The City of Montgomery

Mental Health and Substance Abuse Benefits Handbook

Effective June 1, 2022, through May 31, 2023

Important Information

The benefits described in this Mental Health and Substance Abuse Benefits Handbook (Handbook) are provided in conjunction with The City of Montgomery Group Health Plan. Please refer to The City of Montgomery Group Health Plan booklet for important additional information such as eligibility, enrollment, privacy, and security of your protected health information, and COBRA rights. This Handbook is considered to be a supplement to The City of Montgomery Group Health Plan Summary Plan Description (SPD), which may be the same document as the group health plan booklet discussed above.

This is not an insured benefit plan. The mental health and substance abuse benefits described in this Handbook are self-insured by The City of Montgomery Group Health Plan. Uprise Health American Behavioral provides utilization management, claim administration, and provider *network* services to the plan, but Uprise Health American Behavioral does not insure the benefits described in this Handbook.

Mental Health Parity and Addiction Equity Act

Every effort is made to ensure that this Mental Health and Substance Abuse Benefits Handbook complies with the requirements of the Mental Health Parity and Addiction Equity Act (Parity). However, if we determine that a provision does not comply with Parity or there are legislative or regulatory changes to Parity rules, we may immediately implement benefit changes that are not reflected in this Handbook.

Welcome Employees and Family Members

We are pleased that The City of Montgomery has selected Uprise Health American Behavioral to serve as your behavioral health care benefits administrators.

Since its inception in 1990, Uprise Health American Behavioral has earned a continuing solid pattern of growth, achieving success as a managed behavioral health organization through responsive, flexible service to businesses, industries, employees, and families. Uprise Health American Behavioral currently serves corporations throughout the United States.

Uprise Health American Behavioral has developed a model of care that encompasses planning, educating, monitoring, and coordinating access to care while maintaining and improving quality of service. From outpatient visits to inpatient care, Uprise Health American Behavioral is there every step of the way to ensure that you and your loved ones receive the appropriate level and type of care.

Managed Behavioral Healthcare Services

A managed behavioral healthcare program is available to provide additional resources when needed. It is a program of care designed to provide disorder identification, clinical treatment referrals, and crisis intervention for employees and family members who experience clinical mental health or behavioral conditions such as:

- Adjustment disorders
- Attention deficit disorder
- Anxiety disorders
- Mood disorders
- Alcohol and/or substance abuse disorders

Uprise Health American Behavioral has a large *network* of providers who are credentialed in a variety of areas to meet your needs and provide clinical assistance in your area of concern. Providers include psychiatrists, psychologists, nurse practitioners, clinical social workers and licensed professional counselors, among others.

The following levels of care are available through this program:

- Crisis assessment
- Outpatient treatment
- Intensive outpatient treatment program
- Partial *hospitalization*/day treatment program
- Acute psychiatric inpatient *hospitalization*
- Detoxification services
- Electroconvulsive therapy
- Care management.

This document contains valuable information about the specific benefits available through your program along with descriptions and definitions of available services. We look forward to assisting you in your behavioral health care needs.

Note: Italicized words in this document indicate terms that are defined in the Glossary.

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Important Contact Information

Do You Have Questions?

Please call Uprise Health American Behavioral at 1-800-677-4544 for assistance with any questions you have concerning the provisions outlined in this Handbook. If needed, a translation service will be available to assist you.

TTY Services for the Hearing or Speech Impaired

Call the Nationwide Relay Service at 711.

Birmingham Office

Uprise Health American Behavioral
2204 Lakeshore Drive, Suite 135
Birmingham, Alabama 35209

Telephone: 1-205-871-7814
Toll Free: 1-800-677-4544
Fax: 1-205-868-9625

Web Site

www.americanbehavioral.com

Online Mental Health Appointment Requests

www.americanbehavioral.com

Uprise Health American Behavioral Web Portal

The portal gives you additional access to clinical services and ease of obtaining *network provider* information. Additionally, you can access up-to-date *deductible* and *out-of-pocket maximum* amounts.

Other actions you can perform through the Member Web Portal include:

- Submitting claims for reimbursement;
- Changing demographic information;
- Tracking requests; and
- Contacting Uprise Health American Behavioral.

You can also view the following information:

- Authorizations;
- Claims;
- Pending Requests;
- *Explanation of Benefits* (EOB's);
- Coverage and Benefits Overview; and
- Detailed Coverage and Benefits.

To register for the Member Web Portal, go to **https://members.ibhsolutions.com/**. Enter your last name and date of birth, then verify your employer's name. Once you submit your information, it will be validated for access. An e-mail notification will be sent to the address you provide.

Finding a Behavioral Health Care Provider

How to Find a Network Provider

As an Uprise Health American Behavioral *member*, you have access to a *network* of providers. To find a *network provider*, call Uprise Health American Behavioral at 1-800-677-4544.

Using Out-of-Network Providers Costs You Money

IMPORTANT: Some benefit packages provide coverage for treatment by out-of-network providers. However, *out-of-network providers* do not have an agreement with the Plan, so you could be *balance billed* and responsible in part or in full for the cost of the services provided.

See your Summary of Mental Health and Substance Abuse Benefits included with this Handbook to verify availability of out-of-network coverage. If you have such coverage, you can get an estimate of your out-of-pocket costs by calling Uprise Health American Behavioral at 1-800-677-4544 before services are rendered.

Covered Provider Types

The Plan pays for covered services only when performed by the following *covered provider types*:

Mental Health

- Licensed clinical therapists;
- Neuropsychologists
- Physician assistants;
- Psychiatrists;
- Psychiatric nurse practitioners; and
- Psychologists.

IMPORTANT: A provider can be a *covered provider type* but not a *network provider*. Call Uprise Health American Behavioral at 1-800-677-4544, and one of our associates will assist you with finding an in-network provider.

All *network providers* are *covered provider types*. If you see an *out-of-network provider* that is not a *covered provider type*, the Plan will not pay for any of the services received. As with all noncovered services, any payments you make to a noncovered provider type will not apply toward your *deductible* or *out-of-pocket maximum*.

Benefits: What the Plan Covers

Guidelines for Coverage

The fact that a physician or other provider prescribes, orders, recommends, or provides a service or supply does not mean it is covered. The following section describes benefits provided by this Plan. Be sure to read it carefully for important information that can help you get the most from your behavioral health coverage.

For the Plan to cover a service, it must meet all of the following conditions. The service is:

- Listed as covered;
- *Medically necessary*; and
- Consistent with the Plan's coverage policies and pre-certification requirements.

Even if a specific benefit is not covered, you and your provider may decide that the care and treatment are necessary. You and your provider are responsible for making this decision.

List of Benefits

IMPORTANT: Some of the services described in the List of Benefits may not be applicable to your specific benefit package. Please see your Summary of Mental Health and Substance Abuse Benefits included with this Handbook for specific coverage information. If you have any questions, please call Uprise Health American Behavioral at 1-800-677-4544.

Mental Health and Substance Abuse Services

Mental illnesses are serious disorders that can affect your thinking mood and behavior. There are many causes of these disorders. Your genes and family history may play a role, as well as life experiences, such as stress or a history of abuse. Biological factors can also play a role in mental illness.

Chemical dependency is a chronic, progressive disease which, if left untreated, can lead to life-threatening health problems and premature death. Chemical dependency also causes severe problems in other life areas, such as the familial, psychological, emotional, social, vocational, and spiritual aspects.

The following benefits are provided to address mental illnesses and substance abuse:

Personal Care Management for Complex Health Care Needs

Care management is a service offered by the Plan to assist you with your behavioral health care needs. You have a personal care manager who acts as your advocate, assisting you whenever you have questions or concerns.

This voluntary service helps you navigate the healthcare system and evaluate your health care goals. Your personal care manager helps you by identifying issues and barriers that may prevent you from getting better, as well as providing motivational support for chronic

behavioral and/or medical conditions.

Call Uprise Health American Behavioral at 1-800-677-4544 to talk to your personal care manager.

Co-occurring Disorders

Programs are available for the treatment of co-occurring disorders. Formerly known as dual diagnosis, co-occurring disorders describe the presence of one or more disorders relating to the use of alcohol and/or other drugs of abuse as well as one or more mental disorders.

Crisis Assessment

Crisis assessment is an immediate, face-to-face assessment by a mental health professional during an urgent situation. The assessment helps identify any need for emergency services, crisis intervention, or referrals to other resources.

Day Treatment/Partial *Hospitalization* Program (PHP) Services

The Plan covers PHP services, which are provided while you reside in your community and not as part of a 24-hour-per-day program. PHP services include nursing, psychiatric evaluation and medication management, group and individual/family therapy, psychological testing, substance abuse evaluation and counseling. This highly structured level of treatment includes up to eight (8) hours of clinical services per day.

Facilities providing PHP services must be licensed by the state and accredited and certified by an appropriate, nationally-recognized accrediting agency.

NOTE: *Precertification* is required for PHP services.

Electroconvulsive Therapy (ECT)

ECT treatments are administered by a specially trained psychiatrist for a therapeutic effect. ECT treatments are provided in an outpatient *facility* or, when necessary, during an acute inpatient *hospitalization*.

