

Auburn University

Mental Health and Substance Abuse Benefits Handbook

Effective January 1- December 31, 2023



Important Information

The benefits described in this *Mental Health and Substance Abuse Benefits Handbook (Handbook)* are provided in conjunction with the *Auburn University Employee Health Plan*. Please refer to the *Auburn University Employee Health Plan* benefit 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 *Auburn University Employee Health Plan Benefit Handbook* 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 Auburn University. Uprise Health provides utilization management, claim administration, and provider network services to the plan, but Uprise Health does not insure the benefits described in this *Handbook*.

Welcome Employees and Family Members

We are pleased that Auburn University has selected Uprise Health to serve as your behavioral health care benefits administrators.

Since its inception in 1990, Uprise Health 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 currently serves corporations throughout the United States.

Uprise Health 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 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 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.

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Important Contact Information

Do You Have Questions?

Please call Uprise Health 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.

Corporate Headquarters

2 Park Plaza, Ste 1200
Irvine, CA 92614

Telephone: 1-205-871-7814

Toll Free: 1-800-677-4544

Main Fax: 1-205-868-9600

Clinical Services Fax: 1-205-868-9625

Web Site

www.uprisehealth.com

Uprise Health Web Portal

The Uprise Health Member Web Portal allows you to take charge of your benefit information. The portal gives you additional access to services and ease of obtaining network provider information.

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

- Requesting EAP Authorizations;
- Searching for Providers in-network;
- Submitting Claims for Reimbursement;
- Changing Demographic Information;
- Tracking Requests; and
- Contacting Uprise Health.

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/> and click "Don't Have an Account? → Register Now!" under the Member Portal Login section. Enter your Last name and Date of Birth and press "Next." Verify your Health Plan matches your employe name and click "Next." Once you submit your information, it will be validated for access. An e-mail notification will be sent to the address you provide. Please note that each member and/or dependent must register separately and have his/her own login. Your log-in information is confidential. If you want to exclude your information from this Web site in the future, call the Customer Service number Monday - Friday during business hours.

Finding a Behavioral Health Care Provider

How to Find a Network Provider

As an Uprise Health member, you have access to a network of providers. To find a network provider, call Uprise Health 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 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 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
- Psychiatrists;
- Psychiatric nurse practitioners; and
- Psychologists.

IMPORTANT: A provider can be a covered provider type but not a network provider. Call Uprise Health 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.

What You Pay for Behavioral Health Services

Your Deductibles

A deductible is a fixed dollar amount you pay each calendar year before the *Plan* begins paying most benefits.

What Does Not Count Toward My Deductible?

- Services you pay for that are not covered by the *Plan*;
- Services that are exempt from the deductible, even if you had out-of-pockets costs;
- Charges for services exceeding benefit maximums; and
- Charges for services beyond benefit limits.

How Does the Deductible Work with Families?

The family deductible is embedded, meaning that each member has his or her own deductible in addition to the shared family deductible. Any amount paid toward an individual's deductible also applies toward the family's deductible. This allows individuals in the family to have their costs covered before the family deductible has been met. Once the family deductible is met, the plan covers charges for any family member.

What Is Co-insurance?

Co-insurance refers to the percentage of the allowed amount that you pay for most services when the *Plan* pays less than 100% of the allowed amount.

What Is a Copayment?

A copayment is a flat dollar amount you pay when you receive services. Depending on the type of service, the copayment may be applied per visit, per day, etc.

NOTE: See your *Summary of Mental Health and Substance Abuse Benefits* included with this *Handbook* for specific copayment amounts.

When Do I Pay?

Copayments are due at the time services are rendered.

What Is the Out-of-Pocket Maximum?

The out-of-pocket maximum is the maximum total amount you pay to your providers for covered services during a plan year (see below for expenses not included). Once you have reached this limit, the *Plan* pays 100% of the allowed amount for covered services for the rest of the plan year.

The family out-of-pocket maximum is embedded, meaning that each member has his or her own out-of-pocket maximum in addition to the shared family out-of-pocket maximum. Any amount paid toward an individual's out-of-pocket maximum also applies toward the family's out-of-pocket maximum. This allows individuals in the family to have their costs covered before the family out-of-pocket maximum has been met. Once the family out-of-pocket maximum is met, the plan covers charges for any family member.

