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.	**$5,000** self-only coverage; **$10,000** family coverage.
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	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. The Calendar Year Deductible and the Calendar Year Out-of-Pocket Maximum are accounted for separately. They do not apply to each other. (Exception: In case of an emergency, the out-of-network would apply to the calendar year out-of-pocket maximum.)

MENTAL HEALTH PROGRAM

1. *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 Allowed 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 Allowed charges Not Covered by The *Plan*

2. *OUTPATIENT OFFICE VISITS*

Description	In-Network	Out-of-Network

Outpatient Office Visits	Covered At **80%** Of Allowed Amount Subject to Calendar Year Deductible **Patient Responsibility:** All Allowed charges Not Covered by The *Plan*	Covered At **60%** Of Allowed Amount Subject to Calendar Year Deductible **Patient Responsibility:** All Allowed charges Not Covered by The *Plan*
3. PSYCHOLOGICAL/NEUROPSYCHOLOGICAL TESTING		
Description	**In-Network**	**Out-of-Network**
Psychological/Neuropsychological Testing	**Precertification Required** **Call 800-677-4544** Covered At **80%** Of Allowed Amount Subject to Calendar Year Deductible **Patient Responsibility:** All Allowed charges Not Covered by The *Plan*	**Precertification Required** **Call 800-677-4544** Covered At **60%** Of Allowed Amount Subject to Calendar Year Deductible **Patient Responsibility:** All Allowed charges Not Covered by The *Plan*
SUBSTANCE ABUSE PROGRAM		
1. 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 Allowed 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 Allowed charges Not Covered by The Plan
2. OUTPATIENT OFFICE VISITS		
Ambulatory Detoxification (Office Visit)	Covered At **80%** Of Allowed Amount Subject to Calendar Year Deductible **Patient Responsibility:** All Allowed charges Not Covered by The Plan	Covered At **60%** Of Allowed Amount Subject to Calendar Year Deductible **Patient Responsibility:** All Allowed 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 Allowed charges Not Covered by The Plan **Exclusion: In-home care not covered**	Covered At **60%** Of Allowed Amount after deductible **Patient Responsibility:** All Allowed 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 Allowed charges Not Covered by The Plan	Covered At **60%** Of Allowed Amount after deductible **Patient Responsibility:** All Allowed charges Not Covered by The *Plan*
Anesthesia in Conjunction with Approved ECT Treatment	Covered At **80%** Of Allowed Amount after deductible **Patient Responsibility:** All Allowed charges Not Covered by The Plan	Covered At **60%** Of Allowed Amount after deductible **Patient Responsibility:** All Allowed 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.		