

Aramco U.S. Dental Plan

MetLife PDP

**A Component Benefit Plan under the Aramco
U.S. Welfare Benefit Plan**

Active Employees

January 1, 2025

Notice to Employees

This document describes the Aramco U.S. Dental Plan (the “Plan”) that Aramco Shared Benefits Company (“ASBCO”) sponsors for Employees on the U.S. Dollar payroll of ASBCO and the Participating Companies (as defined below) (collectively referred to as the “Company”) and their eligible Dependents (as described herein), as in effect on January 1, 2025. “Participating Companies” include Saudi Arabian Oil Company; Aramco Services Company; Aramco Associated Company; Aramco Overseas Company B.V.; Aramco Capital Company, LLC; Saudi Petroleum International, Inc.; Aramco Performance Materials; LLC (USA); Saudi Aramco Energy Ventures, LLC; Saudi Refining, Inc.; and Aramco Venture Management Consulting Company.

This document constitutes the Summary Plan Description (“SPD”) of the Plan as required by the Employee Retirement Income Security Act of 1974, as amended (“ERISA”). ASBCO is the Plan Sponsor and it reserves the right to amend, modify or terminate the Plan, in whole or in part, at any time and for any reason, subject to applicable law.

The Plan is a component benefit plan under the Aramco U.S. Welfare Benefit Plan. The Plan is a welfare benefit plan providing dental benefits for purposes of ERISA.

The Plan is fully insured. Employees pay the entire cost of insurance premiums for the Plan. There are no Company contributions. Employee contributions are paid to Dental Service Plan Insurance Company (“MetLife”) which provides and administers these Plan benefits.

This is only a summary of key provisions of the Plan. The Plan is governed by contracts, policies of insurance and insurance certificates with MetLife, the terms of which are controlling over the information in this summary. Copies of such documents may be made available to Employees by MetLife upon request of the Employee.

Table of Contents

WHAT IS IN THIS DOCUMENT	4
PARTICIPATION	5
ELIGIBILITY	5
ENROLLMENT	6
LEVEL OF COVERAGE	6
COST	7
CHANGING COVERAGE	7
HOW THE PLAN WORKS	8
LIST OF PRIMARY COVERED SERVICES & LIMITATIONS	9
EXCLUSIONS	10
LIMITATIONS	12
EVENTS AFFECTING COVERAGE	12
CONTINUATION OF COVERAGE	14
CONVERSION PRIVILEGE	14
ADDITIONAL PLAN INFORMATION	15
FREQUENTLY ASKED QUESTIONS AND ANSWERS	17

WHAT IS IN THIS DOCUMENT

This SPD describes who is eligible to participate in the Plan, how to enroll, what benefits and services are covered, benefits limitations and exclusions. If you need additional information, there are a variety of resources to help you. Contact information is listed below.

Businessolver

Website	MyAramcoBenefits.com
Member Service	888-532-4144

MetLife

Website	www.metlife.com/mybenefits
Member Service	800-942-0854
Group	93277

ARAMCO U.S. DENTAL PLAN

The Plan, fully insured by MetLife, makes it easy to get the dental care you need. MetLife provides coverage for the cost of preventive care, minor and major restorative and orthodontia for you and your family.

PARTICIPATION

ELIGIBILITY

Coverage under the Plan is available to regular full-time salaried employees of the Company who are employed on a U.S. dollar payroll, working not less than 30 hours per week who elect to participate in the Program. An independent contractor, leased employee, consultant, supplemental contract worker or hourly or daily paid employee are excluded. For these purposes, the Company's classification of an individual is conclusive. An individual will be ineligible for participation even if the individual is later re-classified to be an employee, whether by a court, administrative body, or otherwise; any re-classification will be prospective only and is subject to the Company reclassifying the individual as an eligible employee. Eligible dependent(s) include:

Contact
Businessolver at
888-532-4144 to
enroll or to ask
questions about your
eligibility.

- Spouse – your legally recognized spouse not covered under another Company-sponsored dental plan.
- Child or Children – your and your Spouse's Children under age 26 ⁽¹⁾, including:
 - Your biological children, stepchildren, legally adopted children and children for whom you are the legal guardian;
 - Your foster children, including any children placed with you for adoption;
 - Children for whom you are responsible under a Qualified Medical Child Support Order (“QMCSO”);
 - Your grandchildren who are your legal dependents.
- Your and your spouse's Children age 26 or older who were disabled as determined by the Active U.S. Medical Plan before age 19 while their coverage under the Plan was in force. The request to enroll for this coverage must be submitted to the Claims Administrator no later than 31 days after the disabled Dependent's 26th birthday.

