

Aramco U.S. Retiree Medical Payment Plan

**Health Reimbursement Arrangement (HRA)
for Medicare-Eligible U.S. Dollar Retirees & Dependents**

January 1, 2021

Notice to Participants

Medicare-eligible U.S. Dollar retirees and dependents are not eligible for medical and prescription drug coverage administered by Aetna and Express Scripts sponsored by Aramco Shared Benefits Company (“ASBCO”). Instead, Medicare-eligible U.S. Dollar retirees and dependents* are eligible for a Health Reimbursement Arrangement (“HRA”) provided they enroll in a Medicare Advantage or Medicare Supplement plan through the Mercer Marketplace 365.

* This term also includes certain surviving spouses and individuals receiving Long-Term Disability (LTD) benefits who have reached Medicare eligibility age of 65. For ease of reference, ASBCO generally refers to all of these individuals collectively as Medicare-eligible retirees and dependents. A formal definition around qualification can be found below in Section 1.

This document describes the HRA for Medicare-eligible Retired Employees who were on the U.S. Dollar payroll of ASBCO and the Participating Companies (collectively, the “Company”) and their enrolled Medicare-eligible Dependents. The HRA is offered under the Aramco U.S. Retiree Medical Payment Plan (the “Plan”). This document constitutes the Summary Plan Description (“SPD”) of the HRA offered under the Plan.

Prior to April 1, 2020, the Plan was sponsored by the Saudi Arabian Oil Company and named as the “Saudi Aramco Retiree Medical Payment Plan.”

Effective January 1, 2020, all eligible non-Medicare retirees or dependent spouses ineligible for Medicare Part A and B upon attaining age 65, will be offered an HRA benefit when enrolling in a qualified individual Healthcare Plan from the non-Medicare eligible marketplace. Medicare ineligibility must be verified in writing by the Centers for Medicaid and Medicare. A separate SPD applies for the Aetna-administered PPO Plan and Indemnity Plan coverage.

Participating Companies under the Plan include:

- Aramco Services Company;
- Aramco Associated Company;
- Aramco Overseas Company B.V.;
- Aramco Capital Company, LLC;
- Saudi Petroleum International, Inc.;
- Saudi Refining, Inc
- Saudi Arabian Oil Company; and
- Aramco Performance Materials, LLC (USA)

Saudi Aramco Energy Ventures U.S. LLC (“SAEV US”), is no longer a participating employer effective March 1, 2019, and all service with SAEV US on and after such effective date will not count toward eligibility and employees of SAEV US will not be eligible as of the effective date, with the exception such employees who already met all eligibility requirements prior to such effective date. Motiva Enterprises, LLC, Johns Hopkins Aramco Healthcare (“JHAH”), and Aramco Venture Management Consultant Company (“AVMCC”) are not, and have not been, Participating Companies under the Plan. The Plan and this SPD do not apply to retirees from Motiva Enterprises, LLC, JHAH or AVMCC or to retirees of any other affiliates of Saudi Aramco not specifically identified above.

This SPD does not include all of the information about benefits under the Plan. Additional information can be found in the Plan Document for the Plan, which is the legal instrument under which the Plan is operated. If there

is any inconsistency between this SPD and the Plan Document, the Plan Document will govern. As you read this SPD, you will see certain capitalized terms, which are defined in the "Glossary of Terms", at the end of this SPD.

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.

Please note that "you" and "your" when used in this SPD refer to you, the retiree.

Contact Information

This SPD describes eligibility and benefits under the HRA. If you need additional information there are a variety of resources to help you. Contact information is listed below.

**Aramco
Benefits Center**

1-855-604-6220
www.ybr.com/benefits/saudiaramco

Aramco Benefits Center

For COBRA coverage and questions regarding Retiree Life Insurance or retiree medical eligibility and enrollment

Website <http://www.ybr.com/benefits/saudiaramco>
Member Services 1-855-604-6220

Mercer Marketplace 365

Website <http://retiree.mercermarketplace.com/saudiaramco>
Member Services 1-855-230-2064 (toll free)
1-515-243-1776 (outside U.S.)
Dial 711 (deaf or hard of hearing individuals)
1-857-362-2999 (fax)
Address P.O. Box 14401
Des Moines, IA 50306-3401

NOTE: Mercer Marketplace 365 is a third-party health care coordinator that offers phone support and enrollment services to retirees to help you select individual health care insurance plans. Mercer is also the third-party administrator of the HRA.

Mercer Marketplace 365 is not affiliated with the federal or state health insurance exchanges. Nor is Mercer Marketplace 365 affiliated with the Company or the Plan. The coverage options offered through Mercer Marketplace 365 are individual insurance options, are not sponsored or maintained by the Company, are not part of the Plan, and are not subject to the requirements of ERISA.

Mercer chooses the carriers and plan designs on Mercer Marketplace 365 based on its selection criteria, including selection of carriers that have historically been able to demonstrate long-term rate stability. If a carrier or plan design does not fit into this select criteria, Mercer has chosen not to offer such a plan on Mercer Marketplace.

