

## Schedule of Benefits Chorus Bronze 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](https://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> <sup>^</sup>	\$8,700
Family Maximum <i>Out-of-Pocket Limit</i> <sup>^</sup>	\$17,400
Office Visits	
<i>Primary Care Provider/Practitioner/Physician/Doctor Visit</i>	\$55/visit
<i>Specialist Visit</i>	\$120/visit
<i>Chiropractic Care Visit</i>	\$55/visit
Diagnostic Services	
Outpatient Laboratory Tests	\$60/visit
Diagnostic X-Rays	\$140/visit
<i>Diagnostic Imaging</i> *	\$1,000/visit

<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	\$1,850/visit
Urgent Care	\$55/visit
Ambulance (Ground and Air)	\$130
<ul style="list-style-type: none"> <li>Maximum Allowed Amount applies. Out-of-Network Providers may Balance Bill.</li> </ul>	
<b>Hearing Services</b>	
Hearing Aids (Replacement every 3 years) *	\$130
Cochlear Implants (Replacement every 3 years) *	\$130
Bone-anchored hearing device (Limited to 1 per lifetime) *	\$130
<b>Hospital Services</b>	
Inpatient Hospital Service (Facility) *	\$1,500/day
Inpatient Physician Services (Professional) *	\$120/visit
<b>Maternity Services</b>	
Facility Services	\$1,500/day
Physician Services	\$120/visit**
<b>Mental Health and Substance Use Disorder Services</b>	
Outpatient – Office Visit (select services *)	\$55/visit
Inpatient *	\$1,500/day
<b>Other Services</b>	
Home Health Care (60 visits per calendar year) *	\$55/visit
Transplants *	\$120**
Durable Medical Equipment (over \$500 *)	\$130**
Diabetic Equipment and Supplies (select services *)	\$130**
Autism Spectrum Disorder *	\$55/visit**
Hospice *	\$120/visit**
Prosthetic Devices *	\$130**
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> <li>** Copay amounts vary depending on services provided. Additional charges may apply.</li> </ul>	

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<b>Rehabilitative and Habilitative Services</b>	
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"> <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)	\$80/visit
Pulmonary Rehabilitation (20 visits per calendar year)	\$80/visit
Skilled Nursing Facility (30 days per stay) *	\$1,500/day
<b>Prescription Drugs</b>	
Individual Prescription Drug <i>Deductible</i>	\$3,000
Family Prescription Drug <i>Deductible</i>	\$6,000
Prescription Drug <i>Coinsurance</i>	50%
Generic *	\$20
Preferred Brand *	\$130
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
Preferred Brand *	\$325
Non-Preferred Brand *	Subject to <i>Deductible &amp; Coinsurance</i>
<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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