CERTIFICATE FOR GROUP MENTAL HEALTH AND SUBSTANCE ABUSE BENEFITS

PLAN 300

ADDENDUM B

CITY OF FOLEY

Effective Date: JANUARY 1, 2014

Administered By:

APPROVED:

_____

Signature Date

_____

Its:

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American Behavioral®

Welcome Covered Employees And Family Members

We are pleased that your employer has selected American Behavioral to serve as your behavioral healthcare benefits administrator. Since its inception in 1990, our company has achieved success as a managed behavioral health organization by being responsive and flexible in serving businesses, industries, employees and families. American Behavioral has continued to earn a solid pattern of growth throughout this time, and currently serves corporations throughout the United States.

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

Employee Assistance Program Services (If Applicable)

The Employee Assistance Program (EAP) is designed to provide assessment, brief counseling and referral services for eligible employees and dependents. It is a confidential service to assist you in identifying and resolving common problems of every day life, including issues such as:

- Marital and Family Problems
- Job Stress
- Alcohol and other Drug Dependencies
- Financial/Legal Referrals
- Child Care or Elder Care Concerns
- Wellness Coaching

Both face-to-face and telephonic counseling sessions are available through the EAP. Call our toll free number to schedule an appointment today, 800-925-5EAP (5327).

There are also an additional 20,000 on-line resources in the Personal Advantage section of the American Behavioral website including:

- Over 3,500 Clinically Reviewed Articles
- 700 Videos on Behavioral Health and Well-Being
- 150 Videos on Parenting, Child Care, Family Care and Elder Care
- Numerous Health and Well-Being Videos
- 300 Consumer Friendly Financial Calculators
- Thousands of Helpful Federal and State Tax Forms
- Hundreds of Legal Forms, including Wills and Advance Directives

Visit our website: www.americanbehavioral.com or ask your Human Resource Representative for information on how to access the website.

Managed Behavioral Healthcare Services (If Applicable)

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 Disorders
- Anxiety Disorders
- Mood Disorders
- Alcohol and/or Substance Abuse Disorders

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

The following levels of care are available through this program:

- Crisis Assessment
- Outpatient Treatment
- Intensive Outpatient Treatment Program
- Partial Hospitalization/Day Treatment Program
- Acute Psychiatric Inpatient Hospitalization
- Detoxification Services
- Electroconvulsive Therapy
- Case Management
- Ambulance and Emergency Care

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 healthcare needs.

Summary Plan Description

The benefits described in this *Certificate For Group Mental Health and Substance Abuse Benefits Plan 300 (Certificate)* are provided in conjunction with your Employer's group health plan. Please refer to your Employer's group health plan booklet for important additional information such as eligibility, enrollment, privacy and security of your protected health information, and COBRA rights. To the extent that the benefits described in this *Certificate* and your Employer's group health plan are subject to the *Employee Retirement Income Security Act of 1974* ("ERISA"), this *Certificate* is considered to be a supplement to your Employer's group health plan *Summary Plan Description* (SPD), which may be the same document as the group health plan booklet discussed above.

Member Rights and Responsibilities

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

Member Rights

American Behavioral believes that every Member has 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 American Behavioral services, Providers, clinical guidelines, quality improvement programs, Member rights and responsibilities and any other rules or guidelines used in making coverage and payment decisions;
- A clear explanation of your health plan benefits and how to access services;
- Access to services and Providers that meet your needs;
- Choose or change your Provider;
- Request an interpreter or assistance for language translation or hearing problems;
- Participate in making your health care decisions by receiving appropriate information about your diagnosis, treatment options and prognosis;
- Participate in decisions concerning your care and treatment plan;
- An individualized treatment plan that is periodically reviewed and updated;
- Refuse or consent to treatment or tests to the extent provided by law and be made aware of the medical consequences of such decisions;
- Refuse to participate in any proposed investigational studies, clinical trials, or research projects;
- Receive treatment within the least restrictive environment;
- Give your health care Provider "advanced directives" (also called a "living will" or a "durable power of attorney for health care") concerning options when you are unable to direct your own care. This may include your wishes concerning life support such as a respirator, tube feedings or the use of dialysis;
- Be informed of the reason for any adverse determination by utilization management, including the specific utilization review criteria or benefits provision used in the determination;
- Utilization Management decisions based on appropriateness of care. American Behavioral does not reward Providers or other individuals conducting Utilization Review for issuing adverse determinations;
- Submit either positive or negative comments concerning your care to American Behavioral, your health care Provider(s) or your employer;
- Information about how to file a formal complaint or appeal;
- Voice complaints regarding use or disclosure of protected health information;
- Receive a copy of these rights and responsibilities;
- Make recommendations regarding these rights and responsibilities; and
- To appoint your next of kin, a legal guardian or legal designee to exercise these rights if you are unable to do so.

Member Responsibilities

American Behavioral believes that every Member has 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
- Ensure timely payment for your treatment.

I. Eligibility

Employee and Dependent eligibility is determined by the Employer. Please see your Employer's group health plan booklet and/or SPD for additional information.

II. Coordination of Benefits

Coordination of Benefits applies when a Covered Employee or Covered Dependent has health coverage under the *Group Mental Health and Substance Abuse Benefits Plan 300* (*Plan*) and one or more other plans. The Coordination of Benefits provisions in this section apply to the benefits described in this *Certificate*. Separate Coordination of Benefits rules may apply to other benefits provided by your employer through its group health plan. Please refer to your Employer's group health plan booklet/SPD for any such Coordination of Benefits provisions.

