

## Schedule of Benefits Chorus Elite Gold 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>	\$1,250
Family Medical Calendar Year <i>Deductible</i>	\$2,500
Medical <i>Coinsurance</i>	10%
Individual Maximum <i>Out-of-Pocket Limit</i> <sup>^</sup>	\$5,250
Family Maximum <i>Out-of-Pocket Limit</i> <sup>^</sup>	\$10,500
<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>	\$35 Copay
<i>Specialist Visit</i>	\$70 Copay
<i>Chiropractic Care Visit</i>	\$35 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>
Emergency and Ambulance Services	
<i>Emergency Room</i>	Subject to <i>Deductible &amp; Coinsurance</i>
<i>Urgent Care</i>	Subject to <i>Deductible &amp; Coinsurance</i>
<i>Ambulance (Ground and Air)</i>	Subject to <i>Deductible &amp; Coinsurance</i>
<ul style="list-style-type: none"> <li><i>Out-of-Network Providers</i> may <i>Balance Bill</i> for ground ambulance services.</li> </ul>	

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

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<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>	
<i>Inpatient Hospital Service (Facility) *</i>	Subject to <i>Deductible &amp; Coinsurance</i>
<i>Inpatient Physician Services (Professional) *</i>	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 *)	\$35 Copay
<ul style="list-style-type: none"> <li>Other outpatient services will be subject to <i>Deductible &amp; Coinsurance</i>.</li> </ul>	
<i>Inpatient *</i>	Subject to <i>Deductible &amp; Coinsurance</i>
<b>Other Services</b>	
<i>Home Health Care (60 visits per calendar year) *</i>	Subject to <i>Deductible &amp; Coinsurance</i>
Transplants *	Subject to <i>Deductible &amp; Coinsurance</i>
<i>Durable Medical Equipment (over \$500 *)</i>	Subject to <i>Deductible &amp; Coinsurance</i>
Diabetic Equipment and Supplies (select services *)	Subject to <i>Deductible &amp; Coinsurance</i>
<i>Autism Spectrum Disorder *</i>	Subject to <i>Deductible &amp; Coinsurance</i>
<i>Hospice *</i>	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>	
<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>

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Prescription Drugs	
Generic *	\$10 Copay
Preferred Brand *	\$65 Copay
Non-Preferred Brand *	Subject to <i>Deductible &amp; Coinsurance</i>
Specialty *	Subject to <i>Deductible &amp; Coinsurance</i>
Prescription Drugs – Mail Order (90-day supply)	
Generic	\$25 Copay
Preferred Brand	\$162.50 Copay
Non-Preferred Brand	Subject to <i>Deductible &amp; Coinsurance</i>
Dental	
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>	
Routine Pediatric Vision	
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.