Table of Contents

Section 1: ELIGIBILITY & COVERAGE	3
A: Who Is Eligible	3
Retiree Eligibility	3
Spouse & Surviving Spouse Eligibility	3
Dependent Eligibility	4
Special Eligibility Rules	4
B. Who is Not Eligible	4
C. Enrollment	5
New Retirees & Newly Medicare-Eligible Spouses or Dependents	5
Annual Enrollment	5
D. When Participation Ends	5
E. Continuing HRA Participation Under COBRA	6
Section 2: USING YOUR HRA	6
A. Aramco Allocation to the HRA	7
B. Reimbursements from the HRA	7
Eligible Expenses	7
Ineligible Expenses	8
Dependent Expenses	8
Reimbursement Process	9
<i>Information Required for Reimbursement Request</i>	9
<i>Direct Deposit</i>	9
<i>Automatic and Recurring Premium Reimbursement Requests</i>	9
<i>One-Time Reimbursement Requests</i>	9
<i>Documentation Required for Reimbursement</i>	9
<i>Deadline for Reimbursement Requests</i>	10
Forfeiture of Unclaimed Reimbursements	10
C. Taxes	10
D. HRA Status When Participation Ends	10
E. Overpayments	10
Section 3: CATASTROPHIC DRUG HRA	11
Eligibility and Activation of Catastrophic Supplemental Reimbursement	11
Eligible Expenses	11
Ineligible Expenses	11
Reimbursement of Qualifying Expenses	11
Forfeiture of Unclaimed Reimbursements	12
Section 4: CLAIMS & APPEALS PROCEDURES	12
A. If Your Claim is Denied	12
B. First-Level Mandatory Appeal	13
C. Second-Level Voluntary Appeal	13
D. Authorized Representative	13
E. Non-Assignment of Benefits or Claims	14
F. Lawsuits Relating to the Plan	14
Exhaustion	14
Deadline for Lawsuit	14
Section 5: PLAN ADMINISTRATION	15
A. Plan Information	15
B. Amendment Authority	16
C. Plan Administration	16

Authority of Plan Administrator	16
Plan Expenses	16
Plan Document	16
SPD	16
D. HIPAA Privacy Rights.....	16
E. Miscellaneous	16
No Employment or Other Rights	16
No Warranty.....	16
Fraud Against the Plan.....	17
Section 6: ERISA RIGHTS	17
Receive Information About Your Plan & Benefits	17
Prudent Actions by Plan Fiduciaries.....	17
Enforce Your Rights.....	18
Assistance With Your Questions	18
Section 7: GLOSSARY.....	18
Section 8: APPENDICES.....	20

Section 1: ELIGIBILITY & COVERAGE

A: Who Is Eligible

Retiree Eligibility

You are eligible for HRA participation as a retiree if you meet ALL of the following requirements:

(1) You are either

- A Retiree age 65 or older and eligible for subsidized post-retirement coverage under the Plan, as explained below, or
- Receiving benefits under the Aramco U.S. Long Term Disability Plan and are age 65 or older; and

(2) You are either

- Medicare eligible and enrolled in individual medical coverage through the Mercer Marketplace 365 exchange. (To enroll in coverage through Mercer Marketplace 365, you must be enrolled in Medicare Part A and B and have a United States address and a United States bank account), or
- you are non-Medicare eligible, have a United States address and a United States bank account and enroll in a qualifying medical plan in the non-Medicare eligible individual marketplace.

(3) Satisfy requirement one above and are enrolled and participating in TRICARE or CHAMPVA.

In general, you are a Retiree eligible for subsidized post-retirement coverage under the Plan if you meet one of the following eligibility tests on the date of termination of service:

- **If you were hired or rehired by the Company before August 1, 2016:** as of your termination of service, you must have attained at least age 50, and have completed ten (10) or more years of Service under the Retirement Income Plan¹, or

- **If you were hired on or after August 1, 2016:** as of your termination of service, you must have attained at least age 55 with ten (10) or more years of Service under the Retirement Income Plan¹, or
- **If you are a former Employee who was rehired on or after August 1, 2016, but you were not eligible for retiree medical coverage under the Plan prior to your most recent termination occurring before your rehire:** as of your subsequent termination of service, you must have attained at least age 55 and have 10 years of Service under the Retirement Income Plan.¹
- **Certain Employees/Retirees as of March 31, 1990:** You were eligible for normal or late retirement under the Retirement Income Plan effective on the date of your termination and you either:
 - Retired before April 1, 1990; or
 - Were an active Employee on March 31, 1990 who was continuously employed by the Company from that date until your normal or late retirement date.
- **For all of the foregoing eligibility tests in this Plan, effective January 1, 2019:** the years of Service referenced will continue to mean years of "Service" under the Retirement Income Plan, however for purposes of this Plan, on and after this effective date, **only such Service earned while on a U.S. Dollar payroll of a Participating Company under this Plan will be counted toward eligibility** under these tests/rules. For the avoidance of doubt, periods of service with an affiliated company that is not a Participating Company and/or while on a non-U.S. Dollar payroll do not count as Service.

Spouse & Surviving Spouse Eligibility

You are eligible for HRA participation as a Spouse or Surviving Spouse of a Retiree if you meet ALL of the following requirements:

(1) The Retiree is eligible for HRA participation.

existing age and Service requirements as set forth above) in order to be eligible to be covered under the Plan, unless you have attained age 60 as of the date of your termination of employment.

¹If you were an Employee who had not previously qualified for coverage under the Plan prior to termination of employment and you were rehired at any time after January 1, 2012, you are required to accrue a minimum of two additional years of continuous Service after rehire (in addition to meeting the

(2) You are age 65 or older and are an eligible Spouse or Surviving Spouse of a Retiree who is eligible for subsidized post-retirement, post-age 65 coverage under the Plan; and

(3) You are either

- Medicare eligible and enrolled in individual medical coverage through the Mercer Marketplace 365 exchange. (To enroll in coverage through Mercer Marketplace 365, you must be enrolled in Medicare Part A and B and have a United States address and a United States bank account), or
- you are an eligible spouse age 65 or older who is non-Medicare eligible, have a United States address and a United States bank account and enroll in qualifying individual medical coverage in the non-Medicare eligible individual marketplace. Eligible spouses are expected to gain eligibility for Medicare through the retiree. The non-Medicare eligible HRA allocation will not exceed 5 years. The non-Medicare eligible HRA allocation is adjusted when the spouse becomes eligible for Medicare Part A (free or for a premium). Spouses who are covered under the Post-age 65 non-Medicare eligible Exchange are expected to gain eligibility for Medicare through the retiree. Coverage through the non-Medicare eligible Exchange is limited to 5 years regardless of the age of the spouse.

