# TRS-Care Dental Plan Summary insured by MetLife

## Monthly Premiums

The following monthly costs are effective January 1, 2027, through December 31, 2027. TRS will deduct your premium from your annuity payment. If your annuity does not cover the premium, you will receive a monthly bill. The monthly costs shown below for "Retiree + Child(ren)" and "Retiree + Family" include the cost for all eligible children.

| | | | |
|---|---|---|---|
| Retiree Only | $41.64 | Retiree + Child(ren) | $87.45 |
| Retiree + Spouse | $83.29 | Retiree + Family | $129.93 |

## Network: MetLife Preferred Dentist Program (PDP) Plus

| | In-Network[1]<br>% of Negotiated Fee[2] |
|---|---|
| **Coverage Type** | |
| **Type A[3]: Preventive**<br>(for example: cleanings, exams) | 100% |
| **Type B[3]: Basic**<br>(for example: fillings, sealants) | 70% |
| **Type C[3]: Major**<br>(for example: bridges, extractions, dentures) | 50% |
| **Deductible† [3]** | |
| Individual | $50 |
| Family | $150 Aggregate |
| **Annual Maximum Benefit [3]** | |
| Per Person | $1,500 |
| **Incentive Provisions** | Receiving 2 exams and cleanings in the plan year will result in an Annual Maximum increase of $250 in the following year: subject to a total Annual Maximum increase of $500 |

**Child(ren)'s eligibility**: A child is covered up to age 26.



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Check with your Out-of-Network provider for costs before receiving services. Your out-of-pocket costs may be higher.

| | Out-of-Network[1]<br>% of Maximum Allowable Charge* (MAC)[4] |
|---|---|
| **Coverage Type** | |
| **Type A[3]: Preventive**<br>(for example: cleanings, exams) | 100% of MAC |
| **Type B[3]: Basic**<br>(for example: fillings, sealants) | 70% of MAC |
| **Type C[3]: Major**<br>(for example: bridges, extractions, dentures) | 50% of MAC |
| **Deductible† [3]** | |
| Individual | $50 |
| Family | $150 Aggregate |
| **Annual Maximum Benefit [3]** | |
| Per Person | $1,500 |
| **Incentive Provisions** | Receiving 2 exams and cleanings in the plan year will result in an Annual Maximum increase of $250 in the following year: subject to a total Annual Maximum increase of $500 |

**Child(ren)'s eligibility**: A child is covered up to age 26.

[1] "In-Network Benefits" refers to benefits provided under this plan for covered dental services that are provided by a participating dentist. "Out-of-Network Benefits" refers to benefits provided under this plan for covered dental services that are not provided by a participating dentist.

[2]Negotiated fees refer to the fees that in-network dentists have agreed to accept as payment in full for certain services, subject to any copayments, deductibles, cost sharing and benefits maximums. Negotiated fees are subject to change. Negotiated fees do not apply to non-covered services in states that prohibit limitations for services not covered under a plan. Participating providers in these states may charge their non-negotiated fees for non-covered services.

[3]Your plan includes incentive provisions. Deductibles, plan maximums and/or co-insurance percentages may differ by plan member.

[4]**Out-of-network:** Reimbursement for out-of-network services is based on the lesser of the dentist's actual fee or the Maximum Allowable Charge (MAC). *The out-of-network MAC is a scheduled amount determined by MetLife. For Alaska and Montana residents, the out-of-network reimbursement will be the 70th percentile due to Extraterritorial limits. Your out-of-pocket costs may be higher.

†Applies only to Type B & C Services.




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# TRS-Care Dental Plan Summary insured by MetLife

## List of Primary Covered Services & Limitations*

The service categories and plan limitations shown represent an overview of your Plan Benefits. This document presents the majority of services within each category, but is not a complete description of the Plan.

