TakeCare℠
A TanHoldings Company

2027 Non-PSHB Supplemental Dental Package

TakeCare is pleased to continue offering its popular Supplemental Dental Plan to TakeCare PSHB Members for Benefit Year 2027 with **enhanced benefits!**

As a valued member, you'll enjoy a wide range of benefits for a lot less cost. Here are some reasons you should sign up for the TakeCare Supplemental Dental Plan.*

**The TakeCare Supplemental Dental Plan is a non-PSHB benefit and not offered outside of the annual Open Season period.*

Coverage Highlights

- **Expanded Basic Restorative Coverage for 2027!**
- **100% coverage for eligible services through TakeCare's Expanded Philippine Dental Network**
- **Orthodontia coverage of Phase II, children to age 17, up to $1,500 per person per lifetime**
- **Annual Benefit Maximum of $1,500 with additional $500 at FHP Dental Center**

Coordinating Benefits

TakeCare will coordinate benefits if you have another TakeCare Dental Plan. You have the full combined benefits of both plans.

Hassle Free Payments

A requirement for the 2027 Supplemental Dental Plan is automatic payments from your checking, savings account, or credit card. For details, see the payment section of the Dental Application and Direct Payment form. Choose monthly premium payments, or save money by choosing to pay a one-time annual premium amount.

Easy to sign up

Fill out the Supplemental Dental Application and Direct Payment form and email to membership accounting services at mas@takecareasia.com, or fax to **671-647-3544 or 671-647-3542**. **Last day to enroll is December 14, 2026.**

2027 Supplemental Dental Premiums

Self Only (monthly)	$41.90	Self Only (annually)	$496.90
Self Plus One (monthly)	$83.79	Self Plus One (annually)	$993.80
Self and Family (monthly)	$132.67	Self and Family (annually)	$1573.52

Supplemental Dental Coverage

This is a summary only. Please refer to Dental Schedule of Benefits (Dental 8850 1500 FS) for a full listing of benefits, limitations, and exclusions.

Supplemental Dental Benefits	Member Pays	
Covered Services	In Network	Out of Network
Deductible	Nothing	Nothing
Basic Restorative Routine fillings, including silver amalgam and composite resin restorations (anterior and posterior).	20% of eligible charges	50% of our allowance plus difference between our allowance and billed charges.
Major Restorative Porcelain, ceramic and/or resin/resin metal and/or gold crowns, and bridges, plastic/stainless steel crowns and space maintainers. Occlusal guards are not covered.	50% of eligible charges	70% of our allowance plus difference between our allowance and billed charges.
Oral and Maxillofacial Surgery ▪ Simple non-surgical extractions of fully erupted teeth (includes anesthesia, suturing, routine follow up). Extractions solely for the purposes of orthodontic treatment are not covered. ▪ Oral surgery for impacted teeth and complicated extractions. **Endodontics** Complete root canal therapy (including pulpectomy and intra-operative radiographs), pulpotomy and pulpal therapy. **Periodontics** Consultation, evaluation and treatment of the soft tissue and pones supporting the teeth, subgingival curettage, gross scaling (excessive calculus removal), subgingival scaling and root planning, periodontal maintenance (applicable only to member undergoing or member who completed periodontal treatment) and periodontal surgery.	20% of eligible charges	50% of our allowance plus difference between our allowance and billed charges.
Prosthodontics, Removable and Fixed Full and partial dentures, denture retainers and repairs, relining and/or reconstruction of dentures.	50% of eligible charges	70% of our allowance plus difference between our allowance and billed charges.
Maxillofacial Prosthetics & Implant Services	Not Covered	Not Covered
Adjunctive General Services **Anesthesia** ▪ Deep sedation/general anesthesia. ▪ Nitrous oxide or analgesia (laughing gas/conscious sedation) for members under 13 years old. ▪ All anesthesia limited to one (1) dose per member per procedure. **Emergency** ▪ Palliative treatment of dental pain ▪ Fixed partial denture sectioning	20% of eligible charges	70% of our allowance plus difference between our allowance and billed charges.
Orthodontics Coverage only applies to orthodontic treatment received during Phase II or the active treatment phase after banding has occurred and applies to children up to the age of 17. Orthodontic consults, extractions, study models, records, diagnostic fees, x-rays and appliances installed wile under a non-TakeCare dental plan are not covered.	All charges above $1,500 per member per lifetime.	Not Covered
Prescription Drugs Coverage is limited to prescription drugs dispensed at the pharmacy located at FHP Health Center.	50% of eligible charges	Not Covered
Dental Coverage in the Philippines Your cost share (coinsurance) is waived for covered services when using in-network dental providers in the Philippines. Prior authorization required.	100% covered	Not Covered
Dental Plan Maximum	The plan will pay a maximum benefit of $1,500 per member per year with an additional $500 at FHP Dental Center.	