The legally recognized Spouse of a Retiree is considered an eligible Spouse, except for a Spouse who is a salaried Employee covered by a medical plan of the Company. (The provision of medical services to employees or dependents by Johns Hopkins Aramco Healthcare or any successor or joint venture partner while located in the Kingdom of Saudi Arabia is not considered for this purpose.)

Surviving Spouse eligibility for the HRA following the Retiree's death is subject to the following conditions:

- If the Retiree died as an active Employee while eligible for early, normal or late retirement with 10 or more years of Retiree Medical Eligibility Service and at the time of death the Surviving Spouse is age 60 or older, the Surviving Spouse is eligible under the Plan and may become eligible for HRA participation upon Medicare

eligibility.

- If the Retiree died before age 65 while an Employee but after becoming eligible for normal or late retirement with at least 2 but fewer than 10 years of Retiree Medical Eligibility Service, the Surviving Spouse is eligible under the Plan and may be eligible for HRA participation upon Medicare eligibility. However, Plan eligibility continues only until the earlier of the last day of the month prior to the month in which the Retiree would have attained age 65 or the date of the loss of eligibility for coverage of the Surviving Spouse.
- If a Surviving Spouse remarries, he or she (and all other eligible Dependents) cease to be eligible for the HRA or Plan.

Dependent Eligibility

Certain unmarried Dependent Children who rely primarily on the Retiree or Surviving Spouse for support, are Medicare eligible, have been continuously disabled since age 19 and were covered under a Saudi Aramco plan at the time of such disability, may be eligible for HRA participation. Contact the Plan Administrator for more information if you think this may apply to your situation.

Special Eligibility Rules

Special eligibility rules apply in certain cases. See the Appendix to this SPD for more information.

B. Who is Not Eligible

You are not eligible for the HRA if any one or more of the following conditions apply:

- You are employed as a regular full-time salaried Employee of the Company or any Affiliate.
- You fail to meet the eligibility requirements described above.
- You are enrolled in Medicaid.
- You are age 65 or older, eligible for Medicare, and do not enroll in, or remain actively enrolled in an individual Medicare medical plan through Mercer Marketplace 365 Exchange, with the exception of TRICARE or CHAMPVA. .
- You are age 65 or older, non-Medicare eligible and do not enroll in, or remain actively enrolled in an individual medical plan through the Post-65

non-Medicare eligible Exchange.

- You receive other medical coverage under the Plan, such as the self-insured coverage administered by Aetna (for medical) and Express Scripts (for prescription drug).

For example, you are not eligible for an HRA if you reside outside the United States and do not maintain a U.S. address or bank account. All non-Medicare eligible participants covered by the Retiree Medical Payment Plan and eligible for benefits past age 65 are provided coverage only through the Mercer Post-65 non-Medicare eligible exchange.

C. Enrollment

New Retirees & Newly Medicare-Eligible Spouses or Dependents

The Plan requires all those who are eligible for Medicare and are covered under the Plan, to enroll in Medicare Parts A and B as soon as they become eligible for Medicare on the basis of age or disability. Such Medicare coverage is considered primary over the Plan regardless of any other coverage the retiree or dependent may otherwise have.

During your retirement planning, if you are 65 years of age or if you will turn 65 within the first 60 days after you retire, you should call Social Security approximately 120 days prior to your retirement to initiate enrollment in Medicare Parts A and B for you (and any Medicare-eligible dependents) to ensure your coverage will be effective when you retire. This will ensure you don't have a gap in coverage.

New retirees over age 65 or turning 65 within the first 60 days after retirement should also contact Mercer approximately 120 days prior to retirement to ensure that you receive information regarding Mercer Marketplace 365 enrollment and your HRA eligibility. You will need to enroll in individual medical coverage through Mercer Marketplace 365 a few months in advance with a future effective date when your Medicare becomes effective so that your HRA is established as of this same date. You are also eligible to enroll in prescription drug, dental and vision coverage through Mercer Marketplace 365.

If you are a Retiree or dependent who is under age 65 and receiving pre-65 retiree medical coverage from the Company under the Aetna-administered PPO Plan, you should receive information regarding Mercer Marketplace 365 from Mercer approximately 120 days prior to reaching age 65. If you do not

receive this information, you should contact Mercer or the Plan Administrator to avoid an interruption in coverage.

Annual Enrollment

The individual Medicare medical and prescription drug plans are fully insured policies provided by insurance carriers available through Mercer Marketplace. Each year during the Medicare Annual Enrollment period, you can review your plan options and, if you choose, enroll in a different Medicare plan option. Medicare determines the annual enrollment period, which is October 15th to December 7th. You may also review your Medicare Supplement plan, if applicable, with Mercer Marketplace at any point in the year, although you may be subject to underwriting requirements.

If you had not previously enrolled in individual Mercer Marketplace 365 coverage, either because you were ineligible (for example, because you lived outside the U.S. without a U.S. address) or you declined to enroll, you may be eligible to enroll at future Annual Enrollment periods, subject to the Plan's eligibility requirements. However, you generally will need to have maintained continuous coverage under some combination of this Plan, or another employer's plan covering active or retired employees or dependents and will need to provide documentation supporting the continuous coverage.

The Annual Enrollment period for a Post 65 non-Medicare eligible participant is from November 1 to December 15. Each year during the annual enrollment period participants may review their coverage and, if they choose, enroll in a different plan. Should you choose to change your coverage you may be required to undergo medical underwriting with your new insurance company.

