MetLife | Dental Insurance

How to find a participating Dentist?

You can find the names, addresses, languages spoken and phone numbers of participating dentists by searching our online **Find a Dentist** directory.

Step 1:

Go to metlife.com

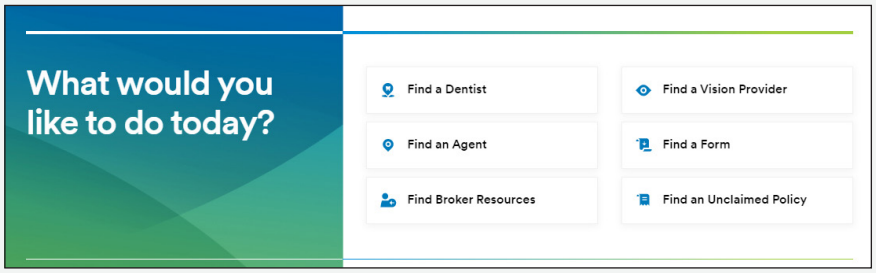
Step 2:

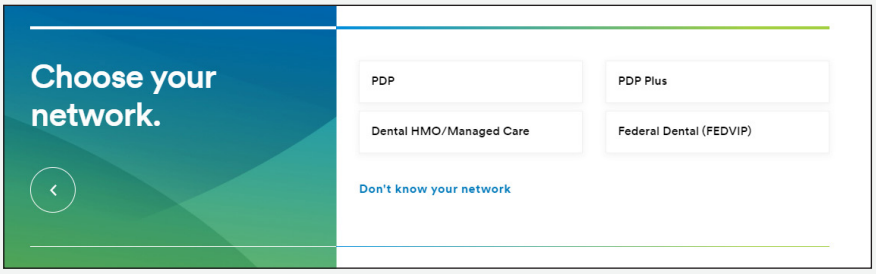
Select "Find a Dentist" next to "What would you like to do today?"

Step 3:

Choose your network.

Enter your Zip, City or State and select the "Find a Dentist" button. You will then be prompted to select your plan from the list. The plan name is located in your Schedule of Benefits.





Like most group benefit programs, benefit programs offered by MetLife and its affiliates contain certain exclusions, exceptions, waiting periods, reductions, limitations and terms for keeping them in force. Please contact MetLife or your plan administrator for complete details.

MetLife

Metropolitan Life Insurance Company | 200 Park Avenue | New York, NY 10166

Dental Benefits

Savings flexibility and service.
For healthier smiles.

Plan Design for: Value Plan 4
Network: PDP

Overview of Benefits

The Preferred Dentist Program was designed to help you get the dental care you need and help lower your costs. You get benefits for a wide range of covered services — both in and out of the network. The goal is to deliver affordable protection for a healthier smile and a healthier you.

Coverage Type	In Network[1] % of Negotiated Fee[2]	Out of Network[1] % of R&C Fee[4]
Type A — Preventive Care (subject to frequency limitations)	100%	100%
Type B — Basic Services	80%	80%
Type C — Major Services	50%	50%
Type D — Orthodontia	50%	50%
Deductible[3]: Per Individual	$50 Applies to Type B & C services only	$50 Applies to Type B & C services only
Deductible[3]: Per Family	$150 Applies to Type B & C services only	$150 Applies to Type B & C services only
Annual Maximum Benefits: Per Individual	$1,500	$1,500
Orthodontia Lifetime Maximum: Per Individual	$1,000	$1,000
	Orthodontia applies to Child Only up to Age 19	

Understanding Your Dental Benefits Plans

The Preferred Dentist Program is designed to provide the dental coverage you need with the features you want. Like the freedom to visit the dentist of your choice — in or out of the network.

If you receive services from an in-network dentist, you will be responsible for any applicable deductibles, cost sharing, negotiated fee for covered service after benefit maximums are met, and charges for non-covered services. If you receive services from an out-of-network dentist, you will be responsible for any applicable deductibles, cost sharing, charges in excess of the benefit maximum, charges in excess of the R&C Fee, and charges for non-covered services.

Plan benefits for in-network covered services are based on a percentage of the Negotiated Fee — the fee that participating dentists have agreed to accept as payment in full for covered services.[1,2]

Plan benefits for out-of-network services are based on a percentage of the Reasonable and Customary (R&C) Fee. If you choose a dentist who does not participate in the network, your out-of-pocket expenses may be greater than if you had visited an in-network dentist.[1,4]

(continued)

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 participating dentists have agreed to accept as payment in full for covered services, subject to any copayments, deductibles, cost sharing and benefits maximums. Negotiated fees are subject to change.
3. Applies to Type B and C services only.
4. R&C Fee refers to the Reasonable and Customary charge, which is based on the lowest of (1) the dentist's actual charge, (2) the dentist's usual charge for the same or similar services, or (3) the charge of most dentists in the same geographic area for the same or similar services as determined by MetLife.

