

## Schedule of Benefits Chorus Silver 100

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.

In-Network Benefits Only	Member Responsibility		
Individual Medical Calendar Year Deductible	\$150		
Family Medical Calendar Year Deductible	\$300		
Medical Coinsurance	10%		
Individual Maximum Out-of-Pocket Limit ^	\$1,600		
Family Maximum Out-of-Pocket Limit ^	\$3,200		
Prescription benefits are included as part of the medical benefit amounts listed above.			
Office Visits			
Primary Care Provider/Practitioner/Physician/Doctor Visit	\$5 Copay		
Specialist Visit	\$10 Copay		
Chiropractic Care Visit	\$5 Copay		
Diagnostic Services			
Outpatient Laboratory Tests	\$5 Copay		
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	Subject to Deductible & Coinsurance		
Ambulance (Ground and Air)	Subject to Deductible & Coinsurance		
Out-of-Network Providers may Balance Bill for ground am	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 Silver 100 SOB 2025(Rev 2024.06.05)

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

© Chorus Community Health Plans. All rights reserved. CCHP complies with Federal civil rights laws. We do not discriminate based on race, color, national origin, age, disability or sex. Si habla español, los servicios de asistencia de idiomas están disponibles sin cargo, llame al 1-844-201-4672 (TTY: 7-1-1). Yog koj hais lus Hmoob, kev pab rau lwm yam lus muaj rau koj dawb xwb. 1-844-201-4672 (TTY: 7-1-1).



Hearing Aids (Replacement every 3 years)*       Subject to Deductible & Coinsurance         Cochlear Implants (Replacement every 3 years)*       Subject to Deductible & Coinsurance         Bone-anchored hearing device (Limited to 1 per lifetime)*       Subject to Deductible & Coinsurance         Inpatient Haspital Services       Inpatient Haspital Services (Professional)*       Subject to Deductible & Coinsurance         Inpatient Physician Services (Professional)*       Subject to Deductible & Coinsurance         Physician Services       Subject to Deductible & Coinsurance         Outpatient - Office Visit (select services)*       \$S Copay         Other outpatient services will be subject to Deductible & Coinsurance       Subject to Deductible & Coinsurance         Inpatient*       Subject to Deductible & Coinsurance       Subject to Deductible & Coinsurance         Inpatient *       Other Services       Subject to Deductible & Coinsurance         Proventise       Coinsurance       Subject to Deductible & Coinsurance         Inpatient *       Other Services       Subject to Deductible & Coinsurance         Proventis	Hearing Services	
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Members are permitted 30 Rehabilitative therapy sessions and 30 Habilitative therapy sessions for <u>each</u> therapy service listed above per calendar year. <u>Rehabilitative Services - Other</u> Cardiac Rehabilitation (36 sessions per calendar year) Pulmonary Rehabilitation (20 visits per calendar year) Subject to Deductible & Coinsurance	Physical Therapy (30 visits per calendar year)	Subject to Deductible & Coinsurance
each therapy service listed above per calendar year.Rehabilitative Services - OtherCardiac Rehabilitation (36 sessions per calendar year)Subject to Deductible & CoinsurancePulmonary Rehabilitation (20 visits per calendar year)Subject to Deductible & Coinsurance	Occupational Therapy (30 visits per calendar year)	Subject to Deductible & Coinsurance
Rehabilitative Services - OtherCardiac Rehabilitation (36 sessions per calendar year)Subject to Deductible & CoinsurancePulmonary Rehabilitation (20 visits per calendar year)Subject to Deductible & Coinsurance	• Members are permitted 30 Rehabilitative therapy sessior	ns and 30 Habilitative therapy sessions for
Cardiac Rehabilitation (36 sessions per calendar year)Subject to Deductible & CoinsurancePulmonary Rehabilitation (20 visits per calendar year)Subject to Deductible & Coinsurance		
Pulmonary Rehabilitation (20 visits per calendar year) Subject to Deductible & Coinsurance	Rehabilitative Services - Other	
	Cardiac Rehabilitation (36 sessions per calendar year)	Subject to Deductible & Coinsurance
Skilled Nursing Eacility (30 days per calendar year) * Subject to Deductible & Coinsurance	Pulmonary Rehabilitation (20 visits per calendar year)	Subject to Deductible & Coinsurance
	Skilled Nursing Facility (30 days per calendar year) *	Subject to Deductible & Coinsurance

## Chorus Silver 100 SOB 2025(Rev 2024.06.05)

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Prescription Drugs		
Generic *	\$5 Copay	
Preferred Brand *	\$70 Copay	
Non-Preferred Brand *	Subject to Deductible & Coinsurance	
Specialty *	Subject to Deductible & Coinsurance	
Prescription Drugs – Mail Order (90-day supply)		
Generic *	\$12.50 Copay	
Preferred Brand *	175 Copay	
Non-Preferred Brand *	Subject to Deductible & Coinsurance	
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	
• 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.

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