

Schedule of Benefits Chorus Bronze Copay Zero

For Covered Services to be paid at the level described in Your Schedule of Benefits, they must be *Medically Necessary*. They must also meet all other criteria described in Your Evidence of Coverage. Please note that Your plan may not cover all of Your health care expenses, such as *Copayment* and *Coinsurance*. To understand what Your plan covers, review Your Evidence of Coverage.

If You have any questions about Your Benefits, or would like to find an *In-Network Provider* near You, visit chorushealthplans.org/Find-a-Doc. You can also call CCHP's Customer Service at 844-201-4672.

Copayment, Deductible, and Coinsurance will not apply to Covered Services when a member obtains care through an *Urban Indian Organization Provider* or when essential health benefits are rendered. No referral is required from an *Urban Indian Organization Provider* when receiving essential health benefits.

Please note that the benefits listed on the following pages are applicable for Essential Health Benefits. Non-Essential Health Benefits, such as nutritional counseling, may be covered differently. For further information on coverage for Non-Essential Health Benefits, please reference your Evidence of Coverage or contact Customer Service.

In-Network Benefits Only	Member Responsibility for Essential Health Benefits	Member Responsibility for Non-Essential Health Benefits
Individual Medical Calendar Year <i>Deductible</i>	\$0	\$0
Family Medical Calendar Year <i>Deductible</i>	\$0	\$0
Medical <i>Coinsurance</i>	0%	0%
Individual Maximum <i>Out-of-Pocket Limit</i> [^]	\$0	\$8,700
Family Maximum <i>Out-of-Pocket Limit</i> [^]	\$0	\$17,400
Office Visits		
<i>Primary Care Provider/Practitioner/Physician/Doctor Visit</i>		\$0
<i>Specialist Visit</i>		\$0
<i>Chiropractic Care Visit</i>		\$0

[^] *Maximum Out-of-Pocket Limit* in the calendar year includes *Deductible, Coinsurance, and Copayments*.

Chorus Bronze Copay Zero SOB 2022 (Rev 2022.07.08)

PO Box 1997, MS 6280 • Milwaukee, WI 53201-1997 • Toll-free: 1-844-201-4672

Diagnostic Services	
Outpatient Laboratory Tests	\$0
Diagnostic X-Rays	\$0
Diagnostic Imaging *	\$0
Emergency and Ambulance Services	
Emergency Room	\$0
Urgent Care	\$0
Ambulance (Ground and Air)	\$0
Hearing Services	
Hearing Aids (Replacement every 3 years) *	\$0
Cochlear Implants (Replacement every 3 years) *	\$0
Bone-anchored hearing device (Limited to 1 per lifetime) *	\$0
Hospital Services	
Inpatient Hospital Service (Facility) *	\$0
Inpatient Physician Services (Professional) *	\$0
Maternity Services	
Facility Services	\$0
Physician Services	\$0
Mental Health and Substance Use Disorder Services	
Outpatient – Office Visit (select services *)	\$0
Inpatient *	\$0
Other Services	
Home Health Care (60 visits per calendar year) *	\$0
Transplants *	\$0
Durable Medical Equipment (over \$500 *)	\$0
Diabetic Equipment and Supplies (select services *)	\$0
Autism Spectrum Disorder *	\$0
Hospice *	\$0
Prosthetic Devices *	\$0
Preventive Care	\$0
<ul style="list-style-type: none"> For a full list of Preventive Care services that are covered at a \$0 Copay, please visit our website at chorushealthplans.org. 	

Chorus Bronze Copay Zero SOB 2022 (Rev 2022.07.08)

PO Box 1997, MS 6280 • Milwaukee, WI 53201-1997 • Toll-free: 1-844-201-4672

Rehabilitative and Habilitative Services	
Speech Therapy (30 visits per calendar year)	\$0
Physical Therapy (30 visits per calendar year)	\$0
Occupational Therapy (30 visits per calendar year)	\$0
<ul style="list-style-type: none"> Members are permitted 30 <i>Rehabilitative</i> therapy sessions and 30 <i>Habilitative</i> therapy sessions for <u>each</u> therapy service listed above per calendar year. 	
Rehabilitative Services - Other	
Cardiac Rehabilitation (36 sessions per calendar year)	\$0
Pulmonary Rehabilitation (20 visits per calendar year)	\$0
Skilled Nursing Facility (30 days per stay) *	\$0
Prescription Drugs	
Individual Prescription Drug <i>Deductible</i>	\$0
Family Prescription Drug <i>Deductible</i>	\$0
Prescription Drug <i>Coinsurance</i>	0%
Generic *	\$0
Preferred Brand *	\$0
Non-Preferred Brand *	\$0
Specialty *	\$0
Prescription Drugs – Mail Order (90-day supply)	
Generic	\$0
Preferred Brand	\$0
Non-Preferred Brand	\$0
Dental	
TMJ	\$0
Dental Services – Accident Only	\$0
<ul style="list-style-type: none"> Routine dental services are not <i>Covered Services</i>, but can be purchased as a stand-alone plan with Chorus Dental at chorushealthplans.org. 	
Routine Pediatric Vision	
Children's Routine Vision Exam (1 exam per calendar year)	\$0
Children's Eyewear	\$0
<ul style="list-style-type: none"> Children's eyewear includes one set of lenses (contacts or glasses) per year, and one pair of eyeglass frames every two years (in the <i>Pediatric Eyewear Collection</i>). 	

* Indicates that services may require a *Prior Authorization* to be filed. Please refer to Your Evidence of Coverage for the full *Prior Authorization* list.

Chorus Bronze Copay Zero SOB 2022 (Rev 2022.07.08)