A. Duplicate Coverage Not Intended

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, in the case of duplicate coverage, 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.

B. Workers' Compensation

The *Plan* will not cover services required to be covered under applicable Workers' Compensation Law whether or not the Employer has Workers' Compensation coverage.

C. Benefit Determinations

The *Plan* 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 *Certificate* 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:

1. 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.

2. 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 Participating Provider.

3. The *Plan* shall not be liable for payments for any services or supplies that are not Covered Services as outlined in this *Certificate*. All requirements must be met in order for services to be Covered Services even when the *Plan* is secondary.

4. Benefits will only be paid when Covered Services are provided by Participating Providers, or when the *Plan* has an out-of-network coverage benefit, except for treatment of Emergency Psychiatric Conditions when a non-Participating Provider is the nearest Provider as determined by American Behavioral (unless use of a non-Participating Provider is dictated by ambulance or hospital policy). You are required to notify us within 48 hours or as soon as reasonably possible after Emergency Services are initially provided

D. Order of Benefit Determination Rules

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

1. The plan having no coordination of benefits provision or non-duplication coverage exclusion shall always be primary.

2. 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 on the order of benefits, this provision is ignored.

3. 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:

    a. If the parents have the same birthday, the benefits of the plan which covered one parent longer are determined before those of the plan which covered the other parent for a shorter period of time.
    b. 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.
    c. 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.

d. In the absence of a court decree, the plan of the parent with legal custody will be primary.

e. If the parent with custody has remarried, the order of benefits will be:

i. The plan of the parent with custody;
ii. The plan of the stepparent with custody;
iii. The plan of the parent without custody.

4. 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.

III. Right to Release and Receive Necessary Information

A. Additional Information

At times we may need additional information from you. You must agree to furnish us with all information and proofs that may be reasonably required regarding any matters pertaining to the *Plan*.

B. 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.

C. Rights of American Behavioral

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

2. 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.

D. Member 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.

IV. Recovery Provisions

A. Refund of Overpayments

1. 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:

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

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

3. 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.

B. Subrogation

1. 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.

2. 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.

3. 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.

4. 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.

5. 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 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.

V. Termination of Coverage

A. Employee Coverage

1. Employee coverage ends on the earliest of the following:

a. The day the *Plan* ends;
b. The end of the month for which contributions for the cost of coverage have been made after employment stops. See *Disability* below; or
c. The last day of a period for which contributions for the cost of coverage have been made if the contributions for the next period are not made when due.

2. Disability

a. The Employer has the right to continue a person's employment and coverage under the *Plan* during a period in which the person is away from work due to disability.
b. The period of continuation is determined by the Employer based on the Employer's general practice for an Employee in the person's job class.
c. Coverage ends on the date the Employer notifies us that the person's employment has stopped and coverage is to be ended.

VI. Member Complaints and Administrative Appeals

A. Types of Complaints

1. Inquiry

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

2. Quality of Care Complaint

a. A Quality of Care Complaint is a report of behavior that could

adversely impact a person's health and well-being.

b. Quality of Care Complaints are not subject to appeal.

B. Complaint Procedure

1. To submit a complaint by telephone, you may call us at (205) 871-7814 or (800) 677-4544. We will assist you with the specific process.

2. To submit a written complaint, mail all pertinent documentation to:

Attn: Quality Management
American Behavioral
3680 Grandview Parkway, Suite 100
Birmingham, AL 35243

3. We reserve the right to require complaints be submitted in writing, depending on the nature of the allegation.

VII. Member Claims and Appeals Rights

This section explains the rules for filing claims and appeals.

A. In General

Claims for benefits under the plan can be post-service, pre-service, or concurrent. This section of the certificate 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.

B. 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. If your provider does not file a claim form for you, then you can call us and ask for a claim form. When you receive the claim form, complete it, attach an itemized bill, and send it to us at 3680 Grandview Parkway, Suite 100 Birmingham, AL 35243. Claims must be submitted and received by us within 45 days after the service takes place to be eligible for benefits.

If we receive a submission from you or your provider that does not qualify as a claim, we will notify you or your provider of any additional information that we need. After we receive that information, we will process the submission as a claim.

Sometimes we may need additional information in order to determine whether the claim is payable. If we need additional information, we will ask you to furnish it to us, and we will suspend processing of your claim until the information is received. We may request the information directly from your provider and send you a copy of our request. You will have 90 days to provide the information to

us.

Ordinarily, we will notify you of our decision within 30 days of the date on which your claim was filed. If we request additional information, we will notify you of our decision within 15 days after we receive the requested information. If the requested information is not provided within the 90-day period that we gave you for furnishing the additional information, then your claim will be considered denied.

In some cases, we may ask for additional time (up to 90 days) to process your claim. In such cases our request will be made in writing and will indicate the special circumstances requiring the extension of time. If you do not wish to give us time, then we will process your claim based on the information that we have.

C. Pre-Service Claims

Non-emergency Mental Health and Substance Abuse Services must meet established medical necessity guidelines. American Behavioral is available 24 hours per day, seven (7) days per week. The toll-free number is 1-800-677-4544. If you attempt to file a pre-service claim but fail to follow our procedures for doing so, we will notify you of the failure and the proper procedures within 24 hours (for urgent pre-service claims) or five days (for non-urgent pre-service claims).