Your calendar year deductible counts toward your out-of-pocket maximum, but the following costs do not:

- Services and expenses that are not covered;
- Charges for services exceeding benefit maximums;
- Charges in excess of the allowed amount; and
- Charges for services beyond benefit limits.

IMPORTANT: In and out-of-network out-of-pocket maximums may accumulate separately. See the *Summary of Mental Health & Substance Abuse Benefits* included with this *Handbook*.

IMPORTANT: Services by out-of-network providers are never paid at 100%. Even after you reach your out-of-pocket maximum, the provider may balance bill you for costs in excess of the allowed amount.

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 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 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:

Autism Treatment

The *Plan* offers coverage for screening, diagnosis, and treatment of autism spectrum disorder, including applied behavior analysis (ABA). Treatment for autism spectrum disorder must be prescribed by the child's treating physician or psychologist in accordance with a treatment plan and can include medication management and counseling.

Note: See the *Auburn University Autism Spectrum Disorder Benefits Handbook* for more specific information about autism benefits.

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 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 with The Joint Commission or the Commission on Accreditation of Rehabilitation Facilities (CARF).

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.

Inpatient Catastrophic 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.

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 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 psychoeducation 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.

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 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 pre-certified.

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

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 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 pre-certification are not approved before being provided, no benefits will be payable for the admission or the services provided by the admitting physician.

Receiving pre-certification 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 pre-certification requirements, call Uprise Health 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
 - Neurofeedback
 - 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. **Aroma therapy**
7. **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 during 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. **Expressive therapies** (e.g., psychodrama) when billed as separate services

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
7. Any services or expenses incurred during treatment that is **investigational or experimental** in nature. These services do not meet the following criteria:
 - They have not been demonstrated through existing peer-reviewed, evidence-based, scientific literature to be safe and effective for treating or diagnosing the condition or sickness for which its use is proposed, and/or
 - These services have not been approved by the U.S. Food and Drug Administration (FDA) or other appropriate regulatory agency to be lawfully marketed for the proposed use

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. **Marriage therapy**
2. 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

3. 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
4. Over-the-counter or prescription **medication**
5. The *Plan* shall not be responsible for charges incurred for **missed appointments**
6. Any services or expenses incurred during care provided when the member does not demonstrate **motivation for treatment** or willingness to comply with the treatment plan

N

1. **Neuropsychological testing** that is not conducted by a licensed clinical neuropsychologist
2. **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
3. Therapy services or expenses of any kind for **nicotine addiction** (e.g., smoking cessation treatment)
4. **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 **pre-certified**
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. Any services or expenses incurred during **respite care**
4. Any services or expenses incurred during **rest cures**
5. **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** 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**, email, 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. Services or expenses of any kind for **caffeine intoxication**
2. **Intellectual disability** as the primary diagnosis except for the purpose of making the initial diagnosis
3. **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.
4. **Specific learning disorders** as the primary diagnosis, except for making the initial diagnosis.
5. **Motor disorders** as the primary diagnosis, except for making the initial diagnosis.
6. **Truancy, disciplinary, or other behavioral problems** as the primary diagnosis.

If You Have Other Coverage

Coordination of Benefits

Coordination of benefits applies when you have coverage under this benefit package and one or more other benefit plans. The coordination of benefits provisions in this section apply to the benefits described in this *Handbook*. Separate coordination of benefits rules may apply to other benefits provided by your employer through its group health plan.

NOTE: In order for Uprise Health to determine which plan is primary, you are required to notify the *Plan* about any other behavioral health care coverage you have in addition to the coverage provided by the *Plan*.

NOTE: If you have questions concerning coordination of benefits, call Uprise Health at 1-800-677-4544.

Workers' Compensation

Compensation is dependent on your employer's Workers' Compensation benefit.

