Scott & White Traditional Dental Plans - 2 to 99 Eligible Lives

Plan Name		Basic Plan	Mid Plan	High Plan
Plan Type		PPO	PPO	PPO
Deductible		$0 per person/$0 per family per calendar year	$0 per person/$0 per family per calendar year	$0 per person/$0 per family per calendar year
Annual Maximum		$500 per person	$750 per person	$1,000 per person
Preventive Care (cleanings, exams, bitewings)		100%	100%	100%
Basic Services (fillings, root canals, extractions)		50%	80%	80%
Major Services (crowns, bridges, dentures)		25%	50%	70%
Ortho (lifetime maximum)		Not Covered	Not Covered	Child Only, 50% to $500
Out-of-Network Reimbursement Level[1]		90th R&C	90th R&C	90th R&C
Rates Without Pediatric EHB	**Employee Only**	$21.10	$36.32	$46.43
	Employee + Spouse	$42.00	$72.56	$90.33
	Employee + Child(ren)	$56.26	$79.35	$92.35
	Family	$82.28	$121.69	$144.84
Rates With Pediatric EHB[2] **(2-50 Lives Only)**	**Employee Only**	$21.10	$36.32	$46.43
	Employee + Spouse	$42.00	$72.56	$90.33
	Employee + Child(ren)	$60.19	$84.91	$98.81
	Family	$86.39	$127.77	$152.08

Rates illustrated above are valid for effective dates 01/01/2024 to 12/31/2024

Groups must have a minimum of 2 enrolled lives

[1]Out of Network benefits are payable for services rendered by a dentist who is not a participating provider. The Reasonable and Customary charge is based on the lowest of (1) the dentist's actual charge (the 'Actual Charge'), (2) the dentist's usual charge for the same or similar services (the 'Usual Charge') or (3) the charge of most dentists in the same geographic area for the same or similar services as determined by MetLife (the 'Customary Charge'). Services must be necessary in terms of generally accepted dental standards.

[2]Plan summary shown above does not include a description of the EHB coverage. The EHB portion of the plan is described in the following pages.

Group dental insurance policies featuring the MetLife Preferred Dentist Program are underwritten by Metropolitan Life Insurance Company, 200 Park Avenue, New York, NY 10166.

Exclusions - High, Mid and Basic Plans
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 a covered person would not be required to pay in the absence of dental insurance.
Services or supplies received by a covered person before the insurance starts for that person.
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 or polishing of teeth or fluoride treatment.
Services which are primarily cosmetic unless required for the treatment or correction of a congenital defect of a newborn child.
Services or appliances which restore or alter occlusion or vertical dimension.
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 piks, toothbrushes, or dental floss.
Initial installation of a Denture to replace one or more teeth which were missing before such person was insured for Dental Insurance, except for congenitally missing natural teeth.
Decoration or inscription of any tooth, device, appliance, crown or other dental work.
Missed appointments.
Services covered under any workers' compensation or occupational disease law.
Services covered under any employer liability law.
Services for which the employer of the person receiving such services is not required to pay.
Services received at a facility maintained by the Policyholder, labor union, mutual benefit association, or 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 and biting of food.
Caries susceptibility tests.
Precision attachments associated with fixed and removable prostheses.
Adjustment of a denture made within 6 months after installation by the same dentist who installed it.
Duplicate prosthetic devices or appliances.
Replacement of a lost or stolen appliance, cast restoration or denture.
Intra and extraoral photographic images.
Fixed and removable appliances for correction of harmful habits.
Appliances or treatment for bruxism (grinding teeth), including but not limited to occlusal guards and night guards.
Implantology, including repairs.
Treatment of temporomandibular joint disorder. This exclusion does not apply to residents of Minnesota.
Pulp Capping.
Periodontal Maintenance.
Implant Supported Prosthetics.
Pulp Therapy
Periodontal Surgery.
Non-Surgical Periodontal services including Scaling and Root planning.
Orthodontia services or appliances. (does not apply to High Plan)
Repair or a replacement of an orthodontic appliance. (does not apply to High Plan)

