



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 -Inpatient & Outpatient Facility -Office Visit	- \$150 after deductible - \$0	- 20% of approved amount after deductible - \$0
RESIDENTIAL TREATMENT	5% of approved amount after deductible (25 day limit per year)	20% of approved amount after deductible (25 day limit per year)
PHYSICAL THERAPY	\$5 (20 visit limit per year)	\$40 after deductible (20 visit limit per year)
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.



CO-PAY SUMMARY

Premier Access: 1-877-854-4242 • www.health.utah.gov/chip • DentaQuest: 1-800-483-0031

BENEFITS CON'T (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**)	50% of approved amount (\$1,000 lifetime maximum**)
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.