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Scott&White HEALTH PLAN
PART OF BAYLOR SCOTT & WHITE HEALTH

ADF# D1153.16

An Example of Savings

An Example of Savings* When You Visit a MetLife PDP Dentist

Take a look at an example that shows how receiving services from a MetLife PDP dentist can save you money:

Your Dentist says you need a Crown, Type C Service**

PDP Fee: $375.00 R&C Fee: $500.00

Dentist's Usual Fee: $550.00

(In-Network) When you receive care from a MetLife PDP dentist...		**(Out-of-Network)** When you receive care from a Non-Participating dentist...	
The PDP Fee is:	$375.00	Dentist's Usual Fee is:	$550.00
Your Plan Pays: (50% x $375.00 PDP Fee)	- $187.50	Your Plan Pays: (50% x $500.00 R&C Fee)	- $250.00
Your Out-of-Pocket Cost:	$187.50	Your Out-of-Pocket Cost:	$300.00

In this example, YOU SAVE $112.50 ($300.00 minus $187.50) ... by using a MetLife PDP dentist!

Please note, this is an example only. Actual savings may differ.

* Savings from enrolling in a MetLife dental plan featuring the PDP Program will depend on various factors, including the cost of the plan, how often participants visit the dentist and the cost of services rendered.

** Please note: this example assumes that your annual deductible has been met and your annual maximum benefit has not been reached.

(continued)

Selected Covered Services and Frequency Limitations*

Type A — Preventive	How Many/How Often
• Prophylaxis — Cleanings	2 in 1 year.
• Oral Examinations	2 in 1 year.
• Bitewing X-Rays (Adult/Child)	Adult: 2 in one year Children (up to 14 years old): 2 in one year
Type B — Basic Restorative	**How Many/How Often**
• Topical Fluoride Applications	1 in 12 months for children up to 14th birthday.
• Full Mouth X-Rays	1 in 36 months.
• Sealants	1 per molar in 36 months for a child under age 15.
• Endodontics — Root Canal	1 per tooth per lifetime.
• Oral Surgery (Simple Extractions)	
• Oral Surgery (Surgical Extractions)	
• Periodontal Surgery	1 in 36 months.
• Periodontal Scaling & Root Planing	1 in 24 months.
• Periodontal Maintenance	2 in 1 year, includes 2 cleanings.
• Amalgam & Composite Fillings	
• Consultations	2 in 12 months.
• Emergency Palliative Treatment	
• Prefabricated Stainless Steel & Resin Crowns	1 per tooth in 24 months.
Type C — Major Restorative	**How Many/How Often**
• Space Maintainers	Children up to 14th birthday. Limited to 1 per lifetime per area.
• Repairs	1 per tooth in 12 months.
• General Anesthesia	For oral surgery, extractions or other covered services.
• Other Oral Surgery	
• Bridges	1 per tooth in 60 months.
• Dentures	1 per tooth in 60 months.
Type — D Orthodontia	**How Many/How Often**
• Dependent children up to age 19. Age limitations may vary by state. Please see your Plan description for complete details. In the event conflict with this summary, the terms of the certificate will govern.	
• All dental procedures performed in connection with orthodontic treatment are payable as Orthodontia.	
• Benefits for the initial placement will not exceed 20% of the Lifetime Maximum Benefit Amount for Orthodontia. Periodic follow-up visits will be payable on a monthly basis during the scheduled course of the orthodontic treatment. Allowable expenses for the initial placement, periodic follow-up visits and procedures performed in connection with the orthodontic treatment, are all subject to the Orthodontia coinsurance level and Lifetime Maximum Benefit Amount as defined in the Plan Summary.	
• Orthodontic benefits end at cancellation of coverage	

*** Alternate Benefits:** Where two or more professionally acceptable dental treatments for a dental condition exist, reimbursement 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 pretreatment 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 reimbursement 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.

The service categories and plan limitations shown above represent an overview of your benefits plan. This document presents many services within each category, but is not a complete description of the plan. Please see your insurance certificate for complete details. In the event of a conflict with this summary, the terms of your insurance certificate will govern.

(continued)

Exclusions

We will not pay Dental Insurance benefits for charges incurred for:

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;
2. Services for which You would not be required to pay in the absence of Dental Insurance;
3. Services or supplies received by You or Your Dependent before the Dental Insurance starts for that person;
4. Services which are primarily cosmetic (For residents of Texas, see notice page section in your certificate);
5. 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.