*If Dentally Necessary, You and Your Dependents may be eligible for additional dental treatment if diagnosed with one or more specified medical conditions. Please see the Description of Covered Services section of the Certificate of Insurance for additional details. You may view the Certificate of Insurance after enrollment at metlife.com/mybenefits.

| Plan Type | How Many/ and How Often |
|---|---|
| **Type A — Preventive** | |
| Prophylaxis (cleanings) | Two per calendar year |
| Oral Examinations | Two exams per calendar year |
| Topical Fluoride Applications | One fluoride treatment per 12 months for dependent children up to their 16th birthday |
| X-rays | Full mouth X-rays; one per 60 months<br>Bitewings X-rays; one set per calendar year |
| Periodontal Maintenance | 4 Perio treatments in 1 calendar year – only with a periodontal disease diagnosis, Includes 2 additional cleanings (total comb: 4) |
| Labs & Other Tests | |
| **Type B — Basic Restorative** | |
| Fillings | 1 per tooth surface per 24 months |
| Emergency Palliative Treatment | |
| Other X-rays | Other X-rays not covered under preventative |
| Space Maintainers | Space maintainers for dependent children up to their 16th birthday, once per tooth per lifetime. |
| Sealants | One application of sealant material every 60 months for each non-restored, non-decayed 1st and 2nd molar of a dependent child up to their 16th birthday |
| **Type C — Major Restorative** | |
| Simple Extractions | |




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| | |
|---|---|
| Crown, Denture and Bridge Repair/ Recementations | Repairs once per 12 months<br>Recementations once per 12 months |
| Oral Surgery | |
| Periodontics | |
| Implants | Replacement once every 10 calendar years |
| Bridges and Dentures | Initial placement to replace one or more natural teeth<br><br>Dentures and bridgework replacement; one every 10 calendar years<br><br>Replacement of an existing temporary full denture if the temporary denture cannot be repaired and the permanent denture is installed within 12 months after the temporary denture was installed |
| Crowns, Inlays and Onlays | Replacement once every 10 calendar years |
| Endodontics | Root canal treatment limited to once per tooth per lifetime |
| General Anesthesia | When dentally necessary in connection with oral surgery, extractions, or other covered dental services |

The service categories and plan limitations shown above represent an overview of your plan benefits. This document presents the majority of services within each category, but is not a complete description of the plan.

## Exclusions

**This plan does not cover the following services, treatments and supplies:**

- Services which are not Dentally Necessary, those which do not meet generally accepted standards of care for treating the particular dental condition, or which we deem experimental in nature;
- Services for which you would not be required to pay in the absence of Dental Insurance;
- Services or supplies received by you or your Dependent before the Dental Insurance starts for that person;
- Services which are primarily cosmetic (for Texas residents, see notice page section in the Certificate of Insurance);
- Services which are neither performed nor prescribed by a Dentist except for those services of a licensed dental hygienist which are supervised and billed by a Dentist and which are for:
  - Scaling and polishing of teeth; or
  - Fluoride treatments;
- Services or appliances which restore or alter occlusion or vertical dimension;




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- Restoration of tooth structure damaged by attrition, abrasion or erosion unless caused by disease;
- Restorations or appliances used for the purpose of periodontal splinting;
- Counseling or instruction about oral hygiene, plaque control, nutrition and tobacco;
- Personal supplies or devices including, but not limited to water picks, toothbrushes, or dental floss;
- Decoration, personalization or inscription of any tooth, device, appliance, crown or other dental work;
- Missed appointments;
- Services:
  - Covered under any workers' compensation or occupational disease law;
  - Covered under any employer liability law;
  - For which the employer of the person receiving such services is not required to pay; or
  - Received at a facility maintained by the Policyholder, labor union, mutual benefit association, or Veteran's Affairs (VA) hospital;
- Services covered under other coverage provided by the Policyholder;
- Temporary or provisional restorations;
- Temporary or provisional appliances;
- Prescription drugs;
- Services for which the submitted documentation indicates a poor prognosis;
- Services, to the extent such services, or benefits for such services, are available under a government plan. This exclusion will apply whether or not the person receiving the services is enrolled for the government plan. We will not exclude payment of benefits for such services if the government plan requires that Dental Insurance under the group policy be paid first.
- The following when charged by the Dentist on a separate basis:
  - Claim form completion;
  - Infection control such as gloves, masks, and sterilization of supplies; or
  - Local anesthesia, non-intravenous conscious sedation or analgesia such as nitrous oxide.
- Dental services arising out of accidental injury to the teeth and supporting structures, except for injuries to the teeth due to chewing or biting of food;
- Caries susceptibility tests;
- Precision attachments, except when the precision attachment is related to implant prosthetics;
- Adjustment of a Denture made within 6 months after installation by the same Dentist who installed it;
- Orthodontia services or appliances;
- Fixed and removable appliances for correction of harmful habits;




