

Schedule of Benefits Chorus Standard Silver 150

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.

| In-Network Benefits Only | Member Responsibility |
|---|---|
| Individual Medical Calendar Year <i>Deductible</i> | \$1,000 |
| Family Medical Calendar Year <i>Deductible</i> | \$2,000 |
| Medical <i>Coinsurance</i> | 10% |
| Individual Maximum <i>Out-of-Pocket Limit</i> [^] | \$3,000 |
| Family Maximum <i>Out-of-Pocket Limit</i> [^] | \$6,000 |
| <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> | \$20 Copay |
| <i>Specialist Visit</i> | \$50 Copay |
| <i>Chiropractic Care Visit</i> | \$20 Copay |
| Diagnostic Services | |
| Outpatient Laboratory Tests | \$35 Copay per visit |
| Diagnostic X-Rays | Subject to <i>Deductible</i> & <i>Coinsurance</i> |
| <i>Diagnostic Imaging</i> * | Subject to <i>Deductible</i> & <i>Coinsurance</i> |

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

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| Emergency and Ambulance Services | |
|--|--|
| Emergency Room | Subject to <i>Deductible & Coinsurance</i> |
| Urgent Care | Subject to <i>Deductible & Coinsurance</i> |
| Ambulance (Ground and Air) | Subject to <i>Deductible & Coinsurance</i> |
| <ul style="list-style-type: none"> Out-of-Network Providers may Balance Bill for ground ambulance services. | |
| 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 | |
| Inpatient Hospital Service (Facility) * | Subject to <i>Deductible & Coinsurance</i> |
| Inpatient Physician Services (Professional) * | 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 *) | \$20 Copay |
| <ul style="list-style-type: none"> Other outpatient services will be subject to <i>Deductible & Coinsurance</i>. | |
| Inpatient * | Subject to <i>Deductible & Coinsurance</i> |
| Other Services | |
| Home Health Care (60 visits per calendar year) * | Subject to <i>Deductible & Coinsurance</i> |
| Transplants * | Subject to <i>Deductible & Coinsurance</i> |
| Durable Medical Equipment (over \$500 *) | Subject to <i>Deductible & Coinsurance</i> |
| Diabetic Equipment and Supplies (select services *) | Subject to <i>Deductible & Coinsurance</i> |
| Autism Spectrum Disorder * | Subject to <i>Deductible & Coinsurance</i> |
| Hospice * | 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 each 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 * | \$10 Copay |
| Preferred Brand * | \$25 Copay |
| Non-Preferred Brand * | Subject to <i>Deductible & Coinsurance</i> |
| Specialty * | Subject to <i>Deductible & Coinsurance</i> |
| Prescription Drugs – Mail Order (90-day supply) | |
| Generic * | \$25 Copay |
| Preferred Brand * | \$62.50 Copay |
| 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.

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