



# Comparison Chart

for health insurance

We have provided you with this chart to help you make an informed decision about which health insurance plan is best for your family. Compare the benefits, co-pays and premiums for health insurance between CHIP and your COBRA or employer's health insurance plan. Decide if it is better to a) Insure your child with CHIP; or b) Insure your child with your COBRA or employer's health insurance and receive up to \$120 per child each month from UPP.

BENEFITS (per plan year)	INSURANCE CO-PAY	CHIP CO-PAY PLAN A*	CHIP CO-PAY PLAN B*	CHIP CO-PAY PLAN C*
<b>OUT-OF-POCKET MAXIMUM</b>		5% of family's annual gross income, including dental expenses**	5% of family's annual gross income, including dental expenses**	5% of family's annual gross income, including dental expenses**
<b>PREMIUM</b>	UPP pays you up to \$120 per child every month	\$0	\$30/family/quarter	\$75/family/quarter
<b>PRE-EXISTING CONDITION</b>		No waiting period	No waiting period	No waiting period
<b>MEDICAL BENEFITS</b>				
<b>DEDUCTIBLE</b>		None	\$40/family	\$500/child; \$1,500/family
<b>WELL-CHILD EXAMS</b>		\$0	\$0	\$0
<b>IMMUNIZATIONS</b>		\$0	\$0	\$0
<b>DOCTOR VISITS</b>		\$3	\$5	\$25
<b>SPECIALIST VISITS</b>		\$3	\$5	\$40
<b>EMERGENCY ROOM</b>		\$3	\$5 \$10 non-emergency	\$300 after deductible
<b>AMBULANCE</b>		5% of approved amount	5% of approved amount after deductible	20% of approved amount after deductible
<b>URGENT CARE CENTER</b>		\$3	\$5	\$40
<b>AMBULATORY SURGICAL &amp; OUTPATIENT HOSPITAL</b>		\$3	5% of approved amount after deductible	20% of approved amount after deductible
<b>INPATIENT HOSPITAL SERVICES</b>		\$50	\$150 after deductible	20% of approved amount after deductible
<b>LAB &amp; X-RAY</b>		\$0 for minor diagnostic tests and x-rays; \$3 for major diagnostic tests and x-rays	\$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
<b>SURGEON</b>		\$0	5% of approved amount	20% of approved amount after deductible
<b>ANESTHESIOLOGIST</b>		\$0	5% of approved amount	20% of approved amount after deductible
<b>PRESCRIPTIONS</b> - Preferred Generic - Preferred Brand Name - Non-Preferred		- \$1 - \$1 - 5% of approved amount	- \$5 - 5% of approved amount - 5% of approved amount	- \$15 - 25% of approved amount - 50% of approved amount
<b>MENTAL HEALTH</b> - Inpatient Hospital  - Outpatient Visit		- \$50  - \$0	- \$150 after deductible  - \$0	- 20% of approved amount after deductible  - \$0

\* 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.

BENEFITS Continued (per plan year)	INSURANCE CO-PAY	CHIP CO-PAY PLAN A*	CHIP CO-PAY PLAN B*	CHIP CO-PAY PLAN C*
RESIDENTIAL TREATMENT		5% of approved amount (25 day limit per year)	5% of approved amount after deductible (25 day limit per year)	20% of approved amount after deductible (25 day limit per year)
PHYSICAL THERAPY		\$3 (20 visit limit per year)	\$5 (20 visit limit per year)	\$40 after deductible (20 visit limit per year)
CHIROPRACTIC VISITS		Not a covered benefit	Not a covered benefit	Not a covered benefit
HOME HEALTH & HOSPICE CARE		\$3	5% of approved amount after deductible	20% of approved amount after deductible
MEDICAL EQUIPMENT & MEDICAL SUPPLIES		\$3	5% of approved amount after deductible	20% of approved amount after deductible
DIABETES EDUCATION		\$0	\$0	\$0
VISION SCREENING		\$3 (1 visit limit per year)	\$5 (1 visit limit per year)	\$25 (1 visit limit per year)
HEARING SCREENING		\$3 (1 visit limit per year)	\$5 (1 visit limit per year)	\$25 (1 visit limit per year)
<b>DENTAL BENEFITS</b>				
DEDUCTIBLE		\$0	\$0	\$50/child; \$150/family
MAXIMUM BENEFIT - Preventive, Basic & Major services per child, per year	UPP pays you an additional \$20 per child every month	\$1,000 per plan 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	\$0
BASIC SERVICES - Fillings - Extractions - Oral surgery - Endodontics - Periodontics		\$0	5% of approved amount	20% of approved amount after deductible
MAJOR SERVICES - Crowns - Bridges - Dentures		5% of approved amount	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**)	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	5% of approved amount	Talk to your dental plan for an estimate of additional charges.

\* Co-pay plans are based on your income. American Indian/Alaska Natives will not be charged co-pays, premiums, or a deductible.

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