American Behavioral will retrospectively review claims for Emergency Services to determine if each of the criteria listed in *Section VII* is met and that the Services are not listed as excluded by the *Plan*.

We will treat your claim as urgent if a delay in processing your claim could seriously jeopardize your life, health, or ability to regain maximum function or, in the opinion of your treating physician, a delay would subject you to severe pain that cannot be managed without the care or treatment that is the subject of your claim. If your treating physician tells us that your claim is urgent, we will treat it as such.

If your claim is urgent, we will notify you of our decision within 72 hours. If we need more information we will notify you within 24 hours of your claim. We will tell you what further information we need, and you will then have 48 hours to provide that information to us. We will notify you of our decision within 48 hours after we receive the requested information. If we do not receive the information, your claim will be considered denied at the expiration of the 48-hour period that you were given for furnishing the information to us.

If your claim is not urgent, we will notify you of our decision within 15 days. If we need more information, we will let you know before the 15-day period expires. We will tell you what further information we need, and you will then have 90 days to provide this information to us. We may request the information directly from your provider and send you a copy of the request. We will notify you of our decision within 15 days after we receive the requested information. If

we do not receive the information, your claim will be considered denied at the expiration of the 90-day period that you were given for furnishing the information to us.

D. 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 we later decide to limit or reduce the previously approved stay or course of treatment, we will give you enough advance written notice to permit you to initiate an appeal and obtain a decision before the date on which the care or treatments are no longer approved. You must follow any reasonable rules we establish for the filing of your appeal, such as time limits within which your appeal must be filed.

If a previously approved course of treatment is about to expire, you may submit a request to extend your approved care. The phone number to request an extension of care is 1-800-677-4544.

If your request for additional care is urgent and is submitted no later than 24 hours before the end of your pre-approved course of treatment, we will give you our decision within 24 hours of when your request is submitted. If your request is not made before this 24-hour time, and your request is urgent, we will give you our determination within 72 hours. If your request is not urgent, we will treat it as a new claim for benefits.

E. 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.

F. Appeals

1. In General

a. 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:

(i) 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;
(ii) Our denial of a pre-service claim;
(iii) An adverse concurrent care determination (for example, we deny your request to extend previously approved care); or
(iv) An adverse medical necessity decision.

b. 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:

(i) A significant increase to the risk of the Member's health or the health of others;
(ii) Severe pain; or
(iii) The inability to regain maximum functioning.

2. How to Initiate an Internal Appeal Review Through American Behavioral

a. You or your authorized representative may initiate an appeal by contacting us at the address or numbers listed below.

Attn: Appeals
American Behavioral
3680 Grandview Parkway, Suite 100
Birmingham, AL 35243

Toll Free Telephone: (800) 677-4544
Fax Number: (205) 868-9625

b. The appeal request should include all of the following:

(i) The Member's name;
(ii) The Member's date of birth;
(iii) An identification number, if applicable;
(iv) The date(s) of service(s);
(v) The name of the treating Provider;
(vi) Any additional information to be considered during the appeal process.

c. Information that can be included in an appeal is:

(i) Records relating to the current conditions of treatment,
(ii) Notation of coexisting conditions; and
(iii) Any other relevant information.

d. For clinical cases, a Physician in the same or similar specialty area as your treating Physician will review and make the decision about the appeal request. If the treating Provider is not a Physician, a

doctoral level Psychologist or a Physician will review and make a decision about the appeal request. The Physician or Psychologist will have no previous involvement in decisions about the case.

3. Appeal Review Process

a. We have 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.

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

(ii) We will notify you, as well as your Provider(s), of the appeal resolution in writing within 30 calendar days from the receipt date of the request.

(iii) If you request an appeal of a denied pre-service request, we will complete the review and notify you of the outcome within 15 calendar days from the receipt date of the request.

b. Urgent Process (Expedited Appeal)

(i) You or your Provider(s) may request an expedited appeal by calling (205) 871-7814 or (800) 677-4544.

(ii) American Behavioral will review the urgent appeal, render a decision, and notify you and your Provider(s) within 48 hours of the appeal request.

4. Additional Rights

a. You may request, free of charge, a paper copy of any relevant documents, records, guidelines or other information we used to make our decision. To request a copy of this information, contact us at the address or numbers listed below:

Attn: Appeals
American Behavioral
3680 Grandview Parkway, Suite 100
Birmingham, AL 35243

Toll Free Telephone: (800) 677-4544
Fax Number: (205) 868-9625

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

VIII. Benefit Conditions

A. Mental Health and Substance Abuse Services are services which are:

1. Covered Benefits as outlined in this *Certificate*;

2. Rendered by a Participating Provider or Facility;

3. Furnished by a Provider or Facility we recognize as an Approved Provider or Facility for the type of services being furnished. For example, we reserve the right not to pay for some or all services furnished by Providers who are not Medical Doctors (M.D.s), even if the services are within the scope of the Provider's license.

B. No benefits will be provided for services you receive after the *Plan* or your coverage ends, even if they are for a condition which began before the *Plan* or coverage ended.