Note 1: Coverage for Dependents attaining age 26 terminates at the end of the month they reach 26 years of age, at which time they will be eligible to elect COBRA benefits.

ENROLLMENT

For You

If you are a regular salaried employee who is newly eligible, you will receive enrollment materials from the Aramco Benefits Center. If you wish to enroll, you must do so within 31 days after your hire date or 60 days after your eligibility as detailed in the “Changing Coverage” section below. If you enroll within the applicable period, your coverage takes effect as of your hire date, the first of the month following the hire date, or your eligibility date. If you fail to enroll for coverage within 31 days after your hire date or 60 days after your eligibility date, or if you were enrolled in the Plan, subsequently canceled your coverage, and later wish to re-enroll, you may enroll within 60 days after a qualified status change or during the next group annual enrollment period. You are not permitted to enroll at any other time.

Contact
Businessolver at
888-532-4144 to
enroll or to ask
questions about your
eligibility.

For Your Dependent(s)

If you want to cover any of your *eligible dependent(s)* under your dental option, you need to enroll them:

- Within 31 days after your hire date; or
- Within 60 days after a qualified status change; or
- The date they become eligible for coverage.

If you do not meet the deadlines, you generally cannot enroll your *eligible dependent(s)* until the next enrollment period, unless you have a subsequent *qualified status change* in your family or employment as noted in “Changing Coverage” section below. Coverage for *eligible dependent(s)* enrolled when you enroll begins the day your coverage begins.

LEVEL OF COVERAGE

When you enroll, you must choose one of the following coverage tiers under the Plan:

- Employee only; or
- Employee + 1 Dependent; or
- Employee + 2 or more Dependents.

If both you and your spouse are eligible to enroll in the Plan as *employees* and you both wish to be covered:

- Each of you may enroll for *Employee only coverage*; or
- One of you may enroll for *Employee plus one* or *Employee plus 2 or more coverage*.

NOTE: You must be enrolled for coverage under the Plan in order to enroll your Dependents for coverage. To enroll, you must contact the Aramco Benefits Center within 31 days from your date of hire or within 60 days after a qualified status change.

COST

You, the employee enrolled in the Plan, pay full cost for dental coverage.

CHANGING COVERAGE

You may only change/drop your coverage each year during the *group* annual enrollment *period* or if you experience a *qualified status change as noted below*:

- Your family status; or
- Your, your Spouse's or your Child's employment status.

A "Qualified Change" in your family status includes:

- Marriage;
- Divorce;
- The birth or adoption of a Child;
- Declaration of guardianship of a Child;
- The death of a Spouse or a Child; or
- Loss of Dependent eligibility.

A "Qualified Change" in employment status includes:

- The employment or unemployment of your Spouse or a Child; or
- A reduction or increase in hours of employment for you, your Spouse or a Child, including a switch between part time and full- time employment, or commencement or return from an unpaid leave of absence.

If you have a *qualified status change*, you may change your coverage only if:

- You submit your request to change your coverage within 60 days after the *qualified status change*.
- Except for with respect to *qualified status changes* that are considered special enrollment rights, the change in coverage must be consistent with the *qualified status change* event.

The change in coverage becomes effective on the date of a Qualified Change in family or employment status, or in the case of marriage on the first day of the following month if the Employee so elects. Failure to timely drop an ineligible dependent may result in company discipline, up to and including termination, and any medical expenses paid on behalf of an ineligible dependent may be charged back to you, or the assessment of COBRA premiums for the period from the date the dependent became ineligible to the date their coverage was subsequently cancelled.

HOW THE PLAN WORKS

Network: PDP Plus

	In-Network % of Negotiated Fee*	Out-of-Network % of R&C Fee
Coverage Type		
Type A: Preventive (cleanings, exams, X-rays)	100%	100%
Type B: Basic Restorative (fillings, extractions)	80%	80%
Type C: Major Restorative (bridges, dentures)	50%	50%
Type D: Orthodontia	50%	50%
Deductible[†]		
Individual	\$50.00	\$50.00
Family	\$150.00	\$150.00
Annual Maximum Bene		
Per Person	\$2,000	\$2,000
Orthodontia Lifetime Maximum		
Per Person	\$2,000	\$2,000
Child(ren)'s eligibility for dental coverage is from birth up to age 26.		

