

NEBRASKA CO-PAY CHART

Covered Services	Co-payments	Coverage/Limits
Ambulance Services	\$0 co-pay	<ul style="list-style-type: none"> Covers Medically Necessary and reasonable ambulance services required to transport a client to obtain or after receiving covered medical care services include: Ground Ambulance Services – Basic Life Support (BLS) Ambulance: A BLS ambulance provides transportation plus the equipment and staff needed for basic services such as control of bleeding, splinting fractures, treatment for shock, delivery of babies, treatment of heart attacks and similar situations Advanced Life Support (ALS) Services – An ALS ambulance provides transportation and has special life-saving equipment and trained staff Air Ambulance – NMAP covers Medically Necessary air ambulance services only when transportation by ground ambulance would not be appropriate and: Great distances or other obstacles are involved in getting a Member to the destination Transportation is needed right away due to severe trauma The point of pickup can't be reached by a land vehicle
Ambulatory Surgical Center (ASC) Services	\$0 co-pay	<ul style="list-style-type: none"> Covered when Medically Necessary
Chiropractic Services	\$0 co-pay	<ul style="list-style-type: none"> Covered when services are provided in the office or the Member's home Limited to X-rays and manual manipulation of the spine For Members 21 and older: Manual manipulation of the spine is limited to 12 treatments per calendar year For members 20 and younger: Manual manipulation of the spine is limited to 18 treatments during the initial 5-month period from the date of initiation of treatment for the reported diagnosis. A maximum of one treatment per month is covered thereafter if needed for stabilization care. Only one treatment per Member per day is covered
Durable Medical Equipment, Orthotics, Prosthetics, and Medical Supplies	\$3 per specified service	<ul style="list-style-type: none"> Certain medical equipment and supplies are covered when they are Medically Necessary and prescribed by a physician Limitations may apply
Family Planning Services	\$0 co-pay	<ul style="list-style-type: none"> Covered services include consultation and treatment This may include initial physical examinations and health history, annual and follow-up visits, laboratory services, prescribing and supplying contraceptives, counseling and medications
Free Standing Birth Center Services	\$0 co-pay	<ul style="list-style-type: none"> Covered when Medically Necessary
HEALTH CHECK Services (EPSDT)	\$0 co-pay	<ul style="list-style-type: none"> Available to all individuals age 20 or younger HEALTH CHECK provides checkups, provides diagnosis and treatment for any health problems found at a checkup Some treatment services provided as a result of a HEALTH CHECK exam require prior approval HEALTH CHECK services include: <ul style="list-style-type: none"> Health and developmental history Complete physical exams Immunizations (shots) Necessary lab tests Health education Hearing checkup Eye exams Dental exams Treatment for identified problems Well-baby, well-child, Head Start, school and sport physicals
Hearing Services (Adult)	\$0 co-pay	<ul style="list-style-type: none"> Coverage for hearing aids includes, hearing aid repairs, hearing aid rental, assistive listening devices, and other hearing aid services when the services are medically necessary and are prescribed by a physician. Limitations may apply
Home Health Agency Services	\$0 co-pay	<ul style="list-style-type: none"> Home health agency services when prescribed by a doctor and provided in your home (this does not include a hospital or nursing facility) Covered Services include nursing services, aide services, necessary medical supplies and equipment, and physical, speech, and occupational therapies if there is no other way to receive these services There are limitations on some services
Hospice Services	\$0 co-pay	<ul style="list-style-type: none"> Hospice services are designed to ease the pain of a terminal illness Hospice services include nursing services, Provider services, medical social services, counseling services, home health aide/homemaker, medical equipment, medical supplies, drugs and biologicals, physical therapy, occupational therapy, speech language pathology, volunteer services and pastoral care services offered on the Member's needs Hospice services require approval before they can be received Hospice services are not covered if provided in a nursing facility
Hospital Services (Inpatient)	\$0 co-pay	<ul style="list-style-type: none"> Inpatient and emergency room services, as long as they are Medically Necessary There are no specific limitations on the amount of care that will be paid for as long as the care received is medically necessary (required) through prior authorizations and concurrent review. Not covered are items such as: private rooms, private-duty nursing, any services not Medically Necessary and emergency room services for routine treatment
Hospital Services (Outpatient)	\$0 co-pay	<ul style="list-style-type: none"> Diagnostic services such as x-rays and laboratory services provided on an outpatient basis at a hospital are covered when medically necessary and ordered by a physician. Treatment services such as physical therapy, dialysis and radiation may also be covered when coverage criteria are met. This includes all services except laboratory, X-ray and dialysis
Laboratory and Radiology (X-ray) Services	\$0 co-pay	<ul style="list-style-type: none"> Payment may be made for Medically Necessary diagnostic tests, X-rays and other procedures that are part of your diagnosis or treatment For members unable to leave their home, a portable X-ray device is available.
