

Schedule of Benefits Chorus Dental – Premier Plan

Services received must meet all criteria described in *Your Evidence of Coverage* to be considered a *Covered Service*. Please note that *Your plan* may not cover all of *Your dental care expenses*, such as *Deductible* and *Coinsurance*. To understand *Your plan coverage* and to see a full list of *Covered Services*, please reference *Your Evidence of Coverage* found online at chorushealthplans.org.

Out-of-Network providers are permitted to charge for the difference between the allowed amount and the billed charges, which may result in balance billing. To ensure you are using an *In-Network Provider* please visit our website at chorushealthplans.org/Find-a-Doc. You can also call CCHP's Customer Service team at the phone number on the back of *Your member ID card* for any benefit inquiries.

Annual Benefit Limits	Pediatric Benefits -18 years or younger-		Adult Benefits -19 years or older-	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Individual Deductible*	\$50	\$100	\$50	\$100
Family Deductible (3 or more members*)	\$150	\$300	\$150	\$300
Individual Out-of-Pocket Limit**	\$375	N/A	N/A	N/A
Family Out-of-Pocket Limit (2 or more children**)	\$750	N/A	N/A	N/A
Individual Maximum Coverage Allowance	N/A	N/A	\$1,500	
Family Maximum Coverage Allowance	N/A	N/A	\$3,000	
*The individual deductible for in-network, covered services for 1 member is \$50 annually. The deductible for 2 members is \$100 annually. The deductible for 3 or more members is \$150 annually.				
**The maximum out-of-pocket limit for in-network, covered services for 1 child will not exceed \$375 annually. The maximum out-of-pocket limit for 2 or more children will not exceed \$750 annually. This limit does not apply to adults.				

	Pediatric Benefits		Adults Benefits	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Class A – Preventive & Diagnostic Oral exam, teeth cleaning, x-rays	\$0	50%	\$0	50%
Class B – Basic Services Fillings and routine extractions	20%	60%	20%	60%
Class C – Major Services* Crowns, endodontics, and periodontics	50%	75%	50%	75%
			12 month waiting period applies	
Class D – Orthodontic Services* Must meet medical necessity	50%	50%	Not Covered	Not Covered
Coinsurance listed above is the percentage <i>You</i> are responsible for after meeting <i>Your deductible</i> .				
* Indicates that services may require a <i>Prior Authorization</i> to be filed. Please refer to <i>Your Evidence of Coverage</i> for the full <i>Prior Authorization</i> list.				