CHIP
Children's Health Insurance Program

CO-PAY SUMMARY

Molina: 1-888-483-0760 | **www.health.utah.gov/chip** | **SelectHealth: 1-800-538-5038**

BENEFITS (per plan year)	CO-PAY PLAN B*	CO-PAY PLAN C*
OUT-OF-POCKET MAXIMUM	5% of family's annual gross income, including dental expenses**	5% of family's annual gross income, including dental expenses**
PREMIUM	$30/family/quarter	$75/family/quarter
PRE-EXISTING CONDITION	No waiting period	No waiting period
DEDUCTIBLE	$40/family	$500/child; $1,500/family
WELL-CHILD EXAMS	$0	$0
IMMUNIZATIONS	$0	$0
DOCTOR VISITS	$5	$25
SPECIALIST VISITS	$5	$40
EMERGENCY ROOM	$5; $10 non-emergency	$300 after deductible
AMBULANCE	5% of approved amount after deductible	20% of approved amount after deductible
URGENT CARE CENTER	$5	$40
AMBULATORY SURGICAL & OUTPATIENT HOSPITAL	5% of approved amount after deductible	20% of approved amount after deductible
INPATIENT HOSPITAL SERVICES	$150 after deductible	20% of approved amount after deductible
LAB & X-RAY	$0 for minor diagnostic tests and x-rays; 5% of approved amount after deductible for major diagnostic tests and x-rays	$0 for minor diagnostic tests and x-rays; 20% of approved amount after deductible for major diagnostic tests and x-rays
SURGEON	5% of approved amount	20% of approved amount after deductible
ANESTHESIOLOGIST	5% of approved amount	20% of approved amount after deductible
PRESCRIPTIONS **-Preferred Generic Drugs** **-Preferred Brand Name Drugs** **-Non-Preferred Drugs**	 - $5 - 5% of approved amount - 5% of approved amount	 - $15 - 25% of approved amount - 50% of approved amount
MENTAL HEALTH & SUBSTANCE USE DISORDER **-Inpatient** **-Outpatient, Office Visit & Urgent Care Center**	 - $150 after deductible - $0	 - 20% of approved amount after deductible - $0
RESIDENTIAL TREATMENT	5% of approved amount after deductible	20% of approved amount after deductible
PHYSICAL THERAPY	$5 (20 visit limit per year)	$40 after deductible (20 visit limit per year)
APPLIED BEHAVIOR ANALYSIS (ABA) **-Treatment of Autism Spectrum Disorder**	$0	$0
CHIROPRACTIC VISITS	Not a covered benefit	Not a covered benefit
HOME HEALTH & HOSPICE CARE	5% of approved amount after deductible	20% of approved amount after deductible
MEDICAL EQUIPMENT & MEDICAL SUPPLIES	5% of approved amount after deductible	20% of approved amount after deductible
DIABETES EDUCATION	$0	$0
VISION SCREENING	$5 (1 visit limit per year)	$25 (1 visit limit per year)
HEARING SCREENING	$5 (1 visit limit per year)	$25 (1 visit limit per year)

*Co-pay plans are based on your income. American Indian/Alaska Natives will not be charged co-pays, premiums, or a deductible.
** CHIP will send you an approval letter telling you the approximate out-of-pocket maximum amount for your family.

CHIP
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CO-PAY SUMMARY

Premier Access: 1-877-854-4242 **www.health.utah.gov/chip**

DENTAL BENEFITS (per plan year)	CO-PAY PLAN B*	CO-PAY PLAN C*
DEDUCTIBLE	$0	$50/child; $150/family
MAXIMUM BENEFIT **- Preventive, Basic & Major services per child, per year**	$1,000 per plan year	$1,000 per plan year
PREVENTIVE SERVICES **- Routine exams** **- Cleanings (2 per year)** **- Topical fluoride** **- X-rays**	$0	$0
BASIC SERVICES **- Fillings** **- Extractions** **- Oral surgery** **- Endodontics** **- Periodontics**	5% of approved amount	20% of approved amount after deductible
MAJOR SERVICES **- Crowns** **- Bridges** **- Dentures**	5% of approved amount	50% of approved amount after deductible
ORTHODONTICS **- requires prior authorization** **- covered only if medically necessary**	5% of approved amount ($1,000 lifetime maximum**) Requires prior authorization	50% of approved amount ($1,000 lifetime maximum**) Requires prior authorization
SPECIALISTS **- Endodontists** **- Oral Surgeons** **- Periodontists** **- Pediatric Specialists** **- Prosthodontists**	5% of approved amount	Talk to your dental plan for an estimate of additional charges.

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** Orthodontic services are not included in the annual maximum benefit.