

**ATHENS AREA HEALTH PLAN SELECT, INC.**  
**295 West Clayton Street**  
**Athens, Georgia 30601**  
**(706) 549-0549**

**AMENDMENT TO EVIDENCE OF COVERAGE**

**NOTICE REGARDING THIS AMENDMENT TO EVIDENCE OF COVERAGE**

This Amendment to Evidence of Coverage, Form HPS Healthcare Reform Amendment to EOC (Rev 09/10), is intended to comply with the requirements of the Patient Protection and Affordable Care Act of 2010, the Health Care and Education Reconciliation Act of 2010, and the regulations adopted in compliance with those laws. Any condition or provision of the Amendment or the Evidence of Coverage to which it is attached that is found not to be compliance with those laws or regulations shall not be rendered invalid due to the noncomplying condition or provision but shall be construed and applied in accordance with such conditions or provisions as would have applied had the Amendment or Evidence of Coverage been in full compliance with said laws and regulations.

**I. Healthcare Reform Provisions**

The Evidence of Coverage to which this Amendment is attached is hereby amended as follows to comply with the Patient Protection and Affordable Care Act of 2010 and the Healthcare and Education Reconciliation Act of 2010 (the "Healthcare Reform Bill"):

1. There is no Lifetime Maximum Benefit for this Plan. Any reference to "Lifetime Maximum Benefit" is hereby deleted.

2. Coverage for Dependent Children is extended up to age 26 regardless of marital status, dependency status, residency with the Member or any other person, employment of the Dependent Child, or student status:

- (a) A Dependent Child will remain eligible for coverage until he or she has attained twenty-six (26) years of age, regardless of financial dependency, residency with the Member or any other person, student status, employment, or eligibility for any other coverage.
- (b) This Plan will cover the child regardless of whether or not the Dependent Child is married. However, no coverage is provided for a child of a dependent child (grandchildren are not covered).
- (c) The term "Dependent Child" as used herein shall include any stepchild, legally adopted child or child placed in the Subscriber's home prior to adoption, or a child for whom the Subscriber is legal guardian.
- (d) Coverage for a Dependent Child shall end on the last day of the month in which the Dependent Child attains the age of 26 years unless the Dependent Child is incapable of self-support because of mental illness, mental retardation, developmental disability, or physical handicap. See the definition of "Dependent Child" in the Evidence of Coverage.

3. Paragraph 1 of Section IX, (B), Termination of Coverage, is hereby deleted in its entirety and is replaced by the following:

“Fraud or Making Intentional Misrepresentation of Material fact: HPS relies upon the information contained in all information and documents submitted by Members and such information must be true and complete. HPS may rescind coverage of a Member who commits fraud or makes a misrepresentation of a material fact relating to obtaining coverage or maintaining coverage under this plan. Proper notice will be given to the Member of such rescission at least sixty days prior to the date of rescission. Members must advise HPS of any change in family status or Medicare coverage status that affects eligibility or benefits.”

4. Athens Area Health Plan Select, Inc. generally requires the designation of a Primary Care Provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care provider, contact Member Services at (706) 549-0549 or 1(800) 293-6260. Members may also select any in-network OB/GYN physician or pediatrician as their Primary Care Physician subject to the availability of that OB/GYN physician or pediatrician and their acceptance of the Member as a patient. No referral or authorization is needed for treatment by in-network pediatricians, OB/GYN physicians, dermatologists, or ophthalmologists/optometrists.

5. Certain preventive services will be covered without being subject to copays, coinsurance, or deductibles. These services include mammograms and PAP smears for women, child wellness services including immunizations, routine vision and hearing examinations for children through age seventeen (17), colorectal cancer screening, and other recommended preventive services as required by Section 2713 of the Patient Protection and Affordable Care Act of 2010 as may hereafter be amended.

6. Coverage will be provided for routine patient costs for items and services furnished in connection with a Member’s participation in an approved Clinical Trial. Coverage will not be provided for the cost of the item, device, or service that is the subject of the clinical trial or the costs of data collection and analysis of the research. If the Member’s plan does not cover Out-of-Network services then no Out-of-Network coverage will be provided in connection with participation in a clinical trial. Approved clinical trials mean those trials that receive Federal funding, are conducted under the guidelines of the National Institutes of Health, are a drug trial reviewed by the Federal Food and Drug Administration or that is exempt from having a new drug application.

## **II. Mental Health and Substance Use Disorder Treatment:**

1. The language contained in Section I, Paragraph H, “Prior Notification and Authorization” of the Evidence of Coverage, which states: “All mental health services and substance use disorder treatment.” is deleted in its entirety and is hereby replaced by the following language:

“All non-emergency inpatient mental health services and substance use disorder.”

2. The language contained in Section IV, Paragraph A(1), Prior Authorization Requirements and Charges for Services”, which reads: All mental health services and

substance use disorder treatment.” is deleted in its entirety and is hereby replaced by the following language:

“All non-emergency inpatient mental health services and substance use disorder.”

3. The language contained in Section V, Paragraph L, “Mental Healthcare Services and Substance Use Disorder Treatment Services” of the Evidence of Coverage, which states: “Prior Authorization is required for all non-emergency mental health and substance use disorder treatment.” is deleted in its entirety and is hereby replaced by the following language:

“Prior Authorization is required for all non-emergency inpatient mental health and substance use disorder treatment.”

This Amendment is to the HMO Evidence of Coverage, Form Number: HMO Evidence of Coverage (Rev 07/09), Point of Service Evidence of Coverage, Form Number: HPS Group POS Evidence of Coverage (Rev 07/09), the PPO Evidence of Coverage, Form Number: HPS Group PPO Evidence of Coverage (Rev 07/09), and the High Deductible Health Benefit Plan Evidence of Coverage, Form Number: HPS Group High Deductible Plan (Rev 07/09).

This Amendment does not modify or amend any provision of the Evidence of Coverage to which it is attached except as is specifically set out herein.

Athens Area Health Plan Select, Inc.



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Jeff Kunkle Executive Director