AUBURN UNIVERSITY
TRADITIONAL PLAN

Employee Assistance Program, Mental Health And Substance Abuse Treatment Benefits Summary Plan Description

Emergency Admissions Require Notification Within 48 Hours Of Admission.
Call 800-925-5327 for benefit and eligibility information.

Benefit	In Network			Out-Of-Network		
	Limitations	**Coverage**	**Member Responsibility**	**Limitations**	**Coverage**	**Member Responsibility**
EAP Services	**Up To 3 Free, Confidential EAP Counseling Sessions Per Plan Year.**					
Calendar Year Deductible	**$150 per person per year (applies to Emergency Department services)**					
Outpatient Services	Up To 30 Visits/Sessions/ Group Therapy Sessions (Or Any Combination Thereof) Total For Outpatient Care (*Mental Health & Substance Abuse Treatment*) Each Plan Year	100% Of Allowed Amount* after copay	$25 copay per Visit/Session/ Group Therapy Session	Up To 30 Visits/Sessions/ Group Therapy Sessions (Or Any Combination Thereof) Total For Outpatient Care (*Mental Health & Substance Abuse Treatment*) Each Plan Year	80% Of Allowed Amount*	Any Amount **Not Covered** by the Plan
Psychological Testing	Limited To 5 Hours Of Psychological Testing For Each Plan Year	100% Of Allowed Amount* after copay	$25 copay per hour	Limited To 5 Hours Of Psychological Testing For Each Plan Year	80% Of Allowed Amount*	Any Amount **Not Covered** by the Plan
Inpatient Hospital Services Partial Hospitalization = 2:1 Intensive Outpatient = 2:1	Up To 30 Days Total For Inpatient Care (*Mental Health & Substance Abuse Treatment*) Each 12 Consecutive Months	100% Of Allowed Amount* after copay	$100 copay per admission	Up To 30 Days Total For Inpatient Care (*Mental Health & Substance Abuse Treatment*) Each 12 Consecutive Months	80% Of Allowed Amount* after copay	$100 per admission copay and Any Amount **Not Covered** by the Plan
Substance Abuse Program ***Substance Abuse Treatment* = *1 Per Lifetime***	Combination Of Detoxification, Inpatient Rehab, PHP And IOP Treatment applies to inpatient hospital services days total.	100% Of Allowed Amount* after copay	$100 copay per admission	**NO OUT-OF-NETWORK BENEFIT**		
Inpatient Physician Services	Up To 30 Days Total For Inpatient Care (*Mental Health & Substance Abuse Treatment*) Each 12 Consecutive Months	100% Of Allowed Amount*	None	Up To 30 Days Total For Inpatient Care (*Mental Health & Substance Abuse Treatment*) Each 12 Consecutive Months	80% Of Allowed Amount*	Any Amount **Not Covered** by the Plan
Electroconvulsive Therapy	Applied Toward The Inpatient Mental Health Treatment Benefit.					
Anesthesia *(In Conjunction With ECT)*		100% Of Allowed Amount*	Subject to inpatient copay amounts		80% Of Allowed Amount*	Any Amount **Not Covered** by the Plan
Ambulance Services		80% Of Allowed Amount*	20% of Allowed Amount*		80% Of Allowed Amount*	Any Amount **Not Covered** by the Plan
Emergency Department		100% Of Allowed Amount* after copay	$100 copay		100 % Of Allowed Amount* after deductible	Subject to $150 per person calendar year deductible
Notation	In Network And Out-Of-Network Days/Visits/Units Shall Not Be Combined So That The Combination Exceeds The Total Number Of Days/Visits/Units Available In The In Network Section Of The *Employee Assistance Program, Mental Health And Substance Abuse Treatment Benefits Summary Plan Description.*					

***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.**

Administered by:

American Behavioral