D. When Participation Ends

You will cease being eligible for and cease participating in the HRA under the Plan on the last day of the earliest month in which any one or more of the following occurs:

If you were eligible for the HRA due solely to your receipt of Long Term Disability benefits, the date you are no longer receiving benefits under the Company's Long Term Disability Plan;

The date you are rehired by the Company or any Affiliate as an active employee and for the duration of your active employment;

The date you cease to be eligible for Medicare;

Your date of death;

The date as of which you are no longer enrolled in individual medical insurance coverage through Mercer Marketplace;

The date as of which you permanently waive or opt out of your HRA participation;

The effective date of any amendment terminating your HRA or Plan eligibility;

The date the HRA or Plan is terminated; or

The date you no longer are eligible for benefits under the Plan because you cease to be an eligible Retiree or for any other reason;

For a Surviving Spouse (and all other eligible Dependents), the date the Surviving Spouse remarries, or, if you die before age 65 while an Employee but after becoming eligible for normal or late retirement with at least 2 but less than 10 years of Service, your Surviving Spouse's HRA eligibility will cease on the earlier of the last day of the month prior to the month in which you would have attained age 65 or the date of the loss of eligibility for coverage of the Surviving Spouse for any other reason.

Your participation in the HRA and/or Plan also may be terminated if you submit materially false information or commit fraud in connection with your HRA or Plan

participation. See "**Fraud Against the Plan**" in Section 5.D, below.

When your participation in the HRA ends, see "**Section 2.D HRA Status Upon End of Participation**" for information regarding how to submit claims for expenses incurred during participation.

E. Continuing HRA Participation Under COBRA

The HRA is subject to the Consolidated Omnibus Budget Reconciliation Act (COBRA). Eligible participants who experience a COBRA qualifying event and lose HRA coverage as a result will be offered the opportunity to continue their HRA as a COBRA participant at the full COBRA rate. In most cases, the rate will be based on the date of the qualifying event. Qualifying event could include for example, the death of a Retiree or divorce; a qualifying event will be considered to have occurred when the eligible surviving dependent no longer has access to the Retiree's HRA.

If you or a covered Dependent loses coverage under the Plan due to **divorce, legal separation, or loss of Dependent eligibility**, it is your responsibility to notify the Aramco Benefits Center within 60 days after the occurrence of the Qualifying Event.

Following receipt of timely notification from you that a Qualifying Event has occurred, the Aramco Benefits Center will inform you, your Spouse or your Dependent within 14 days of the right to obtain continuation coverage under COBRA.

Alight Solutions provides administration services for COBRA benefits under the Plan. To reach Alight Solutions, call 1-855-604-6220.

Section 2: USING YOUR HRA

Once you become eligible for an HRA (as described in **Section 2: Eligibility & Coverage**), Mercer will set up an HRA in the name of the eligible Retiree, Surviving Spouse, or eligible Surviving Dependent. If there are multiple eligible members, the HRA will be a household account, which means that subsidies for each eligible member will be made to the same account and allows you to share the HRA amounts across the household instead of just one member.

Note that the HRA is a "notional" account that is tracked for record-keeping purposes only. There are no actual funds held in your name, and the account is not portable. The account merely tracks credits and debits; it does not bear interest or accrue any earnings.

When the time comes to pay benefits on your behalf, the money comes from the Plan or the Company's

general assets.

A. Aramco Allocation to the HRA

For each Plan Year, the Company may allocate a fixed dollar amount to your HRA. The amount of any HRA allocation will depend on your eligibility, service, retirement date, or other factors determined by the Company. The amount is determined each Plan Year in the Company's sole discretion as sponsor of the Plan. If your participation in the HRA begins after January 1 (such as, for example, for the new participation effective July 1, 2018), the amount of your HRA credit for that year will be pro-rated based on the number of months remaining in the Plan Year.

The Company's annual allocation is \$1,756.00 per eligible individual ages 65-79. The annual allocation for each eligible individual age 80 and older is \$2,256.00.

The Company's monthly allocation for the Post 65 non Medicare eligible participants is \$1,300.00 per eligible individual.

Your HRA will be reduced by the amount of any eligible medical expenses for which you are reimbursed from the HRA during the Plan Year. At any time, you may receive reimbursement for eligible substantiated expenses up to the amount in your HRA account. Note: you are not permitted to make any contributions to your HRA account.

Any balance remaining in your HRA at the end of the Plan Year can be carried forward to future Plan Years provided that you continue to meet the eligibility requirements for HRA coverage.

Note: You can only use a federal tax credit or employer provided subsidy, but may not use both. If you choose to use a federal tax credit, you will not be eligible to receive the HRA while receiving the tax credit.

B. Reimbursements from the HRA

Expenses for health care services and supplies are eligible for reimbursement if they are:

For health care;

Considered tax-deductible by the IRS;

Not reimbursable by a benefits plan, an HMO, insurance or any other source;

Incurred by you, your spouse or eligible dependents during your coverage period; and

Submitted for reimbursement in accordance with the procedures, required documentation and by the necessary deadlines as established by the Plan Administrator.

Eligible Expenses

You can use the amounts in the HRA to reimburse your expenses for:

All (or a portion of) the monthly premiums for individual Medicare supplemental insurance, such as Medicare Advantage, Medicare Supplement and prescription drug plans purchased through Mercer Marketplace 365, TRICARE, or CHAMPVA for you (and your tax-qualified dependents);

All (or a portion of) the monthly premiums for a qualifying individual medical plan for a Post 65 non-Medicare eligible retiree or spouse;

Medicare Part B or D premiums (if any), for you and your tax-qualified dependents;

Eligible medical and out-of-pocket expenses such as coinsurance, co-payments and deductibles, for you and your tax-qualified dependents;

Dental and/or vision premiums for plans purchased through Mercer Marketplace 365, for you and your tax-qualified dependents; or

Any "eligible health care expense."