Benefit Determinations

Uprise Health and the other plan(s) providing benefits shall determine which plan is primarily responsible for payment of covered benefits (e.g., the primary plan). If the *Plan* is primary, only those services outlined in this *Handbook* are covered services. If your other plan is primary, the *Plan* is secondary. The other plan must, therefore, pay up to its maximum benefit level after which the *Plan* shall pay for any remaining expenses subject to the following provisions:

- The total combined payment by the *Plan* and any other plan to you or on your behalf shall not exceed the maximum amount that the *Plan* would pay if it were primary
- The *Plan* shall not cover services rendered to you that were denied by the primary plan due to your failure to comply with its terms and conditions, except when such services were provided by or under the care of a network provider.
- The *Plan* shall not be liable for payments for any services or supplies that are not covered services as outlined in this *Handbook*. All requirements must be met in order for services to be covered services even when the *Plan* is secondary.
- Benefits will only be paid when covered services are provided by network providers, or when the *Plan* has an out-of-network coverage benefit.

Which Plan is Primary?

The rules determining whether the *Plan* or another plan is primary will be applied in the following order:

- The noncompliant plan or the plan having no coordination of benefits provision or non-

duplication of coverage exclusion shall always be primary. A noncompliant plan has coordination of benefits rules that are not consistent with the order of benefit determination rules of this Plan, e.g., a plan that states its benefits are always secondary.

- The plan covering a member who is the subscriber is the primary plan. In addition, the benefits of a plan that covers a member as an employee who is neither laid off nor retired (or as that employee's dependent) are determined before those of a plan that covers the member as a laid off or retired employee (or as that employee's dependent). If the other plan does not have this rule, and if, as a result, the plans do not agree about benefits, this provision is ignored.
- The following is known as *The Birthday Rule*: The plan of the parent whose birthday comes first in the calendar year shall be primary with respect to dependent coverage. The year of birth is ignored. This rule is subject to the following rules for divorced or separated parents:
 - If the parents have the same birthday, the benefits of the plan that covered one parent longer are determined before those of the plan that covered the other parent for a shorter period.
 - If there is a court decree that establishes financial responsibility for medical, dental, or other health care expenses for the child, the plan covering the child as a dependent of the parent who has the responsibility will be primary.
 - If the specific terms of a court decree state that the parents shall share joint custody without stating that one of the parents is responsible for the health care expenses of the child, the plans covering the child shall follow the order of benefit determination rules that apply to dependents of parents who are not separated or divorced.
 - In the absence of a court decree, the plan of the parent with legal custody will be primary.
 - If the parent with custody has remarried, the order of benefits will be:
 - The plan of the parent with custody;
 - The plan of the stepparent with custody;
 - The plan of the parent without custody; and
 - The plan of the stepparent without custody.
- If none of the above rules determine the order of benefits, the benefits of the plan that covered a member or subscriber longer are determined before those of a plan that covered that person for the shorter time.

How Does Uprise Health Pay When They Are Primary?

When Uprise Health is the primary payer (pays first), Uprise Health pays its normal benefit (as described in this *Handbook*). You may need to send the Uprise Health *Explanation of Benefits* (EOB) and a copy of your provider's bill to your secondary payer to receive payment. Check with that plan for more information.

What Happens When Medicare is Secondary to Uprise Health?

NOTE: When Medicare pays after Uprise Health, your provider must bill Medicare after Uprise

Health pays; Uprise Health does not bill Medicare.

If Uprise Health is your primary coverage and Medicare is secondary, make sure that you tell Medicare about your Uprise Health coverage and that your provider agrees to bill Medicare as secondary to get the maximum benefit from both plans. The provider would need to bill Medicare after Uprise Health has processed the claim.

NOTE: For more detailed information concerning how the *Plan* coordinates benefits with Medicare, see the *Coordination of Benefits* section of the health plan *Summary Plan Description*.

How Does Uprise Health Coordinate Benefits When They Are Secondary?

It is not intended that payments made for services rendered to you shall exceed one hundred percent (100%) of the cost of the services provided. Therefore, Uprise Health pays only an amount needed to bring the total benefit up to the amount the *Plan* would have paid if you did not have other coverage. This is called nonduplication of benefits.

If duplicate coverage occurs, the *Plan* may recover from you or from any other plan under which you are covered proceeds consisting of benefits payable to you or on your behalf, up to the amount of the *Plan's* cost obligation for covered services.

Billing & Payment: Filing a Claim

Submitting a Claim for Behavioral Health Services

When Uprise Health 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 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 for payment if you receive services from an out-of-network provider or if you have other coverage that pays first and Uprise Health is secondary.

How Do I Submit a Claim?