   For New York Sitused Groups, this exclusion does not apply.
6. Services or appliances which restore or alter occlusion or vertical dimension.
7. Restoration of tooth structure damaged by attrition, abrasion or erosion.
8. Restorations or appliances used for the purpose of periodontal splinting.
9. Counseling or instruction about oral hygiene, plaque control, nutrition and tobacco.
10. Personal supplies or devices including, but not limited to: water piks, toothbrushes, or dental floss.
11. Decoration, personalization or inscription of any tooth, device, appliance, crown or other dental work.
12. Missed appointments.
13. 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 required to pay; or
    - received at a facility maintained by the Employer, labor union, mutual benefit association, or VA hospital.

    For North Carolina and Virginia Sitused Groups, this exclusion does not apply.
14. Services paid under any workers' compensation, occupational disease or employer liability law as follows:
    - for persons who are covered in North Carolina for the treatment of an Occupational Injury or Sickness which are paid under the North Carolina Workers' Compensation Act only to the extent such services are the liability of the employee, employer or workers' compensation insurance carrier according to a final adjudication under the North Carolina Workers' Compensation Act or an order of the North Carolina Industrial Commission approving a settlement agreement under the North Carolina Workers' compensation Act;
    - or for persons who are not covered in North Carolina, services paid or payable under any workers compensation or occupational disease law.

    This exclusion only applies for North Carolina Sitused Groups.
15. Services:
    - for which the employer of the person receiving such services is required to pay; or
    - received at a facility maintained by the Employer, labor union, mutual benefit association, or VA hospital.

    This exclusion only applies for North Carolina Sitused Groups.
16. Services covered under any workers' compensation, occupational disease or employer liability law for which the employee/or Dependent received benefits under that law.

    This exclusion only applies for Virginia Sitused Groups.
17. Services:
    - for which the employer of the person receiving such services is required to pay; or
    - received at a facility maintained by the policyholder, labor union, mutual benefit association, or VA hospital.

    This exclusion only applies for Virginia Sitused Groups.
18. Services covered under other coverage provided by the Employer.
19. Temporary or provisional restorations.
20. Temporary or provisional appliances.
21. Prescription drugs.
22. Services for which the submitted documentation indicates a poor prognosis.
23. 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.

(continued)

Exclusions (continued)

24. 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.

    For New York Sitused Groups, this exclusion does not apply.
25. Carries susceptibility tests.
26. Initial installation of a fixed and permanent Denture to replace one or more natural teeth which were missing before such person was insured for Dental Insurance, except for congenitally missing natural teeth.
27. Other fixed Denture prosthetic services not described elsewhere in this certificate.
28. Precision attachments, except when the precision attachment is related to implant prosthetics.
29. Initial installation or replacement of a full or removable Denture to replace one or more natural teeth which were missing before such person was insured for Dental Insurance, except for congenitally missing natural teeth.
30. Addition of teeth to a partial removable Denture to replace one or more natural teeth which were missing before such person was insured for Dental Insurance, except for congenitally missing natural teeth.
31. Adjustment of a Denture made within 6 months after installation by the same Dentist who installed it.
32. Implants to replace one or more natural teeth which were missing before such person was insured for Dental Insurance, except for congenitally missing natural teeth.
33. Implants supported prosthetics to replace one or more natural teeth which were missing before such person was insured for Dental Insurance, except for congenitally missing natural teeth.
34. Fixed and removable appliances for correction of harmful habits.[1]
35. Appliances or treatment for bruxism (grinding teeth), including but not limited to occlusal guards and night guards.[1]
36. Diagnosis and treatment of temporomandibular joint (TMJ) disorders. This exclusion does not apply to residents of Minnesota.[1]
37. Repair or replacement of an orthodontic device.[1]
38. Duplicate prosthetic devices or appliances.
39. Replacement of a lost or stolen appliance, Cast Restoration, or Denture.
40. Intra and extraoral photographic images.
41. Services or supplies furnished as a result of a referral prohibited by Section 1-302 of the Maryland Health Occupations Article. A prohibited referral is one in which a Health Care Practitioner refers You to a Health Care Entity in which the Health Care Practitioner or Health Care Practitioner's immediate family or both own a Beneficial Interest or have a Compensation Agreement. For the purposes of this exclusion, the terms "Referral", "Health Care Practitioner", "Health Care Entity", "Beneficial Interest" and Compensation Agreement have the same meaning as provided in Section 1-301 of the Maryland Health Occupations Article.

