



## Schedule of Benefits Chorus Silver Copay 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](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 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.

In-Network Benefits Only	Member Responsibility for Essential Health Benefits	Member Responsibility for Non-Essential Health Benefits
Individual Medical Calendar Year <i>Deductible</i>	\$0	\$0
Family Medical Calendar Year <i>Deductible</i>	\$0	\$0
Medical <i>Coinsurance</i>	0%	0%
Individual Maximum <i>Out-of-Pocket Limit</i> ^	\$0	\$8,700
Family Maximum <i>Out-of-Pocket Limit</i> ^	\$0	\$17,400
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*.

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<b>Diagnostic Services</b>	
Outpatient Laboratory Tests	\$0
Diagnostic X-Rays	\$0
Diagnostic Imaging *	\$0
<b>Emergency and Ambulance Services</b>	
Emergency Room	\$0
Urgent Care	\$0
Ambulance (Ground and Air)	\$0
<b>Hearing Services</b>	
Hearing Aids (Replacement every 3 years) *	\$0
Cochlear Implants (Replacement every 3 years) *	\$0
Bone-anchored hearing device (Limited to 1 per lifetime) *	\$0
<b>Hospital Services</b>	
Inpatient Hospital Service (Facility) *	\$0
Inpatient Physician Services (Professional) *	\$0
<b>Maternity Services</b>	
Facility Services	\$0
Physician Services	\$0
<b>Mental Health and Substance Use Disorder Services</b>	
Outpatient – Office Visit (select services *)	\$0
Inpatient *	\$0
<b>Other Services</b>	
Home Health Care (60 visits per calendar year) *	\$0
Transplants *	\$0
Durable Medical Equipment (over \$500 *)	\$0
Diabetic Equipment and Supplies (select services *)	\$0
Autism Spectrum Disorder *	\$0
Hospice *	\$0
Prosthetic Devices *	\$0
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="https://chorushealthplans.org">chorushealthplans.org</a>.</li> </ul>	

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<b>Rehabilitative and Habilitative Services</b>	
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"> <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)	\$0
Pulmonary Rehabilitation (20 visits per calendar year)	\$0
Skilled Nursing Facility (30 days per stay) *	\$0
<b>Prescription Drugs</b>	
Individual Prescription Drug <i>Deductible</i>	\$0
Family Prescription Drug <i>Deductible</i>	\$0
Prescription Drug <i>Coinsurance</i>	0%
Generic *	\$0
Preferred Brand *	\$0
Non-Preferred Brand *	\$0
Specialty *	\$0
<b>Prescription Drugs – Mail Order (90-day supply)</b>	
Generic	\$0
Preferred Brand	\$0
Non-Preferred Brand	\$0
<b>Dental</b>	
TMJ	\$0
Dental Services – Accident Only	\$0
<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	\$0
<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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