*Negotiated Fee refers 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.

**R&C fee refers to the Reasonable and Customary (R&C) 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. Applies only to Type B & C Services.

LIST OF PRIMARY COVERED SERVICES & LIMITATIONS

The service categories and plan limitations shown represent an overview of your Plan Benefits. This document presents the majority of services within each category, but it is not a complete description of the Plan.

Plan Type	How Many/How Often
Type A - Preventive	
Prophylaxis (cleanings)	<ul style="list-style-type: none"> • Two per calendar year
Oral Examinations	<ul style="list-style-type: none"> • Two exams per calendar year
Topical Fluoride Applications	<ul style="list-style-type: none"> • One fluoride treatment per calendar year for dependent children up to 19th birthday
X-rays	<ul style="list-style-type: none"> • Full mouth X-rays: one per 60 months • Bitewing X-rays: one set per calendar year for adults; one sets per calendar year for children
Space Maintainers	<ul style="list-style-type: none"> • Space Maintainers for dependent children up to 19th birthday
Sealants or Repairs	<ul style="list-style-type: none"> • One application of sealant material every 60 months for each non-restored, non-decayed 1st and 2nd molar of a dependent child up to his/her 19th birthday
Type B - Basic Restorative	
Fillings	<ul style="list-style-type: none"> • One per 24 months
Simple Extractions	
Endodontics	<ul style="list-style-type: none"> • Root canal treatment limited to once per tooth per 24 months
Oral Surgery	
General Anesthesia	<ul style="list-style-type: none"> • When dentally necessary in connection with oral surgery, extractions or other covered dental services
Periodontics	<ul style="list-style-type: none"> • Periodontal scaling and root planning one per 24 months • Periodontal surgery one per 36 months • Total number of periodontal maintenance treatments and prophylaxis cannot exceed four treatments in a calendar year
Type C - Major Restorative	
Implants	<ul style="list-style-type: none"> • Replacement once every 7 years
Bridges and Dentures	<ul style="list-style-type: none"> • Initial placement to replace one or more natural teeth, which are lost while covered by the Plan • Dentures and bridgework replacement: one every 7 years • Replacement of an existing temporary full denture if the temporary denture cannot be repaired and the permanent denture is installed within 12 months after the temporary denture was installed
Crowns/Inlays/Onlays	<ul style="list-style-type: none"> • Replacement once every 7 years

Type D - Orthodontia	
	<ul style="list-style-type: none"> • You, Your Spouse, and Your Children, up to age 26 are covered while Dental Insurance is in effect. • All dental procedures performed in connection with orthodontic treatment are payable as Orthodontia • Payments are on a repetitive basis • 20% of the Orthodontia Lifetime Maximum will be considered at initial placement of the appliance and paid based on the plan benefit's coinsurance level for Orthodontia as defined in the Plan Summary. • Orthodontic benefits end at cancellation of coverage

The service categories and plan limitations shown above represent an overview of your plan benefits. This document presents the majority of services within each category but is not a complete description of the plan.

EXCLUSIONS

This plan does not cover the following services, treatments and supplies:

- 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 you would not be required to pay in the absence of Dental Insurance;
- Services or supplies received by you or your Dependent before the Dental Insurance starts for that person;
- Services which are primarily cosmetic (for Texas residents, see notice page section in Certificate);
- 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;
- Services or appliances which restore or alter occlusion or vertical dimension;
- Restoration of tooth structure damaged by attrition, abrasion or erosion;
- 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 picks, toothbrushes, or dental floss;
- Decoration, personalization or inscription of any tooth, device, appliance, crown or other dental work;
- Missed appointments;
- 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 not required to pay; or
- Received at a facility maintained by the Employer, labor union, mutual benefit association, or VA hospital;
- Services covered under other coverage provided by the Employer;
- Temporary or provisional restorations;
- Temporary or provisional appliances;
- Prescription drugs;
- Services for which the submitted documentation indicates a poor prognosis;
- 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 or biting of food;
- Caries susceptibility tests;
- 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;
- Other fixed Denture prosthetic services not described elsewhere in the certificate;
- Precision attachments, except when the precision attachment is related to implant prosthetics;
- Initial installation 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;
- 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;
- Adjustment of a Denture made within 6 months after installation by the same Dentist who installed it;
- Fixed and removable appliances for correction of harmful habits;
- Diagnosis and treatment of temporomandibular joint (TMJ) disorders. This exclusion does not apply to residents of Minnesota;
- Repair or replacement of an orthodontic device;
- Duplicate prosthetic devices or appliances;
- Replacement of a lost or stolen appliance, Cast Restoration, or Denture; and
- Intra and extraoral photographic images

