CHORUS COMMUNITY HEALTH PLANS

Schedule of Benefits
Chorus Bronze Copay

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.

***In-Network* Benefits Only**	**Member Responsibility**
Individual Medical Calendar Year *Deductible*	$0
Family Medical Calendar Year *Deductible*	$0
Medical *Coinsurance*	0%
Individual Maximum *Out-of-Pocket Limit* ^	$9,450
Family Maximum *Out-of-Pocket Limit* ^	$18,900
Office Visits	
Primary Care Provider/Practitioner/Physician/Doctor Visit	$70/visit
Specialist Visit	$140/visit
Chiropractic Care Visit	$70/visit
Diagnostic Services	
Outpatient Laboratory Tests	$60/visit
Diagnostic X-Rays	$140/visit
Diagnostic Imaging *	$1,000/visit

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

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Emergency and Ambulance Services	
Emergency Room	$2,200/visit
Urgent Care	$65/visit
Ambulance (Ground and Air)	$130
• *Out-of-Network Providers* may *Balance Bill* for ground ambulance services.	
Hearing Services	
Hearing Aids (Replacement every 3 years) *	$130
Cochlear Implants (Replacement every 3 years) *	$130
Bone-anchored hearing device (Limited to 1 per lifetime) *	$130
***Hospital* Services**	
Inpatient Hospital Service (Facility)* (Copay applies each day, up to 2 days)	$1,500/day
Inpatient Physician Services (Professional) *	$140/visit**
Maternity Services	
Facility Services (Copay applies each day, up to 2 days)	$1,500/day
Physician Services	$140/visit**
***Mental Health* and *Substance Use Disorder* Services**	
Outpatient – Office Visit (select services *)	$70/visit
Inpatient * (Copay applies each day, up to 2 days)	$1,500/day
Other Services	
Home Health Care (60 visits per calendar year) *	$70/visit
Transplants *	$140**
Durable Medical Equipment (over $500 *)	$130**
Diabetic Equipment and Supplies (select services *)	$130**
Autism Spectrum Disorder *	$70/visit**
Hospice *	$130/visit**
Prosthetic Devices *	$130**
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.	

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Rehabilitative and Habilitative Services	
Speech Therapy (30 visits per calendar year)	$80/visit
Physical Therapy (30 visits per calendar year)	$80/visit
Occupational Therapy (30 visits per calendar year)	$80/visit
• 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)	$80/visit
Pulmonary Rehabilitation (20 visits per calendar year)	$80/visit
Skilled Nursing Facility (30 days per stay)***** (Copay applies each day, up to 2 days)	$1,500/day
Prescription Drugs	
Individual Prescription Drug *Deductible*	$3,000
Family Prescription Drug *Deductible*	$6,000
Prescription Drug *Coinsurance*	50%
Generic *****	$30
Preferred Brand *****	$150
Non-Preferred Brand *****	Subject to *Deductible* & *Coinsurance*
Specialty *****	Subject to *Deductible* & *Coinsurance*
Prescription Drugs – Mail Order (90-day supply)	
Generic *****	$75
Preferred Brand *****	$375
Non-Preferred Brand *****	Subject to *Deductible* & *Coinsurance*
Dental	
TMJ	$70**
Dental Services – Accident Only	$70**
• 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	$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*).	

***** Indicates that services may require a *Prior Authorization* to be filed. Please refer to *Your Evidence of Coverage* for the full *Prior Authorization* list.

** Copay amounts vary depending on services provided. Additional charges may apply.

Chorus Bronze Copay SOB 2024 (Rev 2023.06.02)