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MEDICARE ADVANTAGE

Benefit or Service	Prior Authorization	Member Cost Share	Additional Information
Abdominal Aortic Aneurysm Screening		$0 copay	For planned preventive services that become diagnostic during the screening, cost sharing may apply.
Acupuncture - Medicare Covered for Chronic Back Pain		20% coinsurance	• Medicare criteria must be met. • Up to 12 visits in 90 days. • 8 additional sessions will be covered if improvement is demonstrated from the initial 12 visits • No more than 20 visits in a calendar year.
Alternative Medicine: acupuncture, chiropractic, massage therapy, naturopathy * New Name for Alternative Medicine, 2023 Health and Wellbeing		0% coinsurance	25 visit limit which is a combination of visits from Acupuncturists, Massage Therapists, Naturopaths and Chiropractor visits not covered by Medicare. X-rays performed by a Chiropractor are not covered. (Now called Health and Wellbeing)
AIR Ambulance (Non-emergency)	Yes	$350.00 copay per one-way trip	Covered, provided Medicare criteria are met.
Ambulance (Emergency)		$350.00 copay per one-way trip	Covered, including air ambulance, provided Medicare criteria are met.
Ambulance (Non-Emergency)		$350.00 copay per one-way trip	Covered, provided Medicare criteria are met.
Anesthesiologist (Anesthesia)		$0 copay	For professional services.
Annual Wellness Visit/AWV (Also, see Welcome to Medicare Preventive Visit)		$0 copay	All Medicare members who are no longer within 12 months after the effective date of their first Medicare Part B coverage period and who have not received a Welcome to Medicare Visit (AWV or Initial Preventive Physical Exam/IPPE) within the past 12 months
Bone mass measurement (Bone Density)	PA Required if more often than once every 2 years.	$0 copay	For planned preventive services that become diagnostic during the screening, cost sharing may apply. CMS limitations apply, every 2 years; or more frequently if medically necessary.

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Benefit or Service	Prior Authorization	Member Cost Share	Additional Information
Breast cancer screening (mammograms, mammography)		$0 copay	For planned preventive services that become diagnostic during the screening, cost sharing may apply. • One baseline mammogram between the ages of 35 and 39 • One screening mammogram every 12 months for age 40 and older • Clinical breast exams once every 24 months
Cardiac rehabilitation services	See Prior Authorization List and Procedure Code Look Up Tool.	20% Coinsurance	Medicare covers 2 sessions per day (1 hour each), up to 36 sessions.
Cardiovascular disease risk reduction visit		$0 copay	For planned preventive services that become diagnostic during the screening, cost sharing may apply.
Cardiovascular disease testing		$0 copay	For planned preventive services that become diagnostic during the screening, cost sharing may apply.
Cervical and vaginal cancer screening (Pap tests, pelvic exams)		$0 copay	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
Chiropractic services (Medicare covered)	Yes, for more than 12 visits	$20.00 copay	Only manual manipulation to correct subluxation. Massage therapy not covered. Per CMS x-rays billed by a chiropractor are not covered. X-rays are covered if performed by Radiologist. Also See supplemental benefit Health and Wellbeing.
Clinical Trials	Yes		

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Benefit or Service	Prior Authorization	Member Cost Share	Additional Information
Colorectal cancer screening (Colonoscopy, Sigmoidoscopy)		$0 copay	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.
Cosmetic surgery or procedures (Partial Exclusion)	Yes and Medicare criteria is met.		Only 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.
Custodial Care (Exclusion)	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*.
Dental Services (Original Medicare Medical Services, Not Routine Dental)	Refer to prior authorization list.	See specific medical services for related copays and coinsurance.	Covered services limited to surgery of the jaw or related structures, setting fractures of the jaw or facial bones, extraction of teeth to prepare the jaw for radiation treatments of neoplastic cancer disease, or services that would be covered when provided by a physician.

