

## Schedule of Benefits Chorus 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](https://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>	\$7,500
Family Medical Calendar Year <i>Deductible</i>	\$15,000
Medical <i>Coinsurance</i>	50%
Individual Maximum <i>Out-of-Pocket Limit</i> <sup>^</sup>	\$9,100
Family Maximum <i>Out-of-Pocket Limit</i> <sup>^</sup>	\$18,200
<ul style="list-style-type: none"> <li>• Prescription benefits are included as part of the medical benefit amounts listed above.</li> </ul>	
Office Visits	
<i>Primary Care Provider/Practitioner/Physician/Doctor Visit</i>	\$60 Copay
<i>Specialist Visit</i>	\$120 Copay
<i>Chiropractic Care Visit</i>	\$60 Copay
Diagnostic Services	
<i>Outpatient Laboratory Tests</i>	Subject to <i>Deductible &amp; Coinsurance</i>
<i>Diagnostic X-Rays</i>	Subject to <i>Deductible &amp; Coinsurance</i>
<i>Diagnostic Imaging</i> *	Subject to <i>Deductible &amp; Coinsurance</i>

<sup>^</sup> *Maximum Out-of-Pocket Limit* in the calendar year includes *Deductible, Coinsurance, and Copayments*.

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<b>Emergency and Ambulance Services</b>	
Emergency Room	Subject to <i>Deductible &amp; Coinsurance</i>
Urgent Care	Subject to <i>Deductible &amp; Coinsurance</i>
Ambulance (Ground and Air)	Subject to <i>Deductible &amp; Coinsurance</i>
<ul style="list-style-type: none"> <li>• <i>Out-of-Network Providers may Balance Bill</i> for ground ambulance services.</li> </ul>	
<b>Hearing Services</b>	
Hearing Aids (Replacement every 3 years) *	Subject to <i>Deductible &amp; Coinsurance</i>
Cochlear Implants (Replacement every 3 years) *	Subject to <i>Deductible &amp; Coinsurance</i>
Bone-anchored hearing device (Limited to 1 per lifetime) *	Subject to <i>Deductible &amp; Coinsurance</i>
<b>Hospital Services</b>	
Inpatient Hospital Service (Facility) *	Subject to <i>Deductible &amp; Coinsurance</i>
Inpatient Physician Services (Professional) *	Subject to <i>Deductible &amp; Coinsurance</i>
<b>Maternity Services</b>	
Facility Services	Subject to <i>Deductible &amp; Coinsurance</i>
Physician Services	Subject to <i>Deductible &amp; Coinsurance</i>
<b>Mental Health and Substance Use Disorder Services</b>	
Outpatient – Office Visit (select services *)	\$60 Copay
<ul style="list-style-type: none"> <li>• Other outpatient services will be subject to <i>Deductible &amp; Coinsurance</i>.</li> </ul>	
Inpatient *	Subject to <i>Deductible &amp; Coinsurance</i>
<b>Other Services</b>	
Home Health Care (60 visits per calendar year) *	Subject to <i>Deductible &amp; Coinsurance</i>
Transplants *	Subject to <i>Deductible &amp; Coinsurance</i>
Durable Medical Equipment (over \$500 *)	Subject to <i>Deductible &amp; Coinsurance</i>
Diabetic Equipment and Supplies (select services *)	Subject to <i>Deductible &amp; Coinsurance</i>
Autism Spectrum Disorder *	Subject to <i>Deductible &amp; Coinsurance</i>
Hospice *	Subject to <i>Deductible &amp; Coinsurance</i>
Prosthetic Devices *	Subject to <i>Deductible &amp; Coinsurance</i>
Preventive Care	\$0
<ul style="list-style-type: none"> <li>• For a full list of Preventive Care services that are covered at a \$0 Copay, please visit our website at <a href="http://chorushealthplans.org">chorushealthplans.org</a>.</li> </ul>	

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<b>Rehabilitative and Habilitative Services</b>	
Speech Therapy (30 visits per calendar year)	Subject to <i>Deductible &amp; Coinsurance</i>
Physical Therapy (30 visits per calendar year)	Subject to <i>Deductible &amp; Coinsurance</i>
Occupational Therapy (30 visits per calendar year)	Subject to <i>Deductible &amp; Coinsurance</i>
<ul style="list-style-type: none"> <li>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.</li> </ul>	
<b>Rehabilitative Services - Other</b>	
Cardiac Rehabilitation (36 sessions per calendar year)	Subject to <i>Deductible &amp; Coinsurance</i>
Pulmonary Rehabilitation (20 visits per calendar year)	Subject to <i>Deductible &amp; Coinsurance</i>
Skilled Nursing Facility (30 days per stay) *	Subject to <i>Deductible &amp; Coinsurance</i>
<b>Prescription Drugs</b>	
Generic *	\$20 Copay
Preferred Brand *	Subject to <i>Deductible &amp; Coinsurance</i>
Non-Preferred Brand *	Subject to <i>Deductible &amp; Coinsurance</i>
Specialty *	Subject to <i>Deductible &amp; Coinsurance</i>
<b>Prescription Drugs – Mail Order (90-day supply)</b>	
Generic *	\$50 Copay
Preferred Brand *	Subject to <i>Deductible &amp; Coinsurance</i>
Non-Preferred Brand *	Subject to <i>Deductible &amp; Coinsurance</i>
<b>Dental</b>	
TMJ	Subject to <i>Deductible &amp; Coinsurance</i>
Dental Services – Accident Only	Subject to <i>Deductible &amp; Coinsurance</i>
<ul style="list-style-type: none"> <li>Routine dental services are not <i>Covered Services</i>, but can be purchased as a stand-alone plan with Chorus Dental at <a href="https://chorushealthplans.org">chorushealthplans.org</a>.</li> </ul>	
<b>Routine Pediatric Vision</b>	
Children's Routine Vision Exam (1 exam per calendar year)	\$0
Children's Eyewear	Subject to <i>Deductible &amp; Coinsurance</i>
<ul style="list-style-type: none"> <li>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>).</li> </ul>	

\* 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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