    This exclusion only applies for Maryland Sitused Groups

(continued)

1. Some of these exclusions may not apply. Please see your Certificate of Insurance.

Common Questions ... Important Answers

Who is a participating dentist?
A participating, or network, dentist is a general dentist or specialist who has agreed to accept negotiated fees as payment in full for 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.*

* Based on internal analysis by MetLife. Savings from enrolling in the MetLife PDP Program will depend on various factors, including the cost of the plan, how often members visit the dentist and the cost of services rendered.

How do I find a participating dentist?
There are thousands of general dentists and specialists to choose from nationwide — so you are sure to find one that meets your needs. You can receive a list of these participating dentists online at www.metlife.com/dental or call 1-800-275-4638 to have a list faxed or mailed to you.

What services are covered by my plan?
Please see your Certificate of Insurance for a list of covered services.

May I choose a non-participating dentist?
Yes. You are always free to select the dentist of your choice. However, if you choose a non-participating (out-of-network) dentist, your out-of-pocket costs may be greater than your out-of-pocket costs when visiting an in-network dentist.

Can my dentist apply for participation in the network?
Yes. If your current dentist does not participate in the network and you would like to encourage him or her to apply, ask your dentist to visit www.metdental.com, or call 1-866-737-6895 for an application.* The website and phone number are for use by dental professionals only.

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

How are claims processed?
Dentists may submit your claims for you, which means you have little or no paperwork. You can track your claims online, and even receive e-mail alerts when a claim has been processed. If you need a claim form, visit www.metlife.com/dental or request one by calling 1-800-275-4638.

Can I get an estimate of what my out-of-pocket expenses will be before receiving a service?
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 pre-treatment estimate for services in excess of $300. Simply have your dentist submit a request online at www.metdental.com or call 1-877-638-3379. You and your dentist will receive a benefit estimate for most procedures while you are still in the office. Actual payments may vary depending upon plan maximums, deductibles, frequency limits and other conditions at time of payment.

Can MetLife help me find a dentist outside of the U.S. if I am traveling?
Yes. Through international dental travel assistance services* you can obtain a referral to a local dentist by calling +1-312-356-5970 (collect) when outside the U.S. to receive immediate care until you can see your dentist. Coverage will be considered under your out-of-network benefits.** Please remember to hold on to all receipts to submit a dental claim.

* International Dental Travel Assistance services are provided by AXA Assistance USA, Inc., which provides dental referral services only. AXA Assistance is not affiliated with MetLife, and the services and benefits they provide are separate and apart from the insurance provided by MetLife. Referral services are not available in all locations.

** Refer to your Certificate of Insurance for your out-of-network dental coverage.

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

Do I need an ID card?
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 a MetLife dental plan featuring the Preferred Dentist Program. Your dentist can easily verify information about your coverage through a toll-free automated Computer Voice Response system.

Do my dependents have to visit the same dentist that I select?
No, you and your dependents each have the freedom to choose any dentist.

If I do not enroll during my initial enrollment period can I still purchase Dental Insurance at a later date?
Yes, employees who do not elect coverage during their enrollment period may still elect coverage later. Dental coverage would be subject to the following waiting periods.

- No waiting period on Preventive Services
- 24 months on Orthodontia Services (if applicable)
- 24 months on Major Services
- 6 months on Basic Restorative (Fillings)
- 12 months on all other Basic Services

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MetLife

Scott&White HEALTH PLAN
PART OF BAYLOR SCOTT & WHITE HEALTH

INTERMEDIARY AND PRODUCER COMPENSATION NOTICE

MetLife enters into arrangements concerning the sale, servicing and/or renewal of MetLife group insurance and certain other group-related products ("Products") with brokers, agents, consultants, thirdparty 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. Under MetLife's current supplemental compensation plan, the amount payable as supplemental compensation may range from 0% to 8% of premium. The supplemental compensation percentage may be based on: (1) the number of Products sold through your Intermediary during a prior one-year period; (2) the amount of premium or fees with respect to Products sold through your Intermediary during a prior one-year period; (3) the persistency percentage of Products inforce through your Intermediary during a prior one-year period; (4) premium growth during a prior one-year period; (5) a fixed percentage of the premium for Products as set by MetLife. The supplemental compensation percentage will be set by MetLife prior to the beginning of each calendar year and it may not be changed until the following calendar 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 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, consulting agreements, 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 Web site at www.metlife.com/brokercompensation. 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 MetLife sales representative. Compensation paid to your MetLife sales 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 MetLife sales representative expects to receive as a result of the sale or concerning compensation for any alternative quotes presented, by contacting your MetLife sales representative or calling (866) 796-1800.

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