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Benefit or Service	Prior Authorization	Member Cost Share	Additional Information
Abortion, Voluntary Termination of Pregnancy		• Inpatient Surgery 20% coinsurance after deductible • Inpatient hospital copay if applies • Outpatient Surgery 20% coinsurance after deductible • Outpatient hospital coinsurance if applies • Other services 20% coinsurance after deductible	Includes abortion for which public funding is prohibited. Cost shares determined by the service.
Acupuncture		$15.00 after deductible	Limited to 12 visits per year calendar year. Unlimited visits for chemical dependency treatment,SUD, substance disuse.
Allergy Care		20% coinsurance after deductible	Includes allergy tests, allergy injections and serums. Allergy serum is only covered under this benefit if received and administered at a providers office.
Ambulance (Emergency Transportation) ground and air		$375.00 copay	
Ambulance (Non-Emergency)	NOT COVERED	NOT COVERED	NOT COVERED
Anesthesiologist (Anesthesia) (professional)		20% coinsurance after deductible does not include facility fee	For the benefit of dental anesthesia provided in a facility, a child must be under 7 yrs. old oris developmentally delayed or if a physician determines a medical condition places the patient at undo risk if performed in the dentist office. Includes services to prepare the jaw for radiation treatment of neoplastic disease. The Dental anesthesia benefit does not include the charges for the dentist or anesthesia performed in a dentist office.
Applied Behavior Analysis Therapy (ABA)	Prior authorization is required. Must be prescribed. Must be performed by a qualified ABA provider. Must be diagnosis of autism spectrum disorder and meet criteria of the plan.	20% coinsurance after deductible	
Birthing Center (Facility)		$525.00 per day	

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Benefit or Service	Prior Authorization	Member Cost Share	Additional Information
Bariatric Surgery	NOT COVERED	NOT COVERED	NOT COVERED
Bone mass measurement (Bone Density)	PA Required if more often than once every 2 years.	$0 Cost Share	
Breast cancer screening (mammograms, mammography, including 3D mammography)		$0 Cost Share	The first mammogram per calendar year is covered under preventive care regardless of diagnosis. Subsequent mammograms within in the same year are covered under lab and radiology benefits and cost shares will apply.
Cardiac rehabilitation services		20% coinsurance after deductible	Coverage for cardiac rehabilitation requires that Members have experienced a cardiac event such as myocardial infarction, chronic stable angina, heart transplant or heart and lung transplants.
Cervical and vaginal cancer screening (Pap tests, pelvic exams)		$0 Cost Share	For planned preventive services that become diagnostic during the screening, cost sharing may apply. • All women: Every 24 months • High risk of cervical cancer or abnormal pap: Every 12 months, is not routine care and is subject to cost shares.
Chemotherapy		20% coinsurance after deductible	
Chiropractor services		$15.00 copay	Limit 10 visits, coverage includes manipulation of the spine and diagnosis and treatment of musculoskeletal disorders, diagnostic radiology, when performed within the scope of the Provider's license. Radiology has separate cost share.
Clinical Trials	Prior authorization	Cost share determined by service, e.g. outpatient hospital coinsurance, specialist visit, etc.	
Colorectal cancer screening (Colonoscopy, Sigmoidoscopy)		$0 Cost Share	For planned preventive services that become diagnostic during the screening, cost sharing may apply. For age 50 and older: • Sigmoidoscopy every 48 months • Fecal occult blood test, every 12 months For at high risk of colon cancer: • Screening colonoscopy every 24 months Not at high risk of colon cancer: • Screening colonoscopy every 10 years (120 months) but not within 48 months (2 years) of a screening sigmoidoscopy.

