

Summary of Mental Health and Substance Abuse Benefits for Auburn University

PPO Plan

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.

Calendar Year Deductible	\$500 Per Person Per Year with a Three (3) Member Family Maximum 4th Quarter Carryover Deductible: Any covered expenses incurred in the last 3 months of any benefit period which may have been allocated toward all or a portion of the Calendar Year Deductible for that year may also be allocated toward next year's Calendar Year Deductible	
Calendar Year Out-of-Pocket	\$9,200 Individual / \$18,400 Aggregate Family 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		
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 100% Of Allowed Amount After Copay, Subject to Calendar Year Deductible Patient Responsibility: \$300 Copay Per Admission Subject to Calendar Year Deductible	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
2. OUTPATIENT OFFICE VISITS		
Description	In-Network	Out-of-Network
Outpatient Office Visits	Covered At 100% Of Allowed Amount After Copay Patient Responsibility: \$30 Copay Per Visit/ Session/Group Therapy Session	Covered At 80% Of Allowed Amount 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 100% Of Allowed Amount After Copay Patient Responsibility: \$30 Copay Per Visit/Session/Group Therapy Session	Precertification Required Call 800-677-4544 Covered At 80% Of Allowed Amount 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 100% Of Allowed Amount After Copay, Subject to Calendar Year Deductible Patient Responsibility: \$300 Copay Per Admission Subject to Calendar Year Deductible	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

2. OUTPATIENT OFFICE VISITS

Ambulatory Detoxification (Office Visit)	Covered At 100% Of Allowed Amount After Copay Patient Responsibility: \$30 Copay Per Visit/Session/Group Therapy Session	Covered At 80% Of Allowed Amount 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 100% Of Allowed Amount Patient Responsibility: None Exclusion: In-home care not covered	Covered At 80% Of Allowed Amount 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 100% Of Allowed Amount Patient Responsibility: None	Covered At 80% Of Allowed Amount Patient Responsibility: All Allowed charges Not Covered by The Plan
Anesthesia in Conjunction with Approved ECT Treatment	Covered At 100% Of Allowed Amount Subject to the Inpatient Copay Amount Patient Responsibility: None	Covered At 80% Of Allowed Amount 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.