

## Schedule of Benefits Chorus Core 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 <u>chorushealthplans.org/find-a-doc</u>. 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	\$1,500
Family Medical Calendar Year Deductible	\$3,000
Medical Coinsurance	25%
Individual Maximum Out-of-Pocket Limit ^	\$8,700
Family Maximum Out-of-Pocket Limit ^	\$17,400
Prescription benefits are included as part of the medical benefit amounts listed above.	
Office Visits	
Primary Care Provider/Practitioner/Physician/Doctor Visit	\$30 Copay
Specialist Visit	\$60 Copay
Chiropractic Care Visit	\$30 Copay
Diagnostic Services	
Outpatient Laboratory Tests	Subject to Deductible & Coinsurance
Diagnostic X-Rays	Subject to Deductible & Coinsurance
Diagnostic Imaging *	Subject to Deductible & Coinsurance
Emergency and Ambulance Services	
Emergency Room	Subject to Deductible & Coinsurance
Urgent Care	\$45 Copay
Ambulance (Ground and Air)	Subject to Deductible & Coinsurance
Out-of-Network Providers may Balance Bill for ground ambulance services.	

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

Chorus Core Gold Limited SOB 2024 (Rev 2023.06.12)

PO Box 1997, MS 6280 • Milwaukee, WI 53201-1997 • Toll-free: 1-844-201-4672

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Hearing Aids (Replacement every 3 years)*         Subject to Deductible & Coinsurance           Cochlear Implants (Replacement every 3 years)*         Subject to Deductible & Coinsurance           Bone-anchored hearing device (Limitled to 1 per lifetime)*         Subject to Deductible & Coinsurance           Inpatient Hospital Services (Professional)*         Subject to Deductible & Coinsurance           Inpatient Hospital Services (Professional)*         Subject to Deductible & Coinsurance           Maternity Services         Subject to Deductible & Coinsurance           Physician Services         Subject to Deductible & Coinsurance           Maternity Services         Subject to Deductible & Coinsurance           Physician Services         Subject to Deductible & Coinsurance           Outpatient - Office Visit (select services*)         \$30 Copay           • Other outpatient services will be subject to Deductible & Coinsurance         Subject to Deductible & Coinsurance           Inpatient*         Subject to Deductible & Coinsurance           Nome Health Care (60 visits per calendar year)*         Subject to Deductible & Coinsurance           Durable Medical Equipment (over \$500*)         Subject to Deductible & Coinsurance           Durable Medical Equipment and Supplies (select services *)         Subject to Deductible & Coinsurance           Preventive Care         Subject to Deductible & Coinsurance           Home Health Care (60 vi	Hearing Services	
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	Skilled Nursing Facility (30 days per stay) *	· · · ·

Chorus Core Gold Limited SOB 2024 (Rev 2023.06.12)

PO Box 1997, MS 6280 • Milwaukee, WI 53201-1997 • Toll-free: 1-844-201-4672

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Prescription Drugs	
Generic *	\$15 Copay
Preferred Brand *	\$30 Copay
Non-Preferred Brand *	\$60 Copay
Specialty * SaveOnSP Service – Specialty (Brand and Generic) SaveOnSP Drug List – <u>www.saveonsp.com/cchp**</u>	\$250 Copay If you participate in SaveOnSP: You pay \$0 for specialty medications (brand and generic) included in this service. If you do not participate in SaveOnSP: You will be responsible for [30%] coinsurance for the medications (brand and generic) listed on the SaveOnSP Drug List found at www.saveonsp.com/cchp**
Prescription Drugs – Mail Order (90-day supply)	
Generic	\$37.50 Copay
Preferred Brand	\$75 Copay
Non-Preferred Brand	\$150 Copay
Dental	
TMJ	Subject to Deductible & Coinsurance
Dental Services – Accident Only	Subject to Deductible & Coinsurance
<ul> <li>Routine dental services are not Covered Services, but can be purchased as a stand-alone plan with Chorus Dental at <u>chorushealthplans.org</u>.</li> </ul>	
Routine Pediatric Vision	
Children's Routine Vision Exam (1 exam per calendar year)	\$0
Children's Eyewear	Subject to Deductible & Coinsurance
<ul> <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 Pediatric Eyewear Collection).</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.

\*\* Pharmacy cost-shares for medications included in SaveOnSP are considered non-essential health benefits and fall outside of the deductible and out-of-pocket limits and are not applied to your deductible or out-of-pocket maximum. For medications not included in the SaveonSP program, the default specialty cost-share applies. Medications included in the SaveonSP program are only available through our preferred Specialty pharmacies. For a list of applicable specialty medications, please visit www.saveonsp.com/cchp, call (800)-683-1074 or call the number on the back of your ID card.

Chorus Core Gold Limited SOB 2024 (Rev 2023.06.12)

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