05-303 DOH UPP 7/12

Comparison Chart

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 $140 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*
OUT-OF-POCKET MAXIMUM		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**
PREMIUM	UPP pays you up to $120 per child every month	$0	$30/family/quarter	$75/family/quarter
PRE-EXISTING CONDITION		No waiting period	No waiting period	No waiting period
MEDICAL BENEFITS				
DEDUCTIBLE		None	$40/family	$500/child; $1,500/family
WELL-CHILD EXAMS		$0	$0	$0
IMMUNIZATIONS		$0	$0	$0
DOCTOR VISITS		$3	$5	$25
SPECIALIST VISITS		$3	$5	$40
EMERGENCY ROOM		$3	$5 $10 non-emergency	$300 after deductible
AMBULANCE		5% of approved amount	5% of approved amount after deductible	20% of approved amount after deductible
URGENT CARE CENTER		$3	$5	$40
AMBULATORY SURGICAL & OUTPATIENT HOSPITAL		$3	5% of approved amount after deductible	20% of approved amount after deductible
INPATIENT HOSPITAL SERVICES		$50	$150 after deductible	20% of approved amount after deductible
LAB & X-RAY		$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
SURGEON		$0	5% of approved amount	20% of approved amount
ANESTHESIOLOGIST		$0	5% of approved amount	20% of approved amount
PRESCRIPTIONS - 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
MENTAL HEALTH - Inpatient Hospital - Outpatient Visit		- $50 - $3	- $150 after deductible - $5	- 20% of approved amount after deductible - $40

* 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)	50% 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 (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)	$40 (1 visit limit per year)
HEARING SCREENING		$3 (1 visit limit per year)	$5 (1 visit limit per year)	$40 (1 visit limit per year)
DENTAL BENEFITS				
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.

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