Medical Benefits	Limits	Co-Payment Amount		
		Free	Low-Cost	Full Cost
Autism-related services	None.	$0	Co-payments based on the type of service	Co-payments based on the type of service
Diagnostic services	Some services may require prior authorization.	$0	$0	$0
Durable medical equipment	Some services may require prior authorization.	$0	$0	$0
Emergency services	None.	$0	$25*	$50*
Emergency transportation	Transportation outside of the service area will only be covered if medically necessary.	$0	$0	$0
Family planning services – OB/GYN	None.	$0	$0	$0
Family planning services – PCP	None.	$0	$0	$0
Hearing care services	One routine hearing and audiometric examination per calendar year. One hearing aid or device per ear every two calendar years. Calendar year may change depending on decision for benefit plan year. No monetary limits for CHIP. *Co-payments apply only when services are rendered by a specialist provider.	$0	$10*	$25*
Home health services	Some services may require prior authorization.	$0	$0	$0
Hospice services	Some services may require prior authorization.	$0	$0	$0

* Waived if admitted to hospital.

CHIP Benefits Summary

Medical Benefits	Limits	Co-Payment Amount		
		Free	Low-Cost	Full Cost
Inpatient hospital and skilled nursing facility stays	Some services may require prior authorization, or be subject to notification and concurrent reviews.	$0	$0	$0
Inpatient rehabilitation stays	Some services may require prior authorization, or be subject to notification and concurrent reviews.	$0	$0	$0
Maternity care services	None.	$0	$0	$0
Medical foods	None.	$0	$0	$0
Oral surgery	Some services may require prior authorization.	$0	$10	$25
Outpatient medical therapy services (chemotherapy, dialysis, radiation treatments, and respiratory therapy)	None.	$0	$0	$0
Outpatient therapies (occupational, physical, and speech therapy), including rehabilitative and habilitative	**Physical Therapy** — limited to 30 visits per year combined rehabilitative and habilitative. **Speech Therapy** — limited to 30 visits per year combined rehabilitative and habilitative. **Occupational Therapy** — limited to 30 visits per year combined rehabilitative and habilitative.	$0	$10	$25
Outpatient surgical services	Some services may require prior authorization.	$0	$0	$0

Medical Benefits	Limits	Co-Payment Amount		
		Free	Low-Cost	Full Cost
PCP office visits	*No co-payment is required for well-child visits.	$0	$5*	$15*
Specialist office visits	None.	$0	$10	$25
Spinal manipulation/ chiropractic care	Limited to 20 visits per year.	$0	$0	$0
Urgent care services	None. *Co-pays may be higher depending on the facility where services are being provided.	$0	$10	$25
Women's health services – OB/GYN	None.	$0	$0	$0
Women's health services – PCP	None.	$0	$0	$0
Pharmacy Benefits	**Limits**	**Co-Payment Amount**		
		Free	**Low-Cost**	**Full Cost**
Brand name drug	None.	$0	$10	$18
Generic drug	None.	$0	$6	$9
Mental Health and Substance Abuse Benefits	**Limits**	**Co-Payment Amount**		
		Free	**Low-Cost**	**Full Cost**
Mental health – inpatient stays	No referral needed. Some services may be subject to notification and concurrent reviews. No limit.	$0	$0	$0
Mental health – outpatient services	None.	$0	$0	$0
Substance abuse – inpatient detoxification stays	No referral needed. Some services may be subject to notification and concurrent reviews.	$0	$0	$0

Mental Health and Substance Abuse Benefits	Limits	Co-Payment Amount		
		Free	Low-Cost	Full Cost
Substance abuse – inpatient residential rehabilitation	None.	$0	$0	$0
Substance abuse – outpatient rehabilitation	None.	$0	$0	$0

Dental Benefits	Limits	Co-Payment Amount		
		Free	Low-Cost	Full Cost
Comprehensive orthodontic services	No annual maximums. Some services will require prior authorization and proof of medical necessity in order to be covered. Some services may be limited based upon age or quantity.	$0	$0	$0
Non-orthodontic services	No lifetime maximum. Requires prior authorization and proof of medical necessity in order to be covered.	$0	$0	$0

Vision Benefits	Limits	Co-Payment Amount		
		Free	Low-Cost	Full Cost
Vision care	**Frames and lenses:** One set of eyeglass lenses that may be plastic or glass, single vision, bifocal, trifocal, lenticular lens powers and/or oversize lenses, fashion and gradient tinting, oversized glass-grey #3 prescription sunglass lenses, polycarbonate prescription lenses with scratch resistance coating and low-vision items. **Frequency of eye exam:** One routine examination and refraction every 12 months. Includes dilation, if professionally indicated. No cost to member In-Network. Out-of-Network — no coverage*.	$0	$0	$0

<table>
<tr><th rowspan="2">Vision Benefits</th><th rowspan="2">Limits</th><th colspan="3">Co-Payment Amount</th></tr>
<tr><th>Free</th><th>Low-Cost</th><th>Full Cost</th></tr>
<tr><td>Vision care
(continued)</td><td>Frequency of lens and frame replacement: One pair of eyeglasses every 12 months, when medically necessary for vision correction.

Lenses: In-Network — One pair covered in full every 12 months. Out-of-Network — no coverage.*

Frames: In-plan frames are available at no cost to member. Non-plan frames: Expenses in excess of $130 allowance payable by member. Additionally, a discount of 20% is available for amounts over $130.* *
Out-of-Network — No coverage.*

Replacement of lost, stolen, broken frames and lenses (one original and one replacement per calendar year, when deemed medically necessary).

Contact lenses: One prescription every 12 months — in lieu of eyeglasses when medically necessary for vision correction.

Additionally, a discount of 15% is available for amounts over $130.* *</td><td>$0</td><td>$0</td><td>$0</td></tr>
</table>

* Out-of-Network exclusion only applies if child is in their coverage area at time of eyeglass/contact replacement. If child is unexpectedly out of the area, e.g., vacation, and they need replacement contacts or eyeglasses, their expenses can be sent to the plan for reimbursement.

** This discount is available from providers who have agreed to contract for the discount.

Vision Benefits	Limits	Co-Payment Amount		
		Free	Low-Cost	Full Cost
Vision care *(continued)*	In some instances, participating providers charge separately for the evaluation, fitting, or follow-up care relating to contact lenses. Should this occur and the value of the contact lenses received is less than the allowance, the difference up to the $130 allowance may be applied toward the cost of evaluation, materials, fitting and follow-up care. You will be responsible for any amounts over $130. Expenses in excess of $600 for medically necessary contact lenses, with pre-approval. These conditions include: Aphakia, pseudophakia or keratoconus, if the patient has had cataract surgery or implant, or corneal transplant surgery, or if visual activity is not correctable to 20/40 in the worse eye by use of spectacle lenses in a frame but can be improved to 20/40 in the worse eye by use of contact lenses. **Low Vision:** One comprehensive low-vision evaluation every five years, with a maximum charge of $300; maximum low-vision aid allowance of $600 with a lifetime maximum of $1,200 for items such as high-power spectacles, magnifiers and telescopes; and follow-up care — four visits in any five-year period, with a maximum charge of $100 per visit. Providers will obtain the necessary pre-authorization for these services.	$0	$0	$0