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Benefit or Service	Prior Authorization	Member Cost Share	Additional Information
Cosmetic surgery or procedures	NOT COVERED	NOT COVERED	NOT COVERED
Custodial Care	NOT COVERED	NOT COVERED	Custodial care is personal care that does not require the continuing attention of trained medical or paramedical personnel, such as care that helps with activities of daily living, such as bathing or dressing. Custodial care is not *medically necessary.*
Deductible,Individual		$500.00 includes any Rx subject to deductible for in network providers.	
Deductible,Family		$1000.00 includes any Rx subject to the deductible for in network providers.	
Dental Medical Services (Not Routine Dental), Oral Surgery	Refer to prior authorization list.	Cost shares determined by the service. • Inpatient Surgery 20% after deductible, inpatient hospital copay applies • Inpatient hospital copay if applies • Outpatient Surgeon $75.00 copay after deductible • Outpatient facility coinsurance if applies • Other 20% coinsurance after deductible	Covered services limited to surgery of the jaw or related structures Examples: - setting fractures of the jaw or facial bones - extraction of teeth to prepare the jaw for radiation treatments of neoplastic cancer disease - excision of lesions, cysts and tumors of the jaw, mouth, lip or tongue
Dental Services, Routine Dental, Orthodontia	NOT COVERED	NOT COVERED	NOT COVERED
Depression screening		$0 Cost Share	
Diabetes self-management training,diabetes education		20% coinsurance after deductible	Must be ordered by a provider. Must be performed through authorized outpatient diabetes education facilities. Includes diabetes education, diabetes self-management training and nutritional counseling services.

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Benefit or Service	Prior Authorization	Member Cost Share	Additional Information
Diabetic services and diabetes supplies (DME)	PA Required if purchase is $500.00 or more or rental is $500.00 per month or more	20% coinsurance after deductible	• The Durable Medical Equipment (DME) benefit only covers insulin pumps and insulin infusion devices and supplies related to this equipment. •The Pharmacy Benefit covers, insulin, oral hypoglycemic agents, blood glucose monitors, insulin syringes with needles, blood glucose test strips, urine test strips, ketone test strips, ketone tablets, lancets and lancet devices.
Dialysis, Kidney dialysis		20% coinsurance after deductible	
Durable medical equipment (DME) and medical supplies. Includes prosthetic devices.	All DME with a purchase price greater than $500.00 or rental of $500.00 per month allowed amount requires prior authorization.	20% coinsurance after deductible	
Emergency Room, ER, Facility Out of Area,		$450.00 copay after deductible for out of network, out of area. Copay cannot exceed the actual cost of the service. For example if the service is $150.00 the copay will be $150.00.	Emergency Care Out of network,same as in-network cost shares. Professional fees and other services are separate from the facility fees, the 20% coinsurance subject to deductible or other copays may apply.
Emergency care (ER Physician)		20% after deductible	Emergency Care Only. Out of network same as in-network cost shares.
Emergency Room, ER (facility)		$450.00 copay after deductible. Copay cannot exceed the actual cost of the service. For example if the service is $150.00 the copay will be $150.00.	•Professional fees and other services are separate from the facility fees, the 20% coinsurance subject to deductible or other copays may apply. •Copay waived if admitted as inpatient within 24 hours of ER visit. •Includes Medically Necessary detoxification services, including Chemical Dependency detoxification. •Prescription medications associated with a Medical Emergency, including those purchased in a foreign country, are also covered.
Enteral Feedings, Tube Feedings,PKU	Prior authorization	20% coinsurance after deductible	

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Benefit or Service	Prior Authorization	Member Cost Share	Additional Information
Enteral Formula, Nutritional and Dietary Formulas,PKU	Prior authorization	20% coinsurance after deductible	Coverage for nutritional and dietary formulas, including elemental formulas, and medical foods, is provided when Medically Necessary. The following conditions must be met: •The formula is a specialized formula for treatment of a recognized life-threatening metabolic deficiency such as phenylketonuria; or •The formula is the significant source of a patient's primary nutrition or is administered in conjunction with intravenous nutrition.
Eye exam - Medical (medical vision disease)		20% coinsurance after deductible	Covered, Exams to diagnose diseases and conditions of the eye. Includes retinal exam for diabetes. Not covered, Orthoptics or vision training and any associated supplemental testing.
Eye exam - Routine Vision (VSP) Children, Up to 19 years of age (Pediatric Vision) Age 19 and over Not covered		$0 Cost Share	
Eye Wear - Medical Vision Hardware		20% coinsurance after deductible	Covered under DME for the following conditions of the eye: - Corneal ulcer - bullous keratopathy - recurrent erosion of cornea - tear film insufficiency - aphakia - Sjorgren's disease - Congenital cataract - Corneal abrasion - Keratoconus