Inpatient *Hospitalization*

Acute inpatient *hospitalization* includes structured treatment services and 24-hour on-site nursing care and monitoring. You can expect an evaluation by a psychiatrist within the first 24 hours of the admission. Daily, active treatment by a psychiatrist supervising the plan of care is required.

Services are considered "inpatient" when you spend the night in a hospital. Inpatient treatment is provided in a secure, protected hospital setting, and is indicated for stabilization of individuals displaying acute mental health and/or substance abuse conditions.

Facilities providing inpatient services must be licensed by the state and accredited with The Joint Commission.

Inpatient Substance Detoxification

Inpatient substance detoxification is a serious medical process usually taking 3-5 days. Detoxification is aided by medications that prevent severe complications.

Facilities providing inpatient services must be licensed by the state and accredited with The Joint Commission or CARF.

Catastrophic Inpatient Hospitalization

A *catastrophic inpatient hospitalization* involves a chronic condition for which long-term stabilization is needed, as indicated by a length of stay greater than 12 days.

IMPORTANT: Some hospital-based physicians who work in a *network* hospital or other *facility* may not be network providers. If an *out-of-network provider* bills separately from the hospital, and his or her billed charges are more than the *allowed amount*, you may be billed for the difference in addition to your *co-insurance*.

NOTE: Pre-admission certification is required for all hospital admissions except emergency hospital admissions. For emergency hospital admissions, Uprise Health American Behavioral must receive *notification* within 48 hours of admission. Please see the Limits on Plan Coverage section of this Handbook and the Summary of Mental Health & Substance Abuse Benefits included with this Handbook for additional information.

Intensive Outpatient Program (IOP) Services

The Plan covers IOP services which are provided while you reside in your community and not as part of a 24-hour-per-day program. Treatment in an IOP includes individual therapy, group therapy, family and/or multi-family therapy and psycho-education to decrease symptoms and improve your level of functioning. Depending on the structure of the program, IOP occurs up to five (5) times per week for up to four (4) hours each session.

Facilities providing IOP services must be licensed by the state and accredited with The Joint Commission or CARF.

NOTE: *Precertification* is required for IOP services.

Medication Management

Medication management is a service to determine your need for a prescribed drug, or to evaluate the effectiveness of the prescribed drug as noted in your written individual treatment plan. It is provided by psychiatrists or nurse practitioners specializing in treating mental disorders using the biomedical approach.
NOTE: Please see your prescription coverage for the cost of specific medications.

Office Visits

NOTE: Most *office visits* do not require pre-authorization. Call Uprise Health American Behavioral at 1-800-677-4544 if you have any questions about pre-authorization requirements.

Psychological and Neuropsychological Testing

Psychological testing is a process that uses a combination of techniques to help arrive at a diagnosis based on your behavior, personality, and capabilities, while neuropsychological testing includes specifically designed tasks used to measure a psychological function known to be linked to a particular brain structure or pathway.

IMPORTANT: Both psychological and neuropsychological tests must have sound psychometric properties including empirically substantiated reliability, validity, standardized administration, and clinically relevant normative data based on age, educational attainment, and when relevant ethnicity and gender.

IMPORTANT: Psychological testing must be performed by a licensed clinical psychologist, and neuropsychological testing must be performed by a licensed neuropsychologist.

NOTE: Psychological and neuropsychological testing must be precertified.

Psychotherapy

Psychotherapy is covered when it is provided by a licensed behavioral health provider in order to treat a mental health or substance abuse disorder. Brief, goal-directed talk therapy may be implemented for individuals, groups, and families.

Residential Treatment

IMPORTANT: Treatment in a residential *facility* is not covered by this Plan. However, the following definition is included to distinguish residential treatment from other levels of care.

Treatment in a residential *facility* provides multidisciplinary treatment under medical leadership and supervision. It is an alternative treatment option when a patient's condition does not improve with community resources and/or outpatient treatment.

Treatment is implemented by a team of mental health and/or substance abuse professionals with graduate level training, including a psychiatrist who visits with the resident at least weekly or more frequently if clinically indicated. The psychiatrist also meets face-to-face with the mental health and/or substance abuse professionals on a weekly basis as a treatment team. The team assesses patient progress and modifies the treatment plan when necessary.

Residential treatment provides resources for the developmental, emotional, physical and educational needs of each resident, including intensive mental and physical health care, as well as access to on-going education at the appropriate developmental levels. Different modalities of evidence-based treatment are utilized that are specific to the resident's psychiatric and/or substance abuse, educational, developmental, and medical disorders.

Residential treatment programs must be licensed by the state.

Note: Wilderness programs are not considered residential treatment programs.

Second Opinions

If there is uncertainty about your diagnosis or uncertainty about your course of treatment, you have the right to a second opinion. All copays, coinsurance and *deductibles* apply.

Limits on Plan Coverage: Notification and Precertification

Precertification is when your provider sends a request for coverage of a service before it occurs, and the Plan sends either an approval or denial of coverage. If services that require *precertification* are not approved before being provided, no benefits will be payable for the admission or the services provided by the admitting physician.

Receiving *precertification* does not necessarily mean that the services you receive are covered. For example, your admission may relate to a benefit that is *excluded* from coverage.

Notification means that your provider must contact the Plan to let us know when you receive services.

FOR MORE INFORMATION: If you have a question concerning *notification* or *precertification* requirements, call Uprise Health American Behavioral at 1-800-677-4544.

What the Plan Does Not Cover

This Plan covers only the services and conditions specifically identified in this Mental Health and Substance Abuse Benefits Handbook. Unless a service or condition fits into one of the specific benefit definitions, it is not covered, even if your provider says the services are *medically necessary*. Non-covered services are known as *exclusions*.

General Exclusions

A____

1. **Achievement testing**
2. **Acupressure or acupuncture**
3. Provider **administrative fees, including,** but not limited to, charges for any of the following:

- Completing forms, including claims
- Copying records
- Report preparation
- Finance charges
- Obtaining medical records
- Completing a treatment report
- Late payment charges

4. **Alternative therapy** or treatment methods that do not meet national standards for behavioral health practice, including, but not limited to:

   - Regressive therapy
   - Neuro-feedback
   - Neuro-biofeedback
   - Hypnotherapy
   - Massage therapy
   - Reiki
   - Thought-field Energy
   - Art or dance therapy
   - Marathon therapy
   - Motivational training
   - Personal growth and development

5. **Animal-assisted therapy** (e.g. equestrian therapy)
6. **Applied Behavior Analysis (ABA)**
7. **Aroma therapy**
8. **Aversion therapy**

B

1. **Biofeedback**
2. **Bio-energetic therapy**

C

1. **Carbon dioxide therapy**
2. Any services or expenses for which a **claim is not properly submitted**
3. Any services or expenses for which a **claim is not filed in a timely manner**
4. Any services or expenses incurred during treatment provided primarily for **clinical trials**, medical or other research
5. Any services or expenses for treatment of mental health or substance abuse conditions that by Federal, state or local law must be treated in a public *facility*, including, but not limited to, **commitments for mental illness**
6. **Confrontation therapy**
7. Any services or expenses incurred during the course of **convalescent care**
8. Any services or expenses incurred during the course of **court-ordered treatment**, unless it is determined that such services are *medically necessary* based on *medical necessity* criteria for the purpose of treating a mental health or substance use disorder, and there is reasonable expectation of improvement of the patient's condition or level of functioning
9. Services delivered by providers not listed as ***covered provider types*** (See the section of this Handbook entitled Finding a Behavioral Health Care Provider, subsection *Covered Provider Types*)
10. Any services or expenses for treatments that are not otherwise **covered services**. Examples include, but are not limited to, when such services or expenses related to the following:
    - Adoption
    - Camp
    - Career
    - Custodial evaluation
    - Education
    - Employment
    - Forensic evaluation
    - Insurance

- Marriage
- Medical research
- Obtaining or maintaining a license of any type
- Sports
- Travel
- Wilderness programs

11. **Crystal healing therapy**
12. Any services or expenses incurred during the course of **cult deprogramming**
13. Any services or expenses incurred during the course of **custodial care** or supportive counseling, including care for conditions not typically resolved by treatment

D

1. Any services or expenses related to treatment provided for **dental, medical, or psychiatric care** not routinely required in the course of chemical dependency treatment
2. Any services or expenses related to **disabilities related to military service** for which the *member* is entitled to service and for which facilities are reasonably available to the *member*
3. Any services or expenses incurred during the course of **domiciliary care**

E

1. Any services or expenses related to non-psychiatric therapy or **education** for autism, intellectual disability (formerly mental retardation), learning disabilities/disorders, or developmental disorders, including social skills training
2. **Educational or professional growth training** or certification related to employment
3. Any services that are primarily to assess or address **remedial educational disorders**, including, but not limited to, materials, devices, and equipment to diagnose or treat learning disabilities
4. Any services or expenses incurred during the course of investigative services related to **employment**
5. Any services or expenses incurred in order to obtain or maintain **employment**
6. Services, care or treatment received after the **ending date of the *member's* coverage**
7. **Experimental, investigational or unproven** means any drug, service, supply, care or treatment that, at the time provided or sought to be provided, is not recognized as conforming to accepted medical practice or to be a safe, effective standard of medical practice for a particular condition. This includes, but is not limited to:

    - Items within the research, investigational or experimental stage of development or performed within or restricted to use in Phase I, II, or III clinical trials (unless identified as a covered service elsewhere);
    - Items that do not have strong research-based evidence to permit conclusions and/or clearly define long-term effects and impact on health outcomes (i.e., that have not yet been shown to be consistently effective for the diagnosis or treatment of the specific condition for which it is sought). Strong research-based evidence is identified as peer-reviewed published data derived from multiple, large, human randomized controlled clinical trials OR at least one or more large controlled national multi-center population-based studies;

- Items based on anecdotal and unproven evidence (literature consists only of case studies or uncontrolled trials), i.e., items that lack scientific validity, but may be common practice within select practitioner groups even though safety and efficacy is not clearly established;
- Items that have been identified through research-based evidence to not be effective for a medical condition and/or to not have a beneficial effect on health outcomes.