LIMITATIONS

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 pre-treatment 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. Procedure charge schedules are subject to change each plan year. You can obtain an updated procedure charge schedule for your area via fax by calling 1-800-942-0854 and using the MetLife Dental Automated Information Service. Actual payments may vary from the pretreatment estimate depending upon annual maximums, plan frequency limits, deductibles and other limits applicable at time of payment.

Cancellation/Termination of Benefits: Coverage is provided under a group insurance policy (Policy form GPNP99 / G.2130-S) issued by Metropolitan Life Insurance Company (MetLife). Coverage terminates when your membership ceases, when your dental contributions cease or upon termination of the group policy by the Policyholder or MetLife. The group policy terminates for non-payment of premium and may terminate if participation requirements are not met or if the Policyholder fails to perform any obligations under the policy. The following services that are in progress while coverage is in effect will be paid after the coverage ends, if the applicable installment or the treatment is finished within 31 days after individual termination of coverage: Completion of a prosthetic device, crown or root canal therapy.

Like most group benefit programs, benefit programs offered by MetLife and its affiliates contain certain exclusions, exceptions, reductions, limitations, waiting periods and terms for keeping them in force. For complete details of coverage and availability, please refer to the certificate of insurance or contact MetLife.

EVENTS AFFECTING COVERAGE

Absence without Pay

During any Company-approved absence without pay, you may continue your coverage under the Plan provided you pay your Employee contributions in advance or in some other manner satisfactory to the Company.

Loss of Eligibility

Coverage ends for you or your *eligible dependent(s)* on the last day of the month in which you or the dependent(s) no longer meets the eligibility requirements. Dependent children that age out at

25 (or 26 as applicable) will be covered through the end of the month they turned 25 (or 26). However, you may be able to continue coverage under COBRA (Consolidated Omnibus Budget Reconciliation Act of 1985) by paying the full cost of coverage plus a 2% COBRA administration fee.

Change in Number of Hours Worked

If your employment status changes to *part-time employee* status, you may elect to end or continue your coverage. Conversely, if your employment status changes from part-time employee status to *regular part-time employee* or *regular full-time employee* status, you become eligible to participate in the Plan, effective on the date of your change in status. Businessolver provides administrative services for COBRA benefits under the Plan. For additional information on COBRA benefits, contact the Aramco Benefits Center at 88-532-4144.

Layoff or Termination of Employment

Your coverage ends on the last day of the month if you are laid off due to lack of work or if your employment is terminated; however, you may be able to continue coverage under COBRA.

Retirement

You are not able to continue dental benefit in retirement; you may enroll in COBRA coverage if you so elect.

Death

If you die while you are an *employee*, and you had dependent coverage at the time of your death, your dependent(s) may continue coverage under COBRA for up to 36 months.

If you die while you are an *employee*, after you meet the *retiree coverage eligibility* requirements or as the result of an occupational accident, and you had dependent coverage at the time of your death, your dependent(s) may continue coverage until they no longer meet the definition of *eligible dependent(s)*. The *eligible dependent(s)* must pay the full cost of coverage.

Plan Amendment or Termination

Your coverage changes or ends on the date this Plan is amended or terminated, respectively. However, if you or your dependent(s) incurred covered expenses before the Plan is amended or terminated, benefits generally are paid according to the Plan provisions in effect before the change.

CONTINUATION OF COVERAGE

You and your *eligible dependent(s)* may be eligible to continue vision coverage under COBRA (Consolidated Omnibus Budget Reconciliation Act of 1985) if you would otherwise lose coverage as the result of a *qualifying event*. You would be responsible for paying the full cost of coverage plus a 2% COBRA administration fee.

