The MCOs shall impose copayments on all Copayment Plan Members. The copayment schedule is as shown in the table below.

Service or Item	Copayment Amount
Brand Name Drug	$4.00
Generic Drug	$1.00
Brand Name Drug Preferred Over Generic	$1.00
Chiropractor	$3.00
Dental – for Members not enrolled in the Alternative Benefit Plan	$3.00
Podiatry	$3.00
Optometry – for Members not enrolled in the Alternative Benefit Plan	$3.00
General ophthalmological services – for Members not enrolled in the Alternative Benefit Plan	$3.00
Office visit for care by a physician, physician's assistant, advanced registered nurse practitioner, certified pediatric and family nurse practitioner, nurse midwife, or any behavioral health professional	$3.00
Physician service	$3.00
Visit to a rural health clinic, primary care center, or federally qualified health center	$3.00
Outpatient hospital service	$4.00
Emergency room visit for a non-emergency service	$8.00
All Inpatient hospital admission	$50.00
Physical therapy, speech therapy, occupational therapy	$3.00
Durable medical equipment	$4.00
Ambulatory surgical center	$4.00
Laboratory, diagnostic, or x-ray service	$3.00

In accordance with 42 CFR §447.52, providers may not deny care or services to any Member at or below one hundred percent (100%) FPL because of his or her inability to pay the copayment.

The MCO shall ensure copayments are not imposed on the following exempt services

A. Emergency services as defined at Section 1932(b)(2) of the Social Security Act and 42 CFR §438.114(a);
B. Family planning services and supplies described in Section 1905(a)(4)(C) of the Social Security Act, including contraceptives and pharmaceuticals for which the State can claim enhanced federal match under Section 1903(a)(5) of the Social Security Act;
C. Preventive Services, defined as (i) all the preventive services assigned a grade of A or B by the United States Preventive Services Task Force (USPSTF); or (ii) all approved adult vaccines, including their administration, recommended by the Advisory Committee on Immunization Practices; or (iii) preventive care and screening recommended by the Health Resources and Services Administration Bright Future Program Project; or (iv) preventive services recommended by the Institute of Medicine;
D. Pregnancy-related services; and
E. Provider-preventable services as defined in 42 CFR §447.26(b).

In imposing the eight-dollar ($8.00) copayment for an emergency room (ER) visit for a non-emergent service, the Contractor shall ensure compliance with 42 CFR §447.54 and Section 42.12. The Contractor shall consider an ER visit emergent, for purposes of waiving the copayment, if the member had a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following:

A. Placing the health of the Member (or, for a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
B. Serious impairment to bodily functions; or
C. Serious dysfunction of any bodily organ or part.

The Contractor shall not limit what constitutes a non-emergent visit, for purposes of imposition of the copayment, on the basis of lists of diagnoses or symptoms
Further clarification can be found in 907 KAR 1:604 Recipient cost sharing.

Additional Information Regarding Pharmacy Copays:

Copays by Product Class – products in these classes are subject to exceptions or exemptions from the brand/generic rules.

A. Certain Antipsychotics: $1.00;
    i. Atypical Antipsychotics (mostly second gen),
    ii. Many Long-acting injectables, and

iii. Other products in this class.

B. Contraceptives for family planning: $0.00
C. Tobacco Cessation:$0.00
D. Diabetes supplies:
    i. Blood Glucose Meters: $0.00
    ii. All other covered diabetic supplies: $4.00 for 1st fill; $0.00 for 2nd fill and beyond, PER DAY, on a first submitted claim basis