Some premiums and out-of-pocket expenses may not be eligible for reimbursement through the HRA. Please contact Mercer Marketplace 365 to inquire regarding specific expenses.

An "eligible health care expense" is an expense incurred during your coverage period by you or any tax-qualified dependent for health care, as defined in Internal Revenue Code Section 213(d) (generally, expenses related to the diagnosis, care, mitigation, treatment or prevention of disease).

For a complete list of expenses allowed by the Internal Revenue Service (IRS) and any special requirements for a service or supply that can be reimbursed from your HRA, refer to IRS Publication 502 or contact your tax advisor. This publication is available by calling 1-800-TAX-FORM (1-800-829-3676). You can also access IRS

Publication 502 by logging on to the IRS website at www.irs.gov/pub502 on the IRS website.

Some common examples of eligible expenses include:

Medications (in reasonable quantities). Note: Medications generally are considered eligible medical expenses only if they are prescribed by a doctor (without regard to whether the medication is available without a prescription) or is an insulin product;

Dental expenses;

Dermatology;

Physical therapy;

Contact lenses or glasses used to correct a vision impairment;

Birth control pills;

Chiropractor treatments;

Hearing aids;

Wheelchairs;

Premiums for medical, prescription drug, dental or vision coverage provided through Mercer Marketplace 365;

Premiums for medical, prescription drug, dental or vision coverage provided outside of Mercer Marketplace 365 (as long as you meet the requirements to qualify for an HRA);

Premiums for long-term care insurance.

Ineligible Expenses

You may receive reimbursement only for eligible expenses and only for amounts that have not been (and will not be) reimbursed by insurance or otherwise. In addition, you may not receive reimbursement for amounts for which you have obtained (or will obtain) an income tax deduction.

Only eligible medical expenses incurred while you are an eligible retiree with an HRA (and submitted in accordance with the procedures and deadlines established by the Plan Administrator) can be reimbursed from your HRA. Similarly, only eligible medical expenses incurred while your tax-qualified dependent remains eligible to be covered under the HRA may be reimbursed from your HRA. Medical expenses are "incurred" when the medical care is provided, not when you or your eligible dependent are billed, charged or pay for services. Thus, an expense that has been paid but not incurred (e.g.,

pre-payment to a physician) will not be reimbursed until the service or treatment giving rise to the expense has been provided.

Some examples of common items that are not eligible expenses include:

Baby-sitting and child care;

Long-term care services;

Cosmetic surgery or similar procedures (unless the surgery is necessary to correct a deformity arising from a congenital abnormality, accident or disfiguring disease);

Funeral and burial expenses;

Household and domestic help;

Massage therapy;

Custodial care;

Health club or fitness program dues;

Cosmetics, toiletries, toothpaste, etc.

Expenses incurred prior to the date that you became eligible for the HRA;

Expenses incurred after the date that you cease to be eligible for the HRA; and

Expenses that have been reimbursed by another plan or for which you plan to seek reimbursement under another administrator of your plan option.

If you need more information regarding whether an expense is an eligible medical expense, contact Mercer.

Dependent Expenses

Your tax-qualified dependents' eligible expenses can be reimbursed through your HRA.

An eligible dependent is anyone you claim as a dependent on your federal tax return, including: your spouse and your dependent children.

Your eligible dependents' expenses will cease being eligible for reimbursement under the HRA on the earliest of:

The date your dependent(s) ceases to be an eligible dependent for any reason;

The date you and your spouse divorce;

The effective date of any amendment terminating your dependent(s) eligibility under the HRA or Plan;

The date the HRA or Plan is terminated; or

The date HRA funds are exhausted.

The date as of which you are no longer enrolled in individual medical insurance coverage through Mercer Marketplace 365

savings account). Reimbursements through direct deposit generally are faster than reimbursement checks mailed to you following claim approval and are the preferred method for payment of HRA benefits under the Plan.

You can sign up for direct deposit by setting it up online or by completing a paper Direct Deposit Form and submitting it to Mercer.

Automatic and Recurring Premium Reimbursement Requests

An automatic premium reimbursement feature is available for most individual insurance coverages purchased through the Mercer Marketplace 365 exchange. If you enroll in such a plan, your premiums can automatically be reimbursed from your HRA after your premium has been reported by your insurer as paid. .

Plans that are not eligible for automatic reimbursement may be eligible for recurring premium reimbursement. If you establish recurring premium reimbursement, your premiums can be reimbursed from your HRA on a specific day each month. Mercer may establish rules for automatic and recurring premium reimbursement requests. In particular, Mercer generally requires that you submit a new recurring premium reimbursement request each year. To avoid a delay in reimbursement, you should submit an annual request by December 15 of the preceding year.

One-Time Reimbursement Requests

One-time reimbursement requests may also be submitted each time you want to be reimbursed for an eligible expense. These one-time requests can be submitted for insurance plan premiums that are not eligible or set-up for automatic or recurring premium reimbursement, or for other eligible health care expenses.

Documentation Required for Reimbursement

Mercer may require you to provide proof and documentation substantiating your reimbursement requests. Examples of such proof include Explanation of Benefit (EOB) statements, bills, itemized receipts, Social Security billing statements, copies of prescriptions, cancelled checks, and other proofs of payments.

Reimbursement Process

Mercer administers the HRA for the Company and processes your reimbursements. To receive reimbursement, you will need to submit a claim in accordance with Mercer's procedures and include all of the required information and documentation. In general, it is faster to submit claims online using the Mercer portal, but you can also submit paper forms.