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Benefit or Service	Prior Authorization	Member Cost Share	Additional Information
Dental Services (Supplemental)		Cost share is anything over the $500.00 comprehensive services maximum.	Unlimited preventive services (exam, cleaning,) with $500.00 comprehensive services max
Depression screening		$0 copay	For planned preventive services that become diagnostic during the screening, cost sharing may apply.
Diabetes screening		$0 copay	For planned preventive services that become diagnostic during the screening, cost sharing may apply.
Diabetes self-management training, diabetic services and diabetes supplies (DME)	Prior auth required when glucose monitor, shoes or inserts (orthotics) greater than $500.00	$0 cost share Self management training requires a referral.	No cost share: • Blood glucose monitor • Blood glucose strips • Lancet devices • Glucose-control solutions for checking accuracy of strips and monitor • One pair of diabetic shoes per calendar year • 2 sets of shoe inserts (orthotics) covered per calendar year (diabetic)

COMMUNITY HEALTH PLAN of Washington™ MEDICARE ADVANTAGE

Benefit or Service	Prior Authorization	Member Cost Share	Additional Information
Durable medical equipment (DME) and related supplies	Some DME requires prior authorization, check procedure codes for details. All DME with a purchase price greater than $500.00 allowed amount requires prior authorization.	*20% Coinsurance	Covered, provided Medicare criteria are met. DME includes, wheelchairs, hospital beds, walkers,oxygen. *When primary diagnosis is COPD the coinsurance is zero.
Emergency care (Emergency Room, ER)		$95.00 (facility) copay for ER visit	$90.00 copayment waived if admitted as inpatient within the same hospital within 24 hrs.
Emergency care (ER Physician Service)		0% coinsurance	
Emergency care: Supplemental World-wide - Facility and Professional Services		20% Coinsurance	$25,000.00 Maximum - ER coinsurance is not waived if admitted to hospital. Amount paid does NOT count toward your maximum-out-of-pocket (MOOP) amount.
Enteral Feedings, Tube Feedings (Infusion Therapy, DME)	Yes	20% Coinsurance	
Enteral Formula (Infusion Therapy, DME)	Yes	20% Coinsurance	
Eye exam - Medicare Covered (medical vision disease)		*20% Coinsurance	Exams to diagnose diseases and conditions of the eye covered by Medicare. *When the primary diagnosis is diabetes for a retinal exam and the exam is performed by an endocrinologist or ophthalmologist, the coinsurance is zero. If provider is not participating, then plan approved referral is required.
Eye exam - Routine Vision (VSP Advantage)		In network $0 copay	Through VSP - One WellVision exam every year. Members must use the VSP Advantage Network for in-network benefits. Out of network - $45.00 is allowed toward the cost of the exam.
Eye Wear - Medicare covered (Post Cataract Vision Surgery)		20% Coinsurance	Covered, provided Medicare criteria are met. One pair of eyeglasses or contact lenses includes insertion of an intraocular lens after each surgery.