Scott & White Value Dental Plans - 2 to 99 Eligible Lives

Plan Name		Value Plan 1	Value Plan 2	Value Plan 3	Value Plan 4	MET290
Plan Type		PPO	PPO	PPO	PPO	DHMO
Deductible		$50 per person/$150 per family per calendar year	$50 per person/$150 per family per calendar year	$50 per person/$150 per family per calendar year	$50 per person/$150 per family per calendar year	N/A
Annual Maximum		$500 per person	$1,000 per person	$1,500 per person	$1,500 per person	N/A
Preventive Care (cleanings, exams, bitewings)		100%	100%	100%	100%	See Copay Schedule in the Following Pages
Basic Services (fillings, consultations, extractions)		50%	80%	80%	80%	
Major Services (crowns, bridges, dentures)		0%	50%	50%	50%	
Ortho (lifetime maximum)		Not Covered	Not Covered	Not Covered	Adult & Child, 50% to $1,000	
Endodontics & Periodontics		Option 1	Option 3	Option 2	Option 2	N/A
		Option 1- Endodontics split between Basic and Major, Periodontics excluded Option 2 - Endodontics and Periodontics covered in Basic Option 3 - Endodontics and Periodontics covered in Major				
Out-of-Network Reimbursement Level[1]		90th R&C	90th R&C	90th R&C	90th R&C	N/A
Rates Without Pediatric EHB	**Employee Only**	$18.47	$39.61	$48.07	$50.47	$13.96
	Employee + Spouse	$36.75	$79.13	$93.53	$98.21	$26.54
	Employee + Child(ren)	$49.22	$86.55	$88.89	$100.84	$26.10
	Family	$71.99	$132.72	$142.16	$158.15	$41.22
Rates With Pediatric EHB[2] **(2-50 Lives Only)**	**Employee Only**	$18.47	$39.61	$48.07	$50.47	$13.96
	Employee + Spouse	$36.75	$79.13	$93.53	$98.21	$26.54
	Employee + Child(ren)	$52.67	$92.61	$95.11	$107.90	$27.93
	Family	$75.59	$139.35	$149.27	$166.06	$43.28

Rates illustrated above are valid for effective dates 01/01/2024 to 12/31/2024

Groups must have a minimum of 2 enrolled lives

[1]Out of Network benefits are payable for services rendered by a dentist who is not a participating provider. The Reasonable and Customary charge is based on the lowest of (1) the dentist's actual charge (the 'Actual Charge'), (2) the dentist's usual charge for the same or similar services (the 'Usual Charge') or (3) the charge of most dentists in the same geographic area for the same or similar services as determined by MetLife (the 'Customary Charge'). Services must be necessary in terms of generally accepted dental standards.

[2]Plan summary shown above does not include a description of the EHB coverage. The EHB portion of the plan is described in the following pages.

Exclusions - Value Plan 1
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 a covered person would not be required to pay in the absence of dental insurance.
Services or supplies received by a covered person before the insurance starts for that person.
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 or polishing of teeth or fluoride treatment.
Services which are primarily cosmetic unless required for the treatment or correction of a congenital defect of a newborn child.
Services or appliances which restore or alter occlusion or vertical dimension.
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 piks, toothbrushes, or dental floss.
Initial installation of a Denture to replace one or more teeth which were missing before such person was insured for Dental Insurance, except for congenitally missing natural teeth.
Decoration or inscription of any tooth, device, appliance, crown or other dental work.
Missed appointments.
Services covered under any workers' compensation or occupational disease law.
Services covered under any employer liability law.
Services for which the employer of the person receiving such services is not required to pay.
Services received at a facility maintained by the Policyholder, labor union, mutual benefit association, or 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 and biting of food.
Caries susceptibility tests.
Precision attachments associated with fixed and removable prostheses.
Adjustment of a denture made within 6 months after installation by the same dentist who installed it.
Duplicate prosthetic devices or appliances.
Replacement of a lost or stolen appliance, cast restoration or denture.
Intra and extraoral photographic images.
Fixed and removable appliances for correction of harmful habits.
Appliances or treatment for bruxism (grinding teeth), including but not limited to occlusal guards and night guards.
Implantology, including repairs.
Treatment of temporomandibular joint disorder. This exclusion does not apply to residents of Minnesota.
Space Maintenance.
Pulp Capping.
Periodontal Maintenance.
Cast restorations - including inlays, onlays crowns.
Implant Supported Prosthetics.
Repairs.
Crown Build-Ups - Post and Cores.
Pulp Therapy
Apexification and Recalcification.
Periodontal Surgery.
Non-Surgical Periodontal services including Scaling and Root planning.
Dentures, including complete, partial and Overdentures.
Denture Adjustments.
Relining and Rebasing.
Fixed Bridges.
General Anesthesia / IV Sedation.
Occlusal Adjustments.
Orthodontia services or appliances.
Repair or a replacement of an orthodontic appliance.