Mental Health and Substance Use Disorder Services for Children and Adolescents (ages 0-20)	\$0 co-pay	<ul style="list-style-type: none"> Mental health and substance abuse services for children and adolescents in the following categories: <ul style="list-style-type: none"> Outpatient Services: This includes evaluation by a psychiatrist/psychologist; individual, group, and family psychotherapy; individual, group, and family substance abuse counseling; family assessment; conferences with family or other responsible persons; mileage for home-based family therapy; community treatment aid services; intensive family preservation services; medication checks; treatment crisis intervention services Middle Intensity Services: These services are designed to prevent hospitalization or to help a hospitalized child or adolescent learn to function within the community with less frequent contact with the mental health or substance abuse Provider. Services include: <ul style="list-style-type: none"> Treatment foster care services Treatment group home services Residential treatment services Hospital Services: <ul style="list-style-type: none"> Inpatient mental health services Inpatient mental health services in institutions for mental disease (IMDs)
Mental Health and Substance Use Disorder Services for Adults (ages 21 and older)	\$0 co-pay	<ul style="list-style-type: none"> Medically Necessary psychiatric services for individuals ages 21 and older in the following categories: <ul style="list-style-type: none"> Outpatient Services – this includes psychiatric evaluation, psychological evaluation, psychological testing, individual psychotherapy, group psychotherapy, family psychotherapy, family assessment, medication checks, and electroconvulsive therapy Day Treatment – an active treatment program for Members who are capable of functioning in the community, but still need significant contact with mental health professionals; the program includes individual, family, and group therapy in addition to other services Adult inpatient hospital psychiatric services Inpatient hospital services for Members age 65 or older in institutions for mental disease (IMDs)
Nurse Midwife Services	\$0 co-pay	<ul style="list-style-type: none"> Pays for the following nurse midwife activities: <ul style="list-style-type: none"> Attending cases of normal childbirth Providing prenatal, intrapartum, and postpartum care Providing normal obstetrical and gynecological services for women Providing care for the newborn immediately following birth
Nurse Practitioner Services	\$0 co-pay	<ul style="list-style-type: none"> Nursing assessments as nurse practitioner services The services must be Medically Necessary The initial medical diagnosis and therapy plan or referral may also be covered Services of certified pediatric nurse practitioners and certified family nurse practitioners also covered, as required by federal law
Nursing Facility Services	\$0 co-pay	<ul style="list-style-type: none"> Services provided in skilled/rehabilitative and transitional nursing facilities Services that a nursing facility must provide include: <ul style="list-style-type: none"> Regular room Dietary Nursing services Social services when required Most medical supplies and equipment Oxygen Other routine services covered when medically necessary and prescribed by a physician or provider practicing within the scope of their practice
Nutrition Services	\$0 co-pay	<ul style="list-style-type: none"> Covered when Medically Necessary, provided by a nutrition therapist, and prescribed by a physician.
Physician Services	\$0 per office visit	<ul style="list-style-type: none"> Covered services include medical and surgical services performed at the physician's office, a member's home, clinic, hospital, or other locations. Payment may also be made for diagnostic tests, x-rays, and other procedures that are part of a member's diagnosis or treatment. Some services have special requirements, limitations, and/or require the provider to obtain approval from WellCare of Nebraska. Wellness Exams are covered at 100% (annual exams, well-child visits).
Podiatry Services	\$0 per visit	<ul style="list-style-type: none"> Medical and surgical services provided by a podiatrist May also cover diagnostic tests, X-rays and other procedures that are part of the treatment
Prescribed Drugs	Generic \$0 per prescription; Brand name \$3 per prescription	<ul style="list-style-type: none"> Covers most drugs prescribed by your Provider Some over-the counter drugs may be covered if prescribed by the Provider and approved by the health plan Limitations may apply
Private-Duty Nursing Services	\$0 co-pay	<ul style="list-style-type: none"> Private-duty nursing services when ordered by the Member's doctor and when Medically Necessary as prescribed by a physician or provider practicing within the scope of practice Private duty nursing services may be provided in the Member's home or some other living arrangement.
Screening Services (Mammograms)	\$0 co-pay	<ul style="list-style-type: none"> Mammograms when provided based on a Medically Necessary diagnosis Without a diagnosis WellCare of Nebraska covers mammograms according to the American Cancer Society's periodicity schedule
Services Provided by Clinics	\$0 co-pay	<ul style="list-style-type: none"> Services provided by clinics, including rural health clinics, federally qualified health centers, community mental health centers, and Indian Health Services clinics if they participate in the Managed Care Program Covered Services may include Provider services, nurse practitioner services, and other services that are usually covered by the health plan
Physical Therapy	\$0 co-pay	<ul style="list-style-type: none"> Physical therapy covered in the office, in the Member's home, hospital, nursing facilities, or other facilities The services must be prescribed by a physician Therapy is limited to restoration of lost function due to illness or injury if you are age 21 and older For members age 20 and younger, services must be reasonable and medically necessary for the treatment of the member's illness or injury; or restorative therapy with a medically appropriate expectation that the member's condition will improve significantly within a reasonable period of time.
Occupational Therapy	\$0 co-pay	<ul style="list-style-type: none"> Occupational therapy covered in the office, in the Member's home, hospital, nursing facilities, or other facilities The services must be prescribed by a doctor Therapy is limited to restoration of lost function due to illness or injury if you are age 21 and older For members age 20 and younger, services must be reasonable and medically necessary for the treatment of the member's illness or injury; or restorative therapy with a medically appropriate expectation that the member's condition will improve significantly within a reasonable period of time.
Speech Therapy & Audiology	\$0 co-pay	<ul style="list-style-type: none"> Speech therapy covered in the office, in the Member's home, hospital, nursing facilities or other facilities The services must be prescribed by a Provider Therapy is limited to restoration of lost function due to illness or injury if you are age 21 and older For members age 20 and younger, services must be reasonable and medically necessary for the treatment of the member's illness or injury; or restorative therapy with a medically appropriate expectation that the member's condition will improve significantly within a reasonable period of time.
Vision Services	\$2 per eyeglasses; \$2 per visit office visit or eye exam	<ul style="list-style-type: none"> Eye examinations to determine the need for glasses, the purchase of eyeglasses and necessary repairs Eye exams for adults 21 years and older are limited to one every 24 months Covers eyeglasses including lenses and frames when needed for the following medical reasons: the Member's first pair of prescription eyeglasses; size change needed due to growth; or a prescribed lens change only if new lenses cannot be accommodated by the current frame. A pair of eyeglasses is covered for members 21 years and older when one of the above conditions is met within a 24 month period.