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Benefit or Service	Prior Authorization	Member Cost Share	Additional Information
Eye Wear - Prescription Contacts, frames,vision lenses,upgrades (VSP Choice)		•Available every 2 years. • In VSP Choice network •Frame or contact lenses instead of glasses - $150.00 every year allowed toward cost. • In VSP Choice network - Lenses (for glasses) - $0 copay for the following lenses: o Single Vision o Lined bifocal o Lined trifocal o Lenticular • Lens enhancements not included in the $0 copay. Lens enhancements are member's responsibility. Average 30% savings on lens and enhancements.	Members must use the VSP Choice Network for in-network benefits. Out of network - Any amount over the out of network annual allowance is patient responsibility. • Frame, $70 allowed toward costs. • Contact lenses (in lieu of lenses and frame) $105. • Single vision Lenses - up to $30 • Lined bifocal - up to $50 • Lined trifocal - up to $65 • Lenticular - up to $100 • Progressive - up to $50
Eye and Vision Services Not Covered by Medicare (Exclusions)		Not Covered. See Additional Information	• Radial keratotomy not covered • LASIK surgery not covered • Vision Therapy not covered • Low Vision Aids not covered
Genetic Testing Not Related to Pregnancy	Yes	20% Coinsurance	
Hearing exam (Medicare covered-to diagnose and treat specific diseases and conditions.)		20% Coinsurance	Covered, provided Medicare criteria are met. Routine hearing exams, hearing aids, and hearing aid fittings are not covered by Medicare.
Hearing exam (Routine not covered by Medicare) Exclusion	Not Covered	Not Covered	Not Covered
Hearing services (hearing aid fittings, hearing aids) Exclusion	Not Covered	Not Covered	Not Covered
HIV screening		$0 copay	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	Required for Home Health Services. Services related to the Home Health care may also require prior authorization, for example medication, enteral nutrition. Review Prior Authorization list for related services.	$0 coinsurance	20% coinsurance for durable medical equipment (DME) still applies when related to Home Health services.
Homemaker Services - See Family on Demand, New Supplemental Benefit	Homemaker Services - See Family on Demand, New Supplemental Benefit	Homemaker Services - See Family on Demand, New Supplemental Benefit	Services include basic household assistance, light housekeeping or light meal preparation. (Not bathing, dressing, etc.)
Hospice care (inpatient and home)	No.		You pay nothing for hospice care from a Medicare certified hospice. You may have to pay part of the cost for drugs and respite care. Hospice is covered outside of our plan.
Hyperbaric oxygen treatment	Yes	20% Coinsurance	
Immunizations		$0 Coinsurance	Covered: - pneumonia - influenza (flu shot) - Hepatitis B - COVID-19 - Other vaccines if at risk and meet Original Medicare Part B coverage rules *Shingles vaccine (Zostavax) is covered under pharmacy - Part D Benefit*
Infusion Therapy, Home Infusion Therapy	Not Required for Infusion Therapy Services. Services related to the Infusion Therapy care may require prior authorization, for example medication, enteral nutrition. Review Prior Authorization list for related services.	20% coinsurance	Not Required for Infusion Therapy Services. Services related to the Infusion Therapy care may require prior authorization, for example medication, enteral nutrition. Review Prior Authorization list for related services.

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Benefit or Service	Prior Authorization	Member Cost Share	Additional Information
Injections, Injectable drugs (Prescription drugs Medicare Part B medical benefits)	See Prior Authorization (PA) List Note: All Unclassified biologics (J3590) require a prior authorization.	20% Coinsurance	Covered, provided Medicare criteria are met. Includes chemotherapy related drugs, drugs related to home dialysis, B12, etc.
Inpatient hospital Blood (including inpatient skilled nursing facility/SNF)		No Blood Deductible 0% coinsurance	Coverage begins with the first pint of blood needed. Includes storage and administration. The patient is responsible for any other applicable coinsurance amounts.
Outpatient Blood		No Blood Deductible 0% coinsurance	Coverage begins with the fourth pint of blood needed. Coverage of storage and administration begins with the first pint of blood needed. The patient is responsible for any other applicable coinsurance amounts.
Inpatient hospital (acute) care	Yes	Days: 1-4 - $450.00 per day 5-90 - $0 per day	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. Plan covers 90 days for an inpatient stay.
Inpatient Professional Services		20% Coinsurance	
Inpatient Hospital (facility) mental health, psychiatric, psychiatrist~~)~~ care	Yes	Days: 1-5 - $310.00 per day 6-90 - $0 per day	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. Not psychiatric hospital, same cost shares as acute care. Plan covers 90 days for an inpatient stay. 190-day lifetime limitation in a psychiatric facility. This limitation does not apply to inpatient psychiatric services furnished in a general hospital.
Inpatient rehabilitation services (physical, speech, occupational therapies)	Yes	Days: 1-4 - $450.00 per day 5-90 - $0 per day	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. Same cost shares as acute care.
Inpatient services covered during a non-covered inpatient stay		20% coinsurance	Covered, provided Medicare criteria are met.

