Christian Brothers Employee Benefit Trust Plan Option:Dental Plan I

Coverage Period: 01/01/2024 - 12/31/2024

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

Coverage for: Individual+Family | **Plan Type:** Dental .

This is only a summary. If you want more detail about your coverage and costs, call **1-800-852-4877.** or visit us at www.myCBS.org/health or email at hbscustomerservice@cbservices.org.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**Dental** $50 Individual / $150 Family **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. $2,000	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	No Charge.	No Charge.	Limited to two exams per year.
	Emergency exam	No Charge.	No Charge.	Limited to exam and x-ray only. No other treatment is allowed at time of emergency exam.
	X-rays	No Charge.	No Charge.	Frequency limits apply.
	Prophylaxis (cleaning) and Fluoride treatment	No Charge.	No Charge.	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

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
				benefits. If you are being treated for a serious medical condition, you may be eligible for an additional cleaning or fluoride treatment. Your medical doctor must submit documentation to the Plan for Pre-Approval.
	Sealants	No Charge.	No Charge.	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	Replacement of fillings limited to once per surface per 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.
	Fixed bridges & full or partial dentures	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
	Temporomandibular Joint Disorders (TMJ)	50% coinsurance	50% coinsurance	Preapproval is required. See other covered services.
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 Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Cancer screening
- Cosmetic Services
- Duplication or replacement of lost or stolen prosthetics
- Fluoride treatments (Adult)
- Nitrous
- Non-emergency service performed outside USA
- Occlusal analysis or adjustment
- Oral hygiene instruction
- Services to alter vertical dimension
- Temporary services

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Temporomandibular Joint Disorders (TMJ) limited to oral appliances used for treatment of TMJ.