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Benefit or Service	Prior Authorization	Member Cost Share	Additional Information
Eye Wear - Routine Vision Hardware (VSP) Children, Up to 19 years of age (Pediatric Vision) Age 19 and over Not covered Prescription Contacts, frames,vision lenses,upgrades, glasses		$0 Cost Share	
Eye and Vision Routine Services Not Covered	N/A	N/A	Eyeglasses or contact lenses for conditions not listed under medical eye wear,vision hardware or covered under the Pediatric Vision benefit.
Family Planning, contraception, birth control		$0 Cost Share	FDA-approved contraceptive services provided in the office or outpatient setting, includes IUDs, subdermal implants, including the insertion and removal, and voluntary sterilization procedures, including vasectomy and tubal ligation with no Cost-Sharing when provided by Network Providers. •Contraceptive methods that require a prescription, including oral contraceptives, transdermal patches, the vaginal ring, Medroxyprogesterone injections and emergency contraceptives, are covered under the Prescription Drug benefit. •FDA-approved over-the-counter contraceptive products for women, such as sponges and spermicides, are covered under the Prescription Drug benefit only when prescribed by a qualified Provider.
Genetic Testing, includes prenatal testing for congenital disorders	Prior Authorization required	20% coinsurance after deductible. Lab copay does not apply to genetic tests.	•Not covered, genetic tests of a child's father as a part of prenatal or newborn care.

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Benefit or Service	Prior Authorization	Member Cost Share	Additional Information
Habilitative Inpatient	Prior Authorization	Days: 1-5 - $525.00 per day No more than 5 days of copayments per stay.	Limit of 30 Days Per Calendar Year All admissions, planned and urgent, require notification within 24 hrs. or next business day. Each time a member is admitted for a new inpatient stay the copay will apply.
Habilitative Outpatient	Prior Authorization	$25.00 copay	25 combined visit limit per calendar year. Prior Authorization is required for additional visits after the initial 12 visits. Evaluation and reevaluation is separate from the 25 visits.
Hearing exam (Medical)		20% coinsurance after deductible	Routine hearing exams, hearing aids, and hearing aid fittings are not covered.
Hearing exam (Routine)	NOT COVERED	NOT COVERED	NOT COVERED
Hearing services (hearing aid fittings, hearing aids)	NOT COVERED	NOT COVERED	NOT COVERED
Hearing services, Cochlear Implants		Cost share determined by service: Outpatient Surgeon $75.00 copay, facility charges if applicable, 20% coinsurance after deductible for DME (implants), anesthesia, etc.	The following conditions must be met: -Services are to keep, restore and significantly improve function that was previously present but lost or impaired due to Disability, Injury or Illness; -Services are not for palliative, recreational, relaxation or maintenance therapy; and -Loss of function was not the result of a work-related Injury.
HIV screening		$0 Cost Share	For planned preventive services that become diagnostic during the screening, cost sharing may apply.

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Benefit or Service	Prior Authorization	Member Cost Share	Additional Information
Home health agency care	Prior Authorization Required for Home Health Services and related services. Review Prior Authorization list for related services.	20% coinsurance after deductible	130 Days per year limit • Pre-Authorization is required for home health care benefits. The patient must be homebound and require Skilled Care services. Home health care is covered when provided as an alternative to hospitalization and prescribed by a physician. • Covers Home infusion Therapy • Home health care listed below is not covered: - Custodial Care; - Private duty nursing; - Housekeeping or meal services; - Maintenance care; or - Shift or hourly care services. 30% coinsurance for durable medical equipment (DME) also applies when related to Home Health services.
Hospice care	Prior Authorization	Cost share determined be where services are performed. Inpatient Hospital copays or Home 20% after deductible.	Hospice care listed below is not covered: - Custodial Care or maintenance care, except palliative care to the terminally ill patient - Financial or legal counseling services; - Housekeeping or meal services; -Services by a Subscriber or the patient's Family or Volunteers; - Services not specifically listed as covered hospice services under this plan; - Supportive equipment such as handrails or ramps; or - Transportation.
Hospice Respite Care	Prior Authorization	20% coinsurance after deductible	14 Days per year
Hyperbaric oxygen treatment	Prior Authorization	20% coinsurance after deductible	
Immunizations		$0 Cost Share	Immunizations administered by pharmacists must be billed as a professional claim (HCFA form).

