CHORUS COMMUNITY HEALTH PLANS

Schedule of Benefits
Chorus Dental – Essential 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*	$75	$150	$75	$150
Family Deductible (3 or more members*)	$225	$450	$225	$450
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	$750	
Family Maximum Coverage Allowance	N/A	N/A	$1,500	
*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**
Class A – Preventive & Diagnostic Oral exam, teeth cleaning, x-rays	$0	50%	$0	50%
Class B – Basic Services Filings and routine extractions	50%	60%	Not Covered	Not Covered
Class C – Major Services* Crowns, endodontics, and periodontics	50%	75%	Not Covered	Not Covered
Class D – Orthodontic Services* Must meet medical necessity	50%	50%	Not Covered	Not Covered
Coinsurance listed above is the percentage *You* are responsible for after meeting *Your Deductible*.				
*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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