Exclusions - Value Plan 2, 3 and 4
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 a covered person would not be required to pay in the absence of dental insurance.
Services or supplies received by a covered person before the insurance starts for that person.
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 or polishing of teeth or fluoride treatment.
Services which are primarily cosmetic unless required for the treatment or correction of a congenital defect of a newborn child.
Services or appliances which restore or alter occlusion or vertical dimension.
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 piks, toothbrushes, or dental floss.
Initial installation of a Denture to replace one or more teeth which were missing before such person was insured for Dental Insurance, except for congenitally missing natural teeth.
Decoration or inscription of any tooth, device, appliance, crown or other dental work.
Missed appointments.
Services covered under any workers' compensation or occupational disease law.
Services covered under any employer liability law.
Services for which the employer of the person receiving such services is not required to pay.
Services received at a facility maintained by the Policyholder, labor union, mutual benefit association, or 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 and biting of food.
Caries susceptibility tests.
Precision attachments associated with fixed and removable prostheses.
Adjustment of a denture made within 6 months after installation by the same dentist who installed it.
Duplicate prosthetic devices or appliances.
Replacement of a lost or stolen appliance, cast restoration or denture.
Intra and extraoral photographic images.
Fixed and removable appliances for correction of harmful habits.
Appliances or treatment for bruxism (grinding teeth), including but not limited to occlusal guards and night guards.
Implantology, including repairs.
Treatment of temporomandibular joint disorder. This exclusion does not apply to residents of Minnesota.
Implant Supported Prosthetics.
Orthodontia services or appliances. (does not apply to Value Plan 4)
Repair or a replacement of an orthodontic appliance. (does not apply to Value Plan 4)

Scott and White PPO EHB Plan Summary

Plan Description	Texas Essential Health Benefits (EHB) Plan	
	This Summary of Benefits only applies to a Child until the end of the year in which the Child reaches age 19.	
	In-Network	**Out-of-Network**
Reimbursement	Negotiated Fee Schedule[1]	Negotiated Fee Schedule
Type A – Preventive (cleanings, exams, bitewings)	90%	90%
Type B – Basic (fillings, consultations, simple extractions)	50%	50%
Type C – Major (crowns, dentures, periodontal surgery)	50%	50%
Plan Year Deductible applies to: ▪ **Individual** ▪ **Family**	A, B & C $100 $300	A, B & C $100 $300
Plan Year Maximum *(applies to A,B,C services)*	None	None
Out-of-Pocket Annual Maximum	$375	None
Family Out-of-Pocket Annual Maximum	$750	None
Orthodontia[2]	50%	50%
Orthodontia Lifetime Maximum	None	None

[1]Negotiated fee refers to the fees that participating dentists have agreed to accept as payment in full, subject to any copayments, deductibles, cost sharing and benefits maximums. Negotiated fees are subject to change.

If you receive in-network services, you will be responsible for any applicable cost sharing, negotiated charges after benefit maximums are met, and costs for non-covered services. If you receive out-of-network services, you will be responsible for any applicable cost sharing, charges in excess of the benefit maximum, charges in excess of the negotiated fee schedule amount, and charges for non-covered services.

[2]Orthodontia must be medically necessary and must begin while this insurance is in force. If the insurance ends during the course of the treatment, the monthly payments will end. Dental procedures performed in connection with Orthodontia treatment are considered under the Orthodontia benefit

Scott & White DHMO with Pediatric EHB - 2 to 50 Lives

DHMO - MET290 with Essential Health Benefits		
	In-Network	Out-of-Network
Out-of-Pocket Annual Maximum**	$375, for one child under age 19	None
Family Out-of-Pocket Annual Maximum**	$750, for 2 or more children under age 19	None

** The Covered Person's out-of-pocket annual maximum includes the Covered Person's Co-Payments for Covered Services provided by the Selected General Dentist or Specialty Care Dentist. The out-of-pocket annual maximum does not include the Covered Person's Co-Payments for: (1) non-medically necessary Orthodontia, (2) services that are not Covered Services or (3) services that are in addition to the Essential Health Benefits as identified by the state of Texas.