Note: FDA and/or Medicare approval does not guarantee that a drug, supply, care or treatment is accepted medical practice; however, lack of such approval will be a consideration in determining whether a drug, service, supply, care or treatment is considered experimental, investigational or unproven.

Off-label drug or device use (sought for outside FDA-approved indications) is subject to medical review for appropriateness based on prevailing peer-reviewed medical literature, published opinions and evaluations by national medical associations, consensus panels, technology evaluation bodies, and/or independent review organizations to evaluate the scientific quality of supporting evidence.

8. **Expressive therapies** (e.g. psychodrama) when billed as a separate service

F

Any services or expenses incurred during the course of therapeutic **foster care**

G

1. Services furnished by or for the US **government**, Federal and State funded agency or a foreign government, unless payment is legally required
2. Services applied under any **government program** or law under which the individual is covered

H

1. Any services or expenses incurred during the course of treatment provided in a **halfway house** or other sober living arrangement
2. Any services or expenses related to **hearing impairment**
3. **Hemodialysis** for schizophrenia
4. Any services or expenses related to **holistic** medicine
5. Any services or expenses incurred during the course of **extended hospital stays** that are unrelated to *medically necessary* and approved treatment
6. **Hyperbaric therapy** or other oxygen therapy

I

1. Any services or expenses required while the *member* is **incarcerated** in a prison, jail, or any other penal institution
2. Any services or expenses incurred during the course of **inpatient treatment** for co-dependency, gambling, and sexual addiction

3. **Insight-oriented therapy**
4. Services administered for **insurance** purposes
5. **Intelligence quotient (IQ) testing**
6. Any services or expenses incurred during treatment of conditions not classified in the Mental, Behavioral and Neurodevelopmental Disorders section of the **International Classification of Diseases**, as periodically updated

J

Any services or expenses related to **judicial** or administrative proceedings

L

1. **Laboratory tests**
2. Services for which you have no **legal obligation to pay** or for which a charge would not ordinarily be made in the absence of coverage under this Plan
3. Services provided by someone **not licensed** by the State to treat the condition for which the claim is made and to independently bill fee for service and/or not trained or experienced to treat a specific condition under review
4. Services and expenses provided to a *member* that could have been provided at a **lower level of care** based on *medical necessity* criteria and given the *member*'s condition and the services provided (e.g. an inpatient admission that could have been treated on an outpatient basis)

M

1. **Maintenance Therapy:** Such services are excluded if, based on medical evidence, treatment or continued treatment could not be expected to resolve or improve the condition, or that clinical evidence indicates that a plateau has been reached in terms of improvement from such services
2. **Marriage therapy**
3. Any services or expenses incurred during care that is not deemed ***medically necessary*** or that is not a covered service even if prescribed, recommended, or approved by your provider
4. Any services, expenses, or supplies to the extent that you are or would be, entitled to **Medicare reimbursement**, regardless of whether you properly and timely applied for, or submitted claims to Medicare, except as otherwise required by Federal law
5. Over-the-counter or prescription **medication**
6. The Plan shall not be responsible for charges incurred for **missed appointments**

N

1. Any services or expenses related to **narcotic maintenance therapy**
2. **Neuropsychological testing** that is not conducted by a licensed clinical neuropsychologist
3. **Neuropsychological testing** is not a covered benefit when undertaken for medical diagnosis of a neurological disorder, traumatic brain injury, stroke, closed head injury,

dementia; for the diagnosis of attention deficit disorders; for legal reasons such as competency to handle business affairs, disability applications or Workers' Compensation claims. Testing under those conditions should be billed under medical insurance or paid for by other entities such as Workers' Compensation. Neuropsychological testing may be a covered benefit in cases where clear confusion exists as to whether a symptom pattern reflects a psychiatric problem as opposed to a neurological pattern

4. Therapy services or expenses of any kind for **nicotine addiction** (e.g. smoking cessation treatment)
5. **Nutritional therapy** (registered dietician)

O

1. **Occupational therapy**
2. Any services or expenses related to treatment provided by ***out-of-network*** *providers* or *facilities*, unless the Plan provides an out-of-network benefit

P

1. **Pastoral counseling**
2. Some services may be excluded if not **precertified**
3. **Pharmaceutical preparations** except as given in an inpatient setting and included in a predetermined hospital per diem or case rate
4. **Physical therapy**
5. **Primal therapy**
6. Any services or expenses incurred during the course of **private duty nursing**
7. Services delivered by **providers delivering services outside the scope of their licenses**
8. Any services or expenses incurred during treatment performed by a **provider for a *member* who is related to the provider** by blood or marriage or who regularly resides in the provider's household
9. **Psychoanalysis**
10. **Psychological testing** that is not conducted by a licensed clinical psychologist
11. **Psychological/neuropsychological testing,** except when conducted for purposes of diagnosing a mental disorder or when rendered in connection with treatment for a mental disorder
12. **Psychological/neuropsychological testing** without sound psychometric properties including empirically substantiated reliability, validity, standardized administration, and clinically relevant normative data based on age, educational attainment, and when relevant ethnicity and gender
13. **Psychological/neuropsychological testing** administration, scoring, and interpretation that is above and beyond the time limit(s) reported in peer review publications
14. **Psychological/neuropsychological testing** in which the provider does not compose a final report that, at minimum, summarizes clinical impressions and recommendations that will be forwarded to the referring provider and discussed with you
15. **Psychological/neuropsychological testing** that is not relevant and valid for evaluating the clinical concerns under consideration
16. **Psychological/neuropsychological testing** that is not otherwise a covered service.

Examples of such excluded testing include when such services relate to career, education, sports, camp, travel, employment, insurance, marriage, adoption, medical research, or to obtain or maintain a license of any type

R

1. **Radiological imaging** conducted in order to find the cause of an organic disorder, e.g. CT scan, MRI, etc.
2. **Recreation therapy**
3. Treatment in a **residential *facility***
4. Any services or expenses incurred during **respite care**
5. Any services or expenses incurred during **rest cures**
6. **Rolfing**

S

1. Any services or expenses incurred during care that is provided in a **school**
2. **Sedative action electro-stimulation therapy**
3. **Sensitivity training**
4. **Self-help training**
5. Any services or expenses incurred for treatment of **sex offenders**
6. Any services or expenses related to **sleep diagnostic clinics**
7. **Speech therapy**
8. **Stress management**
9. Any services or expenses incurred during **substance abuse treatment** that is not abstinence-based
10. Any services or expenses incurred during **substance abuse treatment** for licensed, registered or certified professionals that is not deemed *medically necessary* or is beyond the scope of benefits as outlined in the Summary of Mental Health and Substance Abuse Benefits when recommended or required to maintain a professional license, certification or registration

T

1. Any services or expenses incurred during **telephone,** e-mail, and Internet consultations in the absence of a specific benefit
2. **Transcendental Meditation**
3. **Travel, transportation, and lodging expenses** incurred in order to receive consultation or treatment, even if the treatment is recommended, prescribed, or provided by your provider
4. Any services or expenses incurred during treatment provided when the **treatment plan** does not meet clinically accepted standards of care
5. **Tryptophan therapy**

V

1. **Vitamin (megavitamin) therapy**
2. Any services or expenses related to **vision impairment**

W

1. Any services or expenses received while on active military duty or as a result of **war or any act of war,** whether declared or undeclared, terrorism, participation in a riot, insurrection, rebellion, or direct participation in an act deemed illegal by a court of law
2. Any services or expenses for conditions that require coverage to be purchased or provided through other arrangements such as **Workers' Compensation, no-fault automobile insurance** or similar legislation

Diagnostic Exclusions

NOTE: The diagnostic *exclusions* listed are not all-inclusive.

