CHORUS COMMUNITY HEALTH PLANS

Schedule of Benefits
Chorus Core Bronze

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*	$7,500
Family Medical Calendar Year *Deductible*	$15,000
Medical *Coinsurance*	50%
Individual Maximum *Out-of-Pocket Limit* ^	$9,400
Family Maximum *Out-of-Pocket Limit* ^	$18,800
• Prescription benefits are included as part of the medical benefit amounts listed above.	
Office Visits	
Primary Care Provider/*Practitioner*/Physician/Doctor Visit	$50 *Copay*
Specialist Visit	$100 *Copay*
Chiropractic Care Visit	$50 *Copay*
Diagnostic Services	
Outpatient Laboratory Tests	Subject to *Deductible* & *Coinsurance*
Diagnostic X-Rays	Subject to *Deductible* & *Coinsurance*
Diagnostic Imaging *	Subject to *Deductible* & *Coinsurance*
***Emergency* and Ambulance Services**	
Emergency Room	Subject to *Deductible* & *Coinsurance*
Urgent Care	$75 *Copay*
Ambulance (Ground and Air)	Subject to *Deductible* & *Coinsurance*
• *Out-of-Network Providers* may *Balance Bill* for ground ambulance services.	

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

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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	
Facility Services	Subject to *Deductible* & *Coinsurance*
Physician Services	Subject to *Deductible* & *Coinsurance*
***Mental Health* and *Substance Use Disorder* Services**	
Outpatient – Office Visit (select services *)	$50 *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 chorushealthplans.org.	
Rehabilitative and Habilitative Services	
Speech Therapy (30 visits per calendar year)	$50 *Copay*
Physical Therapy (30 visits per calendar year)	$50 *Copay*
Occupational Therapy (30 visits per calendar year)	$50 *Copay*
• 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)	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*

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Prescription Drugs	
Generic *	$25 *Copay*
Preferred Brand *	$50 *Copay* after *Deductible*
Non-Preferred Brand *	$100 *Copay* after *Deductible*
Specialty * SaveOnSP Service – Specialty (Brand and Generic) SaveOnSP Drug List – www.saveonsp.com/cchp**	$500 *Copay* after *Deductible* If you participate in SaveOnSP: You pay $0 for specialty medications (brand and generic) included in this service. If you do not participate in SaveOnSP: You will be responsible for [30%] coinsurance for the medications (brand and generic) listed on the SaveOnSP Drug List found at www.saveonsp.com/cchp**
Prescription Drugs – Mail Order (90-day supply)	
Generic *	$62.50 *Copay*
Preferred Brand *	$125 *Copay* after *Deductible*
Non-Preferred Brand *	$250 *Copay* after *Deductible*
Dental	
TMJ	Subject to *Deductible* & *Coinsurance*
Dental Services – Accident Only	Subject to *Deductible* & *Coinsurance*
• 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	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*).	

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

** Pharmacy cost-shares for medications included in SaveOnSP are considered non-essential health benefits and fall outside of the deductible and out-of-pocket limits and are not applied to your deductible or out-of-pocket maximum. For medications not included in the SaveonSP program, the default specialty cost-share applies. Medications included in the SaveonSP program are only available through our preferred Specialty pharmacies. For a list of applicable specialty medications, please visit www.saveonsp.com/cchp, call (800)-683-1074 or call the number on the back of your ID card.

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