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- Appliances or treatment for bruxism (grinding teeth), including but not limited to occlusal guards and night guards;
- Diagnosis and treatment of temporomandibular joint (TMJ) disorders;
- Repair or replacement of an orthodontic device;
- Duplicate prosthetic devices or appliances;
- Replacement of a lost or stolen appliance, Cast Restoration, or Denture; and
- Intra and extraoral photographic images

## Limitations

**Alternate Benefits:** Where two or more professionally acceptable dental treatments for a dental condition exist, payment is based on the least costly treatment alternative. If you and your dentist have agreed on a treatment that is more costly than the treatment upon which the plan benefit is based, you will be responsible for any additional payment responsibility. To avoid any misunderstandings, we suggest you discuss treatment options with your dentist before services are rendered, and obtain a pre-treatment estimate of benefits prior to receiving certain high-cost services such as crowns, bridges, or dentures. You and your dentist will each receive an Explanation of Benefits (EOB) outlining the services provided, your plan's payment for those services, and your out-of-pocket expense. Actual payments may vary from the pretreatment estimate depending upon annual maximums, plan frequency limits, deductibles, and other limits applicable at time of payment.

**Cancellation/Termination of Benefits:** Coverage is provided under a group insurance policy (Policy form GPNP99) issued by Metropolitan Life Insurance Company (MetLife). Coverage terminates when your participation ceases, when your dental contributions cease or upon termination of the group policy by the Policyholder or MetLife. The group policy terminates for non-payment of premium and may terminate if the Policyholder fails to perform any obligations under the policy. The following services that are in progress while coverage is in effect will be paid after the coverage ends, if the applicable installment or the treatment is finished within 31 days after individual termination of coverage: Completion of a prosthetic device, crown or root canal therapy.

Group dental insurance policies featuring the Preferred Dentist Program are underwritten by Metropolitan Life Insurance Company, New York, NY 10166.

Like most group benefits programs, benefit programs offered by MetLife and its affiliates contain certain exclusions, exceptions, waiting periods, reductions, limitations and terms for keeping them in force. You may be financially responsible for copayments, deductibles, or any other amounts in excess of those MetLife is required to pay for covered services as described in your dental certificate and/or policy. Ask your MetLife representative for costs and complete details.




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# TRS-Care Dental Plan Summary insured by MetLife

## Questions & Answers

### Q. Who is a participating dentist?

**A.** A participating dentist is a general dentist or specialist who has agreed to accept negotiated fees as payment in full for covered services provided to plan members. Negotiated fees typically range from 30% – 45% below the average fees charged in a dentist's community for the same or substantially similar services.†

### Q. How do I find a participating dentist?

**A.** Our network has thousands of general dentists and specialists to choose from nationwide, so you are sure to find one who meets your needs. You can get a list of these participating dentists online at www.metlife.com/mybenefits or call 1-855-488-0522 to ask for a faxed or mailed list.

### Q. What services does this plan cover?

**A.** The Plan documents list the services your plan covers. The List of Primary Covered Services & Limitations in the document contains a summary of covered services. In the event of a conflict between the Plan documents and this summary, the terms of the Plan documents shall govern.

### Q. May I choose a non-participating dentist?

**A.** Yes. You are free to select the dentist of your choice. However, if you choose a non-participating dentist, your out-of-pocket costs may be higher.

### Q. Can my dentist apply for participation in the network?

**A.** Yes. If your current dentist does not participate in the network and you want to encourage them to apply, ask your dentist to visit www.metdental.com, or call 1-866-PDP-NTWK for an application.†† The website and phone number are for use by dental professionals only.