1. **Autism** as the primary diagnosis, except for making the initial diagnosis.
2. Services or expenses of any kind for **caffeine intoxication**
3. Services or expenses of any kind related to **eating disorders,** including, but not limited to, anorexia nervosa and bulimia nervosa
4. **Developmental delays:** Occupational, physical, and speech therapy services related to developmental delays, intellectual disability or behavioral therapy that are not medically necessary and are not considered by the Plan to be medical treatment. If another mental health or substance abuse condition is identified through the course of diagnostic testing, any coverage of that condition will be subject to Plan provisions
5. **Intellectual disability** as the primary diagnosis except for the purpose of making the initial diagnosis
6. **Communication disorders** as the primary diagnosis, except for making the initial diagnosis. Such disorders include, but are not limited to, language disorder, mixed receptive-expressive language disorder, speech sound disorder, and stuttering.
7. **Specific learning disorders** as the primary diagnosis, except for making the initial diagnosis.
8. **Motor disorders** as the primary diagnosis, except for making the initial diagnosis.
9. **Truancy, disciplinary, or other behavioral problems** as the primary diagnosis.

Coordination of Benefits

Coordination of benefits (COB) is a provision designed to help manage the cost of healthcare by avoiding duplication of benefits when a person is covered by two or more benefit plans. COB provisions determine which plan is primary and which is secondary. A primary plan is one whose benefits for a person's healthcare coverage must be determined first without taking the existence of any other plan into consideration. A secondary plan is one which takes into consideration the benefits of the primary plan before determining benefits available under its

plan. Some COB terms have defined meanings. These terms are set forth at the end of this COB section.

Order of Benefit Determination

Which plan is primary is decided by the first rule below that applies:

Noncompliant Plan: If the other plan is a noncompliant plan, then the other plan shall be primary, and this plan shall be secondary unless the COB terms of both plans provide that this plan is primary.

Employee/*Dependent*: The plan covering a patient as an employee, *member*, subscriber, or contract holder (that is, other than as a *dependent*) is primary over the plan covering the patient as a *dependent*. In some cases, depending upon the size of the group, Medicare secondary payer rules may require us to reverse this order of payment. This can occur when the patient is covered as an inactive or retired employee, is also covered as a *dependent* of an active employee and is also covered by Medicare. In this case, the order of benefit determination will be as follows: first, the plan covering the patient as a *dependent*; second, Medicare; and third, the plan covering the patient as an inactive or retired employee.

***Dependent* Child – Parents Not Separated or Divorced:** If both plans cover the patient as a *dependent* child of parents who are married or living together (regardless of whether they have ever been married),the plan of the parent whose birthday falls earlier in the year will be primary. If the parents have the same birthday, the plan covering the patient longer is primary.

***Dependent* Child – Separated or Divorced Parents:** If two or more plans cover the patient as a *dependent* child of parents who are divorced, separated, or no longer living together (regardless of whether they have ever been married), benefits are determined in this order:

1. If there is no court decree allocating responsibility for the child's healthcare expenses or healthcare coverage, the order of benefits for the child are as follows:

    a. first, the plan of the custodial parent;
    b. second, the plan covering the custodial parent's spouse;
    c. third, the plan covering the non-custodial parent; and,
    d. last, the plan covering the non-custodial parent's spouse.

2. If a court decree states that a parent is responsible for the *dependent* child's healthcare expenses or healthcare coverage and the plan of that parent has actual knowledge of those terms, the plan of the court-ordered parent is primary.

    If the court-ordered parent has no healthcare coverage for the *dependent* child, benefits will be determined in the following order:

    a. first, the plan of the spouse of the court-ordered parent;
    b. second, the plan of the non-court-ordered parent; and,
    c. third, the plan of the spouse of the non-court-ordered parent.

If a court decree states that both parents are responsible for the *dependent* child's healthcare expenses or healthcare coverage, the provisions of "*Dependent* Child – Parents Not Separated or Divorced" (the "birthday rule") above shall determine the order of benefits.

If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the healthcare expenses or healthcare coverage of the *dependen*t child, the provisions of the "birthday rule" shall determine the order of benefits.

3. For a *dependent* child covered under more than one plan of individuals who are not the parents of the child, the order of benefits shall be determined, as applicable, under the "birthday rule" as if those individuals were parents of the child.

Active Employee or Retired or Laid-Off Employee

1. The plan that covers a person as an active employee (that is, an employee who is neither laid off nor retired) or as a *dependent* of an active employee is the primary plan. The plan covering that same person as a retired or laid-off employee or as a *dependent* of a retired or laid-off employee is the secondary plan.
2. If the other plan does not have this rule, and as a result, the plans do not agree on the order of benefits, this rule is ignored.
3. This rule does not apply if the rule in the paragraph "Employee/*Dependent*" above can determine the order of benefits. For example, if a retired employee is covered under his or her own plan as a retiree and is also covered as a *dependent* under an active spouse's plan, the retiree plan will be primary, and the spouse's active plan will be secondary.

COBRA or State Continuation Coverage

1. If a person whose coverage is provided pursuant to COBRA or under a right of continuation pursuant to state or other federal law is covered under another plan, the plan covering the person as an employee, *member*, subscriber or retiree or covering the person as a *dependent* of an employee, *member,* subscriber or retiree is the primary plan and the plan covering that same person pursuant to COBRA or under a right of continuation pursuant to state or other federal law is the secondary plan.
2. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.
3. This rule does not apply if the rule in the paragraph "Employee/*Dependent*" above can determine the order of benefits. For example, if a former employee is receiving COBRA benefits under his former employer's plan (the "COBRA plan") and is also covered as a *dependent* under an active spouse's plan, the COBRA plan will be primary, and the spouse's active plan will be secondary. Similarly, if a divorced spouse is receiving COBRA benefits under his or her former spouse's plan (the "COBRA plan") and is also covered as a *dependent* under a new spouse's plan, the COBRA plan will be primary and the new spouse's plan will be secondary.

Longer/Shorter Length of Coverage: If the preceding rules do not determine the order of benefits, the plan that covered the person for the longer period of time is the primary plan and the plan that covered the person for the shorter period of time is the secondary plan.

Equal Division: If the plans cannot agree on the order of benefits within thirty (30) calendar days after the plans have received all of the information needed to pay the claim, the plans shall immediately pay the claim in equal shares and determine their relative liabilities following payment, except that no plan shall be required to pay more than it would have paid had it been the primary plan.

Determination of Amount of Payment

1. If this plan is primary, it shall pay benefits as if the secondary plan did not exist.
2. If our records indicate this plan is secondary, we will not process your claims until you have filed them with the primary plan and the primary plan has made its benefit determination.

If this plan is a secondary plan on a claim, should it wish to coordinate benefits (that is, pay benefits as a secondary plan rather than as a primary plan with respect to that claim), this plan shall calculate the benefits it would have paid on the claim in the absence of other healthcare coverage and apply that calculated amount to any allowable expense under its plan that is unpaid by the primary plan. When paying secondary, this plan may reduce its payment by the amount so that, when combined with the amount paid by the primary plan, the total benefits paid or provided by all plans for the claim do not exceed 100 percent of the total allowable expense for that claim. In addition, the secondary plan shall credit to its plan *deductible* any amounts it would have credited to its *deductible* in the absence of other healthcare coverage. In some instances, when this plan is a secondary plan, it may be more cost effective for the plan to pay on a claim as if it were the primary plan. If the plan elects to pay a claim as if it were primary, it shall calculate and pay benefits as if no other coverage were involved.

COB Terms

Allowable Expense: Except as set forth below or where a statute requires a different definition, the term "allowable expense" means any healthcare expense, including coinsurance, copayments, and any applicable *deductible* that is covered in full or in part by any of the plans covering the person. The term "allowable expense" does not include the following:

1. An expense or a portion of an expense that is not covered by any of the plans.
2. Any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging a covered person.
3. Any type of coverage or benefit not provided under this plan. For example, if this plan does not provide benefits for medical disorders, prescriptions drugs, or other similar type of coverage or benefit, then it will have no secondary liability with respect to such coverage or benefit. In addition, the term "allowable expense" does not include the amount of any reduction in benefits under a primary plan because (a) the covered person failed to comply with the primary plan's provisions concerning second opinions or *precertification* of admissions or services, or (b), the covered person had a lower benefit because he or she did not use a preferred provider.

Birthday: The term "birthday" refers only to month and day in a calendar year and does not include the year in which the individual is born.

Custodial Parent: The term "custodial parent" means:

1. A parent awarded custody of a child by a court decree; or,
2. In the absence of a court decree, the parent with whom the child resides for more than one half of the calendar year without regard to any temporary visitation.

Group-Type Contract: The term "group-type contract" means a contract that is not available to the general public and is obtained and maintained only because of membership in or a connection with a particular organization or group, including blanket coverage. The term does not include an individually underwritten and issued guaranteed renewable policy even if the policy is purchased through payroll deduction at a premium savings to the insured since the insured would have the right to maintain or renew the policy independently of continued employment with the employer.

Hospital Indemnity Benefits: The term "hospital indemnity benefits" means benefits not related to expenses incurred. The term does not include reimbursement-type benefits even if they are designed or administered to give the insured the right to elect indemnity-type benefits at the time of claim.

