



IMPORTANT NOTE: The following information is a general description of a covered person's benefits arranged by type of coverage (example: medical, dental, vision). It is not intended to be an all-inclusive benefit description and cannot be considered a guarantee of benefits. Please note any limitations that apply to specific benefits or diagnoses. Not all restrictions or limitations are listed.

The benefits available are conditional on the patient's employment status, plan eligibility, payment of contributions, and amount of benefits remaining, plan provisions, and plan exclusions. The benefits quoted are not guaranteed. Final determination as to benefits payable will be made at the time a claim is submitted for payment, and subject to review of the necessary medical records and other information.

INFORMATION LISTED IS IN EFFECT AS OF 01/01/2024

*****Please Refer To Insurance Card for Network Information and Mailing Address for Claim Submission*****

MAJOR MEDICAL BENEFITS		
	IN-NETWORK	OUT OF NETWORK
Group / Plan:	AOIC	AOIC
Lifetime Maximum:	None	None
Individual Deductible:	\$300	\$300 – there is an additional \$350 in-patient hospital deductible (limit of 2 per year)
Family Deductible:	\$600	\$600
Individual Coinsurance Limit	\$900	\$1800
Family Coinsurance Limit	\$1800	\$3600
Maximum Individual Out-of-Pocket:	\$4200	\$5800
Maximum Family Out-of-Pocket:	\$8400	\$10,900

Out of Pocket includes deductible, coinsurance, copays and prescriptions.

CODES: 'A'nnual, 'L'ifetime, 'W'eekly, "D'aily, 'O'ccurrence, '\$' Dollars, 'U'nits, 'C'opay, 'V'isits, 'M'ax Charge;
P = pre-certification or authorization required; S = Continued Stay Certification. * means Deductible applies

OPERATES ON A CALENDAR YEAR.

Precertification is necessary for:

All Surgical procedures – inpatient and outpatient

**Breast MRI's
 Chemotherapy
 Cardiac and Pulmonary rehabilitation
 Cochlear implants
 Dialysis
 Durable Medical Equipment
 ECT treatment
 Epidural/Facet/Injections
 Genetic Testing**

**Home Health Care
 Hospice
 Inpatient Hospitalizations >24 hours
 Prosthetics & Orthotics
 Radiation Therapy
 Skilled Nursing Facility/Extended Care
 Therapies (occupational, speech, physical)
 Treatment of TMJ
 Varicose Vein Treatments**

Outpatient Pre-Certification Authorizations expire 60 days from notification. If an extension is needed, please contact Prairie States Health Management. Please call Prairie States for Pre-Certification at 1-800-615-7020

No Pre-Existing Conditions – No Lifetime Max

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Service	IN-NETWORK	OUT-NETWORK	Limits
Acupuncture or Hypnotism	Not Covered	Not Covered	
Allergy Injections/testing	90%*	80%*	
Ambulance	90%*	80%*	
Ambulatory Surgical Center	90%	80%	Pre-Cert Required
Anesthesia – Inpatient	90%*	80%*	
Anesthesia – Outpatient	90%*	80%*	
Birth Control	100%	100%	
Brest feeding support/counseling	100%	100%	
Breast Pump	100%	100%	Limited to the purchase of one pump per pregnancy up to 6 months after birth.
Breast Pump Supplies	100%	100%	Limited to \$100 per pregnancy or adaption.
Cardiac Rehabilitation	90%*	80%*	Pre-Cert Required
Cataract Surgery	90%*	80%*	Pre-Cert Required
Chemotherapy	90%*	80%*	Pre-Cert Required
Chiropractic	90%*	80%*	\$30 Co-Pay per visit Limited to 24 visits per year
Cochlear implants	80%*	80%*	Pre-cert Required
Colonoscopy – Routine	100%	100%	Routine is limited to age 45 and over once every ten years
Non- Routine (no age limit)	90%*	80%*	No pre-cert required
Dental Expenses under Medical Policy	90%*	80%*	Pre-Cert Required
Durable Medical Equipment (DME)	90%*	80%*	All rentals and individual purchases over \$500 need pre-cert
Emergency Room – Facility	90%*	90%*	\$120 co-pay
Emergency Room – Physician	90%*	90%*	
Extended Care Facility/Skilled Nursing	90%*	80%*	Pre-Cert Required 60 Visits/days Annually per illness/injury
Eye Exam – Routine	Not Covered	Not Covered	
Foot Orthotics	90%*	80%*	Over \$500 Requires Pre-Cert
Hearing Aids – children up to age 18 only	80%*	80%*	Medically necessary due to sensorineural hearing loss \$1500 Max per hearing aid \$10,000 Lifetime max Pre-Cert Required
Hearing Exams	100%	100%	Limited ACA guidelines
Home Health Care	100%	100%	Pre-Cert Required 60 V A
Hospital Outpatient Diagnostic	90%*	80%*	
Hospital Outpatient Surgery	90%*	80%*	Pre-Cert Required
Hospital Inpatient	90%*	80%*	Pre-Cert Required for Hospitalization >24hr
Hospice Care – Inpatient	100%	100%	Pre-Cert Required
Hospice Care – Outpatient	100%	100%	Pre-Cert Required
HPV screening	100%	100%	1 every 3 years ages 30-65
Injections	90%*	80%*	Pre-Cert Required



