

Christian Brothers Employee Benefit Trust Plan Option:Dental Plan A

Coverage Period: 01/01/2025 - 12/31/2025

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 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		Limitations & Exceptions
		In-Network Provider	Out-of-Network Provider	
Preventive Dental	Oral exam	20% <u>coinsurance</u>	20% <u>coinsurance</u>	Limited to two exams per year.
	Emergency exam	20% <u>coinsurance</u>	20% <u>coinsurance</u>	Limited to exam and x-ray only. No other treatment is allowed at time of emergency exam.
	X-rays	20% <u>coinsurance</u>	20% <u>coinsurance</u>	Frequency limits apply.
	Prophylaxis (cleaning) and Fluoride treatment	20% <u>coinsurance</u>	20% <u>coinsurance</u>	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

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.

Christian Brothers Employee Benefit Trust Plan Option:Dental Plan A

Coverage Period: 01/01/2025 - 12/31/2025

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

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

Common Dental Event	Services You May Need	Your Cost If You Use an		Limitations & Exceptions
		In-Network Provider	Out-of-Network Provider	
				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	20% <u>coinsurance</u>	20% <u>coinsurance</u>	Limited to one application per surface per 24 months for children under 16 for first and second permanent molars only.
Basic Dental	Fillings	20% <u>coinsurance</u>	20% <u>coinsurance</u>	Replacement of fillings limited to once per surface per 24 months unless there is further decay.
	Stainless steel crown for children	20% <u>coinsurance</u>	20% <u>coinsurance</u>	Limited to 5 years from last placement for children under 16.
	Extraction of teeth	20% <u>coinsurance</u>	20% <u>coinsurance</u>	None.
	Oral Surgery	20% <u>coinsurance</u>	20% <u>coinsurance</u>	None.
	Periodontal services	20% <u>coinsurance</u>	20% <u>coinsurance</u>	Frequency limits apply.
	Endodontic services	20% <u>coinsurance</u>	20% <u>coinsurance</u>	None.
	General anesthesia	20% <u>coinsurance</u>	20% <u>coinsurance</u>	Limited to complex oral surgery.
	Repairs to bridges or dentures	20% <u>coinsurance</u>	20% <u>coinsurance</u>	None.
	Relining or rebasing of dentures	20% <u>coinsurance</u>	20% <u>coinsurance</u>	Frequency limits apply.
Major Dental	Inlays/onlays and replacements	50% <u>coinsurance</u>	50% <u>coinsurance</u>	Limited to 5 years from last placement.
	Crowns	50% <u>coinsurance</u>	50% <u>coinsurance</u>	Limited to 5 years from last placement.
	Implant services	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.
	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.

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.

Christian Brothers Employee Benefit Trust Plan Option:Dental Plan A

Coverage Period: 01/01/2025 - 12/31/2025

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

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

Common Dental Event	Services You May Need	Your Cost If You Use an		Limitations & Exceptions
		In-Network Provider	Out-of-Network Provider	
	Temporomandibular Joint Disorders (TMJ)	50% <u>coinsurance</u>	50% <u>coinsurance</u>	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 <u>Plan</u> Generally Does NOT Cover (Check your policy or <u>plan</u> document for more information and a list of any other <u>excluded services</u> .)		
<ul style="list-style-type: none"> • Cancer screening • Cosmetic Services • Duplication or replacement of lost or stolen prosthetics • Fluoride treatments (Adult) 	<ul style="list-style-type: none"> • Nitrous • Non-emergency service performed outside USA • Occlusal analysis or adjustment • Oral hygiene instruction 	<ul style="list-style-type: none"> • 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 <u>plan</u> document.)		
<ul style="list-style-type: none"> • Temporomandibular Joint Disorders (TMJ) limited to oral appliances used for treatment of TMJ. 		

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.