C. Benefits for Mental Health and Substance Abuse Services are subject to copayments, deductibles, conditions, limitations and exclusions as noted in this *Certificate*. See the *Summary of Mental Health Benefits* and the *Summary of Substance Abuse Benefits* for the amount we cover and your financial obligations.

D. Treatment Authorization

1. Mental Health and Substance Abuse Services must meet established medical necessity guidelines as described in *Section VII*.

2. American Behavioral will retrospectively review claims for Emergency Services to determine if each of the criteria listed in *Section VII* is met and that the Services are not listed as excluded by the *Plan*.

E. If you are not satisfied with your Participating Provider(s), you may call us and ask for a referral to another Participating Provider(s).

F. Payment to Non-Participating Providers

If the *Plan* allows for out-of-network benefits, you may elect non-Participating Providers or Facilities, but higher copayments, deductibles and other conditions may apply as outlined in this *Certificate.* You must use the services of Participating Providers and Facilities to receive full benefits.

G. <u>Authorization Does Not Guarantee Payment</u>

Excluded treatment of pre-existing conditions, if any, is not covered by the *Plan* even if such treatment is authorized. If the Member has other coverage, and such other coverage is responsible for payment or would have been responsible if the Member had complied with its terms and conditions, the *Plan* is not responsible for payment even if services were authorized.

IX. Explanation of Benefits

A. Mental Health Services may include the following:

1. Assessment;

2. Diagnosis;

3. Treatment Planning;

4. Medication Management;

5. Psychotherapy (e.g. Individual, Family and Group);

B. Mental Health Services may be provided by the following licensed providers:

1. Psychiatrists;

2. Nurse Practitioners;

3. Psychologists;

4. Professional Counselors;

5. Marriage and Family Therapists; and

6. Clinical Social Workers.

C. Mental Health Services include the following:

1. Crisis Assessment

Crisis Assessment is designed to help a Member cope with a crisis and gain access to the next appropriate level of care. Crisis Assessment is usually indicated when there is evidence of an impending or current psychiatric emergency without clear indication for inpatient treatment.

2. Outpatient Treatment

Outpatient Treatment is provided in an ambulatory setting and includes the following services:

a. Psychotherapy provided by a licensed mental health Provider in order to treat a mental health disorder. Brief, goal-directed talk therapy is provided for individuals, groups, and families.

b. Pharmacotherapy provided by psychiatrists who are medical doctors and specialize in treating mental disorders using the biomedical approach, which includes psychotherapy.

Pharmacotherapy may also be provided by licensed nurse practitioners working alongside psychiatrists.

3. Intensive Outpatient Treatment Program (IOP)

Treatment in an intensive outpatient program is an alternative to inpatient or partial hospitalization/day program treatment for certain psychiatric conditions as determined by the patient's symptoms and level of functioning.

An intensive outpatient program is indicated for patients, often in crisis, who require structured treatment (e.g. individual therapy, group therapy, family and/or multi-family therapy and psychoeducation) to decrease symptoms and improve the patient's 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.

4. Partial Hospitalization/Day Treatment Program (PHP)

Partial hospitalization is a day or evening treatment program that may be hospital-based or conducted in a free-standing facility. It is an alternative to inpatient hospital treatment of certain psychiatric or chemical dependency conditions as determined by the patient's level of functioning. These 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 hours of clinical services per day.

Partial hospitalization may be accessed as a transitional level of care (e.g., step-down from inpatient) or a stand-alone. Partial hospitalization is under the supervision of a psychiatrist or addictionologist (a Provider specializing in the treatment of addiction).

5. Acute Inpatient Hospitalization

Acute inpatient treatment is the most intensive level of care and is provided in a secure and protected hospital setting. Inpatient treatment is indicated for stabilization of individuals who display acute conditions or are at a risk of harming themselves or others.

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

All general services relevant to the patient's co-morbid medical condition(s) should be available as needed.

6. Dual Diagnosis

Dual diagnosis programs are usually indicated when a Member has a severe or complex Mental Health Disorder(s) and a comorbid Substance-Related Disorder(s).

7. Psychological Testing

Psychological testing is provided in an ambulatory or confined setting (e.g. hospital, skilled nursing facility or in a rehabilitation facility). Psychological testing is administered and interpreted by a licensed Clinical Psychologist. The testing must have sound psychometric properties and be conducted for purposes of aiding in diagnosis of a Mental Health or Substance-Related Disorder or in the process of reassessing a failed treatment.

8. Electroconvulsive Therapy (ECT)

Electroconvulsive therapy (ECT), also known as electroshock, is a psychiatric treatment in which seizures are electrically induced in patients that are under anesthesia for a therapeutic effect. Electroconvulsive therapy administered by a specially trained psychiatrist may differ in its application. The frequency and total number of treatments will vary depending on the condition being treated, the individual response to treatment and the medical necessity of the treatment. ECTs are provided in an outpatient facility or when necessary during an acute inpatient stay.

9. Emergency Mental Health Services

a. Emergency Mental Health Services, including those rendered in a Hospital Emergency Department, are covered in and out of the Service Area if the following conditions exist:

i. The Member has an Emergency Psychiatric Condition;
ii. The treatment is Medically Necessary; and
iii. Treatment is sought immediately after the onset of symptoms (within 24 hours of occurrence).

b. In determining whether an Emergency Psychiatric Condition existed, we will consider whether a prudent layperson with an average knowledge of health and medicine would reasonably have considered the condition to be an Emergency Psychiatric Condition.
c. If admitted to an Acute Inpatient Hospitalization, the Emergency Department Copayment is applied toward the Inpatient Hospitalization copayment.
d. Follow-up care in an Emergency Department is not a Covered Service. Follow-up care is subject to all provisions of this *Plan*.

