



Schedule of Benefits Chorus Silver Copay

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>	\$0
Family Medical Calendar Year <i>Deductible</i>	\$0
Medical <i>Coinsurance</i>	0%
Individual Maximum <i>Out-of-Pocket Limit</i> [^]	\$8,700
Family Maximum <i>Out-of-Pocket Limit</i> [^]	\$17,400
Office Visits	
<i>Primary Care Provider/Practitioner/Physician/Doctor Visit</i>	\$40/visit
<i>Specialist Visit</i>	\$100/visit
<i>Chiropractic Care Visit</i>	\$40/visit
Diagnostic Services	
<i>Outpatient Laboratory Tests</i>	\$50/visit
<i>Diagnostic X-Rays</i>	\$140/visit
<i>Diagnostic Imaging</i> *	\$1,000/visit

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

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Emergency and Ambulance Services	
Emergency Room	\$1,500/visit
Urgent Care	\$45/visit
Ambulance (Ground and Air)	\$130
<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) *	\$130
Cochlear Implants (Replacement every 3 years) *	\$130
Bone-anchored hearing device (Limited to 1 per lifetime) *	\$130
Hospital Services	
Inpatient Hospital Service (Facility) *	\$1,250/day
Inpatient Physician Services (Professional) *	\$100/visit**
Maternity Services	
Facility Services	\$1,250/day
Physician Services	\$130/visit**
Mental Health and Substance Use Disorder Services	
Outpatient – Office Visit (select services *)	\$40/visit
Inpatient *	\$1,250/day
Other Services	
Home Health Care (60 visits per calendar year) *	\$40/visit
Transplants *	\$130**
Durable Medical Equipment (over \$500 *)	\$130**
Diabetic Equipment and Supplies (select services *)	\$130**
Autism Spectrum Disorder *	\$40/visit**
Hospice *	\$100/visit**
Prosthetic Devices *	\$130**
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)	\$80/visit
Physical Therapy (30 visits per calendar year)	\$80/visit
Occupational Therapy (30 visits per calendar year)	\$80/visit
<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)	\$80/visit
Pulmonary Rehabilitation (20 visits per calendar year)	\$80/visit
Skilled Nursing Facility (30 days per stay) *	\$1,250/day
Prescription Drugs	
Individual Prescription Drug <i>Deductible</i>	\$2,750
Family Prescription Drug <i>Deductible</i>	\$5,500
Prescription Drug <i>Coinsurance</i>	40%
Generic *	\$15
Preferred Brand *	\$120
Non-Preferred Brand *	Subject to <i>Deductible & Coinsurance</i>
Specialty *	Subject to <i>Deductible & Coinsurance</i>
Prescription Drugs – Mail Order (90-day supply)	
Generic *	\$37.50
Preferred Brand *	\$300
Non-Preferred Brand *	Subject to <i>Deductible & Coinsurance</i>
Dental	
TMJ	\$40**
Dental Services – Accident Only	\$40**
<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.

** Copay amounts vary depending on services provided. Additional charges may apply.

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