Schedule of Benefits
Together Silver 150

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*	$750
Family Medical Calendar Year *Deductible*	$1,500
Medical *Coinsurance*	20%
Individual Maximum *Out-of-Pocket Limit* ^	$2,850
Family Maximum *Out-of-Pocket Limit* ^	$5,700
• Prescription benefits are included as part of the medical benefit amounts listed above.	
Office Visits	
Primary Care Provider/Practitioner/Physician/Doctor Visit	$20 *Copay*
Specialist Visit	$40 *Copay*
Chiropractic Care Visit	$20 *Copay*
Diagnostic Services	
Outpatient Laboratory Tests	Subject to *Deductible* & *Coinsurance*
Diagnostic X-Rays	Subject to *Deductible* & *Coinsurance*
Diagnostic Imaging *	Subject to *Deductible* & *Coinsurance*

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).

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) *	$20 *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 *	$5 *Copay*
Preferred Brand *	Subject to *Deductible* & *Coinsurance*
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 *	Subject to *Deductible* & *Coinsurance*
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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