Description	Co-payment for Covered Persons Other than Children Under Age 19	Co-payment for Children Under age 19
Diagnostic Treatment		
Periodic oral evaluation - established patient	$0	$0
Comprehensive oral evaluation - new or established patient	$0	$0
Intraoral - complete series (including bitewings)	$0	$0
Bitewings - four films	$0	$0
Panoramic film	$0	$0
Preventative Services		
Prophylaxis – Adult and Child	$5	$5
Sealant - per tooth	$0	$0
Restorative Services		
Amalgam - one surface, primary or permanent	$12	$12
Resin-based composite - one surface, anterior	$12	$12
Resin-based composite - one surface, posterior	$30	$30
Crowns - Additional fees for metal upgrades and/or porcelain apply		
Crown - porcelain fused to high noble metal	$290	$290
Crown - porcelain fused to predominantly base metal	$290	$290
Endodontics		
Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to dentinocemental junction and application of medicament	$40	$40
Endodontic therapy, molar tooth (excluding final restoration)	$265	$265
Periodontics		
Osseous surgery (including flap entry and closure) – four or more contiguous teeth or tooth bounded spaces per quadrant	$330	$330
Periodontal scaling and root planing - four or more teeth per quadrant	$50	$50
Localized delivery of antimicrobial agents via controlled release vehicle into diseased crevicular tissue, per tooth, by report	$65	$65
Periodontal maintenance	$40	$40
Prosthodontics		
Complete Denture – Maxillary / Mandibular	$440	$440
Partial Denture – Resin Base – Maxillary	$405	$405
Partial Denture – Resin Base – Mandibular	$405	$405
Oral Surgery		
Extraction - erupted tooth or exposed root (elevation and/or forceps removal)	$5	$5
Surgical removal of erupted tooth requiring removal of bone and/or sectioning of tooth and including elevation of mucoperiosteal flap if indicated	$50	$50
Removal of impacted tooth - soft tissue	$50	$50
Removal of impacted tooth - completely bony	$135	$135
Orthodontics		
Limited orthodontic treatment of transitional, adolescent or adult dentition	$1,095	$1,095
Comprehensive orthodontic treatment of transitional, adolescent or adult dentition (full treatment case up to 24 months)	$2,095	$2,095
Adjunctive General Services		
Palliative (emergency) treatment of dental pain - minor procedure	$10	$10
Consultation – diagnostic service provided by dentist or physician other than requesting dentist or physician	$0	$0

Scott & White Basic Life and AD&D 2 to 99 Lives

Plan Type	Flat $15,000			Flat $25,000			Flat $35,000			Flat $50,000		
Guarantee Issue	Full Amount			Full Amount			Full Amount			Full Amount		
Age Reduction Schedule	35% at age 65, 50% at age 70			35% at age 65, 50% at age 70			35% at age 65, 50% at age 70			35% at age 65, 50% at age 70		
Disability Provision	Disabled prior to age 60, coverage continues to age 65			Disabled prior to age 60, coverage continues to age 65			Disabled prior to age 60, coverage continues to age 65			Disabled prior to age 60, coverage continues to age 65		
Rates Per Employee Per Month	**Level 1**	**Level 2**	**Level 3**	**Level 1**	**Level 2**	**Level 3**	**Level 1**	**Level 2**	**Level 3**	**Level 1**	**Level 2**	**Level 3**
Basic Life	$7.36	$9.61	$11.86	$11.51	$13.76	$17.13	$15.68	$19.05	$22.42	$21.91	$26.41	$32.03
AD&D	$0.45	$0.45	$0.45	$0.75	$0.75	$0.75	$1.05	$1.05	$1.05	$1.50	$1.50	$1.50
Total	**$7.81**	**$10.06**	**$12.31**	**$12.26**	**$14.51**	**$17.88**	**$16.73**	**$20.10**	**$23.47**	**$23.41**	**$27.91**	**$33.53**
Rates illustrated above are valid for effective dates 01/01/2024 to 12/31/2024												

The above information is intended for general plan description purposes only. Please reference the specific plan documents for complete plan information.

