## Schedule of Benefits
## Together Silver Select

This document is *Your* Schedule of Benefits. If *You* enroll in this plan, this Schedule of Benefits will be an important part of *Your Contract*. *Your* Evidence of Coverage describes in detail the services *Your* plan covers, while the Schedule of Benefits describes what *You* pay for those services.

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 togetherCCHP.org/Find-a-Doc. *You* can also call Together with CCHP's Customer Service at the phone number on the back of *Your* member ID card.

| ***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* ^ | $8,550 |
| Family Maximum *Out-of-Pocket Limit* ^ | $17,100 |
| • 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* |



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| ***Emergency* and Ambulance Services** | |
|---|---|
| *Emergency* Room | Subject to *Deductible* & *Coinsurance* |
| *Urgent Care* | Subject to *Deductible* & *Coinsurance* |
| Ambulance (Ground and Air) | Subject to *Deductible* & *Coinsurance* |
| • *Maximum Allowed Amount* applies. *Out-of-Network Providers* may *Balance Bill*. | |
| **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** | |
| Prenatal Care and Postnatal Care | Subject to *Deductible* & *Coinsurance* |
| *Inpatient* 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 togetherCCHP.org. | |



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| ***Rehabilitative and Habilitative Services*** | |
|---|---|
| Speech Therapy (20 visits per calendar year) | Subject to *Deductible* & *Coinsurance* |
| Physical Therapy (20 visits per calendar year) | Subject to *Deductible* & *Coinsurance* |
| Occupational Therapy (20 visits per calendar year) | Subject to *Deductible* & *Coinsurance* |
| • Members are permitted 20 *Rehabilitative* therapy sessions and 20 *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 * | $55 *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 * | $137.50 *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.* | |
| **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*). | |

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

* 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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