

## Schedule of Benefits Chorus Dental – Standard 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](http://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](http://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
<b>Individual Deductible*</b>	\$75	\$150	\$75	\$150
<b>Family Deductible (3 or more members*)</b>	\$225	\$450	\$225	\$450
<b>Individual Out-of-Pocket Limit**</b>	\$375	N/A	N/A	N/A
<b>Family Out-of-Pocket Limit (2 or more children**)</b>	\$750	N/A	N/A	N/A
<b>Individual Maximum Coverage Allowance</b>	N/A	N/A	\$1,000	
<b>Family Maximum Coverage Allowance</b>	N/A	N/A	\$2,000	
*The individual deductible for in-network, covered services for 1 member is \$75 annually. The deductible for 2 members is \$150 annually. The deductible for 3 or more members is \$225 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
<b>Class A – Preventive &amp; Diagnostic</b> Oral exam, teeth cleaning, x-rays	\$0	50%	\$0	50%
<b>Class B – Basic Services</b> Fillings and routine extractions	20%	60%	20%	60%
<b>Class C – Major Services*</b> Crowns, endodontics, and periodontics	50%	75%	6 month waiting period applies	
			50%	75%
<b>Class D – Orthodontic Services*</b> Must meet medical necessity	50%	50%	12 month waiting period applies	
			Not Covered	Not Covered
<i>Coinsurance</i> 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.				

Chorus Dental Standard SOB 2025 (Rev 2024.06.07)

PO Box 1997 • Milwaukee, WI 53201-1997 • Toll-free: 1-844-201-4672