Schedule of Benefits
Together Silver Select 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	$3,250
Family Medical Calendar Year *Deductible*	$0	$6,500
Medical *Coinsurance*	0%	40%
Individual Maximum *Out-of-Pocket Limit* ^	$0	$8,550
Family Maximum *Out-of-Pocket Limit* ^	$0	$17,100
• Prescription benefits are included as part of the medical benefit amounts listed above.		

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

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• 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
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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