Noncompliant Plan: The term "noncompliant plan" means a plan with COB rules that are inconsistent in substance with the order of benefit determination rules of this plan. Examples of noncompliant plans are those that state their benefits are "excess" or "always secondary."

Plan: The term "plan" includes group insurance contracts, health maintenance organization (HMO) contracts, closed panel plans or other forms of group or group-type coverage (whether insured or uninsured); medical care components of long-term care contracts, such as skilled nursing care; medical benefits under group or individual automobile contracts; and Medicare or any other federal governmental plan, as permitted by law.
The term "plan" does not include non-group or individual health or medical reimbursement insurance contracts. The term "plan" also does not include hospital indemnity coverage or other fixed indemnity coverage; accident-only coverage; specified disease or specified accident coverage; limited benefit health coverage, as defined by state law; school accident type coverage; benefits for non-medical components of long-term care policies; Medicare supplement policies; Medicaid policies; or coverage under other federal governmental plans, unless permitted by law.

Primary Plan: The term "primary plan" means a plan whose benefits for a person's healthcare coverage must be determined without taking the existence of any other plan into consideration. A plan is a primary plan if:

1. The plan either has no order of benefit determination rules, or its rules differ from those permitted by this regulation; or,
2. All plans that cover the person use the order of benefit determination rules required by this regulation, and under those rules the plan determines its benefits first.

Secondary Plan: The term "secondary plan" means a plan that is not a primary plan.

Billing & Payment: Filing a Claim

Submitting a Claim for Behavioral Health Services

When Uprise Health American Behavioral is your primary coverage and your provider is in network, you do not need to submit claims. The provider will do it for you.

FOR MORE INFORMATION: If you have a question about whether your provider's office has submitted a claim, call the Uprise Health American Behavioral Claims Department at 1-800-677-4544.

When Do I Need to Submit a Claim?

You may need to submit a claim to Uprise Health American Behavioral for payment if you receive services from an *out-of-network provider* or if you have other coverage that pays first and Uprise Health American Behavioral is secondary.

How Do I Submit a Claim?

Claims should be submitted for reimbursement through the Uprise Health American Behavioral Web Portal.

IMPORTANT: See the Uprise Health American Behavioral Web Portal portion of the Important Contact Information section of this Handbook for instructions for accessing the web portal.

You will need to submit the following information:

- The *superbill*,
- The date of service, and
- The receipt showing payment for services.

If you cannot access the Web Portal, please call 1-800-677-4544 for assistance.

Information About Submitting Claims

IMPORTANT: You or your provider must submit claims within 24 months from the date you received health care services; this is called the timely filing deadline. The Plan will not pay claims submitted more than 24 months after the date of service.

What You Need to Know as a Plan Member

Your Rights and Responsibilities

Through Uprise Health American Behavioral, you have the following rights and responsibilities:

Your Rights

Uprise Health American Behavioral believes that you have the right to:

- Be treated with dignity, respect and courtesy
- Be treated without regard to race, religion, gender, sexual orientation, ethnicity, age, disability or communication needs
- Confidentiality of protected health information and treatment information
- Receive information about Uprise Health American Behavioral services, providers, clinical guidelines, quality improvement programs, *member* rights and responsibilities and any other rules or guidelines used in making coverage and payment decisions
- A clear explanation of your health plan benefits and how to access services
- Access to services and providers that meet your needs
- Choose or change your provider
- Request an interpreter or assistance for language translation or hearing problems
- Participate in making your health care decisions by receiving appropriate information about your diagnosis, treatment options and prognosis
- Participate in decisions concerning your care and treatment plan
- An individualized treatment plan that is periodically reviewed and updated
- Refuse or consent to treatment or tests to the extent provided by law and be made aware of the medical consequences of such decisions
- Refuse to participate in any proposed investigational studies, clinical trials, or research projects
- Receive treatment within the least restrictive environment
- Be informed of the reason for any adverse determination by Uprise Health American Behavioral utilization management, including the specific utilization review criteria or benefits provision used in the determination

- Utilization management decisions based on appropriateness of care. Uprise Health American Behavioral does not reward providers or other individuals conducting utilization review for issuing adverse determinations
- Submit either positive or negative comments concerning your care to Uprise Health American Behavioral, your health care provider(s), or your employer
- Information about how to file a formal complaint or *appeal*
- Voice complaints regarding use or disclosure of protected health information
- Receive a copy of these rights and responsibilities
- Make recommendations regarding these rights and responsibilities and
- To appoint your next of kin, a legal guardian or legal designee to exercise these rights if you are unable to do so.

Your Responsibilities

Uprise Health American Behavioral believes that you have the responsibility to:

- Know your health plan benefits and adhere to the guidelines of your policy

- Provide an accurate medical and social history. This includes granting a release of medical records from former providers, if needed
- Respect the rights, privacy, and confidentiality of other patients and their families
- Gather and carefully consider all information needed to give consent for treatment or to refuse care
- Cooperate with the agreed upon treatment plan, instructions and guidelines, and to discuss the results with your Provider
- Notify your health care Provider when you expect to be late for an appointment or need to cancel
- Ask questions regarding your illness or treatment and to tell your provider about your expectations of treatment
- Provide a copy of your "advanced directives" to your provider whenever changes are made and
- Promptly pay any applicable copayments, *co-insurance*, and *deductibles*

Your Right to Information

We support the goal of giving you and your family the detailed information you need to make the best possible behavioral health care decisions. You can find the following information in this Handbook:

- A list of covered expenses
- Benefit *exclusions*, reductions, and maximums or limits
- A clear explanation of complaint and *appeal* procedures
- A uniform glossary of terms (UGI) and
- The process for pre-authorization or review

You also have the right to receive copies of any internal rules, guidelines, or protocols that we may have relied upon in reaching our decision. If our decision was based on a medical or scientific determination (such as *medical necessity*), you may also request that we provide you with a statement explaining our application of those medical and scientific principles to you. If we obtained advice from a health care professional (regardless of whether we relied on that advice), you may request that we give you the name of that person. Any request that you make for information under this paragraph must be in writing. We will not charge you for any information that you request under this paragraph.

Uprise Health American Behavioral does not prevent or discourage providers from telling you about the care you require, including various treatment options and whether the provider thinks that care is consistent with coverage criteria. You may, at any time, get health care outside of Plan coverage for any reason however, you must pay for those services and supplies. In addition, the Plan does not prevent or discourage you from talking about other health plans with your provider.

Confidentiality of Your Health Information

Uprise Health American Behavioral follows its Privacy Policy, which is available online at www.americanbehavioral.com or by calling us at 1-800-677-4544. The Plan will release *member* health information only as described in that notice or as required or permitted by law

or court order.

Notice of Nondiscrimination

Uprise Health American Behavioral complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. We do not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Uprise Health American Behavioral:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as qualified interpreters and in formation written in other languages

If you need these services, contact Uprise Health American Behavioral at 1-800-677-4544. If you believe that we have failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a *grievance* in person, by mail, or by fax.

IMPORTANT: See the Birmingham Office portion of the Important Contact Information section of this Handbook for address, telephone, and fax information.

Send *grievances* to the attention of Compliance & Quality Improvement. When initiating a *grievance* by fax, please use the Clinical Services fax number.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Service
200 Independence Avenue SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019
1-800-537-7697 (TDD).

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html

Requests for Medical Records or Billing Statements

You may contact your provider to request complete listings of medical records or billing statements pertaining to you. Providers may charge a fee to cover the cost of providing records or completing requested forms.

Complaints

Types of Complaints

Inquiry: An inquiry is the act of requesting information or a close examination of facts or evidence. Inquiries are not subject to *appeal*.

Quality of Care Complaint: A quality of care complaint is a report of behavior that could adversely impact your health and wellbeing. Quality of care complaints are not subject to *appeal*.

Complaint Procedure

To submit a verbal complaint, call Uprise Health American Behavioral, and we will assist you with the specific process. To submit a written complaint, mail all pertinent documentation the attention of "Quality Management."

IMPORTANT: See the Birmingham Office portion of the Important Contact Information section of this Handbook for address and telephone information.

Uprise Health American Behavioral reserves the right to require that complaints be submitted in writing, depending on the nature of the allegation.

Your Claims and Appeals Rights

This section explains the rules for filing claims and *appeals*.

Claims

Claims for benefits under the Plan can be post-service, pre-service, or concurrent. This section of the Handbook explains how these claims are processed and how you can *appeal* a partial or complete denial of a claim. You must act on your own behalf or through an *authorized representative*. (See the section of this Handbook entitled How to Designate an *Authorized Representative*.) For urgent pre-service claims, we will presume that your provider is your *authorized representative* unless you tell us otherwise in writing.

Post-Service Claims

For you to obtain benefits after services have been rendered, we must receive a properly completed claim form from you or your provider. Most providers are aware of our claim filing requirements and will file claims for you.

NOTE: If your provider does not file a claim form for you, then you can go to the Uprise Health American Behavioral Web Portal to submit claims for reimbursement.