Exclusions and Limitations

General Exclusions

The following services and plan exclusions are not covered by TakeCare. Member is responsible for all related charges for:

A. (1) All services not specifically included in the "Schedule of Benefits". (2) Services received prior to a member's start date of coverage or after the time coverage ends.

B. TakeCare is not responsible for the cost of services rendered by a non-participating dentist when the member has refused treatment provided or authorized through a member's primary dentist.

C. TakeCare is not responsible for the cost of services, which are not necessary or not required in accordance with professionally recognized standards of dental practice.

Plan Exclusions

- All hospital costs and additional fees charged by the dentist for hospital treatment.
- Cultures and/or histologic tests.
- Dental services which are provided to the eligible patient by any federal, local or state government agency or program.
- Experimental procedures.
- Extraction, study models and X-rays solely for orthodontic purposes.
- Extra-oral grafts, implants of any kind including component parts (including but not limited to abutment attachments and special or additional screws).
- Implant related restorative services, procedures and supplies.
- General anesthetic, conscious sedation and other forms of relative analgesia including, but not limited to, sedation and oral pre-medication except as provided for in the Schedule of Benefits.
- Oral surgical procedures including, but not limited to, surgical extraction of erupted teeth, impacted teeth and unerupted teeth (including third molars (wisdom teeth).
- Prescription and over-the-counter drugs except as provided for in the Schedule of Benefits.
- Fees for missed appointments and for copies of or transfer of dental records (including x-rays).
- Procedures, appliances or restorations necessary to increase vertical dimensions and/or restore or maintain the occlusion. Such procedures include, but are not limited to, full mouth rehabilitation, equilibration, periodontal splinting, restoration of tooth structure lost from attrition and restoration for malalignment of the teeth.
- Prosthodontic services or devices (including crowns and bridges) of any single procedure started prior to the date the patient became eligible for such services under this Policy.
- Replacement of lost or stolen dentures, bridges or other dental appliances.
- Services with respect to congenital or developmental malformations or cosmetic surgery or dentistry for purely cosmetic reasons including, but not limited to, cleft palate, maxillary and mandibular malformation, and enamel hypoplasia, fluorosis and anodontia.
- Cosmetic dentistry including, but not limited to, bleaching, veneers and posterior composites unless specified as covered in your Schedule of Benefits.
- Temporomandibular joint (jaw) dysfunction and other related diseases.
- Orthognathic surgery and other related services.
- Orthodontia except as provided for in the Schedule of Benefits and the Plan Limitations.
- Treatment and/or removal of oral tumors, treatment of traumatic injuries except of the teeth and adjacent soft tissues as provided in covered benefits.
- Work-related injuries.
- Benefits and services not specified as covered.
- Special orthodontic appliances including but not limited to Invisalign® and Fastbraces®.

Plan Exclusions continued

- Any orthodontic appliances, services or treatment received prior or after eligible member's benefit coverage.
- Any restoration done by the same dentist or dental office on the same tooth within twelve (12) months after the insertion of any crown.
- Replacement of any restoration on the same tooth and surface within twenty-four (24) months.
- Treatment not conforming to accepted dental standards..

Plan Limitations

The following are limitations of the benefit provided by this plan:

- Complete mouth x-rays are covered only once in a three (3) year period unless additional services are approved and authorized by TakeCare. One (1) panoramic , two (2) periapical, and four (4) bitewing x-rays will be considered a full mouth series.
  Supplementary bitewing x-rays are provided upon request but no more than once every six (6) months unless specified as covered in your Schedule of Benefits..
- Prophylaxis (routine teeth cleaning) and fluoride are limited to twice a year, once every six (6) months unless specified as covered in your Schedule of Benefits.
- Crowns, jackets and gold restorations are covered only when other restorative material will not result in an adequate restoration. Replacement will be made only after five (5) years have elapsed following any prior provision of crowns, jackets or gold restorations under a TakeCare plan as provided for in the Schedule of Benefits.
- Prosthodontic appliances (including, but not limited to fixed bridges, partial or complete dentures) will be replaced only after five (5) years have elapsed following any prior provisions of such appliances under any TakeCare plan, except when the plan determines that there is such extensive loss of remaining teeth or change in supporting tissues that the existing appliance cannot be made satisfactory as provided for in the Schedule of Benefits.
- In all cases in which the member selects a more expensive plan of treatment than is customarily provided, the plan will pay the applicable percentage of the lesser fee. The member is responsible for the remainder of the dentist's fees.
- Posterior resin restorations are not a covered benefit. An allowance for a comparable amalgam restoration will be made. The difference in fees is the member's responsibility. Resin restorations on the facial/cervical surface of any posterior teeth are payable as one (1) surface anterior restoration unless specified as covered in your Schedule of Benefits.
- In the event that more than one (1) dentist furnishes services for one (1) dental procedure, the plan shall pay not more than its liability had one (1) dentist furnished all of the services.
- The orthodontic benefit is limited to the active orthodontic treatment phase only and applies only to children up to the age of seventeen (17) years who become new orthodontic patients under the TakeCare plan. The benefit does not apply to members whose appliances were installed while under a non-TakeCare dental plan.
- The orthodontic benefit will be equally paid during the active treatment period while the member is still eligible under the TakeCare plan. An orthodontic treatment plan together with valid payment receipt for the treatment must be submitted with the reimbursement form to be eligible for coverage.

