

Children’s Health Insurance Program (CHIP) medical copay summary



Molina: 1-888-483-0760

Select Health: 1-800-538-5038

Healthy U: 1-833-404-4300

Medical Benefits (per plan year)	Copay Plan B* (member responsibility)	Copay Plan C* (member responsibility)
Out-of-pocket maximum	5% of family’s annual gross income, including dental expenses**	5% of family’s annual gross income, including dental expenses**
Deductible	\$70/family	\$575/child; \$1,600/family
Well-child exams	\$0	\$0
Immunizations	\$0	\$0
Doctor visits	\$5	\$25
Specialist visits	\$5	\$40
Emergency room	\$10	20% after deductible; minimum \$150 per visit
Ambulance	5% of approved amount after deductible	20% of approved amount after deductible
Urgent care center	\$5	\$45
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	- \$5	- \$15
-preferred brand name drugs	- 5% of approved amount	- 25% of approved amount
-non-preferred drugs	- 5% of approved amount	- 50% of approved amount
Mental health & substance use disorder		
-inpatient	- \$150 after deductible	- 20% of approved amount after deductible
-outpatient, office visit & urgent care center	- \$0	- \$0
Residential treatment	\$0	\$0
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	10% of approved amount after deductible	25% 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)

*American Indian/Alaska Natives will not be charged copays or a deductible.

** CHIP will send you an approval letter telling you the approximate out-of-pocket maximum amount for your family.

Children's Health Insurance Program (CHIP)

dental copay summary



Premier Access: 1-877-854-4242

Dental benefits (per plan year)	Copay Plan B* (member responsibility)	Copay Plan C* (member responsibility)
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.