You are responsible for submitting claims in compliance with Mercer's rules and requirements.

Information Required for Reimbursement Request

To request reimbursement, you must do so in writing in accordance with Mercer's procedures, which generally require you to include the following:

The amount of the expense for which you are requesting reimbursement;

The date you incurred the expense;

A brief description and the purpose of the expense;

The name of the person who incurred the expense and their relationship to you;

The name of the person to whom you paid the expense;

A statement that you have not been and will not be reimbursed by insurance or otherwise for the expense; and

Any required documentation reasonably requested by Mercer for processing your request.

Direct Deposit

The preferred method of payment is direct deposit and you are strongly encouraged to sign up for direct deposit of reimbursements to an account in a financial institution (for example, your checking or

Deadline for Reimbursement Requests

While you are a Participant in the HRA, you have until March 31, of the year following the year in which an expense is incurred to submit reimbursement requests. See **Section 2.D: HRA Status When Participation Ends**, below, for the deadline for submitting reimbursement requests upon your ceasing participation in the HRA.

Forfeiture of Unclaimed Reimbursements

Any HRA payments that are unclaimed shall automatically forfeit 12 months after the check was mailed or the payment was otherwise attempted. Forfeited payments will be returned to the Plan and applied to reduce future contributions of the Company, to offset reasonable expenses of administering the Plan, or as otherwise provided in the Plan document.

C. Taxes

The amount that is credited to your HRA and any expenses reimbursed from your HRA generally are not taxable to you or your dependents. However, expenses reimbursed for any non-dependents may be taxable to you. In addition, any reimbursements for ineligible health care expenses may be taxable to you.

Health care reimbursements are not eligible deductions or credits on your individual tax return.

Tax treatment is not guaranteed to any Participant. The Plan, Company, and Mercer cannot provide you tax advice. You are responsible for the tax treatment of any Plan participation or benefits.

If you have any questions about taxes, contact your tax advisor.

D. HRA Status When Participation Ends

When your participation in the HRA ends (due to your ineligibility or for any other reason):

You will not receive additional Company HRA allocations.

You will not be eligible to obtain reimbursement for expenses incurred after you cease to be eligible.

You will have until March 31 following the end of the year in which you cease participation to request reimbursement for expenses incurred while you had HRA coverage.

Any remaining HRA balance will be permanently forfeited.

For example, if you are a Retiree who cancels your enrollment in individual coverage under Mercer Marketplace 365, effective June 30th:

You will stop receiving any additional HRA allocations for any period after June 30;

You will not be eligible to use your HRA balance to reimburse for any expenses incurred after June 30; and

If you have any eligible expenses incurred on or before June 30, you may request reimbursement but you must do so by March 31 of the following year.

E. Overpayments

It is your responsibility to reimburse the Plan if you and/or your covered family members receive a Plan benefit to which you (or they) are not entitled — for example, because of an administrative error, or processing error, payment from another benefit plan, Medicare or other source primary over the Plan coverage (e.g., automobile insurance or proceeds from litigation). If such an overpayment occurs for any reason, you are obligated to reimburse the Plan for the amount of the overpayment.

Failure to reimburse the Plan may result in any or all of the following actions: Collection measures by the Plan and/or a debt collector, application of all or any portion of an overpayment toward satisfaction of other claims for benefits, loss of eligibility under the Plan, civil litigation and criminal prosecution. These actions are not the exclusive remedies available to the Company or the Plan Administrator for recovering overpayments.

Section 3: CATASTROPHIC DRUG HRA

If you are HRA-eligible and enroll in prescription drug coverage through Mercer Marketplace 365 (including a Medicare Advantage prescription drug plan), you will be eligible for a Catastrophic Supplemental Prescription Drug Reimbursement benefit. This benefit reimburses 100% of your eligible out-of-pocket prescription drug costs in a Plan Year after you reach the catastrophic phase of Medicare Part D Prescription Drug Plan for the Plan Year. Retirees who reach the catastrophic phase of cost may apply for reimbursement of eligible costs. You can apply for reimbursement for such expenses in accordance with the same rules described in Section 2 above for HRA reimbursements. However, these benefits are payable by the Plan and are not deducted from your HRA balance.

Eligibility and Activation of Catastrophic Supplemental Reimbursement

Once you have accumulated covered Medicare Part D expenses in an amount equal to the true out of pocket (TrOOP) limit set by the Center for Medicare and Medicaid Services (CMS) for the applicable Plan Year, you will enter the catastrophic coverage stage of Medicare Part D.

For more information visit the Drug Coverage (Part D) Catastrophic Coverage section on www.medicare.gov for the catastrophic coverage level for the current calendar year. For example, in 2018 the catastrophic coverage level is reached when a member reaches the Medicare prescription threshold of \$5,000 of prescription drug expenses.

When the catastrophic level of coverage is reached for the calendar year, you must contact Mercer to request reimbursement online or via paper. This form will include instructions for substantiating each eligible prescription drug expense. To activate the Catastrophic Supplemental Reimbursement, you must submit the claim form with relevant documentation that the TrOOP limit has been met.

Upon review and approval of your claim, Mercer will activate Catastrophic Supplemental Reimbursement for you. Reimbursement for qualifying prescription drug expenses will be paid for the remainder of the

calendar year. This account will be subject to certain limitations.

Eligible Expenses

The Catastrophic Supplemental Prescription Drug reimbursement is available to reimburse qualifying Medicare Part D Prescription Drug expenses incurred after the date you reached the TrOOP limit through the end of the calendar year in which the TrOOP limit was met.