Life and Supplemental Life SIC Classifications	
SIC Level 1	2500 - 2599 , 3540 - 3549 , 3570 - 3579 , 3610 - 3629 , 3660 - 3689 , 3700 - 3709 , 3720 - 3729 , 3740 - 3899 , 4000 - 4099 , 4800 - 4909 , 4940 - 4999 , 5100 - 5199 , 5310 - 5319 , 5900 - 5999 , 6010 - 6029 , 6100 - 6299 , 6500 - 6799 , 7300 - 7399 , 8000 - 8299 , 8610 - 8619 , 8660 - 8669 , 8700 - 8799
SIC Level 2	100 - 999 , 1300 - 1599 , 1700 - 2099 , 2200 - 2399 , 2600 - 3099 , 3140 - 3149 , 3400 - 3439 , 3450 - 3539 , 3550 - 3569 , 3590 - 3609 , 3630 - 3659 , 3690 - 3699 , 3730 - 3739 , 3900 - 3999 , 4300 - 4399 , 4500 - 4799 , 4910 - 4939 , 5000 - 5099 , 5200 - 5309 , 5320 - 5399 , 5500 - 5899 , 6000 - 6009 , 6030 - 6099 , 6400 - 6499 , 7000 - 7299 , 7600 - 7999 , 8300 - 8609 , 8620 - 8659 , 8670 - 8699 , 9100 - 9199 , 9300 - 9799
SIC Level 3	1000 - 1299 , 1600 - 1699 , 2100 - 2199 , 2400 - 2499 , 3100 - 3139 , 3150 - 3399 , 3440 - 3449 , 3580 - 3589 , 3710 - 3719 , 4100 - 4299 , 4400 - 4499 , 5400 - 5499 , 6300 - 6399 , 7500 - 7599 , 9200 - 9299

Scott & White Short Term Disability 5 to 99 Lives

Maximum Weekly Benefit	60% to $1,000		
Elimination Period	Accident - 0 days Sickness - 7 days		
Benefit Duration	13 weeks		
Pre Existing Condition	Groups <10 Eligible: 3/12, Groups 10+ Eligible: None		
Participation	100%		
Rates Per Employee Per Month	**SIC 1**	**SIC 2**	**SIC 3**
STD	$17.75	$20.00	$23.15
Rates illustrated above are valid for effective dates 01/01/2024 to 12/31/2024			

The above information is intended for general plan description purposes only. Please reference the specific plan documents for complete plan information.

STD SIC Classifications	
SIC Level 1	4800-4899, 5600-5799, 5912, 5932-6411, 6712-6799, 7311-7379, 7382-7389, 8111, 8211-8299, 8412-8748
SIC Level 2	741-742, 1521-1629, 2011-2099, 2211-2399, 2421-2599, 2652-2796, 2833-2836, 3571-3579, 3612-3699, 3812-3999, 4612-4789, 4911-4952, 4959-5092, 5094-5599, 6512-6553, 7011-7299, 7513-7519, 7532-7539, 7549-7999, 8322-8399, 9111-9721
SIC Level 3	1711-1781, 2611-2631, 2812-2824, 2841-3089, 3131-3291, 3295-3479, 3491-3569, 3581-3599, 3711-3728, 3743-3799, 4111-4215, 4222-4231, 4412-4581, 5812, 5813, 8051-8059, 8071-8099

Scott & White Long Term Disability 5 to 99 Lives

Maximum Monthly Benefit	60% to $5,000		
Elimination Period	90 Days		
Own Occupation	24 Months		
Benefit Duration	**The lesser of 5 years of benefits or the period shown below:**		
	Age on Date of Disability	**Duration**	
	Less than 60	To age 65	
	60	60 months	
	61	48 months	
	62	42 months	
	63	36 months	
	64	30 months	
	65	24 months	
	66	21 months	
	67	18 months	
	68	15 months	
	69 and over	12 months	
Pre Existing Condition	3/12		
Participation	100% of total eligible		
Rates Per Employee Per Month	**SIC Level 1**	**SIC Level 2**	**SIC Level 3**
LTD	$13.75	$18.80	$23.00
Rates illustrated above are valid for effective dates 01/01/2024 to 12/31/2024			

The above information is intended for general plan description purposes only. Please reference the specific plan documents for complete plan information.

