CoverKids Copays

	BENEFIT LEVEL		
	1	**2**	**3**
Office/Outpatient Services			
Primary Care Visit • Office visit with family practice, general practice, internal medicine, OB/GYN, pediatrics, and walk in clinics • Includes nurse practitioners, physician assistants and nurse midwives (licensed healthcare facility only) working under the supervision of a primary care provider	$15 Copay	$5 Copay	No Copay
Specialist Visit and Outpatient Surgery • Office visit with any specialty provider • Outpatient surgery including invasive diagnostic services (e.g. colonoscopy) - **Single copay per date of service**	$20 Copay	$5 Copay	No Copay
Behavioral Health (Mental Health, Alcohol and Drug Abuse)Services • Office visit • Outpatient Mental health and substance abuse - **Single copay per date of service**	$15 Copay	$5 Copay	No Copay
Chiropractors • Only covered for children under age 19	$15 Copay	$5 Copay	No Copay
Rehabilitation and Therapy Services • Including Speech, Physical and Occupational • Limited to 52 visits per therapy type per Calendar Year	$15 Copay	$5 Copay	No Copay

	BENEFIT LEVEL		
	1	**2**	**3**
Pharmacy - Benefits managed by OptumRx			
30 and 90-Day Supply/Specialty Pharmacy Drugs	$5 generic $20 preferred brand $40 non-preferred brand	$1 generic $3 preferred brand $5 non-preferred brand	No Copay
Non-Emergency Care			
Emergency Room Visit deemed as NOT a True Medical Emergency • Facility (Medical & Behavioral Health (Mental Health, Alcohol and Drug Abuse) • MUST be an In-Network Provider. If Out of Network provider, CoverKids will NOT pay.	$50 Copay	$10 Copay	No Copay
Inpatient Stays			
Inpatient Facility (Medical and Behavioral Health [Mental Health, Alcohol and Drug Abuse]) • Copay waived if readmitted within 48 hours of initial visit for same episode of illness or injury • Rehabilitation services • Mental Health, Alcohol and Drug Abuse Treatment	$100 Copay per admission	$5 Copay per admission	No Copay

	BENEFIT LEVEL		
	1	**2**	**3**
Vision Services - These Services are only eligible for children under age 19. When both frames and lenses are ordered at the same time, one copay is charged.			
Prescription Eyeglass Lenses • Including bifocal or trifocal • Limited to one per Plan Year	$15 Copay $85 Max Benefit	$5 Copay $85 Max Benefit	No Copay
Prescription Contact Lenses instead of Eyeglass Lenses • Limited to one per Plan Year	$15 Copay $150 Max Benefit	$5 Copay $150 Max Benefit	No Copay
Frames • Limited to every 2 Plan Years	$15 Copay $100 Max Benefit	$5 Copay $100 Max Benefit	No Copay
Dental Services- These Services are only eligible for children under age 19.			
Dental Services • No copay for routine preventive oral exam, X-ray, and fluoride application	$15 Copay	$5 Copay	No Copay
Orthodontic Services	$15 Copay	$5 Copay	No Copay

The following services do <u>NOT</u> require a copay
Preventive Care
Office Visits • Routine Health Assessments • Immunizations • Annual hearing and vision screening
Office/Outpatient Services
• Lab and X-Ray
Emergency Care
• Emergency Room Visit Deemed as an Emergency
Services for Pregnant Women
• Pregnant Women do not have copays
Ambulance
• Land and Air
Home Health
• Home Nursing Care limited to 125 visits per Calendar Year
Hospice
• Copay waived for all services if member is under hospice care
Vision Services - These Services are only eligible **for Children under 19.**
Annual Vision Exam • Including refractive exam and annual glaucoma testing • Must go to an In-Network provider