IMPORTANT: See the Uprise Health American Behavioral Web Portal portion of the Important

Contact Information section of this Handbook for instructions for accessing the web portal.

You will need to submit the following information:

- The *superbill*,
- The date of service, and
- The receipt showing payment for services.

If you cannot access the Web Portal, please call 1-800-677-4544 for assistance.

Claims must be submitted and received by us within 24 months after the service takes place to be eligible for benefits.

Pre-Service Claims

Mental health and substance abuse services must meet established *medical necessity* guidelines. You or your *authorized representative* may call us before services are received at 1-800-677-4544. Uprise Health American Behavioral is available 24-hours-per-day, seven-days-per-week.

Concurrent Care Determinations

If we have previously approved a course of treatment to be provided over a period of time or number of treatments, and the course of treatment is about to expire, you may submit a request to extend your approved care. The phone number for requesting an extension of care is 1-800-677-4544.

Your Right to Information

Upon request, you have the right to receive copies of any documents that we relied on in reaching our decision and any documents that were submitted, considered, or generated by us in the course of reaching our decision. You also have the right to receive copies of any internal rules, guidelines, or protocols that we may have relied upon in reaching our decision. If our decision was based on a medical or scientific determination (such as *medical necessity*), you may also request that we provide you with a statement explaining our application of those medical and scientific principles to you. If we obtained advice from a health care professional (regardless of whether we relied on that advice), you may request that we give you the name of that person. Any request that you make for information under this paragraph must be in writing. We will not charge you for any information that you request under this paragraph.

Appeals

You or your *authorized representative* may *appea*l (either verbally or in writing) any adverse benefit determination. An adverse benefit determination includes any of the following:

- Any determination that we make with respect to a post-service claim that results in your owing any money to your provider other than copayments you make, or are required

to make, to your provider
- Our denial of a pre-service claim
- An adverse concurrent care determination (for example, we deny your request to extend previously approved care) or
- An adverse *medical necessity* decision.

Either an urgent/expedited *appeal* or a non-urgent/standard *appeal*/mandatory can be requested. An urgent/expedited *appeal* can be requested if a delay in treatment would result in:

- A significant increase to the risk of your health or the health of others
- Severe pain or
- The inability to regain maximum functioning.

How to Initiate an Internal Appeal Review

IMPORTANT: Uprise Health American Behavioral does not perform retrospective *medical necessity* review. You or your *authorized representative* may file a standard *appeal* for payment after services have been rendered. You must request an *appeal* within 180 calendar days from the receipt date of our letter that contained the adverse determination decision.

You or your *authorized representative* may initiate an *appeal* by calling Uprise Health American Behavioral or submitting the documentation in writing to the attention of "Appeals."

IMPORTANT: See the Birmingham Office portion of the Important Contact Information section of this Handbook for address, telephone, and fax information. Please use the Clinical Services fax number when initiating an *appeal* by fax.

The *appeal* request should include all of the following:

- The *member's* name
- The *member's* date of birth
- An identification number, if applicable
- The date(s) of service(s)
- The name of the treating provider
- Any additional information to be considered during the *appeal* process. Information that can be included in an *appeal* includes:
- Records relating to the current conditions of treatment
- Notation of coexisting conditions and
- Any other relevant information.

Appeal Review Process

Uprise Health American Behavioral has two levels of *appeal*. The non-urgent/standard *appeal*/mandatory is the final level of *appeal*. You have the option to request a non-urgent/standard/mandatory *appeal* even if you did not file an urgent/expedited *appeal*.
You must request an *appeal* within 180 calendar days from the receipt date of our letter that contained the adverse determination decision.

Urgent/Expedited Appeal Process

You or your provider(s) may request an expedited *appeal* by calling 1-800-677-4544. We will review the urgent *appeal*, render a decision, and notify you and your provider(s) within 48 hours of the *appeal* request.

Non-Urgent/Standard/Mandatory Process

This is a **mandatory** *appeal* level. The *member* must exhaust the following internal procedures before taking any outside legal action.

- The *member* must file the *appeal* within 180 days of the date he or she received the *Explanation of Benefits* (EOB) from the Plan showing that the claim was denied. Uprise Health American Behavioral will assume that the EOB was received seven (7) days after the Plan mailed it.
- The *member* or his or her personal representative will be allowed reasonable access to review or copy pertinent documents at no charge.
- The *member* may submit written comments, documents, records, and other information relating to the claim to explain why he or she believes the denial should be overturned. This information should be submitted at the same time the written request for a review is submitted.
- The review will take into account all comments, documents, records, and other information submitted relating to the claim. This includes comments, documents, records, and other information that were not submitted previously or were not considered in the initial benefit decision. The review will be conducted by individuals who were not involved in the original denial decision and are not under the supervision of the person who originally denied the claim.
- If the benefit denial was based in whole or in part on a medical judgment, Uprise Health American Behavioral will consult with a health care professional with training and experience in the relevant medical field. This health care professional may not have been involved in the original denial decision and may not be supervised by the health care professional who was involved. If Uprise Health American Behavioral consulted with medical experts in connection with the claim, these experts will be identified upon the *member's* request, regardless of whether or not the Plan relies on their advice in making any benefit determinations.
- After Uprise Health American Behavioral has reviewed the *appeal*, the *member* will receive written notification of the claim's approval or denial. The notice will include the same information as described above in the adverse benefit determination section. In the event of new or additional evidence or any new rationale relied upon during the *appeal* process in connection with a claim that is being *appealed*, Uprise Health American Behavioral will automatically provide the relevant information to the *member*. The notification will provide the *member* with the information outlined under the "Adverse Benefit Determination" section above. It will also notify the *member* of his or her right to file suit under ERISA after he or she has completed all mandatory *appeal* levels described in this handbook.

Additional Rights

You may request, free of charge, a paper copy of any relevant documents, records, guidelines or other information we used to make our decision. You can call Uprise Health American Behavioral or submit your request in writing, sending the documentation to the attention of "Appeals."

IMPORTANT: See the Birmingham Office portion of the Important Contact Information section of this Handbook for address, telephone, and fax information. Please use the Clinical Services fax number when requesting information by fax.

Some information will require you to provide a written request or consent before it can be released.

FOR MORE INFORMATION: If you have coverage through an ERISA plan, you may have additional *appeal* rights. Please contact your plan administrator for more information.

NOTE: *Appeals* procedures are subject to change during the year if required by federal or state law.

You may request an *appeal* yourself, or an *authorized representative* may request an *appeal* for you. There are three parts to the *appeals* process: first-level *appeal*, second-level *appeal*.

If your request involves a decision to change, reduce, or terminate coverage for services already being covered, the Plan must continue coverage for these services during your *appeal*. However, if the Plan upholds the decision to change, reduce, or terminate coverage, you will be responsible for any payments made by the Plan during that period. If you request payment for denied claims or approval of services, not yet covered by the Plan, we do not have to cover the services while the *appeal* is under consideration.

The Plan will consult with a health care professional on *appeals* where the Plan's decision was based in whole or in part on a medical judgment. That includes decisions based on determinations that a particular treatment is experimental, investigational, or not *medically necessary* or appropriate. In this case, the Plan will consult with a health care professional who has appropriate training and experience in the field of behavioral health care involved.

You may send written comments, documents, and any other information when you request an *appeal*. You may also request copies of documents the Plan has that are relevant to your *appeal*, which the Plan will provide at no cost. Our review will consider any information you or your provider submits to us.

How to Designate an Authorized Representative

IMPORTANT: Because of privacy laws, the Plan usually cannot share information on *appeals* or complaints with family m*embers* or other persons unless the patient is a minor, or the Plan has received written authorization to release personal health information to the other person. If you want to authorize someone to receive your protected health information or designate a representative, you may request an Authorization to Disclose Protected Health Information from Uprise Health American Behavioral. This form must be completed and returned to Uprise

Health American Behavioral before we can share information. If you are designating someone else to represent you in an *appeal* or complaint, the form must specifically state this.

In most cases, Uprise Health American Behavioral must have written authorization to communicate with anyone but the enrollee (patient) except when the enrollee is under age 14 a parent or legal guardian may act as representative.

Under some circumstances, written authorization is necessary when the enrollee is age 14 to 17. You may choose to authorize a representative to:

- Talk to Uprise Health American Behavioral about claims or services
- Share your protected health information and/or
- Handle an *appeal* on your behalf.

To designate an *authorized representative*, you must complete an Authorization to Disclose Protected Health Information form, available by calling Uprise Health American Behavioral at 1-800-677-4544 or through www.americanbehavioral.com. Send the form to the address on the form. Uprise Health American Behavioral cannot share information or proceed with an *appeal* until we receive the completed form. On the form, you must specify:

- What information may be disclosed
- The purpose of the disclosure (for example, handling an *appeal* on your behalf) and
- Who is designated to receive or release the information.

Rights of Uprise Health American Behavioral

Right to Release and Receive Necessary Information

Certain facts about health care coverage and services are needed for determining benefit coverage and *coordination of benefits*, under this Plan and others. We may get the needed information from other organizations or persons for these purposes, or we may give the facts to another organization or person. We are not required to tell or get consent from any person to do this. Each *member* claiming benefits under this Plan must give us any facts needed to make the determinations noted above.