LTD SIC Classifications	
SIC Level 1	741, 742, 2511-2599, 2711-2796, 3131-3199, 3612-3699, 3812-3999, 5012-5088, 5094, 5311-5399, 6011-6411, 6712-6799, 7322-7338, 7352, 7361-7379, 7384, 8211-8299, 8412-8748
SIC Level 2	2011-2099, 2311-2399, 2431-2499, 2611-2679, 2812-2899, 3011-3089, 3211-3291, 3295-3299, 3411-3449, 3462-3479, 3491-3599, 3711-3799, 4412-4899, 5111-5193, 5198-5271, 5411-5499, 5611-5699, 5912-5999, 6512-6553, 7011-7319, 7342-7349, 7353-7359, 7381-7383, 7389-7549, 7812-7999, 9111-9721
SIC Level 3	1521-1799, 2211-2299, 2911-2999, 3312-3399, 4111-4311, 4911-4952, 4959-4971, 5511-5599, 5712-5813, 7622-7699, 8051-8059, 8071-8099, 8322-8399,

Scott & White
Underwriting Guidelines

Eligibility
Must be an active full time employee working at least 30 hours per week
Retirees, part time, temporary, seasonal, leased and independent contractors (1099) are not eligible
Documented proof of active, full time employment is required for all employees who are age 70 or older
For groups with < 10 employees, no more than 75% of the group can be members of the same family (spouses, siblings, children, and parents).

Dental
Minimum of 2 enrolled lives
Employees on COBRA cannot exceed 15% of the enrolled lives
Coverage is not available to groups that fall into the following industries: 8020 , 8021 , 8070 , 8072 , 8200-8299 , 8800 - 8999 , 9900 - 9999
Rates are for Texas based companies. Please contact MetLife when more than 10% of the employees reside outside of Texas.

Vision -NOT OFFERED
Minimum of 10% participation with at least 2 enrolled
Employees age 65 and over must be less than 20% of the group
Coverage is not available to groups that fall into the following industries: 8020 , 8021 , 8070 , 8072 , 8200-8299 , 8800 - 8999 , 9900 - 9999

Basic Life
Minimum of 2 enrolled lives
Coverage must be non-contributory with 100% participation
Benefits are reduced by 35% at age 65; reduced to 50% of the original amount at age 70
Coverage is not available to groups that fall into the following industries: 8800 - 8999 , 9900 - 9999
Pilots and elected officials are not eligible for coverage
A completed Risk Assessment Summary is required on all cases

Supplemental Life-NOT OFFERED
Total participation must meet or exceed 25% of the total eligible lives with a minimum of 5 enrolled
The spouse benefit cannot exceed 50% of the employee's benefit

Statement of Health is required in the following circumstances:

1. Request coverage amounts during their initial 31-day enrollment that exceed the stated MEOI level.
2. Have been hospitalized in the last 90 days.
   *Hospitalized means admission for inpatient care in a hospital; receipt of care in a hospice facility; intermediate care facility, or long term care facility, or receipt of the following treatments wherever performed: chemotherapy, radiation therapy or dialysis.
3. Have indicated a medical condition on their enrollment form.
4. Apply for coverage after the period which begins on the first day on which they are eligible for coverage (or the first day following a qualifying event, if applicable) and ends at the earlier of the next following annual enrollment period or the day before the next following Policy Anniversary. In no event will this period be more than a year, or less than 31 days.
5. Are Actively-at-Work but who are not currently enrolled in the plan and experience a Qualifying Event. SOH must be submitted in order to enroll for any amount of coverage.

Coverage is not available to groups that fall into the following industries: 8800 - 8999 , 9900 - 9999
Pilots and elected officials are not eligible for coverage
A completed Risk Assessment Summary is required on all cases

LTD
Minimum of 5 enrolled lives
Coverage must be non-contributory with 100% participation
Pilots and elected officials are not eligible
All employees must participate in social security
A completed Risk Assessment Summary is required on all cases

STD
Minimum of 5 enrolled lives
Coverage must be non-contributory with 100% participation
Groups or employees located in California, Hawaii, New Jersery, New York, or Rhode Island are not eligible
Pilots and elected officials are not eligible
A completed Risk Assessment Summary is required on all cases

U.S. Business Intermediary and Producer Compensation Notice

Metropolitan Life Insurance Company, Metropolitan Tower Life Insurance Company, MetLife Consumer Services, Inc. and Metropolitan General Insurance Company (collectively herein called "MetLife"), enters into arrangements concerning the sale, servicing and/or renewal of MetLife group insurance and certain other group-related insurance and non-insurance products ("Products") with brokers, agents, consultants, third party administrators, general agents, associations, and other parties that may participate in the sale, servicing and/or renewal of such products (each an "Intermediary"). MetLife may pay your Intermediary compensation, which may include, among other things, base compensation, supplemental compensation and/or a service fee. MetLife may pay compensation for the sale, servicing and/or renewal of products, or remit compensation to an Intermediary on your behalf. Your Intermediary may also be owned by, controlled by or affiliated with another person or party, which may also be an Intermediary and who may also perform marketing and/or administration services in connection with your products and be paid compensation by MetLife.