To submit a claim yourself, you will need to obtain and mail the following documents:

- The *Behavioral Health Reimbursement Form* (You can receive a copy of this form by calling Uprise Health at 1-800-677-4544);
- The provider claim document;
- Your receipt; and
- If applicable, the *Explanation of Benefits* (EOB) from the primary payer.

Be sure to make copies of your documents for your records and mail the original documentation to the attention of "Claims." If you have a question about the processing of your claim, call the Uprise Health Claims Department at 1-800-677-4544.

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, you have the following rights and responsibilities:

Your Rights

Uprise Health 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 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 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 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, 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 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 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 follows its *Privacy Policy*, which is available 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 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:

- 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 information written in other languages

If you need these services, contact Uprise Health 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, 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 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.

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.

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.

To submit a claim yourself, you will need to obtain and mail the following documents:

- The *Behavioral Health Reimbursement Form* (You can receive a copy of this form by calling Uprise Health at 1-800-677-4544);
- The provider claim document;
- Your receipt; and
- If applicable, the *Explanation of Benefits (EOB)* from the primary payer.

Be sure to make copies of your documents for your records and mail the original documentation to the attention of "Claims." If you have a question about the processing of your claim, call the Uprise Health Claims Department at 1-800-677-4544.

Claims must be submitted and received by us within 180 days 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 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 appeal (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 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 Through Uprise Health

IMPORTANT: Uprise Health 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 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.

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 has two levels of appeal. The non-urgent/standard appeal is the final level of appeal. You may request a non-urgent/standard appeal if a previously filed urgent/expedited appeal resulted in an adverse determination.

You must request an appeal within 180 calendar days from the receipt date of our letter that contained the adverse determination decision.

Urgent Process (Expedited Appeal)

You or your provider(s) may request an expedited appeal by calling 1-800-677-4544. We will review the hours of the appeal request.

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 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.

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

FOR MORE INFORMATION: If you have any questions about appeals or complaints, contact Uprise Health using the contact information listed in the *Birmingham Office* portion of the *Important Contact Information* section of this *Handbook*.

NOTE: Appeals procedures are subject to change during the year if required by Federal or Alabama 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, and external or independent review.

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 members 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. This form must be completed and returned to Uprise Health 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 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 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 at 1-800-677-4544. Send the form to the address on the form. Uprise Health 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.

External or Independent Review

You may request an external or independent review only when the denial is based on one of the following:

- Medical necessity;
- Appropriateness;
- Health care setting;
- Level of care; and/or
- Effectiveness of a covered benefit.

If you have gone through both a first- and second-level appeal and your appeal was based

on one of the issues listed above, you may request an external or independent review in the following situations:

- If the *Plan* has exceeded the timelines for response to your appeal without good cause and without reaching a decision;
- If you are dissatisfied with the decision of your second-level appeal.; and/or
- If the *Plan* has failed to strictly adhere to the requirements of the appeals process.

You must request an independent review no more than 180 days after the date of the letter responding to your second-level appeal. The enrollee or an authorized representative can request an independent review.

To request an external or independent review, contact the *Plan* by telephone or you can submit your request in writing. (See the *Birmingham Office* portion of the *Important Contact Information* section of this *Handbook*.)

Uprise Health will send the relevant medical information and correspondence to the independent review organization.

You may pursue litigation against Uprise Health

- Instead of requesting an independent review;
- After an independent review decision; and
- When your appeal is not eligible for an independent review.

An external review determination is binding unless other remedies are available under state or federal law. If a final external review determination reverses the *Plan's* decision and you or the *Plan* decides to pursue other remedies available under state or federal law, the *Plan* must provide benefits, including making payment on a claim until there is a judicial decision changing the external review determination.

NOTE: An independent review organization (IRO) will conduct the external review. An IRO is a group of medical and benefit experts qualified to perform the review. These experts are not employed or otherwise related to Uprise Health.

An IRO is intended to provide unbiased, independent clinical and benefit expertise as well as evidence-based decision making while ensuring confidentiality. The IRO reviews your appeal to determine if the *Plan's* decision is consistent with State law and the *Plan's Mental Health and Substance Abuse Benefits Handbook*. The *Plan* will pay the IRO's charges.

