

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 Level¹		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 EHB² (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 01/01/2026 to 12/31/2026

Groups must have a minimum of 2 enrolled lives

¹Out 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.

²Plan 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 Copy 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						
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 EHB² (2-50 Lives Only)						
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

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Groups must have a minimum of 2 enrolled lives

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²Plan 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:	A, B & C	A, B & C
▪ Individual	\$100	\$100
▪ Family	\$300	\$300
Plan Year Maximum <i>(applies to A,B,C services)</i>	None	None
Out-of-Pocket Annual Maximum	\$450	None
Family Out-of-Pocket Annual Maximum	\$900	None
Orthodontia²	50%	50%
Orthodontia Lifetime Maximum	None	None

¹Negotiated 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.

²Orthodontia 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 - 2 to 99 Lives

DHMO - MET290	
Description	Co-payment
Diagnostic Treatment	
Periodic oral evaluation - established patient	\$0
Comprehensive oral evaluation - new or established patient	\$0
Intraoral - complete series (including bitewings)	\$0
Bitewings - four films	\$0
Panoramic film	\$0
Preventative Services	
Prophylaxis – Adult and Child	\$5
Sealant - per tooth	\$0
Restorative Services	
Amalgam - one surface, primary or permanent	\$12
Resin-based composite - one surface, anterior	\$12
Resin-based composite - one surface, posterior	\$30
Crowns - Additional fees for metal upgrades and/or porcelain apply	
Crown - porcelain fused to high noble metal	\$290
Crown - porcelain fused to predominantly base metal	\$290
Endodontics	
Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to dentinocemental junction and application of medicament	\$40
Endodontic therapy, molar tooth (excluding final restoration)	\$265
Periodontics	
Osseous surgery (including flap entry and closure) – four or more contiguous teeth or tooth bounded spaces per quadrant	\$330
Periodontal scaling and root planing - four or more teeth per quadrant	\$50
Localized delivery of antimicrobial agents via controlled release vehicle into diseased crevicular tissue, per tooth, by report	\$65
Periodontal maintenance	\$40
Prosthodontics	
Complete Denture – Maxillary / Mandibular	\$440
Partial Denture – Resin Base – Maxillary	\$405
Partial Denture – Resin Base – Mandibular	\$405
Oral Surgery	
Extraction - erupted tooth or exposed root (elevation and/or forceps removal)	\$5
Surgical removal of erupted tooth requiring removal of bone and/or sectioning of tooth and including elevation of mucoperiosteal flap if indicated	\$50
Removal of impacted tooth - soft tissue	\$50
Removal of impacted tooth - completely bony	\$135
Orthodontics	
Limited orthodontic treatment of transitional, adolescent or adult dentition	\$1,095
Comprehensive orthodontic treatment of transitional, adolescent or adult dentition (full treatment case up to 24 months)	\$2,095
Adjunctive General Services	
Palliative (emergency) treatment of dental pain - minor procedure	\$10
Consultation – diagnostic service provided by dentist or physician other than requesting dentist or physician	\$0

Dental HMO plan benefits are provided by SafeGuard Health Plans, Inc., a Texas corporation, 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 "Single Service Health Maintenance Organizations" in Texas.

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 01/01/2026 to 12/31/2026												

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 Basic Supplemental Life and AD&D 5 to 99 Lives

Plan Name	Supplemental Life			Dependent Supplemental Life			
	Employee			Spouse		Child	
Plan Options	Less than 10 Lives - \$25,000 or \$50,000 10+ Lives - \$25,000 , \$50,000 , \$75,000 , or \$100,000			Less than 10 Lives - \$10,000 10+ Lives - \$10,000 , \$20,000 or \$30,000 (limited to 50% of the employee amount)		Less than 10 Lives - \$5,000 10+ Lives - \$5,000 or \$10,000	
Non-Medical Maximum Amount	\$100,000			\$30,000		\$10,000	
Participation	Greater of 25% or 5 enrolled			Greater of 25% or 5 enrolled		Greater of 25% or 5 enrolled	
Age Reduction Schedule	None			None		None	
Disability Provision	Waiver of Premium - disabled prior to age 60, coverage continues to age 65						
Rates per \$1000 of covered volume							
Supplemental Life Rates	Level 1	Level 2	Level 3	Level 1	Level 2	Level 3	All SIC Codes
Less than 30	0.080	0.120	0.170	0.080	0.120	0.170	All Ages: 0.26 per \$1,000 of coverage
30-34	0.140	0.180	0.250	0.140	0.180	0.250	
35-39	0.170	0.220	0.300	0.170	0.220	0.300	
40-44	0.210	0.260	0.360	0.210	0.260	0.360	
45-49	0.330	0.410	0.570	0.330	0.410	0.570	
50-54	0.590	0.720	0.980	0.590	0.720	0.980	
55-59	0.980	1.200	1.670	0.980	1.200	1.670	
60-64	1.480	1.810	2.510	1.480	1.810	2.510	
65-69	2.150	2.580	3.510	2.150	2.580	3.510	
70+	3.790	4.570	6.210	3.790	4.570	6.210	
Supplemental AD&D	0.032			0.032		0.051	
Rates illustrated above are valid for effective dates 01/01/2026 to 12/31/2026							

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 01/01/2026 to 12/31/2026			

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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:		
	<u>Age on Date of Disability</u>		<u>Duration</u>
	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 01/01/2026 to 12/31/2026			

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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 Jersey, 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