person or entity;
- With knowledge that the dishonest action or misrepresentation could result in an inappropriate gain or benefit.

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 are 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/.

HEDIS: The Healthcare Effectiveness Data and Information Set (HEDIS®) is a tool used by more than 90 percent of America's health plans to measure performance on important dimensions of care and service.

HIPAA: The Health Insurance Portability and Accountability Act is a set of national standards set for, the protection of certain health care information. The standards address the use and disclosure of an individual's "Protected Health Information" (PHI) by organizations subject to the Privacy Rule ("covered entities"). These standards also include privacy rights for individuals to understand and control how their health information is used.

HOSPITAL: With regard to a behavioral health facility, a health care institution that provide 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.

Some Hospitals specialize in short term or outpatient therapy. Others specialize in temporary or permanent care for patients who require routine assistance or a specialized and controlled environment.

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 chemical dependency 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.

MEMBER: An eligible employee and eligible dependent who is participating in the benefit plan.

NETWORK MANAGER: A Quest professional who provides services and information to Providers and assists the Quest clinical department to contract and retain experienced and licensed mental health and

substance abuse treatment professionals.

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.

OUT-OF-NETWORK: A facility, individual provider, or group provider, who does not have a contract with Quest and therefore is not included in the Quest Network.

OUT-OF-POCKET: The amount a Member is responsible to pay annually based upon the amounts listed on the benefit schedule, based on the Individual Plan, Individual & Spouse Plan, or the Individual & Children Plan.

OUT-OF-POCKET MAXIMUM: The maximum amount a Member may pay for Out-of-Network Behavioral Health Services.

OUTPATIENT: Assessment, diagnosis and active behavioral health treatment for mental health and chemical dependency 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 services may include in-person or HIPAA-compliant audio-visual platforms.

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, chemical dependency related disorders, or the treatment of co-occurring mental health and chemical dependency disorders.

PLAN: LG HEALTH's Medical Plan that allows for Behavioral Health Benefits to be available to eligible employees, their dependents, retirees, and COBRA members.

PLAN OF TREATMENT: A plan of care that 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 Necessary for the Covered Person's diagnosis and condition.

PREAUTHORIZATION: Providers and Facilities are required by the Plan to contact Quest with clinical information to determine benefit coverage and Medical Necessity of Members accessing non-routine outpatient services and inpatient admissions. Preauthorization should occur prior to the delivery of services or as soon as reasonably possible for an emergency admission. A Preauthorization is not a guarantee of payment and final determinations are made based on eligibility and the terms and conditions of the benefit plan when the service is delivered

PROVIDER: Licensed individual or group of professionals, psychiatrists, psychologists, psychiatric nurses, clinical social workers, or other master level mental health/chemical dependency clinicians contracted with Quest to deliver behavioral health care services to Members. Also includes a person, entity, or group providing services for the treatment of autism spectrum disorder that is "Licensed" or "Certified" in the state in which they practice.

PSYCHIATRIC CRISIS : Members determined to require immediate psychiatric evaluation in the absence of remarkable medical issues who go to crisis centers or freestanding mental health facilities that provide 24-

hour evaluations, assessment and stabilization to changes in the Member's signs and symptoms, psychosocial and environmental factors, or level of functioning.

PSYCHOLOGICAL TESTING: 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.

QUALITY ASSURANCE: Formal set of activities to review and affect the quality of services provided. Quality Assurance includes assessment and corrective actions to remedy any deficiencies identified in the quality of direct patient services. Federal and state regulations typically require health plans to have Quality Assurance programs.

QUALITY IMPROVEMENT: Continuous process that identifies opportunities for improvement in health care delivery, tests solutions, and routinely monitors solutions for effectiveness.

USUAL AND CUSTOMARY RATE (UCR): The amount that is the usual or customary charge for the service or supply as determined by Quest; the chosen standard is Medicare reimbursement rates plus 10%, or Resource Based Relative Value Studies (RBRVS). Also called Reasonable and Customary, if a Medicare reimbursement rate does not exist, Quest determines what is reasonable and customary by the severity and/or complexity of the patient's condition for which the service is provided.

RELEASE OF INFORMATION: An authorization signed by the member allowing the use and disclosure of protected health information to specific medical treatment or consultation, billing or claims payment, or other purposes the member may direct.

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

RESIDENTIAL TREATMENT – Mental Health / Eating Disorder / Autism: 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.

RETROSPECTIVE REVIEW: When services that require authorization or Preauthorization emergent or other unusual circumstances interfere with the Preauthorization processes. Requests for a retrospective review of services must be submitted within 180 calendar days of the date(s) of service.

ROUTINE CARE: Those situations in which the Covered Person is not in imminent danger and where further deterioration and crisis is *not* likely to occur before accessing treatment.

SUBSCRIBER: An employee who meets the eligibility requirements for enrollment, also called Covered Person or Member. However, not all covered persons or members are subscribers (i.e. dependents).

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.

TREATMENT GUIDELINES: Objective, evidence-based admission and continuing stay criteria for MH/CD services intended to standardize Care Management decisions regarding the most appropriate and available level of care needed to support a Member's path to recovery.

URGENT CARE: An urgent situation is less clinically compelling than an emergent situation; management of the situation is considered most effective when a face-to-face contact occurs within a short period after the request for service. The clinical situation would likely deteriorate and escalate to an emergent situation if the patient were not seen within 48 hours or less.

WASTE: Inaccurate payments for services, such as unintentional duplicate payments, and can include inappropriate utilization and/or inefficient use of resources.

QUEST
BEHAVIORAL HEALTH

Plan Information

Name of Plan:

Penn Medicine Lancaster General Health Mental Health, Chemical Dependency, Autism and Behavioral Health Services Summary Plan Description

Name, Address and Phone Number of Employer/Plan Sponsor:

Lancaster General Health
555 North Duke Street
Lancaster, PA 17604-3555
717-544-5511

Employer Identification Number:

23-2250941

Plan Number:

501

Type of Plan:

Welfare Benefit Plan: behavioral health

Type of Administration:

Contract administration: The processing of claims for benefits under the terms of the ***Plan*** is provided through one or more companies contracted by the ***employer*** and shall herein after be referred to as the ***claims processor***.

Name, Address and Phone Number of Plan Administrator, Fiduciary, and Agent for Service of Legal Process:

Chief Human Resources Officer
Lancaster General Health
555 North Duke Street
P.O. Box 3555
Lancaster, PA 17604-3555
717-544-5511

Legal process may be served upon the ***plan administrator***.

Source of Plan Contributions:

Contributions for ***Plan*** expenses are obtained from the ***employer*** and from covered ***employees***. The ***employer*** evaluates the costs of the ***Plan*** based on projected ***Plan*** expenses and determines the amount to be contributed by the ***employer*** and the amount to be contributed by the covered ***employees***.

QUEST
BEHAVIORAL HEALTH

Funding Method:

The ***employer*** pays ***Plan*** benefits and administration expenses directly from general assets. Contributions received from ***covered persons*** are used to cover ***Plan*** costs and are expended immediately.

Ending Date of Plan Year:

June 30

Procedures for Filing Claims:

For detailed information on how to submit a claim for benefits, or how to file an appeal on a processed claim, refer to the section entitled, *Filing Claims.*

The designated ***Claims Processor*** for behavioral health claims is:

Quest
P.O. Box 565
Arnold, MD 21012

IMPORTANT

Lancaster General Health's Employee Benefits Plan is comprised of several components, which may include medical, dental, vision, prescription drug benefits and those plan documents will prevail for the applicable component programs. For details on those component programs and related documentation, contact Human Resources – Benefits Dept.