Base compensation, which may vary from case to case and may change if you renew your products with MetLife, may be payable to your Intermediary as a percentage of premium or a fixed dollar amount. MetLife may also pay your Intermediary compensation that is based upon your Intermediary placing and/or retaining a certain volume of business (number of products sold or dollar value of premium) with MetLife. In addition, supplemental compensation may be payable to your Intermediary for eligible Products. Under MetLife's current supplemental compensation plan (SCP), the amount payable as supplemental compensation may range from 0% to 8% of premium or fees. The supplemental compensation percentage may be based on one or more of: (1) the number of products sold through your Intermediary during a one-year period, or other defined period; (2) the amount of eligible new or renewal premium or fees with respect to products sold through your Intermediary during a one-year period; (3) the persistency percentage of products inforce through your Intermediary during a one-year period; (4) the block growth of the products inforce through your Intermediary during a one-year period; (5) eligible new or renewal premium or fees growth during a one-year period; or (6) a flat amount, fixed percentage or sliding scale of the premium or fees for products as set by MetLife. The supplemental compensation percentage will be set by MetLife based on the achievement of the outlined qualification criteria and it may not be changed until the following SCP plan year. As such, the supplemental compensation percentage may vary from year to year, but will not exceed 8% under the current supplemental compensation plan.

The cost of supplemental compensation is not directly charged to the price of our products except as an allocation of overhead expense, which is applied to all eligible group insurance products, whether or not supplemental compensation is paid in relation to a particular sale or renewal. As a result, your rates will not differ by whether or not your Intermediary receives supplemental compensation. If your Intermediary collects the premium or fees from you in relation to your products, your Intermediary may earn a return on such amounts. Additionally, MetLife may have a variety of other relationships with your Intermediary or its affiliates, or with other parties, that involve the payment of compensation and benefits that may or may not be related to your relationship with MetLife (e.g., insurance and employee benefits exchanges, enrollment firms and platforms, sales contests, consulting agreements, participation in an insurer panel, or reinsurance arrangements).

More information about the eligibility criteria, limitations, payment calculations and other terms and conditions under MetLife's base compensation and supplemental compensation plans can be found on MetLife's Website at www.metlife.com/business-and-brokers/broker-resources/broker-compensation. Questions regarding Intermediary compensation can be directed to ask4met@metlifeservice.com, or if you would like to speak to someone about Intermediary compensation, please call (800) ASK 4MET. In addition to the compensation paid to an Intermediary, MetLife may also pay compensation to your representative. Compensation paid to your representative is for participating in the sale, servicing, and/or renewal of products, and the compensation paid may vary based on a number of factors including the type of product(s) and volume of business sold. If you are the person or entity to be charged under an insurance policy or annuity contract, you may request additional information about the compensation your representative expects to receive as a result of the sale or concerning compensation for any alternative quotes presented, by contacting your representative or calling (866) 796-1800.

Non-U.S. Coverage

When providing you with information concerning an eligible group insurance policy issued or proposed to your affiliate or subsidiary outside the United States by a MetLife affiliate or by other locally licensed insurers that are members of the MAXIS Global Benefits Network (MAXIS GBN), New York insurance law requires the person providing the information to be licensed as an insurance broker. In this capacity, the information provided to you will only be on behalf of such insurers and not on behalf of MetLife or any other insurer that is not a member of MAXIS GBN. Please note that while MetLife is a member of MAXISGBN and is licensed to transact insurance business in New York, the other MAXIS GBN member insurers are not licensed or authorized to do business in New York. The group insurance policies they issue are for coverage outside the United States and are governed by the laws of the country they were issued in. These policies have not been approved by the New York Superintendent of Financial Services, are not subject to all of the laws of New York, and are not protected by the New York State Guaranty Fund.

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