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Benefit or Service	Prior Authorization	Member Cost Share	Additional Information
Inpatient substance abuse	Yes	Days: 1-5 - $450.00 per day 6-90 - $0 per day Over 90 - $0 per day	All admissions, planned and urgent, require notification within 24 hrs. or next business day. Same cost shares as acute care.
Kidney disease and conditions (Hemodialysis, Dialysis, End Stage Renal Disease/ESRD)	NO. Effective 01/01/2016 Notification is required.	20% coinsurance	
Kidney disease education (on dialysis)	No.	0% cost share	Medicare covers 6 sessions of kidney disease education per lifetime per Medicare.
Mastectomy related bras and supplies (DME)	If over $500.00	20% cost share	
Meal, Meals Benefit (Supplemental)		0% cost share	Meals can be delivered to the home upon discharge from a hospital or skilled nursing facility. 2 meals per day up to 14 days after discharge, up to 6 occurrences per year. Meals to dine with members that are inpatient are not covered.
Medical nutrition therapy education	No	0% cost share	Education for people with diabetes, kidney disease (patient not on dialysis) post kidney transplant. 3 hrs. for first year. 2 hrs. each year after the first year.
Nurse Advice Line		0% cost share	24 hour nurse hotline available: 1-866-418-1002 or TTY 1-866-418-1006
Obesity screening and obesity (counseling) therapy		0% cost share	Covered, provided Medicare criteria are met, e.g., body mass index (BMI) of 30 or more, etc.
Organ (Living) Donation (Transplant)	Yes	20% coinsurance	All admissions, planned and urgent, require notification within 24 hrs. or next business day.
Orthotics (Supportive Devices for feet)	Only covered for diabetic foot disease. Prior auth required for orthotics (shoe inserts) greater than $500.00.	$0 cost share	• 2 sets of shoe inserts (orthotics) covered per calendar year only for diabetic foot disease.

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Benefit or Service	Prior Authorization	Member Cost Share	Additional Information
Outpatient diagnostic tests and therapeutic services (lab, radiology, x-ray)	Some require prior authorization. Check PA List and Procedure Codes for more details.	0% Medicare covered lab $15 copay x-ray outpatient facility fee does not include scans (CT, MRI, PET, etc.) Does not include professional fees. 20% Other diagnostic procedures (includes scans)	
Outpatient hospital services, includes Observation	See Prior Authorization (PA) List	$365.00 copay outpatient facility fee maximum. Does not include professional services.	
Outpatient mental health (not psychiatrist)		$30 copay	Copay the same for group therapy. Must be Medicare eligible provider. Per CMS, some 'counselors' are not eligible to perform services for Medicare and Medicare Advantage members.
Outpatient psychiatrist care		20% coinsurance	Copay the same for group therapy.
Outpatient rehabilitation services (physical,PT, speech, ST, occupational therapy,OT)	Prior authorization required after initial 12 visits.	$40 copay	12 visits allowed for each type of therapy. 12 PT, 12 OT and 12 ST. Prior Authorization is required for additional visits after the initial 12 visits. Evaluation and reevaluation is separate from the 12 visits.
Outpatient substance abuse services	Yes	20% coinsurance	Opioid Treatment Services, to allow codes G2067 through G2080, the provider must be certified with SAMSAH and enrolled with Medicare.
Outpatient surgery, ambulatory surgical centers (ASC)	See Prior Authorization (PA) List	$365.00 copay outpatient facility fee maximum. Does not include professional services.	
Over the Counter (OTC) medication/pharmacy	Not Covered by Original Medicare, see OVER-THE - COUNTER (OTC) MAIL ORDER for Supplemental Benefit		
Partial hospitalization service (intensive outpatient mental health services)		20% coinsurance	Must be Medicare eligible provider. Per CMS, some 'counselors' are not eligible to perform services for Medicare and Medicare Advantage members.