10. Ambulance Services:

Emergency Ambulance Transportation by a licensed ambulance service to a Hospital for treatment of an Emergency Psychiatric Condition is a Covered Service. See the *Summary of Mental Health Benefits*.

D. Substance Abuse Services may include the following:

1. Assessment and Testing to Determine the Need for Treatment;

2. Treatment Planning;

3. Psychotherapy (e.g. Individual, Family and Group); and

4. Psychological Testing.

E. Substance Abuse Services may be provided by the following licensed Providers:

1. Psychiatrists;

2. Addictionologists;

3. Nurse Practitioners

4. Psychologists;

5. Professional Counselors;

6. Marriage and Family Therapists; and

7. Clinical Social Workers.

F. Substance Abuse Services include the following levels of care:

1. Crisis Assessment

Crisis Assessment is designed to help a Member cope with a crisis and gain access to the next appropriate level of care. Crisis Assessment is usually indicated when there is evidence of an impending or current Substance-Related Emergency without clear indication for inpatient treatment.

2. Outpatient Treatment

Outpatient Treatment is provided in an ambulatory setting and includes the following services:

a. Psychotherapy provided by a licensed mental health professional in order to treat a chemical dependency. Brief goal-directed talk therapy is provided for individuals, groups, and families.

b. Pharmacotherapy provided by psychiatrists, addictionologists or nurse practitioners specializing in treating chemical dependency using the biomedical approach, which includes psychotherapy.

3. Ambulatory Detoxification

Ambulatory detoxification (also known as outpatient detoxification) is a medical procedure designed to safely detoxify patients from drugs and alcohol without an admission to a hospital. Ambulatory detoxification can be undertaken by patients who show mild symptoms of withdrawal. Appropriate candidates should have transportation, a support system and the ability to monitor progress while at the same time showing no signs of medical complications or severe withdrawal risk.

Ambulatory Detoxification includes an evaluation by a psychiatrist or addictionologist within the first 24 hours of admission followed by regularly-scheduled visits for evaluation.

4. Intensive Outpatient Treatment Program (IOP)

Treatment in an intensive outpatient program is an alternative to inpatient or partial hospitalization/day program treatment for certain psychiatric conditions as determined by the patient's symptoms and level of functioning.

An intensive outpatient program is indicated for patients, often in crisis, who require structured treatment (e.g. individual therapy, group therapy, family and/or multi-family therapy and psychoeducation) to decrease symptoms and improve the patient's 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.

5. Partial Hospitalization/Day Treatment Program (PHP)

Partial hospitalization is a day or evening treatment program that may be hospital-based or free-standing. It is an alternative to inpatient hospital treatment of certain psychiatric or chemical dependency conditions as determined by the patient's level of functioning. These 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 hours of clinical services per day.

Partial hospitalization may be accessed as a transitional level of care (e.g., step-down from inpatient) or a stand-alone. Partial hospitalization is under the supervision of a psychiatrist or addictionologist.

6. Acute Inpatient Medical Detoxification

Acute Inpatient Medical Detoxification is provided in a Substance Abuse Treatment Facility or in a Hospital that provides Substance Abuse Treatment Services for the purpose of completing a medically safe withdrawal from a substance(s). This treatment is usually indicated when there is a risk of severe withdrawal symptoms or seizures and/or comorbid psychiatric or medical conditions that cannot be safely treated in a less intensive setting.

Acute inpatient medical detoxification includes an initial evaluation within three (3) hours of admission with treatment beginning immediately. A thorough evaluation by a psychiatrist or addictionologist should occur within the first 24 hours of the admission. Daily visits by the psychiatrist or addictionologist (including weekends) should follow.

7. Inpatient Rehabilitation

Inpatient Rehabilitation is provided in a licensed and credentialed Facility for treating Substance-Related Disorders. Inpatient Rehabilitation provides structured treatment services with 24-hour on site nursing care and monitoring.

Inpatient rehabilitation includes an evaluation by a psychiatrist or addictionologist within three 24 hours of admission. Daily and active treatment by a psychiatrist supervising the plan of care is required. All general services relevant to the patient's comorbid medical condition(s) should be available as needed.

8. Dual Diagnosis

Dual diagnosis programs are usually indicated when a Member has a severe or complex comorbid Mental Health condition(s) that make it unlikely he or she would benefit from a program focusing solely on the Substance-Related Disorder(s).

9. Psychological Testing

Psychological testing is provided in an ambulatory or confined setting (e.g. hospital, skilled nursing facility or in a rehabilitation facility). Psychological testing is administered and interpreted by a licensed Clinical Psychologist. The testing must have sound psychometric properties and be conducted for purposes of aiding in diagnosis of a Mental Health or Substance-Related Disorder or in the process of reassessing a failed treatment.

X. *Summary of Mental Health*

CITY OF FOLEY

SUMMARY OF MENTAL HEALTH BENEFITS

Emergency admissions require notification within 48 hours of admission.