Under the Consolidated Omnibus Reconciliation Act of 1985 (known as “COBRA”), you and your covered Dependents may extend your Plan coverage if it is lost due to certain “Qualifying Events.”

COBRA lists specific “Qualifying Events,” which enable you or your covered Dependents to elect to continue coverage under the Plan. Regular coverage for you and your covered Dependents will end as of the last day of the month in which a “Qualifying Event” occurs.

An Employee who is absent from employment for more than 30 days by reason of service in the Uniformed Services of the United States may elect to continue Plan coverage for the Employee and the Employee’s Dependents in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended (“USERRA”).

CONVERSION PRIVILEGE

The Plan does not include an option to convert your coverage to an individual policy.

ADDITIONAL PLAN INFORMATION

The Plan is a component benefit plan under the Aramco U.S. Welfare Benefit Plan.

The legal plan name:

Aramco U.S. Welfare Benefit Plan

Plan Sponsor:

Aramco Shared Benefits Company
Two Allen Center
1200 Smith Street
Houston, TX 77002-4313
Phone: (713) 432-4000

Employer Identification Number: 84-4364434

Plan Number: 501

Plan Year: January 1 – December 31

Plan Administrator

Aramco Shared Benefits Company
Two Allen Center
1200 Smith Street
Houston, TX 77002-4313
Phone: (713) 432-4132

Agent for Service of Legal Process:

Aramco Shared Benefits Company
ATTN: General Counsel
P.O. Box 4536
Houston, Texas 77210-4536

ERISA RIGHTS

As a participant in the Group Insurance Plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

Examine, without charge, at the plan administrator's office and at other specified locations, such as worksites, all documents governing the plan, including insurance contracts, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefit Security Administration.

Obtain, upon written request to the plan administrator, copies of documents governing the operation of the plan, including insurance contracts, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.

Receive a summary of the plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called “fiduciaries” of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your plan, you should contact the plan administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

FREQUENTLY ASKED QUESTIONS AND ANSWERS

Q. Who is a participating dentist?

A. A participating dentist is a general dentist or specialist who has agreed to accept negotiated fees as payment in full for covered 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.

Q. How do I find a participating dentist?

A. 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/mybenefits or call 1-800-942- 0854 to have a list faxed or mailed to you.

Q. What services are covered under this plan?

A. The certificate of insurance/summary plan description sets forth the covered services under the plan.

Q. May I choose a non-participating dentist?

A. Yes. You are always free to select the dentist of your choice. However, if you choose a non-participating dentist your out-of-pocket costs may be higher.

Q. Can my dentist apply for participation in the network?

A. Yes. If your current dentist does not participate in the network and you would like to encourage him/her to apply, ask your dentist to visit www.metdental.com, or call 1-866-PDP-NTWK for an application.^{††} The website and phone number are for use by dental professionals only.

Q. How are claims processed?

A. Dentists may submit your claims for you which means you have little or no paperwork. You can track your claims online and even receive email alerts when a claim has been processed. In the event you need a claim form or more information on filing a claim, visit www.metlife.com/mybenefits or call 1-800-942-0854.

Q. Can I get an estimate of what my out-of-pocket expenses will be before receiving a service?

A. 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-MET-DDS9. 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.

Q. Can MetLife help me find a dentist outside of the U.S. if I am traveling?

A. 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.

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

A. 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, subject to applicable law. If the MetLife dental benefit plan is secondary, most coordination of benefits provisions requires 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, subject to applicable law.

Q. Do I need an ID card?

A. 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 the MetLife Preferred Dentist Program. Your dentist can easily verify information about your coverage through a toll-free automated Computer Voice Response system.

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

Based on internal analysis by MetLife. Negotiated fees refer to the fees that in-network dentists have agreed to accept as payment in full for covered services, subject to any co-payments, deductibles, cost sharing and benefits maximums. Negotiated fees are subject to change.

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

*AXA Assistance USA, Inc. 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 dental benefits plan summary for your out-of-network dental coverage.

Like most group benefit programs, benefit programs offered by MetLife and its affiliates contain certain exclusions, exceptions, reductions, limitations, waiting periods and terms for keeping them in force. For complete details of coverage and availability, please refer to the group policy form GPNP99 or contact MetLife.