Possible Delay or Denial of Payment

If you do not provide information when we request it, there may be a delay in payment or denial of payment of benefits.

Right to Request Information from Providers

By accepting the mental health and substance abuse services under the Plan, you authorize and direct any person or institution that has provided services to you to furnish us with all information or copies of records relating to those services. We have the right to request this

information. This applies to all *members,* including *dependents*. Uprise Health American

Behavioral agrees that such information and records will be considered confidential.

Right to Release Records

We have the right to release any and all records concerning health care services that are necessary to implement and administer the terms of the Plan for appropriate medical review, quality assessment or as we are required to do by law or regulation.

General Provisions

Recovery Provisions

Refund of Overpayments

If we pay benefits for expenses incurred on your behalf, you or any other person or organization that was paid, must make a refund to us if:

- All or some of the expenses were not paid by you or did not legally have to be paid by you
- All or some of the payment we made exceeded the benefits under this Plan and
- The refund equals the amount we paid in excess of the amount it should have paid under the Plan.

If the refund is due from another person or organization, you agree to help us recover the refund amount when requested.

If you or any other person or organization that was paid, does not promptly refund the full amount, we may reduce the amount of any future benefits that are payable under the Plan. We may also reduce future benefits under any other group benefits plan we administer for the employer. The reductions will equal the amount of the required refund. We may have other rights in addition to the right to reduce future benefits.

Right of Subrogation

If we pay or provide any benefits for you under this Plan, we are subrogated to all rights of recovery which you have in contract, tort, or otherwise against any person or organization for the amount of benefits we have paid or provided. That means that we may use your right to recover money from that other person or organization. In addition, we have a security interest in and lien upon any recovery to the extent of the amount of benefits paid by the Plan, and for expenses incurred by the Plan in obtaining a recovery.

Right of Reimbursement

Besides the right of subrogation, we have a separate right to be reimbursed or repaid from any money you, including your family members, recover for an injury or condition for which we have paid Plan benefits. This means that you promise to repay us from any money you recover the amount we have paid or provided in Plan benefits. It also means that if you

recover money as a result of a claim or a lawsuit, whether by settlement or otherwise, you must repay us from the money that you recover. And, if you are paid by any person or company besides us, including the person who injured you, that person's insurer, or your own insurer, you must repay us. In these and all other cases, you must repay us from the funds that you recover.

We have the right to be reimbursed or repaid first from any money you recover, even if you are not paid for all of your claim for damages and you are not made whole for your loss. This means that you promise to repay us first even if the money you recover is for (or said to be for) a loss besides Plan benefits, such as pain and suffering. It also means that you promise to repay us first even if another person or company has paid for part of your loss. And it means that you promise to repay us first even if the person who recovers the money is a minor. In these and all other cases, we still have the right to first reimbursement or repayment out of any recovery you receive from any source.

Right to Recovery

You agree to furnish us promptly all information which you have concerning your rights of recovery or recoveries from other persons or organizations and to fully assist and cooperate with us in protecting and obtaining our reimbursement and subrogation rights in accordance with this section.

You and your attorney must notify us before filing any suit or settling any claim so as to enable us to participate in the suit or settlement to protect and enforce our rights under this section. If you do notify us so that we are able to and do recover the amount of our benefit payments for you, we will share proportionately with you in any attorney's fees charged you by your attorney for obtaining recovery. If you do not give us that notice, our reimbursement or subrogation recovery under this section will not be decreased by any attorney's fee for your attorney.

You further agree not to allow our reimbursement and subrogation rights under this Plan to be limited or harmed by any other acts or failures to act on your part. It is understood and agreed that if you do, we may suspend or terminate payment or provision of any further benefits for you under the Plan.

Our Lien Rights

We have a lien against the amount of any money you or your family member recover for an injury or condition for which we have paid Plan benefits (including any amounts you recover from another person's insurer or from your own insurer). This lien is for the full amount of the medical expenses we paid on account of the injury caused by the other person. The lien will stay in effect until we have been reimbursed in full from any judgment or settlement obtained or we agree to waive some or all of the lien. If we have to sue you or your *dependent* to enforce our lien or to be reimbursed by you or your *dependent*, you or your *dependent* will also have to reimburse us for the costs we had to pay to collect the amount you owed us, including our attorney's fees.

Governing Law

The law governing the Plan and all rights and obligations related to the Plan shall be ERISA, to the extent applicable. To the extent ERISA is not applicable, the plan and all rights and obligations related to the Plan shall be governed by, and construed in accordance with, the laws of the United States of America and the State of Alabama, without regard to any conflicts of law principles or other laws that would result in the applicability of other state laws to the Plan.

Glossary

Allowed Amount: The allowed amount is calculated using one of the following:

- *Fee schedule*
- Negotiated rate
- *Usual and Customary* Rate

See also *Fee Schedule* and *Usual and Customary*.

The allowed amount is the maximum amount on which payment for covered health care services is based. The allowed amount can often be considerably less than a provider's actual charge, so when you use an *out-of-network provider*, you can incur substantial out-of-pocket expenses. See also *Balance Billing*.

Appeal: Your request for the Plan to review a decision or a *grievance* again.

Authorized Representative: An authorized representative is someone you have designated in writing to communicate with the Plan on your behalf and who satisfies the authorization requirements of the Plan.

Balance Billing: When a provider bills you for the difference between the provider's charge and the allowed amount. For example, if the provider's charge is $100.00, and the allowed amount is $70.00, the provider may bill you for the remaining $30.00. A network provider may not balance bill you for covered services.

Catastrophic Inpatient *Hospitalization*: A catastrophic *hospitalization* involves a chronic condition for which long-term stabilization is needed, as indicated by a length of stay greater than 12 days.

Co-insurance: The percentage of the allowed amount that you pay for most services when

the Plan pays less than 100% of the allowed amount.

Coordination of Benefits: For *members* covered by more than one health plan, coordination of benefits is the method the Plan uses to determine which plan pays first, which pays second, and the amounts paid by each plan.

Covered Provider Type: Covered provider types under the Plan include, but are not limited to licensed clinical therapists, neuropsychologists, psychologists, physician assistants, psychiatrists, and psychiatric nurse practitioners. A covered provider type may not be a *network provider*.

Dependent: A spouse, child, or other eligible family member covered by the Plan under the subscriber's account.

Exclusions: Health care services that the Plan does not cover.

Explanation of Benefits (EOB): An EOB is a detailed account of each claim processed by the Plan, which is sent to you to notify you of claim payment or denial.

Facility: An institution, place, building or agency that is a qualified provider furnishing services for the diagnosis, and treatment of mental health and/or substance abuse conditions. A facility can be a private institution or public institution operated for generating profit or nonprofit.

Fee Schedule: Generally, a provider is paid the lesser of the billed amount or the maximum fee schedule for the particular covered service, minus any *deductible, plan participation* rate, copay or penalties that the *member* is responsible for paying. If a *network* contract is in place, the *network* contract determines the Plan's *allowed amount* used in the calculation of the payable benefit. See also *Allowed Amount*.

Grievance: A complaint that you communicate to the Plan.

Hospitalization: Care in a hospital that requires admission as an inpatient and usually requires an overnight stay.

Medically Necessary / Medical Necessity: Health care services provided for the purpose of preventing, evaluating, diagnosing or treating mental health or substance use disorder, conditions that are all of the following as determined by Uprise Health American Behavioral, within our sole discretion:

- In accordance with Generally Accepted Standards of Medical Practice and
- Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for your mental health or substance use disorder(s) and
- Not mainly for your convenience or that of your doctor or other health care provider and
- Not more costly than an alternative service(s) or supply that is at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of your Illness, Injury, disease or symptoms

The fact that a physician has performed, prescribed, recommended, ordered, or approved a service, treatment plan, supply, medicine, equipment or *facility*, or that it is the only available procedure or treatment for a condition, does not, in itself, make the utilization of the service, treatment plan, supply, medicine, equipment or *facility* medically necessary.

Generally Accepted Standards of Medical Practice are standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, relying primarily on controlled clinical trials, or, if not available, observational studies from more than one institution that suggest a causal relationship between the service or treatment and health outcomes.

If no credible scientific evidence is available, then standards that are based on physician specialty society recommendations or professional standards of care may be considered. We reserve the right to consult expert opinion in determining whether health care services are medically necessary. The decision to apply physician specialty society recommendations, the choice of expert and the determination of when to use any such expert opinion, will be within our sole discretion.

Member: A member is an employee, retiree, former employee, or *dependent* enrolled in the Plan.

Network: The facilities and providers the Plan has contracted with to provide health care services.

Network Provider: A qualified provider contracted with the Plan to provide services to you at an agreed upon reimbursement rate.

Noncovered Services: See *Exclusions*.

Notification: An Instance in which your provider must contact the Plan to let us know when you receive certain services. See also *Precertification*

Office Visits: Services provided at an office location other than a hospital, skilled nursing *facility* (SNF), military treatment *facility*, community health center, or a state or local public health clinic.