Call 205-871-7814 or 800-925-5327 for information on benefits and eligibility. Effective Date of This Plan: January 1, 2014

Benefits	In-Network			Out-of-Network (If Applicable)		
	Limitations	**Coverage**	**Member Responsibility**	**Limitations**	**Coverage**	**Member Responsibility**
EAP Services	*Up to three (3) free, confidential EAP counseling sessions per plan year. All EAP services require pre-authorization .Call 800-925-5327 for pre-authorization.*					
Calendar Year Deductible	$200 per individual/$600 aggregate max per family			$200 per individual/$600 aggregate max per family		
Out of Pocket Maximum	$400 per individual			$400 per individual		
Office Visit Outpatient Treatment	Based on appropriate level of care and medical necessity criteria	Covered at 100% of allowed amount*	$25 copay per visit/ session/ group therapy session	Based on appropriate level of care and medical necessity criteria	Covered at 80% of allowed amount*, subject to the calendar year deductible	20% of allowed amount* (subject to the calendar year deductible) and any other amount not covered by the health plan
Psychological Testing	Based on appropriate level of care and medical necessity criteria	Covered at 100% of allowed amount*	No deductible or copay	Based on appropriate level of care and medical necessity criteria	Covered at 80% of allowed amount*, subject to the calendar year deductible	20% of allowed amount* (subject to the calendar year deductible) and any other amount not covered by the health plan
Acute Inpatient Hospitalization	Based on appropriate level of care and medical necessity criteria	Covered at 100% of allowed amount* after per admission deductible	$100 per admission deductible	Based on appropriate level of care and medical necessity criteria	Covered at 100% of allowed amount* after per admission deductible	$100 per admission deductible and any other amount not covered by the health plan
Inpatient Physician Services	Based on appropriate level of care and medical necessity criteria	Covered at 100% of allowed amount*	None	Based on appropriate level of care and medical necessity criteria	Covered at 80% of allowed amount*, subject to the calendar year deductible	20% of allowed amount* (subject to the calendar year deductible) and any other amount not covered by the health plan
Intensive Outpatient Treatment	Based on appropriate level of care and medical necessity criteria	Covered at 100% after copay	$25 per day copay	Based on appropriate level of care and medical necessity criteria	Covered at 80% of allowed amount*, subject to the calendar year deductible	20% of allowed amount* (subject to the calendar year deductible) and any other amount not covered by the health plan
Partial/Day Hospitalization Treatment	Based on appropriate level of care and medical necessity criteria	Covered at 100% of allowed amount* after hospital deductible	$100 per admission deductible	Based on appropriate level of care and medical necessity criteria	Covered at 100% of allowed amount* after per admission deductible	$100 per admission deductible and any other amount not covered by the health plan
Electroconvulsive Therapy (ECT)	Based on appropriate level of care and medical necessity criteria	Covered at 100% of allowed amount*	None	Based on appropriate level of care and medical necessity criteria	Covered at 80% of allowed amount*, subject to the calendar year deductible	20% of allowed amount* (subject to the calendar year deductible) and any other amount not covered by the health plan
Ambulance Services	Covered under the medical plan			Covered under the medical plan		
Anesthesia (In Conjunction with ECT)	Based on appropriate level of care and medical necessity criteria	Covered at 100% of allowed amount*	None	Based on appropriate level of care and medical necessity criteria	Covered at 80% of allowed amount*, subject to the calendar year deductible	20% of allowed amount* (subject to the calendar year deductible) and any other amount not covered by the health plan
Emergency Department	Covered under the medical plan			Covered under the medical plan		
Residential Treatment	**NOT AVAILABLE**					

*Allowed amount: The amount of a provider's/facility's charge that American Behavioral recognizes for payment. This is based on the payment method used by American Behavioral where services are received. The allowed amount shall be determined by American Behavioral using pre-established fee schedules and/or per diem rates in every situation possible.

XI. *Summary of Substance Abuse Benefits*

CITY OF FOLEY

SUMMARY OF SUBSTANCE ABUSE BENEFITS

Call for providers in your area. Emergency admissions require notification within 48 hours of admission.
For information call 205-871-7814 or 800-677-4544. Effective Date of This Plan: January 1, 2014