Rights of Uprise Health

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 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 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.

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: Your share of the costs of a covered health care service, calculated as a percentage.

Copayment: A fixed dollar amount you pay for a covered health care service, usually when you receive the service. The amount can vary by the type of covered health care service.

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: The *Plan* only covers service provided by providers of certain licensures. Covered provider types under the *Plan* include licensed clinical therapists, neuropsychologists, psychologists, physician assistants, psychiatrists, and psychiatric nurse practitioners. A covered provider type may not be a network provider.

Deductible: The amount you owe for health care services your health insurance or plan covers before your health insurance or plan begins to pay. For example, if your deductible is \$1000.00, your plan will not pay anything until you've met your \$1000.00 deductible for covered health care services subject to the deductible. The deductible may not apply to all services.

In addition, the family deductible is embedded, meaning that each member has his or her own deductible and out-of-pocket maximum in addition to the shared family deductible. Any amount paid toward an individual's deductible also applies toward the family's deductible. This allows individuals in the family to have their costs covered before the family deductible has been met. Once the family deductible is met, the plan covers charges for any family member.

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

Embedded: See *Deductible or Out-Pocket-Maximum*

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: See *Provider, Network Provider, and Out-of-Network Provider*.

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: Health care services needed to diagnose and treat behavioral health conditions that meet accepted standards of medicine.

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 provider contracted with the *Plan* to provide services to you at an agreed upon reimbursement rate.

Noncovered Services: See *Exclusions*.

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.

Out-of-Pocket Maximum: The most you pay during a *Plan* year before the *Plan* begins to pay 100% of the allowed amount. This limit never includes your premium, balance-billed charges, charges in excess of the allowed amount, or health care that the *Plan* does not cover.

In addition, the family out-of-pocket maximum is embedded, meaning that each member has his or her own out-of-pocket maximum in addition to the shared family out-of-pocket maximum. Any amount paid toward an individual's out-of-pocket maximum also applies toward the family's out-of-pocket maximum. This allows individuals in the family to have their costs covered before the family out-of-pocket maximum has been met. Once the family out-of-pocket maximum is met, the plan covers charges for any family member.

Physician Services: Health care services coordinated and/or provided by a licensed medical

doctor (MD) or doctor of osteopathic medicine (DO).

Plan: A benefit your employer, union or other group sponsor provides to you to pay for your health care services.

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: A decision by the *Plan* that a health care service or treatment plan has been deemed medically necessary. Pre-certification is not a promise that the *Plan* will cover the cost.

Primary Plan: For members covered by more than one health plan, the primary plan is chiefly responsible for payment of covered benefits.

Provider: A licensed physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine) or health care professional who is licensed and/or certified by Federal and/or State law. A health care facility is a provider that is licensed by Federal and/or State law and accredited by The Joint Commission or CARF.

Secondary Plan: For members covered by more than one health plan, the secondary plan is the plan that pays for any remaining expenses after the primary plan has paid up to its maximum benefit level.

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).

مناحة 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 ગજરાતી બોલતા હોય, તો ભાષા સહાયતા સેવા, તમારા માટે નિ:શુલ્ક ઉપલબ્ધ છે. 1-855-216-3144 પર કોલ 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 सेवा नि:शुल्क उपलब्ध है। 1-855-216-3144 (TTY: 711) पर कॉल करें।

Laotian: ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອ ພາສາ, ໂດຍບໍ່ເສັຽ ຮ່າ ງ, ແມ່ນມີມາ ອມໃຫ້ ທ່ານ. ໂທ 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 and Substance Abuse Benefits for Auburn University

PPO Plan

Uprise Health (formerly American Behavioral)

Effective January 1, 2024

Summary Document #: 559777215383

IMPORTANT INFORMATION: 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.

