

Schedule of Benefits Chorus Bronze 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.

<i>In-Network Benefits Only</i>	Member Responsibility for Essential Health Benefits	Member Responsibility for Non-Essential Health Benefits
Individual Medical Calendar Year <i>Deductible</i>	\$0	\$7,500
Family Medical Calendar Year <i>Deductible</i>	\$0	\$15,000
Medical <i>Coinsurance</i>	0%	50%
Individual Maximum <i>Out-of-Pocket Limit</i> [^]	\$0	\$9,100
Family Maximum <i>Out-of-Pocket Limit</i> [^]	\$0	\$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>		\$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 Zero SOB 2023 (Rev 2022.06.13)

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Diagnostic Services	
Outpatient Laboratory Tests	\$0
Diagnostic X-Rays	\$0
<i>Diagnostic Imaging *</i>	\$0
Emergency and Ambulance Services	
Emergency Room	\$0
<i>Urgent Care</i>	\$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	
<i>Inpatient Hospital Service (Facility) *</i>	\$0
<i>Inpatient Physician Services (Professional) *</i>	\$0
Maternity Services	
Facility Services	\$0
Physician Services	\$0
Mental Health and Substance Use Disorder Services	
Outpatient – Office Visit (select services *)	\$0
<ul style="list-style-type: none"> Other outpatient services will be subject to <i>Deductible & Coinsurance</i>. 	
<i>Inpatient *</i>	\$0
Other Services	
<i>Home Health Care (60 visits per calendar year) *</i>	\$0
<i>Transplants *</i>	\$0
<i>Durable Medical Equipment (over \$500 *)</i>	\$0
<i>Diabetic Equipment and Supplies (select services *)</i>	\$0
<i>Autism Spectrum Disorder *</i>	\$0
<i>Hospice *</i>	\$0
<i>Prosthetic Devices *</i>	\$0
<i>Preventive Care</i>	\$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)	\$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	
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 require a *Prior Authorization* to be filed. Please refer to *Your Evidence of Coverage* for the full *Prior Authorization* list.

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