



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