Calendar Year Deductible	<p>\$500 Per Person Per Year with a Three (3) Member Family Maximum</p> <p>4th Quarter Carryover Deductible: Any covered expenses incurred in the last 3 months of any benefit period which may have been allocated toward all or a portion of the Calendar Year Deductible for that year may also be allocated toward next year's Calendar Year Deductible</p>
Calendar Year Out-of-Pocket Maximum	\$9,450 Individual / \$18,900 Aggregate Family Maximum

1. Your calendar year deductible counts toward your out-of-pocket maximum.
2. The deductible amounts for mental health and substance abuse combine with medical for total deductible.
3. The family calendar year deductible and out-of-pocket maximum is embedded, meaning that each member has his or her own deductible/out-of-pocket maximum in addition to the shared family deductible/out-of-pocket maximum. Any amount paid toward an individual's deductible/out-of-pocket maximum also applies toward the family's deductible/out-of-pocket maximum. This allows individuals in the family to have their costs covered before the family deductible/out-of-pocket maximum has been met. Once the family deductible/out-of-pocket maximum is met, the plan covers charges for any family member.
4. **Deductible Carryover:** When covered charges are applied towards the calendar year deductible for services rendered in October, November, or December, those covered charges will be credited towards the calendar year deductible for the following year.

MENTAL HEALTH PROGRAM

1. INPATIENT SERVICES		
Benefits	In-Network	Out-of-Network
<ul style="list-style-type: none"> • Acute Inpatient Hospitalization • Residential • Inpatient Electroconvulsive Therapy (ECT) • Partial Hospitalization/Day Treatment (PHP) • Intensive Outpatient Program (IOP) 	<p>Pre-admission Certification Required Call 800-677-4544</p> <p>Covered At 100% Of Allowed Amount After Copay, Subject to Calendar Year Deductible Patient Responsibility: \$300 Copay Per Admission Subject to Calendar Year Deductible</p>	<p>Pre-admission Certification Required Call 800-677-4544</p> <p>Covered At 80% Of Allowed Amount Subject to Calendar Year Deductible Patient Responsibility: All Billed Charges Not Covered by The Plan</p>
2. OUTPATIENT OFFICE VISITS		
Description	In-Network	Out-of-Network
Outpatient Office Visits	Covered At 100% Of Allowed Amount After Copay Patient Responsibility: \$30 Copay Per Visit/Session/Group Therapy Session	Covered At 80% Of Allowed Amount Patient Responsibility: All Billed Charges Not Covered by The Plan
3. PSYCHOLOGICAL/NEUROPSYCHOLOGICAL TESTING		
Description	In-Network	Out-of-Network
Psychological/Neuropsychological Testing	<p>Precertification Required Call 800-677-4544</p> <p>Covered At 100% Of Allowed Amount After Copay Patient Responsibility: \$30 Copay Per Visit/Session/Group Therapy Session</p>	<p>Precertification Required Call 800-677-4544</p> <p>Covered At 80% Of Allowed Amount Patient Responsibility: All Billed Charges Not Covered by The Plan</p>

SUBSTANCE ABUSE PROGRAM		
1. INPATIENT SERVICES		
Benefits	In-Network	Out-of-Network
<ul style="list-style-type: none"> • Detoxification • Partial Hospitalization/Day Treatment (PHP) • Intensive Outpatient Program (IOP) • Residential Treatment Services 	<p>Pre-admission Certification Required Call 800-677-4544</p> <p>Covered At 100% Of Allowed Amount After Copay, Subject to Calendar Year Deductible Patient Responsibility: \$300 Copay Per Admission Subject to Calendar Year Deductible</p>	<p>Pre-admission Certification Required Call 800-677-4544</p> <p>Covered At 80% Of Allowed Amount Subject to Calendar Year Deductible Patient Responsibility: All Billed Charges Not Covered by The Plan</p>
2. OUTPATIENT OFFICE VISITS		
Ambulatory Detoxification (Office Visit)	Covered At 100% Of Allowed Amount After Copay Patient Responsibility: \$30 Copay Per Visit/Session/Group Therapy Session	Covered At 80% Of Allowed Amount Patient Responsibility: All Billed Charges Not Covered by The Plan
APPLIED BEHAVIOR ANALYSIS (ABA) FOR THE TREATMENT OF AUTISM SPECTRUM DISORDERS		
Benefits	In-Network	Out-of-Network
<p>Applied Behavior Analysis (ABA) for the Treatment of Autism Spectrum Disorders</p> <p>Based on Eligibility and Clinical Criteria Being Met</p>	<p>Pre-certification Required Call 800-677-4544</p> <p>Covered At 100% Of Allowed Amount Patient Responsibility: None</p> <p>Exclusion: In-home care not covered</p>	<p>Covered At 80% Of Allowed Amount Patient Responsibility: All Billed Charges Not Covered by The Plan</p> <p>Exclusion: In-home care not covered</p>
PROFESSIONAL SERVICES		
Benefits	In-Network	Out-of-Network
Inpatient Physician Services in Conjunction with Approved Inpatient Services	Covered At 100% Of Allowed Amount Patient Responsibility: None	Covered At 80% Of Allowed Amount Patient Responsibility: All Billed Charges Not Covered by The Plan
Anesthesia in Conjunction with Approved ECT Treatment	Covered At 100% Of Allowed Amount Subject to the Inpatient Copay Amount Patient Responsibility: None	Covered At 80% Of Allowed Amount Patient Responsibility: All Billed Charges Not Covered by The Plan
COVERED BY MEDICAL PLAN		
<ul style="list-style-type: none"> • Ambulance • Emergency Department • Imaging • Lab Work 	COVERED BY THE AUBURN UNIVERSITY MEDICAL PLAN THROUGH BCBSAL	COVERED BY THE AUBURN UNIVERSITY MEDICAL PLAN THROUGH BCBSAL
BEHAVIORAL HEALTH CARE MANAGEMENT		
<p>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, (formerly American Behavioral) at 800-677-4544 to talk to your personal care manager.</p>		