Ineligible Expenses

The items below are not considered qualifying Medicare Part D Prescription Drug expenses and are ineligible for reimbursement under the Catastrophic Supplemental Prescription Drug Reimbursement arrangement:

- Prescription drugs not covered by Medicare Part D.

- Prescription drug plan premiums.

- Prescription drug expenses reimbursed from other sources- including other health plan coverage or pharmaceutical manufacturers.

- Other out-of-pocket health care expenses including medical, dental or vision costs.

- Dependent prescription drug expenses.

- Expenses incurred outside the calendar year in which the TrOOP limit was met.

- Expenses incurred while you were not a Retiree HRA Plan participant.

Reimbursement of Qualifying Expenses

After Catastrophic Supplemental Prescription Drug Reimbursement is activated for you, you may submit a claim for reimbursement for qualifying Medicare Part D prescription drug expenses incurred after the date you met the TrOOP limit through the end of the calendar year in which the TrOOP limit was reached.

You have until March 31st of the following year to submit claims for eligible expenses incurred during the calendar year in which the TrOOP limit was reached.

Reimbursement after Termination

When your participation in or eligibility for the Retiree HRA Plan ends, for any reason:

Eligibility for the Catastrophic Supplemental Prescription Drug Benefit also ceases.

Prescription drug expenses incurred after the date participation terminates are not eligible for reimbursement.

You may continue to submit claims for eligible prescription drug expenses incurred prior to the date participation terminated provided you file the claims by March 31 of the following year.

In the event of your death, your estate or representatives may also submit claims for eligible prescription drug expenses incurred

prior to the date participation ended as long as they file the claims within six months following the date of death or by March 31 of the following plan year, whichever is later.

Forfeiture of Unclaimed Reimbursements

Any Catastrophic Supplemental Prescription Drug Reimbursement payments that are unclaimed shall automatically forfeit 12 months after the check was mailed or the payment was otherwise attempted. Forfeited payments will be returned to the Plan and applied to reduce future contributions of the Company, to offset reasonable expenses of administering the Plan, or as otherwise provided in the Plan document.

Section 4: CLAIMS & APPEALS PROCEDURES

You must file an initial claim for reimbursement in accordance with Mercer's procedures and requirements as described in Section 2 above. Claims and first-level appeals are handled by Mercer and must be filed in accordance with these Claims and Appeals Procedures. Claims for benefits under the HRA are considered "Post-service claims." You must follow and exhaust these Claims and Appeals Procedures before you may be eligible to bring a lawsuit relating to HRA benefits under the Plan.

A. If Your Claim is Denied

If your claim for reimbursement is denied, in whole or in part, you will be notified in writing within 30 days after Mercer receives your claim. If Mercer determines that an extension of this time period is necessary due to matters beyond the control of the Plan, it will notify you within the initial 30-day period that an extension of up to an additional 15 days will be required. If the extension is necessary because you failed to provide sufficient information to allow the claim to be decided, you will be notified and you will have at least 45 days to provide the additional information.

The notice of denial will contain:

- The specific reason(s) for the denial.
- Reference to specific Plan terms on which the denial is based.

- Any additional information or material necessary to perfect the claim and an explanation of why such information or material is necessary.
- The process for requesting an appeal, including a statement of your right to bring an action under section 502(a) of the Employee Retirement Income Security Act (ERISA) following a denial of your appeal.
 - If an internal rule, guideline, protocol, or other similar criterion was relied upon for the denial, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon for the denial and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to you upon request.
 - If the denial is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request.
- In the case of a denial of a claim involving urgent care, a description of the expedited review process applicable to such claims.

B. First-Level Mandatory Appeal

If your claim is denied, in whole or in part, you have the right to appeal the decision. Mercer is the first level appeals administrator.

Your written appeal should include the reasons why you believe the benefit should be paid and information that supports, or is relevant to, your claim (written comments, documents, records, etc). Your written appeal may also include a request for reasonable access to, and copies of, all documents, records and other information relevant to your claim. You must submit your written appeal within 180 days from the date of the notice of denial.

The review of your appeal will take into account all comments, documents, records and other information submitted relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination. You will receive a response to the appeal within 60 days after Mercer receives your claim.

If Mercer determines that an extension of this time period is necessary due to matters beyond the control of the Plan, it will notify you within the initial 60-day period that an extension is needed.

If your appeal is denied, you will receive written notice of the decision. The notice will set forth:

- The specific reason(s) for the denial and the Plan provisions upon which the denial is based.
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the denial of your claim.
- A statement of the procedure to appeal the denial of your claim and your right to obtain information about such procedure.
- A statement of your right to bring an action under section 502(a) of ERISA.
- If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to you upon request.

- If the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request.
- The following statement: "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency."

C. Second-Level Voluntary Appeal

If your first-level appeal is denied, you may submit a final voluntary appeal with the ASBCO Plan Administrative Committee within 30 days of the denial of your mandatory appeal. The final voluntary appeal should include any new information pertinent to the claim. You will be notified within 15 days after your request was received whether the information is considered new information.

If it is determined that there is no new information pertinent to your claim, you will be notified that your final appeal will not be considered. If it is determined that there is new information, a decision will be made within 60 days of the date the Plan Administrative Committee receives the voluntary appeal. The Plan Administrative Committee is entitled to obtain an extension of an additional 60 days for consideration of a voluntary appeal. You will be notified if such an extension is necessary.

D. Authorized Representative

A member may designate a designated representative, but only through procedures established by the Plan Administrator. The Plan Administrator will provide a form for designation of representative to the member upon the request of the member. This form will provide the instructions and procedures for properly submitting the valid designation. Only those designations duly made through this process will be valid under the terms of this Plan. Any other attempt of purported designation of a designated representative not submitted to the Plan Administrator in accordance with these procedures is not valid for any purposes under the Plan and will be considered invalid, null and void.