Service	IN-NETWORK	OUT-NETWORK	Limits
Infertility	90%*	80%*	Diagnosis only covered
Laboratory – Inpatient	90%*	80%*	
Laboratory – Outpatient	90%*	80%*	
Mammogram – Routine (3D included)	100%	100%	Age 40-99 1 V A
Non-Routine	90%*	80%*	
Maternity – Global Fee	90%*	80%*	Labor, delivery and postpartum care
Massage Therapy	Not Covered	Not Covered	
Nutritional Counseling for Specific Diagnoses	90%*	80%*	Pre-cert required – must be ordered by a physician
Occupational Therapy	90%*	80%*	Pre-Cert Required-Services must be by a licensed therapist
Office Visit	90%*	80%*	\$30 Copay Virtual visit allowed subject to the plan benefits
Pap smear Routine	100%	100%	
Physical Therapy	90%*	80%*	Pre-Cert Required –Services must be by a licensed therapist
Prenatal Care	100%	80%*	Includes routine prenatal OB visits, immunizations, labs and screenings explicitly identified in PPACA
Psychiatric/Mental Health – Office Visit	90%*	80%*	\$30 co-pay Any visit over 1 hour requires Pre-Cert – ***See below***
Psychiatric/Mental Health inpatient/intensive outpatient	90%*	80%*	Pre-Cert Required ***See below***
Prostate Specific Antigen	100%	100%	Over 18 and one per year
Radiation Therapy	90%*	80%*	Pre-Cert Required
Radiology	90%*	80%*	Breast MRI only Requires Pre-Cert
Routine Preventative Children/adults Immunizations	100%	100%*	
Second Surgical Opinion	90%*	80%*	\$30 co-pay, no referral needed
Sigmoidoscopy	100%	100%	Limited to age 50 one every 3 rd plan year - for diagnostic purposes outside timeframe are subject to deductible and coinsurance
Skilled Nursing Facility	90%*	80%*	Pre Cert required. 60 days max per year
Sleep Studies	90%*	80%*	No Pre Cert needed
Speech Therapy	90%*	80%*	Pre-Cert Required-Services must be by a licensed therapist
Specialist Office Visit	90%*	80%*	\$30 co-pay Referrals are not required
Substance abuse – office / outpatient visit	90%*	80%*	\$30 co-pay Visit over 1 hour requires pre-cert – ***See below***
Substance abuse – inpatient/intensive outpatient	90%*	80%*	Pre-Cert required See below
TMJ	90%*	80%*	Pre-Cert Required for treatment
Urgent Care	90%*	80%*	\$45 co-pay Virtual visit allowed subject to the plan benefits



Service	IN-NETWORK	OUT-NETWORK	Limits
Wigs	100%	100%	\$500 per member per lifetime undergoing chemo/radiation

***Plan limits Mental Health/Psychiatric Benefits: Any services provided by a Licensed Clinical Social Worker (LCSW), Licensed Professional Counselor (LPC), MD, or PhD. Other credentials MUST be under direct supervision of an MD, PhD, or LCSW in order for services to be covered. Family and marriage are NOT covered under policy. Psych testing is covered, subject to deductible/co-insurance. ECT needs to be pre-authorized.

* Virtual visit allowed subject to the plan benefits

***Electronic claims** may be submitted to #36373

*Timely Filing is 15 months from date of service

*Observation is 23 hours or less

* Serve You is Pharmacy Benefit Manager 800-759-3203

* **Co-Pays where applicable are in addition to the deductible and or co-insurance**

***Refer to members ID card for network information and claims submission information**