**Summary of Mental Health and Substance Abuse Benefits for Auburn University
High Deductible Health Plan – HSA Qualified
Uprise Health (formerly American Behavioral)
Effective January 1, 2024**

Summary Document #: 559777215383

IMPORTANT INFORMATION: 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.

SUMMARY OF COST SHARING PROVISIONS

Calendar year deductibles and out-of-pocket maximums will be calculated in accordance with applicable Federal law.

BENEFIT	IN-NETWORK	OUT-OF-NETWORK
<p>Calendar Year Deductible</p> <p>For self-only coverage, no benefits, except preventive care, are paid by the plan until medical expenses paid by the individual equal the deductible amount. For employee + spouse, Employee + child(ren) or family Coverage, no benefits, except preventive care, are paid by the plan until the total medical expenses paid by the covered family members equal the family deductible amount.</p>	<p>\$2,500 self-only coverage; \$5,000 family coverage.</p> <p>Deductible amounts met in-network will apply to the out-of-network deductible</p>	<p>\$5,000 self-only coverage; \$10,000 family coverage.</p> <p>Deductible amounts met out-of-network will apply to the in-network deductible.</p>
<p>Calendar Year Out-of-Pocket Maximum</p> <p>After you reach your self-only Calendar Year Out-of-Pocket Maximum (even if you are covered under a family contract), applicable expenses for you will be covered at 100% of the allowed amount for remainder of calendar year. If you have employee + spouse, employee + child(ren) or family coverage, the total out of pocket expenses for all covered members will not exceed the family out of pocket limit.</p>	<p>\$5,000 self-only coverage; \$10,000 Family coverage</p> <p>Deductibles, copays and coinsurance for in-network services and out-of-network mental health and substance abuse emergency services apply to the in-network out-of-pocket maximum</p>	<p>There is no out-of-network out-of-pocket maximum</p>

- Your calendar year deductible counts toward your out-of-pocket maximum
- The deductible amounts for mental health and substance abuse combine with medical for total deductible.
- The family calendar year deductible and out-of-pocket maximum is embedded, meaning that each member has his or her own deductible/out-of-pocket maximum in addition to the shared family deductible/out-of-pocket maximum. Any amount paid toward an individual's deductible/out-of-pocket maximum also applies toward the family's deductible/out-of-pocket maximum. This allows individuals in the family to have their costs covered before the family deductible/out-of-pocket maximum has been met. Once the family deductible/out-of-pocket maximum is met, the plan covers charges for any family member.
- Deductible Carryover: When covered charges are applied towards the calendar year deductible for services rendered in October, November, or December, those covered charges will be credited towards the calendar year deductible for the following year.