Out-of-Network Provider: A provider that is not a participant in the Plan's provider *network*. The Plan has no contracted reimbursement rate with an out-of-network provider, so you will be responsible in part or in full for the cost of the services provided.

Physician Services: Health care services coordinated and/or provided by a licensed medical doctor (MD) or doctor of osteopathic medicine (DO).

Plan Year: A 12-month period of benefits coverage under a group health plan. This 12-month period may not be the same as the calendar year.

Precertification: An instance in which your provider sends a request for coverage of a service

before it occurs, and the Plan sends either an approval or denial of coverage. If services that require precertification are not approved before being provided, no benefits will be payable for the admission or the services provided by the admitting physician. Precertification of a requested service or treatment is not a promise that the Plan will cover the cost. For example, the service(s)/treatment you receive may relate to a benefit that is excluded from coverage. See also *Notification*

Superbill: A list of all services provided to a *member* for a given date or dates of service, including the diagnosis and procedure codes. The superbill includes information needed for Uprise Health American Behavioral to process a claim for reimbursement by a *member*.

The *member* can request a copy of his or her superbill from the provider.

Usual and Customary: The amount determined to be the reasonable charge for comparable services, treatment, or materials in a geographical area. In determining whether charges are usual and customary, due consideration will be given to the nature and severity of the condition being treated and any medical complications or unusual or extenuating circumstances. The geographical area is a zip code area or a greater area if the Plan determines it is needed to find an appropriate cross-section of accurate data. The usual and customary level is at the 85th percentile. See also Fee Schedule and *Allowed Amount*.

Foreign Language Assistance

Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-855-216-3144 (TTY: 711)

Korean: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-855-216-3144 (TTY: 711)번으로 전화해 주십시오.

Chinese: **注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電** 1-855-216-3144 (TTY: 711).

Vietnamese: CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-855-216-3144 (TTY: 711).

Arabic: انتباه: إذا كنت تتحدث العربية، توجد خدمات مساعدة فيما يتعلق باللغة، بدون تكلفة، 1-855-216-3144 (الهاتف النصي: 711). متاحة لك. اتصل بـ

German: ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-855-216-3144 (TTY: 711).

French: ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-855-216-3144 (ATS: 711).

French Creole: ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-855-216-3144 (TTY: 711).

Gujarati: ધ્યાન આપો: જો તમે ગુજરાતી બોલતા હોય, તો ભાષા સહાયતા સેવા, તમારા માટે નિઃશુલ્ક ઉપલબ્ધ છે. 1-855-216-3144 પર કૉલ કરો (TTY: 711).

Tagalog: PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-855-216-3144 (TTY: 711).

Hindi: ध्यान दें: अगर आपकी भाषा हिंदी है, तो आपके लिए भाषा सहायता सेवाएँ निःशुल्क उपलब्ध हैं। 1-855-216-3144 (TTY: 711) पर कॉल करें।

Laotian: ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-855-216-3144 (TTY: 711).

Russian: ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-855-216-3144 (телетайп: 711).

Portuguese: ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-855-216-3144 (TTY: 711).

Polish: UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-855-216-3144 (TTY: 711).

Turkish: DİKKAT: Eğer Türkçe konuşuyor iseniz, dil yardımı hizmetlerinden ücretsiz olarak yararlanabilirsiniz. 1-855-216-3144 (TTY: 711) irtibat numaralarını arayın.

Italian: ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-855-216-3144 (TTY: 711).

Japanese: 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-855-216-3144（TTY: 711）まで、お電話にてご連絡ください。

Summary of Mental Health Benefits for The City of Montgomery

Effective June 1, 2022 **Summary Document #:** 835090364822

IMPORTANT INFORMATION: 1. All benefits are based on the appropriate level of care and medical necessity guidelines. Provider/facility licensure by the state to provide covered services and facility accreditation by The Joint Commission or CARF is required. 2. In-network and out-of-network days/visits/units shall not be combined so that the combination exceeds the total number of days/visits/units available in this section of the *Mental Health and Substance Abuse Benefits Summary*

	In-Network	Out-of-Network
INPATIENT HOSPITAL FACILITY SERVICES		
• Acute Inpatient Hospitalization • Inpatient Electroconvulsive Therapy (ECT) • Partial Hospitalization/Day Treatment (PHP) **PHP: One (1)** PHP Day Equals **One (1)** Inpatient Day **LIMITATIONS:** Up To **30** Days Total for Inpatient Mental Health Care **Each Contract Year,** and Up to **60** Days Total for Inpatient Mental Health Care Per Lifetime	**Pre-admission Certification Required** **Call 800-925-5327** Covered At **100%** Of Allowed Amount* After Copay **Patient Responsibility:** • **Days 1-3:** **$100** Per Day Copay • **Days 4-19:** **Full Coverage** • **Days 20-30:** **$25** Per Day Copay	**Pre-admission Certification Required** **Call 800-925-5327** Covered At **50%** Of Allowed Amount* **Patient Responsibility:** All Billed Charges Not Covered by The *Plan*
Intensive Outpatient Program (IOP)	**NOT COVERED**	
PROFESSIONAL SERVICES		
• Outpatient Office Visits • Psychological/Neuropsychological Testing **Precertification Required** for Psychological/Neurological Testing if more than **five (5) hours** are requested or **services are provided by an out-of-network provider. Call 800-925-5327** **LIMITATIONS:** Up To **30** Visits/Sessions/ Group Therapy Sessions (Or Any Combination Thereof) Total for Outpatient Mental Health Care **Each Contract Year**	Covered At **100%** Of Allowed Amount* After Copay **Patient Responsibility:** • **Visits 1-5:** **$5** Copay Per Visit • **Visits 6-20:** **$20** Copay Per Visit • **Days 21-30:** **$35** Copay Per Visit	Covered At **50%** Of Allowed Amount* **Patient Responsibility:** All Billed Charges Not Covered by The *Plan*
Inpatient Physician Services in Conjunction with Approved Inpatient Services **LIMITATIONS:** Up To **30** Days Total for Inpatient Mental Health Care **Each Contract Year,** and Up to **60** Days Total for Inpatient Mental Health Care Per Lifetime	Covered At **100%** Of Allowed Amount* **Patient Responsibility: None**	Covered At **50%** Of Allowed Amount* **Patient Responsibility:** All Billed Charges Not Covered by The *Plan*
Anesthesia in Conjunction with Approved ECT Treatment	Covered At **80%** Of Allowed Amount* Subject to the Inpatient Copay Amount **Patient Responsibility: 20%** Of Allowed Amount	Covered At **80%** Of Allowed Amount* **Patient Responsibility:** All Billed Charges Not Covered by The *Plan*
COVERED BY MEDICAL PLAN		
• Ambulance • Emergency Dept. • Imaging • Lab Work	**COVERED BY THE CITY OF MONTGOMERY MEDICAL PLAN**	**COVERED BY THE CITY OF MONTGOMERY MEDICAL PLAN**
BEHAVIORAL HEALTH CARE MANAGEMENT		
Care management is a service offered by *the Plan* to assist you with difficult behavioral health care needs. You have a personal care manager who acts as your advocate, assisting you whenever you have questions or concerns. Call Uprise Health, formerly American Behavioral at 800-925-5327 to talk to your personal care manager.		

***Allowed Amount:** The maximum amount on which payment for covered health care services is based. The allowed amount can often be considerably less than a provider's actual charge, so when you use an out-of-network provider, you can incur substantial out-of-pocket expenses.

Summary of Substance Abuse Benefits for The City of Montgomery

Effective June 1, 2022

Summary Document # 492321101388

IMPORTANT INFORMATION

All benefits are based on the appropriate level of care and medical necessity guidelines.

	In-Network	Out-of-Network
INPATIENT HOSPITAL FACILITY SERVICES		
• Acute Inpatient Hospitalization/Substance Detoxification • Partial Hospitalization/Day Treatment (PHP) **LIMITATION:** Up To **21** Days Total per **12 Consecutive Months** Combined Inpatient Hospitalization/Substance Detoxification, PHP, and IOP	**Pre-admission Certification Required** **Call 800-925-5327** Covered At **100%** Of Allowed Amount* After Per Admission Deductible **Patient Responsibility:** **$500** per Admission Deductible	**NO OUT-OF NETWORK BENEFIT**
Intensive Outpatient Program (IOP) **LIMITATION:** Up To **21** Days Total per **12 Consecutive Months** Combined Inpatient Hospitalization/Substance Detoxification, PHP, and IOP	**Pre-admission Certification Required** **Call 800-925-5327** Covered At **100%** Of Allowed Amount* After Per Admission Deductible **Patient Responsibility:** **$150** per Admission Deductible	

NOTE: Family program and continuing care services are provided through Uprise Health, formerly American Behavioral. Call 800-925-5327

***Allowed Amount:** The maximum amount on which payment for covered health care services is based. The allowed amount can often be considerably less than a provider's actual charge, so when you use an out-of-network provider, you can incur substantial out-of-pocket expenses.