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Benefit or Service	Prior Authorization	Member Cost Share	Additional Information
Infertility Diagnostic Services	Pre-Authorization is required for services provided in an inpatient setting.	Cost share determined by service: Surgeon, facility charges if applicable, 20% coinsurance after deductible for, anesthesia, etc.	Coverage is provided for only the initial evaluation and diagnosis of infertility. Examples of Covered Services for the initial diagnosis of infertility include: endometrial biopsy, hysterosalpingography, reproductive screening services, or sperm count. Not covered: Treatments and procedures for the purposes of producing a pregnancy are not covered.
Infusion Therapy	PA Required if provided in home or feestanding infusion site	20% coinsurance after deductible	Cost share is based on place of service. See cost shares for outpatient facility and professional charges.
Injections, Injectable drugs	See Prior Authorization (PA) List Note: All Unclassified biologics (J3590) require a prior authorization.	20% after deductible.	Drugs that are administered under the supervision of physician, through home infusion or within a medical facility. Includes chemotherapy related drugs, drugs related to home dialysis, B12, etc. Self injectable drugs are covered under the pharmacy benefit.
Inpatient hospital Blood (including inpatient skilled nursing facility/SNF)		20% coinsurance after deductible	
Outpatient Blood		20% coinsurance after deductible	
Inpatient hospital Facility (acute) care	Prior Authorization	Days: 1-5 - $525.00 per day No more than 5 days of copayments per stay.	All admissions, planned and urgent, require notification within 24 hrs. or next business day. Each time a member is admitted for a new inpatient stay the copay will apply.
Inpatient Professional Services including SNF		Cost share determined by service	Only Hospital visits do not have cost shares. Inpatient surgery 20% coinsurance after the deductible (including maternity), CT Scan $300.00 after the deductible, etc.
Inpatient Hospital mental health, psychiatric, psychiatrist-care (facility)	Prior Authorization	Days: 1-5 - $525.00 per day No more than 5 days of copayments per stay.	All admissions, planned and urgent, require notification within 24 hrs. or next business day. Each time a member is admitted for a new inpatient stay the copay will apply.

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Benefit or Service	Prior Authorization	Member Cost Share	Additional Information
Inpatient rehabilitation (facility)	Prior Authorization	Days: 1-5 - $525.00 per day No more than 5 days of copayments per stay.	30 Days Per Calendar Year All admissions, planned and urgent, require notification within 24 hrs. or next business day. Each time a member is admitted for a new inpatient stay the copay will apply.
Inpatient substance disuse, SUD, chemical dependency (facility)	Prior authorization	Days: 1-5 - $525.00 per day No more than 5 days of copayments per stay.	Also applies to residential treatment.
Mastectomy related bras and supplies (DME)		20% cost share after the deductible	
Nutritional Counseling		$15 cost share after deductible	Does not apply to diabetics. See Diabetes self-management training benefits with cost shares for additional information.
Nurse Advice Line		0% cost share	24 hour nurse hotline available: 1-866-418-1002 or TTY 1-866-418-1006

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Benefit or Service	Prior Authorization	Member Cost Share	Additional Information
Obesity counseling, Weight Loss and Weight Management		20% coinsurance after deductible	Weight loss and weight management therapies are covered for children aged 6 and older who qualify as obese and adult members and children age 6 and older with a documented body mass index (BMI) of 30 kg/m2 or higher, when provided by an In-Network provider. The following multicomponent behavioral interventions are covered by the plan: •High intensity group and individual counseling sessions (12-26 sessions within a year), •Behavioral management activities, such as weight-loss goals, •Improving diet or nutrition and increasing physical activity, •Addressing barriers to change, •Self-monitoring, and •Strategizing how to maintain lifestyle changes. Not covered by this plan: •Exercise programs or use of exercise equipment, •Weight-loss diet supplements, such as Optifast liquid protein meals, NutriSystems pre-packaged foods, Medifast foods, phytotherapy, •Jenny Craig, Weight Watchers, Diet Center, Zone diet or other similar programs.
Organ (Living, Donor) Donation (Transplant)	Yes	Cost share determined by service: Inpatient hospital copays, anesthesia, etc.	All admissions, planned and urgent, require notification within 24 hrs. or next business day.
Out of Pocket Max. Per Year, MOOP, Individual, includes pharmacy		$5250, includes copays including pharmacy and all services applied to deductibles for in-network services.	
Out of Pocket Max. Per Year, MOOP, Family, includes pharmacy		$10500, includes all copays including pharmacy and all services applied to deductibles for in-network services.	
Orthotics	See Prior Authorization (PA) List	20% coinsurance after deductible	This benefit does not cover off-the-shelf shoe inserts or orthopedic shoes.

