Attachment C - Schedule of Benefits
CoverKids
Group II

To receive benefits from this Plan, make sure the Provider is a member of the Provider Network shown on the memberships ID card. If You receive services from an Out-of-Network Provider, You will be responsible for the full payment of the Out-of-Network Provider's charge. **No Benefits are payable for services received from Out-of-Network Providers.**

Covered Services	Copayment required for Covered Services received from Network Providers
Services Received at the Practitioner's office	
Office Services for Preventive Care	
Preventive Care – includes periodic physical exams, screenings and immunizations rendered under American Academy of Pediatrics guidelines and nutritional guidance (when Medically Necessary)	No Copayment
Office Services for Diagnosis and Treatment of Illness or Injury	
Office visits for diagnosis and treatment of Illness or Injury by a Primary Care Physician	$5 Copayment
Office Visits for diagnosis and treatment of Illness or Injury by a Specialist	$5 Copayment
Office Surgery, including anesthesia, by a Primary Care Physician	$5 Copayment
Office Surgery, including anesthesia, by a Specialist	$5 Copayment
Non-routine treatments: Includes dialysis and radiation, cobalt, and radioisotope therapy	No Copayment
Routine Diagnostic Services for illness or injury.	No Copayment
Allergy or serum injection by Nurse	No Copayment
Allergy or serum injection by Primary Care Physician	$5 Copayment
Allergy or serum injection by Specialist	$5 Copayment
Rehabilitation Services Therapy services (including speech therapy) limited to 52 visits per therapy type per plan year; chiropractic services limited to 52 visits per plan year	$5 Copayment
Behavioral Health Services	$5 Copayment
DME	No Copayment
Prosthetics/Orthotics Hearing aids are limited to 1 per ear per Calendar Year up to age 5; then 1 per ear every 2 years thereafter.	No Copayment

Covered Services	Copayment required for Covered Services received from Network Providers
Supplies (31 day supply)	$5 Copayment
Services Received at a Facility	
Inpatient Hospital Stays Prior Authorization required. Benefits will be denied for Network Providers outside Tennessee (BlueCard PPO Providers) when Prior Authorization is not obtained. Network Providers in Tennessee are responsible for obtaining Prior Authorization. Member is not responsible for penalty when Tennessee Network Providers do not obtain Prior Authorization.	
Facility Charges Copayment waived if readmitted within 48 hours of initial visit for same episode of illness or injury.	$5 Copayment per admission
Practitioner Charges	No Copayment
Facility Charges related to Behavioral Health Services	$5 Copayment per admission
Practitioner Charges related to Behavioral Health Services.	No Copayment
Rehabilitation Services	$5 Copayment per admission
Skilled Nursing Facility Limited to 100 days per plan year following approved hospitalization.	No Copayment
Hospital Emergency Care services In the event of a true Emergency, benefits are available from Network and Out-of-Network Providers.	
Facility Charges (Copayment waived if admitted.): Emergency Condition Non-emergency Condition	 $5 Copayment per visit $10 Copayment per visit
Practitioner charges	No Copayment
Urgent Care services	
Facility Charges: Emergency Room Walk-in Clinic	 $10 Copayment per visit $5 Copayment per visit
Practitioner charges	No Copayment
Outpatient Facility Services and Outpatient Surgery Surgeries include invasive diagnostic services (e.g. colonoscopy, sigmoidoscopy)	
Facility Charges	$5 Copayment

Covered Services	Copayment required for Covered Services received from Network Providers
Practitioner charges	No Copayment
Outpatient Diagnostic Services	
Routine and Non-Routine Diagnostic Services for illness or injury.	No Copayment
Other Outpatient procedures, services, or supplies	
Facility Charges related to Behavioral Health Services	$5 Copayment
Practitioner charges related to Behavioral Health Services	No Copayment
DME	No Copayment
Prosthetics/Orthotics Hearing aids are limited to 1 per ear per Calendar Year up to age 5; then 1 per ear every 2 years thereafter.	No Copayment
Supplies (31 day supply)	$5 Copayment
Non-routine treatments: Includes dialysis and radiation, cobalt, and radioisotope therapy	No Copayment
All Other services received at an outpatient facility, including chemotherapy and radiation therapy	No Copayment
Other Services	
Ambulance	No Copayment
Home Health Care Services, including home infusion therapy (limited to 125 visits per plan year) Prior Authorization is required.	$5 Copayment
Hospice Care	No Copayment
Diabetic self-management training and education	No Copayment
Services Received at the Pharmacy	
Prescription Drugs Retail up to 30 day supply. Up to 90 day supply for one Copayment through home delivery and certain retail pharmacies. If You choose a Brand Name Drug (Preferred or Non-preferred) when a Generic Drug equivalent is available, You will be financially responsible for the amount by which the cost of the Brand Name Drug exceeds the Generic Drug cost plus the required Generic Drug Copayment.	
Generic	$1 Copayment
Preferred Brand	$3 Copayment
Non-Preferred Brand	$5 Copayment

Covered Services	Copayment required for Covered Services received from Network Providers
Miscellaneous Limits	**Maximum**
Maximum Out of Pocket for all Services	5% of Family Income
Temporomandibular Joint (TMJ) – Non-surgical treatment maximum	$1,500 per Calendar Year

Covered Services	Copayment required for Covered Services received from Network or Out-of-Network Providers
Vision Services • Benefits for Vision Services are payable whether from a Network or Out-of-Network Provider. • Covered services have annual limits. You will be responsible for all charges above the limits. • When both frames and lenses are ordered at the same time, only one Copayment is charged.	
Annual Vision Exam (including refractive exam and annual glaucoma testing)	No Copayment
Prescription Eyeglass Lenses (including bifocal or trifocal, once per Plan Year)	$5 Copayment $85 Maximum Benefit
Prescription Contact Lenses in lieu of Eyeglasses (once per Plan Year)	$5 Copayment $150 Maximum Benefit
Frames, First Time	$5 Copayment $100 Maximum Benefit
Frames, Replacement (once every 2 Plan Years)	$5 Copayment $100 Maximum Benefit