Benefits	In-Network			Out-of-Network (If Applicable)		
	Limitations	Coverage	Member Responsibility	Limitations	Coverage	Member Responsibility
Office Visit Outpatient Treatment	Based on appropriate level of care and medical necessity criteria	Covered at 100% of allowed amount* after copay	$25 per visit/ session/ group therapy session	Based on appropriate level of care and medical necessity criteria	Covered at 80% of allowed amount*, subject to the calendar year deductible	20% of allowed amount* (subject to the calendar year deductible) and any other amount not covered by the health plan
Ambulatory Detoxification	Based on appropriate level of care and medical necessity criteria	Covered at 100% of allowed amount*	$25 per visit/ session/ group therapy session	Based on appropriate level of care and medical necessity criteria	Covered at 80% of allowed amount*, subject to the calendar year deductible	20% of allowed amount* (subject to the calendar year deductible) and any other amount not covered by the health plan
Acute Inpatient Medical Detoxification	Based on appropriate level of care and medical necessity criteria	Covered at 100% of allowed amount* after per admission deductible	$100 per admission deductible	Based on appropriate level of care and medical necessity criteria	Covered at 100% of allowed amount* after per admission deductible	$100 per admission deductible and any other amount not covered by the health plan
Inpatient Rehabilitation	Based on appropriate level of care and medical necessity criteria	Covered at 100% of allowed amount* after per admission deductible	$100 per admission deductible	Based on appropriate level of care and medical necessity criteria	Covered at 100% of allowed amount* after per admission deductible	$100 per admission deductible and any other amount not covered by the health plan
Inpatient Physician Services	Based on appropriate level of care and medical necessity criteria	Covered at 100% of allowed amount*	None	Based on appropriate level of care and medical necessity criteria	Covered at 80% of allowed amount*, subject to the calendar year deductible	20% of allowed amount* (subject to the calendar year deductible) and any other amount not covered by the health plan
Intensive Outpatient Treatment	Based on appropriate level of care and medical necessity criteria	Covered at 100% of allowed amount* after copay	$25 per day copay	Based on appropriate level of care and medical necessity criteria	Covered at 80% of allowed amount*, subject to the calendar year deductible	20% of allowed amount* (subject to the calendar year deductible) and any other amount not covered by the health plan
Partial/Day Hospitalization Treatment	Based on appropriate level of care and medical necessity criteria	Covered at 100% of allowed amount* after per admission deductible	$100 per admission deductible	Based on appropriate level of care and medical necessity criteria	Covered at 100% of allowed amount* after per admission deductible	$100 per admission deductible and any other amount not covered by the health plan
Emergency Department	Covered under the medical plan			Covered under the medical plan		
Psychological Testing	Based on appropriate level of care and medical necessity criteria	Covered at 100% of allowed amount* after copay	$100% of allowed amount, no deductible or copay	Based on appropriate level of care and medical necessity criteria	Covered at 80% of allowed amount*, subject to the calendar year deductible	20% of allowed amount* (subject to the calendar year deductible) and any other amount not covered by the health plan
Residential Treatment	**NOT AVAILABLE**					

*Allowed amount: The amount of a provider's/facility's charge that American Behavioral recognizes for payment. This is based on the payment method used by American Behavioral where services are received. The allowed amount shall be determined by American Behavioral using pre-established fee schedules and/or per diem rates in every situation possible.

XII. Exclusions

There are some services that are not covered under the *Plan's* basic benefits. There are no benefit provisions for the following:

A. General Exclusions

1. Certain services are excluded it not pre-authorized

2. Services, care or treatment received after the date coverage ends

3. Care that is not Medically Necessary or that is not a Covered Service as determined by American Behavioral

4. Services performed in connection with conditions not classified in the current edition of the *Diagnostic and Statistical Manual of Mental Health Disorders*

5. Treatment provided by non-Participating Providers or Facilities, unless the Employer provides an out-of-network benefit

6. Treatment or consultation provided by a Provider with the same legal residence as you or who is a part of your family, including spouse, brother, sister, parent, or child

7. Members who do not keep their appointments for outpatient services shall be responsible to the Provider for any charges incurred as a result. We shall not be responsible for charges incurred for appointments that are not kept

8. Expenses for psychiatric/psychological report preparation and presentation when not required by Participating Providers

9. Psychiatric or psychological examinations or treatments that are not otherwise Covered Services. Examples of such excluded services 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

10. Services or supplies to the extent that you are or would be, entitled to reimbursement under Medicare, regardless of whether you properly and timely applied for, or submitted claims to Medicare, except as otherwise required by Federal law

11. 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*

12. Services and expenses provided to a hospitalized 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)

13. Services and expenses of an Emergency Psychiatric Hospitalization if American Behavioral is not notified within 48 hours after admission, or if American Behavioral determines that the admission was not Medically Necessary

14. Travel and transportation to receive consultation or treatment even though prescribed by a Provider, except for Emergency Psychiatric Ambulance Services

15. Therapies which are not short-term or crisis-oriented

16. Treatment or consultations provided via telephone unless specifically pre-authorized

17. Treatment or consultations provided via web-based practice

18. Services or expenses for which a claim is not filed in a timely manner

19. Services or expenses for which a claim is not properly submitted

20. Treatment at non-credentialed, free-standing treatment facility

B. Mandated/Regulatory Exclusions

1. Services for Mental Health or Substance-Related Conditions that by Federal, State or local law must be treated in a public Facility, including, but not limited to, commitments for mental illness. In addition, to the extent allowed by law, we do not cover care or treatment provided in a Facility that is owned or operated by any Federal, State or other governmental entity.

2. Court-ordered treatment unless it is determined that such services are Medically Necessary based on Medical Necessity Criteria for the treatment of a treatable Mental Health or Substance-Related Disorder.

3. Services for conditions that require coverage to be purchased or provided through other arrangements such as Workers' Compensation, no-fault automobile insurance or similar legislation; care that is provided in a school; health services received while on active military duty or as a result of terrorism, war or any act of war, whether declared or undeclared; care for disabilities related to military service for which you are entitled to service and for which facilities are reasonably available to you.

4. Services required as a result of participation in a riot or in the commission of any assault or felony or required while incarcerated in a prison, jail, or

any other penal institution

C. Diagnostic Exclusions

Note: Where applicable, a list of specific diagnoses codes from the *Diagnostic And Statistical Manual Of Mental Health Disorders* (DSM) follows each exclusion. These are not all inclusive.