Please call the TakeCare Customer Service Department at (671) 674-3526 or via email at customerservice@takecareasia.com for any Benefit, Plan Limitation, or Plan Exclusion clarification.

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Supplemental Dental* 2027

Application and Direct Payment Form

***You and your dependent must be enrolled in the PSHB TakeCare High Option, Standard Option, or HDHP Option to be eligible for the TakeCare Supplemental Dental Plan.**

Last Name _____ First Name _____ M.I. _____ Social Security _____ Date of Birth _____

Mailing Address (P.O. Box/Street) _____ State _____ Zip Code _____

❒ Male ❒ Female

Home Telephone Number _____ Work Telephone Number _____ Email _____

Please indicate below the name of your dental insurance, if you or any of your dependent(s) have other coverage:

❒ _____ Effective Date / /

❒ _____ Effective Date / /

Please list yourself and all family members you wish covered under the Supplemental Dental Plan:

LAST NAME	FIRST NAME	M.I.	SOCIAL SECURITY	RELATION	SEX	D.O.B.	TAKECARE USE ONLY

I understand that TakeCare reserves the right to refuse participation by any applicant in the plan and is not obligated to provide a reason for declining coverage. I further understand that application does not guarantee acceptance into the plan; acceptance of coverage is not granted, under any circumstances, until the application has been approved by TakeCare. Note: *The Supplemental Dental benefits described in the TakeCare PSHB brochure are neither offered nor guaranteed under the contract with the PSHB Program, but are made available to all PSHB enrollees and family members who are members of the TakeCare plan. The cost of the benefits for the supplemental dental plan is not included in the PSHB Premium.* ***Enrollment in the TakeCare Supplemental Dental Plan is locked-in for the benefit year.*** *Voluntary Disenrollment is only allowed during the plan year if I terminate employment with the US Postal Service or cancel my enrollment in the PSHB TakeCare High Option, Standard Option or HDHP Option.*

I (we) hereby authorize TakeCare Insurance Company, hereinafter called the **COMPANY**, to initiate monthly debit entries for a 12 month period (locked-in provision) to our **CHECKINGS**, **SAVINGS**, or **CREDIT CARD** account indicated below at the depository financial institution/credit card company named below, hereinafter called the **DEPOSITORY** or the **CREDIT CARD**, and to debit the same to such account by the 20th of the month. I (we) acknowledge the origination of Automated Clearing House (ACH) transactions to my (our) account must comply with U.S. law.

Monthly or Annual Payment (Select One)

❒ **$41.90 Self Only** Coverage Monthly ❒ **$83.79 Self Plus One** Coverage Monthly ❒ **$132.67 Self and Family** Coverage Monthly

❒ **$496.90 Self Only** Coverage Annually ❒ **$993.80 Self Plus One** Coverage Annually ❒ **$1573.52 Self and Family** Coverage Annually

Payment Method (Select one - Checking Account, Savings Account or Credit Card)

❒ CHECKING ACCOUNT ❒ SAVINGS ACCOUNT

(Attach voided copy of deposit slip or check if making changes from last plan year)

Financial Institution _____

Bank Routing Number _____

Account Number _____

❒ CREDIT CARD (Please indicate credit card): ❒ American Express ❒ Mastercard ❒ VISA

Credit Card #: _____ Exp. Date: _____ CVV#: _____

If the transaction is denied at any time, I understand 1) coverage may be suspended until past due amounts are paid in full and, 2) I will be contacted by TakeCare for an alternative payment method for the remainder of the 12-month policy period.

X _____ _____

Applicant's Signature Date