

Find a participating Dentist in the Dental HMO/ Managed Care plan

The Dental HMO/Managed Care plan’s network includes both private practice dentists and those who are in a clinic environment. 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](https://www.metlife.com)



Step 2:

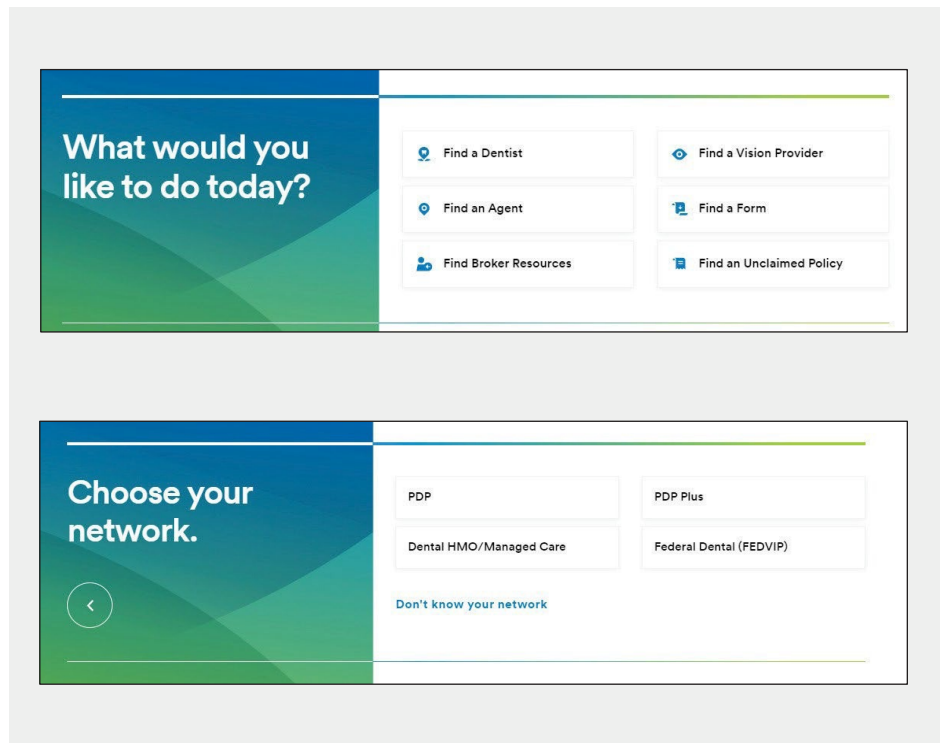
Select “Find a Dentist” next to “What would you like to do today?”



Step 3:

Select “Dental HMO/ Managed Care” next to “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.



The image displays two screenshots of the MetLife website interface. The top screenshot shows the 'What would you like to do today?' section with a grid of buttons: 'Find a Dentist', 'Find a Vision Provider', 'Find an Agent', 'Find a Form', 'Find Broker Resources', and 'Find an Unclaimed Policy'. The bottom screenshot shows the 'Choose your network.' section with a grid of buttons: 'PDP', 'Dental HMO/Managed Care', 'PDP Plus', and 'Federal Dental (FEDVIP)', along with a 'Don't know your network' link.

Dental Managed Care Plan benefits are provided by Metropolitan Life Insurance Company, a New York corporation, in NY. Dental HMO plan benefits are provided by: SafeGuard Health Plans, Inc., a California corporation, in CA; SafeGuard Health Plans, Inc., a Florida corporation, in FL; SafeGuard Health Plans, Inc., a Texas corporation, in TX; and MetLife Health Plans, Inc., a Delaware corporation, and Metropolitan Life Insurance Company, a New York corporation, in NJ. The Dental HMO/ Managed Care companies are part of the MetLife family of companies.

DHMO” is used to refer to product designs that may differ by state of residence of the enrollee, including but not limited to: “Specialized Health Care Service Plans” in California; “Prepaid Limited Health Service Organizations” as described in Chapter 636 of the Florida statutes in Florida; “Single Service Health Maintenance Organizations” in Texas; and “Dental Plan Organizations” as described in the Dental Plan Organization Act in New Jersey.