### Q. What are incentive provisions?

**A.** The TRS-Care Dental incentive provision will increase the annual maximum by $250 the following year if you receive two exams and cleanings in the year prior. The total annual maximum increase is $500. As long as you stay in the plan, you will stay at the increased maximum.

### Q. How are claims processed?

**A.** Dentists may submit your claims for you which means you have little or no paperwork. You can track your claims online and even get email alerts when they process your claim. If you need a claim form, visit www.metlife.com/mybenefits or request one by calling 1-855-488-0522.



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### Q. Can I get an estimate of my out-of-pocket expenses before getting a service?

**A.** Yes. You can ask for a pretreatment estimate. Your general dentist or specialist usually sends MetLife a plan for your care and requests an estimate of benefits. The estimate helps you prepare for the cost of dental services. We recommend that you request a pretreatment estimate for services that cost more than $300.

Ask your dentist to submit a request at www.metdental.com or call 1-877-MET-DDS9. You and your dentist will get a benefit estimate for most procedures while you're still in the office. Actual payments may vary depending upon plan maximums, deductibles, frequency limits and other conditions at time of payment.

### Q. Can MetLife help me find a dentist outside of the U.S. if I am traveling?

**A.** Yes. Through international dental travel assistance services* you can get a referral to a local dentist by calling +1-312-356-5970 (collect). Such coverage is considered out-of-network. **Please remember to keep all receipts to submit your dental claim.

### Q. How does MetLife coordinate benefits with other insurance plans?

**A.** Coordination of benefits provisions in dental benefits plans are a set of rules that are followed when a patient is covered by more than one dental benefits plan. These rules determine the order in which the plans will pay benefits. If the MetLife dental benefit plan is primary, MetLife will pay the full amount of benefits that would normally be available under the plan, subject to applicable law. If the MetLife dental benefit plan is secondary, most coordination of benefits provisions require MetLife to determine benefits after benefits have been determined under the primary plan. The amount of benefits payable by MetLife may be reduced due to the benefits paid under the primary plan, subject to applicable law.

### Q. Do I need an ID card?

**A.** No. You do not need to present an ID card to confirm that you are eligible. You should notify your dentist that you are enrolled in the MetLife Preferred Dentist Program. Your dentist can easily verify information about your coverage through a toll-free automated Computer Voice Response system.

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†Based on internal analysis by MetLife. Negotiated fees refer to the fees that in-network dentists have agreed to accept as payment in full for certain services, subject to any copayments, deductibles, cost sharing and benefits maximums. Negotiated fees are subject to change. Negotiated fees do not apply to non-covered services in states that prohibit limitations for services not covered under a plan. Participating providers in these states may charge their non-negotiated fees for non-covered services.

††Due to contractual requirements, MetLife is prevented from soliciting certain providers.

*AXA Assistance USA, Inc. provides Dental referral services only. AXA Assistance is not affiliated with MetLife, and



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the services and benefits they provide are separate and apart from the insurance provided by MetLife. Referral services are not available in all locations. Exclusions: The AXA Travel Assistance Program is available for participants in traveling status. Whenever a trip exceeds 120 days, the participant is no longer considered to be in traveling status and is therefore no longer eligible for the services. Also, AXA Assistance USA will not evacuate or repatriate participants without medical authorization; with mild lesions, simple injuries such as sprains, simple fractures or mild sickness which can be treated by local doctors and do not prevent the member from continuing his/her trip or returning home; or with infections under treatment and not yet healed. Benefits will not be paid for any loss or injury that is caused by or is the result from: pregnancy and childbirth except for complications of pregnancy, and mental and nervous disorders unless hospitalized. Reimbursements for non-medical services such as hotel, restaurant, taxi expenses or baggage loss while traveling are not covered. The maximum benefit per person for costs associated with evacuations, repatriations or the return of mortal remains is US$500,000. Treatment must be authorized and arranged by AXA Assistance's designated personnel to be eligible for benefits under this program. All services must be provided and arranged by AXA Assistance USA, Inc. No claims for reimbursement will be accepted.

**Refer to your dental benefits plan summary for your out-of-network dental coverage.

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