MENTAL HEALTH PROGRAM

4. INPATIENT SERVICES

Benefits	In-Network	Out-of-Network
<ul style="list-style-type: none"> Acute Inpatient Hospitalization Residential Inpatient Electroconvulsive Therapy (ECT) Partial Hospitalization/Day Treatment (PHP) Intensive Outpatient Program (IOP) 	<p>Pre-admission Certification Required Call 800-677-4544</p> <p>Covered At 80% Of Allowed Amount Subject to Calendar Year Deductible Patient Responsibility: All Billed Charges Not Covered by The Plan</p>	<p>Pre-admission Certification Required Call 800-677-4544</p> <p>Covered At 60% Of Allowed Amount Subject to Calendar Year Deductible Patient Responsibility: All Billed Charges Not Covered by The Plan</p>

5. OUTPATIENT OFFICE VISITS

Description	In-Network	Out-of-Network
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Outpatient Office Visits	Covered At 80% Of Allowed Amount Patient Responsibility: All Billed Charges Not Covered by The Plan	Covered At 60% Of Allowed Amount Patient Responsibility: All Billed Charges Not Covered by The Plan
6. PSYCHOLOGICAL/NEUROPSYCHOLOGICAL TESTING		
Description	In-Network	Out-of-Network
Psychological/Neuropsychological Testing	Pre-certification Required Call 800-677-4544 Covered At 80% Of Allowed Amount Patient Responsibility: All Billed Charges Not Covered by The Plan	Pre-certification Required Call 800-677-4544 Covered At 60% Of Allowed Amount Patient Responsibility: All Billed Charges Not Covered by The Plan
SUBSTANCE ABUSE PROGRAM		
3. INPATIENT SERVICES		
Benefits	In-Network	Out-of-Network
<ul style="list-style-type: none"> • Detoxification • Partial Hospitalization/Day Treatment (PHP) • Intensive Outpatient Program (IOP) • Residential Treatment Services 	Pre-admission Certification Required Call 800-677-4544 Covered At 80% Of Allowed Amount Subject to Calendar Year Deductible Patient Responsibility: All Billed Charges Not Covered by The Plan	Pre-admission Certification Required Call 800-677-4544 Covered At 60% Of Allowed Amount Subject to Calendar Year Deductible Patient Responsibility: All Billed Charges Not Covered by The Plan
4. OUTPATIENT OFFICE VISITS		
Ambulatory Detoxification (Office Visit)	Covered At 80% Of Allowed Amount Subject to Calendar Year Deductible Patient Responsibility: All Billed Charges Not Covered by The Plan	Covered At 60% Of Allowed Amount Patient Responsibility: All Billed Charges Not Covered by The Plan
APPLIED BEHAVIOR ANALYSIS (ABA) FOR THE TREATMENT OF AUTISM SPECTRUM DISORDERS		
Benefits	In-Network	Out-of-Network
Applied Behavior Analysis (ABA) for the Treatment of Autism Spectrum Disorders Based on Eligibility and Clinical Criteria Being Met	Pre-certification Required Call 800-677-4544 Covered At 80% Of Allowed Amount after deductible Patient Responsibility: All Billed Charges Not Covered by The Plan Exclusion: In-home care not covered	Covered At 60% Of Allowed Amount after deductible Patient Responsibility: All Billed Charges Not Covered by The Plan Exclusion: In-home care not covered
PROFESSIONAL SERVICES		
Benefits	In-Network	Out-of-Network
Inpatient Physician Services in Conjunction with Approved Inpatient Services	Covered At 80% Of Allowed Amount after deductible Patient Responsibility: All Billed Charges Not Covered by The Plan	Covered At 60% Of Allowed Amount after deductible Patient Responsibility: All Billed Charges Not Covered by The Plan
Anesthesia in Conjunction with Approved ECT Treatment	Covered At 80% Of Allowed Amount Patient Responsibility: All Billed Charges Not Covered by The Plan	Covered At 60% Of Allowed Amount Patient Responsibility: All Billed Charges Not Covered by The Plan

COVERED BY MEDICAL PLAN

<ul style="list-style-type: none">• Ambulance• Emergency Department• Imaging• Lab Work	<p>COVERED BY THE AUBURN UNIVERSITY MEDICAL PLAN THROUGH BCBSAL</p>	<p>COVERED BY THE AUBURN UNIVERSITY MEDICAL PLAN THROUGH BCBSAL</p>
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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, (formerly American Behavioral) at 800-677-4544 to talk to your personal care manager.