

Summary of Mental Health and Substance Abuse Benefits for Auburn University High Deductible Health Plan – HSA Qualified

Uprise Health
Effective January 1, 2025

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
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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
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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
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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
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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.