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Lab, Tests and Pathology	Some require prior authorization. See Prior Authorization (PA) List	$20.00 copay Genetic Tests - Lab copay does not apply. 20% after deductible. See Genetic Testing.	• One copay when technical component and professional component are performed by the same provider. • Separate copays when the components are performed by separate providers.
X-ray, Radiology (does not include scans)		$30.00 Copay	•One copay when technical component and professional component are performed by the same provider. •Separate copays when the components are performed by separate providers.
Outpatient diagnostic, imaging,scans, includes, MRI, CT scan, PET scan	See Prior Authorization (PA) List	$300.00 copay after deductible	
Outpatient hospital (facility)	See Prior Authorization (PA) List	20% coinsurance after deductible	• Prior Authorization is required for certain outpatient surgery/procedures. Refer to the PA list on CHPW.org • Professional fees are separate from the facility fees.
Outpatient Surgeon and Asst. Surgeon.		$75.00 copay Other services 20% after deductible	
Outpatient mental health visits		$15.00 copay	
Outpatient rehabilitation services (physical (PT), speech (ST), occupational therapy (OT)		$25.00 copay	25 combined visit limit per calendar year. Prior Authorization is required for additional visits after the initial 12 visits. Evaluation and reevaluation is separate from the 25 visits.
Outpatient substance disuse, SUD, chemical dependency visits (professional)		$15.00 copay	Opioid Treatment Services, to allow codes G2067 through G2080, the provider must be certified with SAMSAH and enrolled with Medicare.
Spinal Manipulations (physician)		20% coinsurance after deductible	See separate benefit for Chiropractors.
Surgery, ambulatory surgical centers (ASC)	See Prior Authorization (PA) List	$350.00 copay, after deductible. Copay cannot exceed the actual cost of the service. For example if the service is $150.00 the copay will be $150.00.	• Prior Authorization is required for certain outpatient surgery/procedures. Refer to the PA list on CHPW.org • Professional fees are separate from the facility fees.

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Benefit or Service	Prior Authorization	Member Cost Share	Additional Information
Over the Counter (OTC) medication/pharmacy		NOT COVERED except FDA approved, FDA-approved over-the-counter contraceptive products for women, such as sponges and spermicides. OTC Covid Tests are not covered. See Pharmacy for more information.	
Partial hospitalization service intensive outpatient mental health services	Prior Authorization	$15.00 copay	
Outpatient substance disuse, SUD, chemical dependency (facility)	Prior Authorization	$15.00 copay	Includes outpatient treatment in outpatient hospital, outpatient treatment center, and partial hospitalization or an intensive outpatient program.
Physical Exam, Periodic Exam, Annual Exam, Screenings, Preventive		$0 Cost Share	
Primary Care Physician (PCP) office visits		$15.00 for E & M service not subject to deductible Other services 20% coinsurance subject to deductible	•Services can be performed by a naturopath, nurse practitioner or physician assistant. •Copay applies to E & M (visit) only •Separate copay for lab and x-ray services •Separate cost shares for additional services may apply
Podiatry Services (Routine Foot Care)	NOT COVERED except for diabetics	NOT COVERED except for diabetics	NOT COVERED except for diabetics
Podiatry Services (Foot Care) Medical Covered		20% after deductible	Routine footcare only for diabetics is included in this benefit.