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.



Scott and White Health Plan and MetLife — A Winning Combination

Mid Plan

Dental Benefits – Savings, flexibility and service. For healthier smiles.

Mid Plan Overview and Options:

Procedures	Covered percentage		Members' minimum payment ¹	
	In Network ² – based on the Negotiated Fee	Out of Network ³ – based on the R&C Fee	In Network – based on the Negotiated Fee	Out of Network – based on the R&C Fee
Periodic Oral Evaluations ⁴	100%	100%	0%	0%
Cleanings (prophylaxis) ⁴	100%	100%	0%	0%
Bitewings	100%	100%	0%	0%
Sealants (age 14 & under)	80%	80%	20%	20%
Topical Fluoride (age 14 & under)	80%	80%	20%	20%
Fillings	80%	80%	20%	20%
Root Canals	80%	80%	20%	20%
Extractions	80%	80%	20%	20%
Crowns	50%	50%	50%	50%
Partials & Dentures – Procedures & Services	50%	50%	50%	50%
Bridge Work	50%	50%	50%	50%
Space Maintainers	50%	50%	50%	50%

Annual Maximum Amounts: Mid Plan: \$750

Negotiated fees refer to the fees that in-network dentists have agreed to accept as payment in full for certain services, subject to any co-payments, 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 change their non-negotiated fees for non-covered services.

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 usual charge of most dentists in the same geographic area for the same or similar services as determined by MetLife.

A "Dental Expense Period" means a period which starts on any January 1 and ends on the next December 31.

(continued)

1. If the actual charge is greater than the R&C fee, the member's out-of-pocket expense is the amount remaining after the covered percentage of the R&C fee is paid plus the difference between the R&C fee and the actual charge (subject to plan terms including any applicable deductible and the annual maximum benefit).
2. "In-Network Benefits" means benefits provided under this plan for covered dental services that are provided by a participating dentist.
3. "Out-of-Network Benefits" means benefits provided under this plan for covered dental services that are provided by a non-participating dentist.
4. Limited to two per year.

What's covered – Covered dental expenses fall into one of the following categories:

Basic Services:

- Periodic oral evaluations, two per year.
- Dental prophylaxis (cleanings), two per year.
- Topical fluoride treatment for dependent children age 14 and under.
- Sealants covered on molars only, once per tooth for dependents age 14 and under.
- Radiographs – intraoral, extraoral, bitewings – two per year. Panoramic film (once every 36 months), cephalometric film.
- Fillings – amalgam or resin composite fillings.
- Sedative fillings.
- Recement inlays; recement crowns.
- Prefabricated stainless steel crown – primary or permanent (replacement within 36 months not covered).
- Endodontics – pulpotomy.
- Root canal therapy, limited to one per tooth per lifetime.
- Palliative (emergency) treatment of dental pain – minor procedure.
- Local anesthesia not in conjunction with operative or surgical procedure.
- Oral surgery – extractions of teeth and roots, including local anesthesia and routine postoperative care.
- Professional consultations, two per year.

Complex Services:

- Space maintainers for covered dependents under age 14 (limited to initial passive appliance only).
- Crowns – single restoration only. Limited to one restoration every 60 months.
- Pin retention, per tooth, in addition to restoration.
- Prefabricated post and core in addition to crown.
- Crown repair.
- Endodontics – apicoectomy, retrograde filling per root or root amputation per root; hemisection, not including root canal therapy.
- Installation of a partial or full removable denture. Limited to once every 60 months.
- Repairs or adjustments to complete dentures. Repairs to partial dentures.
- Denture relining or rebasing, limited to once every 24 months.
- Overdenture complete or partial, limited to one every 60 months.
- Installation of fixed bridgework, including bridge pontics, retainers, bridge retainers-crowns. Replacement within 60 months is not a covered expense.
- Recement bridge.
- Bridge repair.
- Oral surgery – alveoplasty and surgical incisions.
- General anesthesia (limited to first 30 minutes) and intravenous sedations.

