Schedule of Benefits
Together Bronze HDHP Zero

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.

Copayment, Deductible, and Coinsurance will not apply to *Covered Services* when a member obtains care through an Urban Indian Organization *Provider* or when essential health benefits are rendered. No referral is required from an Urban Indian Organization *Provider* when receiving essential health benefits.

Please note that the benefits listed on the following pages are applicable for Essential Health Benefits. Non-Essential Health Benefits, such as allergy testing or nutritional counseling, may be covered differently. For further information on coverage for Non-Essential Health Benefits, please reference your Evidence of Coverage or contact Customer Service.

***In-Network* Benefits Only**	**Member Responsibility for Essential Health Benefits**	**Member Responsibility for Non-Essential Health Benefits**
Individual Medical Calendar Year *Deductible*	$0	$7,000
Family Medical Calendar Year *Deductible*	$0	$14,000
Medical *Coinsurance*	0%	0%
Individual Maximum *Out-of-Pocket Limit* ^	$0	$7,000
Family Maximum *Out-of-Pocket Limit* ^	$0	$14,000
• Prescription benefits are included as part of the medical benefit amounts listed above.		

Office Visits	
Primary Care Provider/*Practitioner*/Physician/Doctor Visit	$0
Specialist Visit	$0
Chiropractic Care Visit	$0

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Children's Community Health Plan complies with Federal civil rights laws. We do not discriminate based on race, color, national origin, age, disability or sex. Si no habla inglés, se programarán servicios de idiomas en forma gratuita. Llame al (844) 201-4672 (TTY: 1-844-531-4856). Yog hais tias koj tsis txawj hais lus Askiv, peb yuav teem sij hawm muab kev pab txhais lus pub dawb rau koj. Hu rau (844) 201-4672 (TTY: 1-844-531-4856).

Diagnostic Services	
Outpatient Laboratory Tests	$0
Diagnostic X-Rays	$0
Diagnostic Imaging *	$0
***Emergency* and Ambulance Services**	
Emergency Room	$0
Urgent Care	$0
Ambulance (Ground and Air)	$0
Hearing Services	
Hearing Aids (Replacement every 3 years) *	$0
Cochlear Implants (Replacement every 3 years) *	$0
Bone-anchored hearing device (Limited to 1 per lifetime) *	$0
***Hospital* Services**	
Inpatient Hospital Service (Facility) *	$0
Inpatient Physician Services (Professional) *	$0
Maternity Services	
Prenatal Care and Postnatal Care	$0
Inpatient Services	$0
***Mental Health* and *Substance Use Disorder* Services**	
Outpatient – Office Visit (select services *)	$0
• Other outpatient services will be subject to *Deductible* & *Coinsurance*.	
Inpatient *	$0
Other Services	
Home Health Care (60 visits per calendar year) *	$0
Transplants *	$0
Durable Medical Equipment (over $500 *)	$0
Diabetic Equipment and Supplies (select services *)	$0
Autism Spectrum Disorder *	$0
Hospice *	$0
Prosthetic Devices *	$0
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.	
Rehabilitative and Habilitative Services	
Speech Therapy (20 visits per calendar year)	$0
Physical Therapy (20 visits per calendar year)	$0

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Occupational Therapy (20 visits per calendar year)	$0
• 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)	$0
Pulmonary Rehabilitation (20 visits per calendar year)	$0
Skilled Nursing Facility (30 days per stay) *	$0
Prescription Drugs	
Generic *	$0
Preferred Brand *	$0
Non-Preferred Brand *	$0
Specialty *	$0
Prescription Drugs – Mail Order (90-day supply)	
Generic	$0
Preferred Brand	$0
Non-Preferred Brand	$0
Dental	
TMJ	$0
Dental Services – Accident Only	$0
• Routine dental services are not *Covered Services.*	
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*).	

^ *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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