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Benefit or Service	Prior Authorization	Member Cost Share	Additional Information
Primary Care Physician (PCP) office visits		*$0 copay for PCP E & M service 20% coinsurance for all other services	*Zero copay when primary diagnosis is diabetes *Zero copay when primary diagnosis is COPD *Zero copay when primary diagnosis is CHF
Physical Exam, See Welcome to Medicare Preventive Visit and Annual Wellness Visit		See Welcome to Medicare Preventive Visit and Annual Wellness Visit	See Welcome to Medicare Preventive Visit and Annual Wellness Visit
Podiatry Services (Foot Care) When Not Covered by Medicare (Supplemental Benefit)		No copay $0.00 0% Coinsurance	4 visits each year - Not limited to Medicare covered diagnosis codes. NEW, when the primary care is Diabetes an additional 4 visits each year for a total of 8 Non-Medicare covered visits. The specialist copay does not apply to podiatrists for these services.
Podiatry Services (Foot Care) Medical Medicare Covered		No copay $0.00 0% Coinsurance	Limited to Medicare covered diagnosis codes. The specialist copay does not apply to podiatrists for these services.
Prescription drugs Medicare Part B medical benefits (injectable drugs, injections)	See Prior Authorization (PA) List	20% coinsurance	Includes chemotherapy related drugs, drugs related to home dialysis, etc.
Prescription drugs Medicare Part D pharmacy benefit (drug list, formulary)		Pharmacy Part D is covered.	Over the counter (OTC) 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 (DME)	See Prior Authorization (PA) List	20% coinsurance	

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Benefit or Service	Prior Authorization	Member Cost Share	Additional Information
Pulmonary rehabilitation services	See Prior Authorization List and Procedure Code Look Up Tool.	20% coinsurance	Comprehensive programs of pulmonary rehabilitation are covered for members who have moderate to very severe chronic obstructive pulmonary disease (COPD) and a referral for pulmonary rehabilitation from the doctor treating the chronic respiratory disease.
Screening and counseling to reduce alcohol misuse		$0 copay	For planned preventive services that become diagnostic during the screening, cost sharing may apply.
Screening for sexually transmitted infections (STIs) and counseling to prevent STIs		$0 copay	For planned preventive services that become diagnostic during the screening, cost sharing may apply.
Shoes, Diabetic- SEE Diabetes self-management training, diabetic services and diabetes supplies (DME)			
Shoes, Orthopedic/Prosthetic with Braces (DME)	Yes, greater than $500.00	20% coinsurance	Limited coverage. Prosthetic/Orthopedic Shoes that are part of a leg brace are covered and included in the cost of the leg brace.
Skilled nursing inpatient facility (SNF) care (Part A)	Yes	Days: 1-20 - $ 00.00 per day 21-100 - $160.00 per day	No (zero) acute inpatient hospital days required prior to SNF admission. Custodial (not medically necessary) care is not covered. All admissions, planned and urgent, require notification within 24 hrs. or next business day. Each time member is admitted to a new SNF stay the copay will apply.
Skilled nursing facility (SNF) inpatient care (Part B)		20% coinsurance	Part B (outpatient) coinsurance and benefit limits apply.
Skilled nursing facility (SNF) Blood		No blood deductible 0% coinsurance	
Sleep Studies	No.	20% coinsurance	
Smoking and tobacco use cessation		0% Coinsurance	• Contact Optum at 1-866-784-8454 (1-866-QUIT-4-LIFE). • No disease - 8 sessions per calendar year • Disease related - 8 sessions per calendar year
Sterilization Reversal (Exclusion)	Not Covered	Not Covered	Reversal of sterilization procedures and non-prescription contraceptive supplies.

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Benefit or Service	Prior Authorization	Member Cost Share	Additional Information
Specialist Physician Care/Services (does not apply to psychiatrists, mental health, lab or radiology)		*$40 copay for E & M service 20% coinsurance for all other services	*Zero copay when primary diagnosis is diabetes for endocrinologist *Zero copay when primary diagnosis is COPD for pulmonologist. *Zero copay when primary diagnosis is CHF for cardiologist. *See Eye Exam – Medicare Covered - for Retinal Exam benefit
Telemedicine, Telehealth (Virtual care)		Must meet Original Medicare criteria.	Covered. Must meet Original Medicare criteria.
Telemedicine, Telehealth (Virtual care) - Supplemental		Member cost share same as in-person cost shares for: Urgently Needed Services; Primary Care Physician Services; Physician Specialist Services; Individual and Group Sessions for Mental Health Specialty Services; Individual and Group Sessions for Psychiatric Services; Individual and Group Sessions for Outpatient Substance Abuse.	Medicare criteria does not have to be met.
Transplant Evaluation/Work-Up	Yes	Labs 0% Other professional services, related copays or coinsurance applies.	
Transplant	Yes except for corneal transplants	20% coinsurance	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 SEE AMBULANCE	See Ambulance	See Ambulance	See Ambulance

