Christian Brothers Employee Benefit Trust Plan Option: Dental Plan A

Summary of Plan Benefits: What this Plan Covers & What it Costs

Plan Year 1/1-12/31 | Coverage Period: 1/1/23-12/31/23
Coverage for: Individual+Family | **Plan Type:** Dental

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the summary plan document at www.myCBS.org/health or by calling **1-800-852-4877**.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**Dental** None. **Orthodontia** Not Covered.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Your plan year is January 1 through December 31. Your **deductible** starts over each January 1. See the following chart for how much you pay for covered services after you meet the **deductible**. Your **deductible** does not apply to Preventive services.
Is there an overall annual limit on what the plan pays?	**Dental** Yes. $1,000	Your overall **annual limit** does not apply to Preventive services. The following chart describes limits on specific covered services.
Is there an overall lifetime limit on what the plan pays?	**Orthodontia** Not Covered.	The following chart describes limits on specific covered services.
Does this plan use a network of providers?	Yes. Your network is Aetna Dental Administrators. See myCBS.org/dental for a list of dental participating providers.	If you use an in-network **provider**, this plan will pay some or all of the costs of covered services based on the following schedule. If you choose to use an out-of-network provider, you may be balance billed for any charges above the prevailing charges or above the allowable **co-insurance** for that service.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on following chart. See your summary plan document for additional information about **excluded services**.

Common Dental Event	Services You May Need	Your Cost If You Use an In-Network Provider	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
Preventive Dental	Oral exam	20% **Coinsurance**	20% **Coinsurance**	Limited to two exams per year.
	Emergency exam	20% **Coinsurance**	20% **Coinsurance**	Limited to exam and x-ray only. No other treatment is allowed at time of emergency exam.
	X-rays	20% **Coinsurance**	20% **Coinsurance**	Frequency limits apply.

Questions: Call **1-800-852-4877** or visit us at www.myCBS.org/health or email at hbscustomerservice@cbservices.org. If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.myCBS.org/health or call **1-800-852-4877** to request a copy.

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Common Dental Event	Services You May Need	Your Cost If You Use an In-Network Provider	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
	Prophylaxis (cleaning) and Fluoride treatment	20% **Coinsurance**	20% **Coinsurance**	Limited to one cleaning every 6 months per year. Limited to one fluoride treatment every 6 months per year for children under 16. Benefits will be paid at the Preventive Dental level of benefits. If you are being treated for a serious medical condition, you may be eligibile for an additional cleaning or fluoride treatment. Your medical doctor must submit documentation to the Plan for Pre-Approval.
	Sealants	20% **Coinsurance**	20% **Coinsurance**	Limited to one application per surface per 24 months for children under 16 for first and second permanent molars only.
Basic Dental	Fillings	20% **Coinsurance**	20% **Coinsurance**	Relacement of fillings limited to once per surface every 24 months unless there is further decay.
	Stainless steel crown for children	20% **Coinsurance**	20% **Coinsurance**	Limited to 5 years from last placement for children under 16.
	Extraction of teeth	20% **Coinsurance**	20% **Coinsurance**	None.
	Oral Surgery	20% **Coinsurance**	20% **Coinsurance**	None.
	Periodontal services	20% **Coinsurance**	20% **Coinsurance**	Frequency limits apply.
	Endodontic services	20% **Coinsurance**	20% **Coinsurance**	None.
	General anesthesia	20% **Coinsurance**	20% **Coinsurance**	Limited to complex oral surgery.
	Repairs to bridges or dentures	20% **Coinsurance**	20% **Coinsurance**	None.
	Relining or rebasing of dentures	20% **Coinsurance**	20% **Coinsurance**	Frequency limits apply.
Major Dental	Inlays/onlays and replacements	50% **Coinsurance**	50% **Coinsurance**	Limited to 5 years from last placement.
	Crowns	50% **Coinsurance**	50% **Coinsurance**	Limited to 5 years from last placement.
	Implant services	50% **Coinsurance**	50% **Coinsurance**	**Initial placement** limited to extractions while on the plan. **Replacements** limited to 5 years from last placement.

Common Dental Event	Services You May Need	Your Cost If You Use an In-Network Provider	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
	Fixed bridges & full or partial dentures	50% <u>**Coinsurance**</u>	50% <u>**Coinsurance**</u>	**Initial placement** limited to extractions while on the plan. **Replacements** limited to 5 years from last placement.
	Temporomandibular Joint Disorders (TMJ)	Not Covered	Not Covered	None.
Orthodontia	Formal, full-banded retention and treatment	Not Covered	Not Covered	None.
	X-rays	Not Covered	Not Covered	None.
	Other diagnostic procedures	Not Covered	Not Covered	None.
	Removable or fixed appliances for tooth or bony structure guidance or retention	Not Covered	Not Covered	None.

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other <u>excluded services</u>.)

- Cosmetic services
- Occlusal analysis or adjustment
- Oral hygiene instruction
- Fluoride treatments (Adults)
- Services to alter vertical dimension
- Duplication or replacing lost or stolen prosthetics
- Nitrous
- Temporary services
- Non-emergency service performed outside USA.
- Cancer Screening
- TMJ (Temporomandibular Joint Disorder)

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

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