

Schedule of Benefits Chorus Core Bronze Limited

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*. When utilizing an *In-Network Provider, Copayment, Deductible, and Coinsurance* will apply unless a referral is obtained from an *Urban Indian Organization Provider*.

In-Network Benefits Only	Member Responsibility
Individual Medical Calendar Year <i>Deductible</i>	\$9,100
Family Medical Calendar Year <i>Deductible</i>	\$18,200
Medical <i>Coinsurance</i>	0%
Individual Maximum <i>Out-of-Pocket Limit</i> [^]	\$9,100
Family Maximum <i>Out-of-Pocket Limit</i> [^]	\$18,200
<ul style="list-style-type: none"> • Prescription benefits are included as part of the medical benefit amounts listed above. 	
Office Visits	
<i>Primary Care Provider/Practitioner/Physician/Doctor Visit</i>	Subject to <i>Deductible & Coinsurance</i>
<i>Specialist Visit</i>	Subject to <i>Deductible & Coinsurance</i>
<i>Chiropractic Care Visit</i>	Subject to <i>Deductible & Coinsurance</i>

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

Diagnostic Services	
Outpatient Laboratory Tests	Subject to <i>Deductible & Coinsurance</i>
Diagnostic X-Rays	Subject to <i>Deductible & Coinsurance</i>
<i>Diagnostic Imaging *</i>	Subject to <i>Deductible & Coinsurance</i>
Emergency and Ambulance Services	
Emergency Room	Subject to <i>Deductible & Coinsurance</i>
<i>Urgent Care</i>	Subject to <i>Deductible & Coinsurance</i>
Ambulance (Ground and Air)	Subject to <i>Deductible & Coinsurance</i>
<ul style="list-style-type: none"> <i>Out-of-Network Providers may Balance Bill for ground ambulance services.</i> 	
Hearing Services	
Hearing Aids (Replacement every 3 years) *	Subject to <i>Deductible & Coinsurance</i>
Cochlear Implants (Replacement every 3 years) *	Subject to <i>Deductible & Coinsurance</i>
Bone-anchored hearing device (Limited to 1 per lifetime) *	Subject to <i>Deductible & Coinsurance</i>
Hospital Services	
<i>Inpatient Hospital Service (Facility) *</i>	Subject to <i>Deductible & Coinsurance</i>
<i>Inpatient Physician Services (Professional) *</i>	Subject to <i>Deductible & Coinsurance</i>
Maternity Services	
Facility Services	Subject to <i>Deductible & Coinsurance</i>
Physician Services	Subject to <i>Deductible & Coinsurance</i>
Mental Health and Substance Use Disorder Services	
Outpatient – Office Visit (select services *)	Subject to <i>Deductible & Coinsurance</i>
<ul style="list-style-type: none"> Other outpatient services will be subject to <i>Deductible & Coinsurance</i>. 	
<i>Inpatient *</i>	Subject to <i>Deductible & Coinsurance</i>
Other Services	
<i>Home Health Care (60 visits per calendar year) *</i>	Subject to <i>Deductible & Coinsurance</i>
Transplants *	Subject to <i>Deductible & Coinsurance</i>
<i>Durable Medical Equipment (over \$500 *)</i>	Subject to <i>Deductible & Coinsurance</i>
Diabetic Equipment and Supplies (select services *)	Subject to <i>Deductible & Coinsurance</i>
<i>Autism Spectrum Disorder *</i>	Subject to <i>Deductible & Coinsurance</i>
<i>Hospice *</i>	Subject to <i>Deductible & Coinsurance</i>
Prosthetic Devices *	Subject to <i>Deductible & Coinsurance</i>
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. 	

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Rehabilitative and Habilitative Services	
Speech Therapy (30 visits per calendar year)	Subject to <i>Deductible & Coinsurance</i>
Physical Therapy (30 visits per calendar year)	Subject to <i>Deductible & Coinsurance</i>
Occupational Therapy (30 visits per calendar year)	Subject to <i>Deductible & Coinsurance</i>
<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)	Subject to <i>Deductible & Coinsurance</i>
Pulmonary Rehabilitation (20 visits per calendar year)	Subject to <i>Deductible & Coinsurance</i>
Skilled Nursing Facility (30 days per stay) *	Subject to <i>Deductible & Coinsurance</i>
Prescription Drugs	
Generic *	Subject to <i>Deductible & Coinsurance</i>
Preferred Brand *	Subject to <i>Deductible & Coinsurance</i>
Non-Preferred Brand *	Subject to <i>Deductible & Coinsurance</i>
Specialty *	Subject to <i>Deductible & Coinsurance</i>
Prescription Drugs – Mail Order (90-day supply)	
Generic *	Subject to <i>Deductible & Coinsurance</i>
Preferred Brand *	Subject to <i>Deductible & Coinsurance</i>
Non-Preferred Brand *	Subject to <i>Deductible & Coinsurance</i>
Dental	
TMJ	Subject to <i>Deductible & Coinsurance</i>
Dental Services – Accident Only	Subject to <i>Deductible & Coinsurance</i>
<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	Subject to <i>Deductible & Coinsurance</i>
<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.