

**Athens Area Health Plan Select, Inc.**  
**Benefit Summary - H611**

<b>Benefit</b>	
<b>DEDUCTIBLES &amp; MAXIMUMS</b>	
Calendar Year Deductible	\$1,000 Individual / \$3,000 Family
Annual Out-of-Pocket (Member)	\$3,000 Individual / \$9,000 Family
Calendar Year Maximum (Plan)	\$2,000,000
Coinsurance	Special Diagnostic Procedures (MRI, MRA, CT, PET, Sleep Studies and Specific Cardiology Studies) and DME - Plan Pays 80%; member pays 20%
Lifetime Maximum Benefit	\$5,000,000
<b>OFFICE VISITS: ILLNESS OR INJURY</b>	
Primary Care Physician office visit	\$25 copay
Specialty Care Physician office visit	\$50 copay
Maternity Physician services (prenatal, delivery, postpartum)	\$25 copay per visit with 10 copay maximum.
In-Office Surgery	\$100 copay; plan pays 100% after copay
Urgent Care	\$25 copay
<b>OFFICE VISITS: PREVENTIVE CARE</b>	
Well Child Care Including Immunizations	\$25 copay
Routine Hearing Exam for Children	\$50 copay; one per year through age 17
Routine Vision Exam for Children	\$50 copay; one per year through age 17
Annual Health Exam	\$25 copay. Limit 1 per year
Annual Gynecology Exams	\$25 copay. Limit 1 per year
<b>EMERGENCY ROOM SERVICES</b>	
Emergency Care	\$100 copay; if admitted see Inpatient Benefit
Non-emergency use of Emergency Room	Not covered
<b>INPATIENT SERVICES</b>	
Semi-private room rate; ICU/CCU charges, other medically necessary charges such as diagnostic X-ray, lab services, newborn nursery charges, observation, and other hospital charges	\$500 copay per admission; plan pays 100% after copay
Physician Services (surgeon, anesthesiologist, radiologist, pathologist, etc)	Plan pays 100% after deductible
<b>OUTPATIENT SERVICES</b>	
Surgery facility/hospital charges	\$250 copay ; plan pays 100% after copay
Diagnostic X-Ray and Lab Services	Plan pays 100% after deductible
Special Diagnostic procedures (MRA, MRI, CT, PET Sleep Studies and specific cardiology studies)	Plan pays 80% after deductible
Physician services (surgeon, anesthesiologist, radiologist, pathologist, etc.)	Plan pays 100% after deductible
<b>THERAPY SERVICES</b>	
Physical, Occupational, and Speech Therapy (speech therapy is covered only for speech loss due to illness or injury)	\$50 copay; 30 visit combined maximum per calendar year
Radiation therapy, Chemotherapy	Plan pays 100% after deductible
<b>MENTAL HEALTH/SUBSTANCE ABUSE</b>	
Inpatient	\$250 copay per admission; plan pays 100% after copay; 10 day calendar year maximum Mental Health and 10 day calendar year maximum Substance Abuse
Outpatient	\$50 copay; 20 visit calendar year maximum Mental Health and 20 visit calendar year maximum Substance Abuse

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<b>OTHER SERVICES</b>	
Skilled Nursing Facility	Plan pays 100% after deductible; 30 day calendar year maximum
Home Health Care	Plan pays 100% after deductible; 60 visit calendar year maximum
Pain Management Procedures	\$100 copay; plan pays 100% after copay; \$5,000 calendar year maximum
Hospice Care	Plan pays 100%
Ambulance (when Medically Necessary)	Plan pays 100%
Air Ambulance (See note 3)	Plan pays 100%. \$10,000 calendar year maximum
Organ Transplant (See note 5)	\$500 copay per admission; plan pays 100% after copay
Durable Medical Equipment (See note 6)	Plan pays 80% after deductible; \$2,000 calendar year maximum
Orthotic Devices	Plan pays 80% after deductible; \$2,000 calendar year maximum
Prosthetic Devices	Plan pays 80% after deductible; \$10,000 lifetime maximum
Family Planning	\$25 copay
Infertility Diagnosis and Treatment (medications not covered)	\$50 copay; \$2,000 annual maximum/\$5,000 lifetime
Cardiac Rehabilitation	\$50 copay; plan pays 100% after deductible; 36 visits per episode
Removal of impacted third molars (wisdom teeth)	Plan pays \$200 per tooth. \$800 lifetime maximum.

Notes:

1. All Out-of-Network benefits are subject to HPS allowable Charge Limitations as defined in the Evidence of Coverage.
2. Copay does NOT apply to the Calendar Year Out-of-Pocket.
3. Fixed wing air transport must have Prior Authorization.
4. Calendar Year Visit Limitations are combined for In-Network and Out-of-Network services.
5. Donor charges for organ transplants are subject to a \$30,000 maximum benefit.
6. Nonsurgical treatment of TMJ has a \$1,000 calendar year maximum and a \$2,500 lifetime maximum. Splint Therapy for TMJ is considered DME and is subject to the annual DME maximums. Oral appliances for sleep apnea are considered DME and are subject to the annual DME maximums with a \$2,500 lifetime maximum.
7. Child wellness benefits from birth through five (5) years of age are not subject to the deductible.