CHORUS
COMMUNITY HEALTH PLANS

Schedule of Benefits
Chorus Silver Select 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*	$3,250
Family Medical Calendar Year *Deductible*	$6,500
Medical *Coinsurance*	40%
Individual Maximum *Out-of-Pocket Limit* ^	$9,100
Family Maximum *Out-of-Pocket Limit* ^	$18,200
• Prescription benefits are included as part of the medical benefit amounts listed above.	
Office Visits	
Primary Care Provider/Practitioner/Physician/Doctor Visit	$35 *Copay*
Specialist Visit	$80 *Copay*
Chiropractic Care Visit	$35 *Copay*
Diagnostic Services	
Outpatient Laboratory Tests	Subject to *Deductible* & *Coinsurance*
Diagnostic X-Rays	Subject to *Deductible* & *Coinsurance*
Diagnostic Imaging *****	Subject to *Deductible* & *Coinsurance*

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

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).

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 ambulance services.	
Hearing Services	
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*
***Hospital* Services**	
Inpatient Hospital Service (Facility) *	Subject to *Deductible* & *Coinsurance*
Inpatient Physician Services (Professional) *	Subject to *Deductible* & *Coinsurance*
Maternity Services	
Facility Services	Subject to *Deductible* & *Coinsurance*
Physician Services	Subject to *Deductible* & *Coinsurance*
Mental Health* and *Substance Use Disorder Services	
Outpatient – Office Visit (select services *)	$35 *Copay*
• Other outpatient services will be subject to *Deductible* & *Coinsurance*.	
Inpatient *	Subject to *Deductible* & *Coinsurance*
Other Services	
Home Health Care (60 visits per calendar year) *	Subject to *Deductible* & *Coinsurance*
Transplants *	Subject to *Deductible* & *Coinsurance*
Durable Medical Equipment (over $500 *)	Subject to *Deductible* & *Coinsurance*
Diabetic Equipment and Supplies (select services *)	Subject to *Deductible* & *Coinsurance*
Autism Spectrum Disorder *	Subject to *Deductible* & *Coinsurance*
Hospice *	Subject to *Deductible* & *Coinsurance*
Prosthetic Devices *	Subject to *Deductible* & *Coinsurance*
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.	

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).

CHORUS COMMUNITY HEALTH PLANS

Rehabilitative and Habilitative Services	
Speech Therapy (30 visits per calendar year)	Subject to *Deductible* & *Coinsurance*
Physical Therapy (30 visits per calendar year)	Subject to *Deductible* & *Coinsurance*
Occupational Therapy (30 visits per calendar year)	Subject to *Deductible* & *Coinsurance*
• Members are permitted 30 *Rehabilitative* therapy sessions and 30 *Habilitative* therapy sessions for each therapy service listed above per calendar year.	
Rehabilitative Services - Other	
Cardiac Rehabilitation (36 sessions per calendar year)	Subject to *Deductible* & *Coinsurance*
Pulmonary Rehabilitation (20 visits per calendar year)	Subject to *Deductible* & *Coinsurance*
Skilled Nursing Facility (30 days per stay) *****	Subject to *Deductible* & *Coinsurance*
Prescription Drugs	
Generic *****	$15 *Copay*
Preferred Brand *****	$75 *Copay*
Non-Preferred Brand *****	Subject to *Deductible* & *Coinsurance*
Specialty *****	Subject to *Deductible* & *Coinsurance*
Prescription Drugs – Mail Order (90-day supply)	
Generic *****	$37.50 *Copay*
Preferred Brand *****	$187.50 *Copay*
Non-Preferred Brand *****	Subject to *Deductible* & *Coinsurance*
Dental	
TMJ	Subject to *Deductible* & *Coinsurance*
Dental Services – Accident Only	Subject to *Deductible* & *Coinsurance*
• 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	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 *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.

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).