Benefit or Service	Prior Authorization	Member Cost Share	Additional Information
Unlisted Codes with Charge Greater Than $250.00	Yes		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 needed care		$10 copay for evaluation and management (E & M) service 20% coinsurance for all other services	
Vision Care SEE EYE EXAM AND EYE WEAR	See Eye Exam and Eye Wear	See Eye Exam and Eye Wear	See Eye Exam and Eye Wear
Welcome to Medicare Preventive Visit (Initial Preventive Physical Exam/IPPE or Annual Wellness Visit/AWV)		$0 copay	1 visit lifetime max within 12 months of Part B effective date. For planned preventive services that become diagnostic during the screening, cost sharing may apply. If greater than 12 months from the effective date and did not receive a Welcome Exam see Annual Physical Exam
Wig (DME)	Yes if +$500.00	20% coinsurance	Must be medically necessary and meet criteria to covered by Medicare.
Lung Cancer Screening		$0 copay	Limited to ages 55 through 77, once per year.
FITNESS BENEFIT		$0 copay	Membership at participating fitness centers or 2 Home Fitness Kits per year: Includes: • Access to Silver& Fit website including The Silver Slate newsletter, healthy aging education program, motivational tips and rewards. • 34 Home Fitness Kits to choose from • Single fitness center access; can be changed once per month. • Customer Service, open Monday through Friday, 5 AM through 6 PM PST • Tele. 1-877-427-4788

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Benefit or Service	Prior Authorization	Member Cost Share	Additional Information
Supervised Exercise Therapy (SET)		20% coinsurance	Only for members who have symptomatic peripheral artery disease (PAD). No referral is required. The SET provider must meet Medicare requirements. Covered up to 36 sessions over a 12-week period if all of the components of a SET program are met.
Medicare Diabetes Prevention Program (MDPP)		No Cost Shares	Provider must be enrolled in Medicare as an MDPP supplier to bill for MDPP services. • Therapeutic exercise-training program for PAD. • Conducted in a hospital outpatient setting, or a physician's office • Delivered by qualified auxiliary personnel necessary to ensure benefits exceed harms, and who are trained in exercise therapy for PAD
Pulmonary rehabilitation services	See Prior Authorization List and Procedure Code Look Up Tool.	20% Coinsurance	Comprehensive programs of pulmonary rehabilitation are covered for members who have moderate to very severe chronic obstructive pulmonary disease (COPD) and a referral for pulmonary rehabilitation from the doctor treating the chronic respiratory disease.
Transgender Services		Cost share determined by service, e.g. outpatient hospital copay, specialist visit, etc.	The procedure code must be covered by Original Medicare with an allowed amount on the Medicare fee schedule. The PCLT can be referenced for covered codes and prior authorization requirements: https://forms.chpw.org/pclt.
Member Total Out-of-Pocket (MOOP)		$7,900.00	
Health and Wellbeing		No Cost Share	New: 25 visit limit which is a combination of visits from Acupuncturists, Massage Therapists, Naturopaths and Chiropractor visits not covered by Medicare. X-rays performed by a Chiropractor are not covered.

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Benefit or Service	Prior Authorization	Member Cost Share	Additional Information
Family on Demand		No Cost share	60 hours of assistance per year •Companionship such as playing board games and having conversations, watching a movie, and taking a walk. •Assistance around the house with light cleaning, laundry, and cooking/meal prep. •Everyday tasks such as grocery shopping, taking them to and from the store, and picking up prescription refills. •NOT Home Nursing care, bathing, dressing, etc.
OVER-THE - COUNTER (OTC) MAIL ORDER Supplemental Benefit		All costs over $25.00	Orders are limited to 1 shipment per month (can include multiple items) • Limited to $25.00 allowance only, per month , no cash, checks or credit card payment accepted for amounts over $25.00 (per month). • Items can be ordered: o on-line - https://shopping.drugsourceinc.com/ o by phone at 1-877-603-0402