CHORUS COMMUNITY HEALTH PLANS

Schedule of Benefits
Chorus Silver Copay 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 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 *Deductible*	$0
Family Medical Calendar Year *Deductible*	$0
Medical *Coinsurance*	0%
Individual Maximum *Out-of-Pocket Limit* ^	$700
Family Maximum *Out-of-Pocket Limit* ^	$1,400
Office Visits	
Primary Care Provider/*Practitioner*/Physician/Doctor Visit	$0 for first 3 visits, then $15 Copay
Specialist Visit	$40/visit
Chiropractic Care Visit	$15/visit
Diagnostic Services	
Outpatient Laboratory Tests	$30/visit
Diagnostic X-Rays	$80/visit
Diagnostic Imaging *	$60/visit
***Emergency* and Ambulance Services**	
Emergency Room	$100/visit
Urgent Care	$45/visit
Ambulance (Ground and Air)	$40
• *Out-of-Network Providers* may *Balance Bill* for ground ambulance services.	

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

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Hearing Services	
Hearing Aids (Replacement every 3 years) *	$40
Cochlear Implants (Replacement every 3 years) *	$40
Bone-anchored hearing device (Limited to 1 per lifetime) *	$40
***Hospital* Services**	
Inpatient Hospital Service (Facility) * (Copay applies each day, up to 2 days)	$70/day
Inpatient Physician Services (Professional) *	$40/visit**
Maternity Services	
Facility Services (Copay applies each day, up to 2 days)	$70/day
Physician Services	$40/visit**
***Mental Health* and *Substance Use Disorder* Services**	
Outpatient – Office Visit (select services *)	$15/visit
Inpatient * (Copay applies each day, up to 2 days)	$70/day
Other Services	
Home Health Care (60 visits per calendar year) *	$15/visit
Transplants *	$40**
Durable Medical Equipment (over $500 *)	$40**
Diabetic Equipment and Supplies (select services *)	$40**
Autism Spectrum Disorder *	$15/visit**
Hospice *	$40/visit**
Prosthetic Devices *	$40**
Preventive Care	$0
• For a full list of Preventive Care services that are covered at a $0 *Copay*, please visit our website at chorushealthplans.org.	
Rehabilitative and Habilitative Services	
Speech Therapy (30 visits per calendar year)	$30/visit
Physical Therapy (30 visits per calendar year)	$30/visit
Occupational Therapy (30 visits per calendar year)	$30/visit
• Members are permitted 30 *Rehabilitative* therapy	
***Rehabilitative Services* - Other**	
Cardiac Rehabilitation (36 sessions per calendar year)	$30/visit
Pulmonary Rehabilitation (20 visits per calendar year)	$30/visit
Skilled Nursing Facility (30 days per stay) * (Copay applies each day, up to 2 days)	$75/day

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Prescription Drugs	
Individual Prescription Drug *Deductible*	$100
Family Prescription Drug *Deductible*	$200
Prescription Drug *Coinsurance*	20%
Generic *	$10
Preferred Brand *	$25
Non-Preferred Brand *	Subject to *Deductible* & *Coinsurance*
Specialty * SaveOnSP Service – Specialty (Brand and Generic) SaveOnSP Drug List – www.saveonsp.com/cchp***	Subject to *Deductible* & *Coinsurance* 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 *	$25
Preferred Brand *	$62.50
Non-Preferred Brand *	Subject to *Deductible* & *Coinsurance*
Dental	
TMJ	$15**
Dental Services – Accident Only	$15**
• Routine dental services are not *Covered Services,* 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
• 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*).	

***** 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.

*** 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.

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