Child Health Plan *Plus*
Copayment Summary – Effective July 1, 2012

	COPAYMENT			
	<101% FPL	**101-150% FPL**	**151 - 200% FPL**	**201% - 250% FPL**
1. ANNUAL DEDUCTIBLE Individual Family	None. None.	None. None.	None. None.	None. None.
2. OUT-OF-POCKET LIMIT Individual Family	None.	5% of annual family income adjusted for family size.	5% of annual family income adjusted for family size.	5% of annual family income adjusted for family size.
3. EMERGENCY CARE	$3	$3	$30	$50
4. URGENT/AFTER HOURS CARE	$1	$1	$20	$30
5. EMERGENCY TRANSPORT/AMBULANCE SERVICES	$0	$2	$15	$25
6. HOSPITAL/OTHER FACILITY SERVICES A. INPATIENT B. PHYSICIAN C. OUTPATIENT/ AMBULATORY	 $0 $0 $0	 $2 $2 $2	 $20 $5 $5	 $50 $10 $10
7. ROUTINE MEDICAL OFFICE VISIT [1]	$0	$2	$5	$10
8. FLUORIDE VARNISH APPLICATION	$0	$0	$0	$0
9. LABORATORY AND X-RAY	$0	$0	$5	$10
10. PREVENTIVE, ROUTINE, AND FAMILY PLANNING SERVICES	$0	$0	$0	$0
11. MATERNITY CARE Prenatal Delivery & inpatient well baby care[2]	$0 $0	$0 $0	$0 $0	$0 $0

[1] Routine medical office visits includes physician, mid-level practitioner and specialist visits, including outpatient mental health visits.
[2] Well baby care includes an in-hospital newborn pediatric visit and newborn hearing screening.

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12. MENTAL ILLNESS CARE				
A. NEUROBIOLOGICALLY-BASED MENTAL ILLNESSES[3]				
B. MENTAL DISORDERS	$0	$2/office visit; $2/admission	$5/office visit; $20/admission	$10/office visit $50 /admission
C. ALL OTHER[4]				
1. INPATIENT[5]	$0	$2	$20	$50
2. OUTPATIENT	$0	$2	$5	$10
13. ALCOHOL AND SUBSTANCE ABUSE	$0	$2	$5	$10
14. PHYSICAL THERAPY, SPEECH THERAPY, AND OCCUPATIONAL THERAPY	$0	$2	$5	$10
15. DURABLE MEDICAL EQUIPMENT (DME)[6]	$0	$0	$0	$0
16. TRANSPLANTS	$0	$0	$0	$0
17. HOME HEALTH CARE	$0	$0	$0	$0
18. HOSPICE CARE[7]	$0	$0	$0	$0

[3] Requires the following to be treated as any other illness or condition: schizophrenia, schizoaffective disorder, bipolar affective disorder, major depressive disorder, specific obsessive compulsive disorder, and panic disorder. Applies to all group health benefit plans.

[4] All other mental health benefits include coverage for all mental health conditions recognized in the DSM-IV manual.

[5] The day cost of residential care must be less than or equal to the cost of a partial day of hospitalization. Each two days of residential or partial hospital care counts as one day of inpatient care.

[6] DME includes, but is not limited to, home-administered oxygen, reusable equipment for the treatment of diabetes, and prostheses. Although the cost of prosthetic devises applies to the annual DME cap, benefits for prosthetic devices for arms or legs (or any part thereof) themselves are not subject to this limitation. The benefit level for prosthetic devices for arms or legs or parts thereof shall be as required by 10-16-104(14), C.R.S. Repair or replacement of defective equipment is covered at no additional charge; repair and replacement needed because of normal usage is covered up to the benefit cap; and repair and replacement needed due to misuse/abuse by the member is **not** covered.

[7] Although the number of days for this benefit is not limited, ancillary services, such as bereavement, shall be limited consistent with Colorado Division of Insurance Regulation 4-2-8 as amended.

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19. PRESCRIPTION DRUGS	$0	$1	$3 – generic. $10 – brand name[8].	$5-generic $15-brand name
20. KIDNEY DIALYSIS	$0	$0	$0	$0
21. SKILLED NURSING FACILITY CARE	$0	$0	$0	$0
22. VISION SERVICES	$0	$2 for referral and refraction benefits only	$5 for referral and refraction benefits only	$10 for referral and refraction benefits only
23. AUDIOLOGY SERVICES	$0	$0	$0	$0
24. INTRACTABLE PAIN	$0	$2/office visit; $2/admission	$5/office visit; $20/admission	$10 office visit $50 admission
25. AUTISM COVERAGE	$0	$2/office visit; $2/admission	$5/office visit; $20/admission	$10 office visit $50 admission
26. CASE MANAGEMENT	$0	$0	$0	$0
27. DIETARY COUNSELING /NUTRITIONAL SERVICES	$0	$0	$0	$0
28. LIFETIME MAXIMUM	None.	None.	None.	None.
29. DENTAL RELATED	None.	None.	None.	None.
30. PRE-EXISTING CONDITION LIMITATIONS	Not applicable .	Not applicable.	Not applicable.	Not applicable.
31. THERAPIES: CHEMOTHERAPY AND RADIATION	$0	$0	$0	$0

CONTACT: Please contact your individual health plan with questions.

[8] Prescription drugs otherwise excluded are not covered, regardless of whether preferred generic, preferred brand name, or non-preferred.