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
Calendar Year Deductible 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.	**$2,500** self-only coverage; **$5,000** family coverage. Deductible amounts met in-network will apply to the out-of-network deductible	**$5,000** self-only coverage; **$10,000** family coverage. Deductible amounts met out-of-network will apply to the in-network deductible.
Calendar Year Out-of-Pocket Maximum 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.	**$5,000** self-only coverage; **$10,000** Family coverage 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	There is no out-of-network out-of-pocket 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

4. *INPATIENT SERVICES*

Benefits	In-Network	Out-of-Network
• Acute Inpatient Hospitalization • Residential • Inpatient Electroconvulsive Therapy (ECT) • Partial Hospitalization/Day Treatment (PHP) • Intensive Outpatient Program (IOP)	**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*

5. *OUTPATIENT OFFICE VISITS*

Description	In-Network	Out-of-Network

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	**Precertification Required** **Call 800-677-4544** Covered At 80% Of Allowed Amount **Patient Responsibility:** All Billed Charges Not Covered by The *Plan*	**Precertification 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**
• 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 At 60% Of Allowed Amount after deductible **Patient Responsibility:** All Billed Charges Not

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		
• 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		
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.		