Eligibility:

- Student Age - Dependent children are covered to age 26.

Limitations:

- Coordination of Benefits - Our plans contain a coordination of benefits clause that reduces benefits paid under our plan based on benefits received from other group, employer or government sponsored plans except Medicaid. The benefits under a MetLife group dental plan and any other plan providing benefits for covered dental services cannot exceed 100% of the allowable charge.
- Generally Accepted Dental Standards – MetLife determines benefit payments for dental expenses under a MetLife group dental plan. Benefits will be payable for a recommended dental service only if it is classified as “necessary,” under generally accepted dental standards.

Exclusions:

(The following expenses are not Covered Dental Expenses)

- Services or Supplies:
 - related to teeth lost before dental benefits began or for congenitally missing natural teeth;
 - received by a covered person before the dental expense benefits start for that person;
 - which are covered by any worker's compensation laws or occupational disease laws;
 - which are covered by any employer's liability laws;
 - which an employer is required by law to furnish in whole or in part;
 - received through the medical department or similar facility which is maintained by the covered person's employer;
 - received by a covered person for which no charge would have been made in the absence of dental expense benefits for that covered person;
 - for which a covered person is not required to pay;
 - which are not necessary, according to generally accepted dental standards, or which are not recommended or approved by a dentist;
 - which do not meet generally accepted dental standards, including experimental treatment;
 - received as a result of dental disease, defect, or injury due to an act of war, or warlike act in time of peace, which occurs while the dental expense benefits for the covered person are in effect;
 - which are provided by any other plan which the employer (or an affiliate) contributes to or sponsors.
 - Services not performed by a dentist except for those of a licensed dental hygienist which are supervised and billed by a dentist and which are for cleaning and scaling of teeth or fluoride treatments.

(continued)

What's covered – Covered dental expenses fall into one of the following categories: (continued)

Exclusions: (continued)

- Cosmetic surgery or supplies. However, any such surgery or supply will be covered if it otherwise is a covered dental expense and it is required for reconstructive surgery that is incidental to or follows surgery that results from a trauma, an infection or other disease of the involved part; or is required for reconstructive surgery because of a congenital disease or anomaly of a dependent child that has resulted in a functional defect.
- Replacement of a lost, missing or stolen crown, bridge or denture.
- Repair or replacement of an orthodontic appliance.
- Adjustment of a denture or a bridgework which is made within six months after it is installed by the same dentist who installed it.
- Any duplicate appliance or prosthetic device.
- Use of materials or home health aids to prevent decay, such as toothpaste or fluoride gels, other than the topical application of fluorides.
- Instruction for oral care such as hygiene or diet.
- Periodontal splinting.
- Myofunctional therapy or correction of harmful habits.
- Implantology.
- Charges by a dentist for completing dental forms.
- Charges for broken appointments.
- Treatment of temporomandibular joint disorders.
- Sterilization supplies.
- Services or supplies furnished by a family member.
- Periodontics.
- Orthodontia (For Low and Mid plans only).

Cancellation/Termination:

Coverage is subject to the terms and provisions in the Group Policy (Form GPNP99-DSC-SWM) and certificates of insurance (Form G.23000-Cert.1-SW-FAM) issued to each insured member. In any state validly exercising extraterritorial jurisdiction, the plan will be modified to meet applicable laws.

Coverage terminates:

- All benefits on account of a dependent will end on the earlier of the date that dependent ceases to be a dependent or on the date of the member's death; or
- The date the member ceases to be an active member of the Scott and White Health Plan.

Questions?

Please call 1-800-ASK-4-MET (1-800-275-4638).

Hours of Operation: 8 a.m. – 7 p.m. (CST)

TDD #: 1-888-638-4863 (24 hours)

Dental Claims

Address: MetLife

Dental Claims

P.O. Box 981282

El Paso, TX 79998-1282

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