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Prescription drugs, pharmacy,Rx		•Generic $10 copay for 30-day supply. 90-day supply $27.00, not subject to the deductible. •Preferred $60 copay 30-day supply. 90-day supply $162.00, not subject to the deductible. •Non-Preferred $100 copay 30-day supply not subject to the deductible. Limited to 30-day supply. •Specialty Rx $100.00 copay 30-day supply not subject to the deductible. Limited to 30-day supply. •Insulin, 1-month supply, cost share no more than $100.00, not subject to the deductible.	• Immunizations administered by pharmacists in a pharmacy must be submitted as a professional claim (HCFA). • Not covered: Over the counter (OTC) except FDA approved, FDA-approved over-the-counter contraceptive products for women, such as sponges and spermicides. • OTC Covid Tests are not covered.
Prostate cancer screening exams (PSA)		$0 copay	For planned preventive services that become diagnostic during the screening, cost sharing may apply. For men over age 50: • Every 12 months: Digital rectal exam • Every 12 months PSA test
Prosthetic devices and related supplies	Prior Authorization	20% coinsurance after deductible	Prosthetic/Orthopedic Shoes that are part of a leg brace are covered and included in the cost of the leg brace.
Pulmonary rehabilitation services		20% coinsurance after deductible	
Reconstructive Surgery	Prior Authorization	Cost share determined by service: Inpatient hospital copays, outpatient facility, surgeon, anesthesia, etc. Other - 20% after deductible	Covered because of an accidental injury or to improve a malformed part of the body. All stages of reconstruction are covered for a breast after a mastectomy, as well as for the unaffected breast to produce a symmetrical appearance.
Screening for sexually transmitted infections (STIs) and counseling to prevent STIs		$0 copay	

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Skilled nursing inpatient facility (SNF) care	Yes	Days: $350.00 per day after the deductible	Coverage is limited to 60 inpatient days per year Requires Pre-Authorization. • Nursing Facility services are covered when provided as an alternative to hospitalization and prescribed by your Provider. • Room and board is limited to a semi-private room, except when a private room is determined to be Medically Necessary. • Care must be therapeutic or restorative and require in-facility delivery by licensed professional medical personnel, under the direction of a physician, to obtain the desired medical outcome, including services provided by a licensed behavioral health Provider for a covered diagnosis. Not Covered: Maintenance and Custodial Care are not covered.
Smoking and tobacco use cessation	Covered through Alere Quit-for-Life smoking cessation program.	0% Coinsurance	
Sterilization Reversal	Not Covered	Not Covered	Not Covered reversal of surgical sterilization, including any direct or indirect complications thereof.
Specialist Care/Services (does not apply to psychiatrists, mental health, lab or radiology)		$40.00 for E & M service Other services 20% coinsurance	•Services can be performed by a naturopath, nurse practitioner or physician assistant. •Copay applies to E & M (visit) only •Separate copay for lab and x-ray services •Separate cost shares for additional services may apply
Telemedicine, Telehealth (Virtual care)		Cost shares same as in person visits.	
Transplant Evaluation/Work-Up	Yes	Cost share determined by service: Office Visit, Lab, etc.	
Transplant	Yes, PA required except for corneal transplants	Cost share determined by service: Inpatient hospital copays, anesthesia, etc.	Corneal transplant does not require prior authorization (PA), other transplants do require PA. All admissions, planned and urgent, require notification within 24 hrs. or next business day.
Transportation Non-emergency	Not Covered	Not covered	For emergency see Ambulance

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Benefit or Service	Prior Authorization	Member Cost Share	Additional Information
Unlisted Codes with Charge Greater Than $250.00	Prior Authorization		Unlisted codes is the actual, AMA description of the service. Medical necessity documentation and pricing must be submitted with the request. Example: 43499, Unlisted procedure, esophagus.
Urgently, Urgent needed care, in-network only		$35.00 Copay	Out-of-area or out of network urgent care is not covered. Care is covered under the Emergency Room benefit is covered. Subject to the Emergency Care copays and coinsurance.
Wig (Covered under DME)	Prior Authorization required if purchase exceeds $500.00	20% coinsurance after deductible	Must be medically necessary.
Lung Cancer Screening		$0 Cost Share	Limited to ages 55 through 80, once per year.