1. Chronic pain, except for diagnoses associated with psychological factors

2. Eating disorders (307.1; 307.50; 307.51)

3. Mental retardation as the primary diagnosis except for purposes of making the initial diagnosis (317 -319)

4. Personality disorders as the primary diagnosis except for purpose of making the initial diagnosis (301.0; 301.20-301.9)

5. Personality disorders as the primary diagnosis except for purpose of making the initial diagnosis (301.0; 301.20-301.9)

6. Sexual, paraphilia, and gender identity disorders as the primary diagnosis except for purposes of making the initial diagnosis (302.2- 302.9)

7. Studies conducted in order to find the cause of an organic disorder (e.g.. CT scan, neuropsychological testing, MRI, etc.) or treatment of such disorders are not covered. Organic disorders include, but are not limited to, Organic Brain Disease and Alzheimer's Disease. These studies and treatments are, by design and definition, part of the medical/surgical component of your coverage

8. Truancy, disciplinary or other behavioral problems as the primary diagnosis

D. Psychological Testing Exclusions

1. Psychological testing that is not pre-authorized

2. Psychological testing that is not conducted by a licensed Clinical Psychologist or other Mental Health Providers who are duly licensed to conduct psychological testing

3. Psychological testing, except when conducted for purposes of diagnosing a mental disorder or when rendered in connection with treatment for a mental disorder

4. Psychological 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

5. Psychological testing administration, scoring, and interpretation that is above and beyond the time limit(s) reported in peer review publications

6. Psychological 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

7. Psychological testing that is not relevant and valid for evaluating the clinical concerns under consideration. Psychological testing for Attention Deficit Disorder and pervasive developmental disorders will be considered only after self-report inventories have been administered, scored, and interpreted and reveal equivocal findings

8. 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 workman's compensation claims. Testing under those conditions should be billed under medical insurance or paid for by other entities such as Worker's 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

9. Psychological testing as related to an evaluation process for a surgical procedure (e.g.. gastric bypass surgery, chronic pain stimulator implantation), unless psychological testing is needed to aid in differential diagnosis

10. Psychological 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

11. Achievement testing

12. Intelligence quotient (IQ) testing

E. Specialty Treatment Exclusions

1. Acupressure or acupuncture
2. Alternative therapy
3. Animal assisted therapy (e.g. equestrian therapy)
4. Applied Behavioral Analysis (ABA)
5. Aroma therapy
6. Aversion therapy

7. Biofeedback
8. Bio-energetic therapy
9. Carbon dioxide therapy
10. Co-dependency treatment, except when provided in association with services provided for a treatable mental or substance disorder
11. Confrontation therapy
12. Convalescent care
13. Crystal healing therapy
14. Cult deprogramming
15. Custodial care
16. Developmental delays
17. Domiciliary care
18. Educational or professional growth training or certification related to employment
19. Experimental or investigational treatments or therapies
20. Expressive therapies (e.g. psychodrama) when billed as a separate service
21. Electrical aversion therapy
22. Guided imagery
23. Hearing or vision impairment
24. Hemodialysis for Schizophrenia
25. Holistic medicine
26. Hyperbaric therapy or other oxygen therapy
27. Hypnotherapy
28. Insight-oriented therapy
29. Investigative services related to employment
30. Laboratory tests
31. Marathon therapy
32. Marriage or family counseling when such counseling is in a non-crisis situation, except when rendered in connection with services provided for a Member's treatable mental or substance disorder or through the American Behavioral Employee Assistance Program (EAP), if applicable.
33. Massage therapy
34. Motivational training programs
35. Orthomolecular therapy
36. Personal growth and development
37. Pharmaceutical preparations except as given in an inpatient setting and included in a predetermined Hospital per diem or case rate
38. Primal therapy
39. Private duty nursing
40. Psychoanalysis
41. Rehabilitation programs, regardless of duration or the setting in which the services are provided: Mitral valve prolapsed programs, PMS programs, work hardening programs, vocational rehabilitation, educational rehabilitation or rehabilitation related to learning disabilities
42. Residential treatment
43. Rest cures
44. Respite care
45. Rolfing

46. Sanatorium care
47. Sedative action electrostimulation therapy
48. Sensitivity training
49. Self-help training
50. Services administered for insurance purposes
51. Services provided in order to obtain or maintain employment
52. Services related to judicial or administrative proceedings
53. Sex therapy programs or treatment for sex offenders
54. Sleep diagnostic clinics
55. Speech therapy
56. Stress treatment, except when rendered in association with services provided for a treatable mental or substance disorder
57. Transcendental Meditation
58. Treatment at non-credentialed stand-alone facilities
59. Tryptophan therapy
60. Vitamin (megavitamin) therapy
61. Weight management treatment or any treatment related to weight reduction or obesity

F. Substance Abuse Treatment Exclusions

1. Substance Abuse Treatment that is not abstinence-based

2. Substance Abuse Treatment for licensed, registered or certified professionals that is not medically necessary or beyond the scope of benefits as outlined in the *Summary of Substance Abuse Benefits* when recommended or required to maintain a professional license, certification or registration.

3. Services related to narcotic maintenance therapy

4. Therapy services or expenses of any kind for nicotine addiction (e.g. smoking cessation treatment)

5. Services or expenses of any kind for caffeine addiction

6. Treatment provided in a halfway house or other sober living arrangement

7. Ambulance transportation for a Substance-Related Disorder