E. Non-Assignment of Benefits or Claims

Assignment of benefits or claims by a member or any other covered individual under this Plan to any third party or provider is not permitted. No employee, retiree, member, participant or any other covered individual under this Plan may sell, assign, or in any other manner transfer any rights or claims under the Plan in any manner to any third-party or to any provider or to any other person or individual. Any attempt to so assign or convey the covered individual's rights or claims under this Plan will be considered null and void.

F. Lawsuits Relating to the Plan

Exhaustion

You must follow and exhaust these Claims and Appeal Procedures before you bring legal action relating to HRA benefits under the Plan.

Deadline for Lawsuit

The Plan provides a deadline for filing a lawsuit under ERISA relating to your benefits under the Plan. You should refer to the Plan Document for more information about this deadline.

In general, the deadline for a lawsuit is one year after the earliest of:

- The date an underlying health expense was incurred;
- The date the first benefit payment was actually made or allegedly due (whichever is earlier);
- The date the Plan, Company, Plan Administrator, Mercer, or any other agent or service provider first repudiated the alleged obligation to provide benefits;
- The earliest date on which you or your beneficiary (if applicable) knew or should have known of the material facts on which such action is based, regardless of whether you (or your beneficiary) were aware of the legal theory underlying the claim.

However, if a request for administrative review pursuant to the Plan's Claims and Appeals Procedures is pending when the deadline occurs, the deadline for filing such claim will be extended to the date that is 60 calendar days after the final denial

(or deemed denial) of such claim or appeal on administrative review.

The Plan's deadline replaces and supersedes any later limitations period that otherwise might apply under applicable federal or state law. In the event of a claim or lawsuit brought by more than one person, the Plan's deadline applies separately to each person.

The Plan Administrator has the discretion to extend this deadline upon a showing of exceptional circumstances that provide good cause for an extension, in the Plan Administrator's determination.

This limitations period will apply to the full extent permissible under ERISA.

Section 5: PLAN ADMINISTRATION

A. Plan Information

Plan Name	Aramco U.S. Retiree Medical Payment Plan
Plan Number	502
Plan Sponsor	Aramco Shared Benefits Company c/o Managing Director Two Allen Center 1200 Smith Street Floor 31 Houston, TX 77002-4313 EIN 84-4364434
Plan Administrator	Aramco Shared Benefits Company, through its Employee Benefits Committee Two Allen Center 1200 Smith Street Floor 31 Houston, TX 77002-4313 (713) 432-4000 (800) 343-4272 The Employee Benefits Committee has delegated the authority to determine voluntary appeals to the ASBCO Plan Administrative Committee.
HRA Initial Claims Reviewer and First Level Appeals Administrator	Mercer Marketplace 365 Exchange P.O. Box 1440 Des Moines, IA 50306
Agent for Legal Process	Aramco Shared Benefits Company P.O. Box 4536 Houston, Texas 77210-4536 Attention: General Counsel
Type of Benefits	Group health plan providing welfare benefits under ERISA. The Plan is a “retiree-only” plan and is therefore not subject to certain requirements of the Affordable Care Act.
Type of Administration	HRA is third party administered by Mercer
Plan Year	Calendar year
Funding	The HRA is an unfunded, “notional” account. Reimbursements under the HRA are made from the Plan, which could be from the Company’s general assets or from a trust or other source used for funding benefits under the Plan. The Plan is funded through a VEBA and/or a 401(h) account under the Retirement Income Plan. JP Morgan Chase is the trustee of the trusts holding these assets. Participants are not permitted to make contributions to the HRA.

B. Amendment Authority

ASBCO adopted the Plan with the intent to maintain it indefinitely. However, the Plan Sponsor reserves the right to modify, amend, suspend or terminate the Plan at any time. The Employer does not promise the continuation of any benefits nor does it promise any specific level of benefits at any time, including at or during retirement. **The Plan Sponsor reserves the right to change or discontinue the Plan or to reduce or eliminate benefits at any time.**

The Plan is a voluntary plan on the part of the Company.

C. Plan Administration

Authority of Plan Administrator

The Plan Administrator is responsible for the administration of the Plan and has final discretionary authority to interpret the Plan's provisions, to resolve ambiguities in the Plan and to determine all questions relating to the Plan, including eligibility for benefits. The decisions of the Plan Administrator are final, conclusive and binding on all persons with respect to all issues and questions relating to the Plan. The Company's determination will be conclusive regarding rates of pay, periods of absence with or without full or part pay, length and continuity of service and termination of employment.

The Plan Administrator may delegate to other persons the responsibilities for performing ministerial duties in accordance with the terms of the Plan and may rely on information, data, statistics or analysis provided by these persons.

Plan Expenses

HRA balances are not expected to be debited for administrative costs. Any such expenses are anticipated to be paid by the Company. Any such expenses could also be paid via commissions received by Mercer in connection with Participants' enrollment in individual coverage through the Mercer Marketplace 365.

Plan Document

The Plan Document for the Plan is the legal instrument under which the Plan is operated. If there is any inconsistency between this SPD and the Plan Document, the Plan Document will govern, as determined by the Plan Administrator in its sole

discretion. You may obtain a copy of the Plan Document by written request to the Plan Administrator. There may be a reasonable charge for copies.

No person has authority to make any verbal or written statement or representation of any kind regarding the Plan that alters the Plan Document. If there is any inconsistency between the Plan Document or SPD and any other statement or representation about the Plan, the Plan Document and SPD will govern, as determined by the Plan Administrator in its sole discretion.

SPD

This SPD describes the HRA offered under the Plan in effect as of January 1, 2021. Subsequent SPDs or Summaries of Material Modification may be provided from time to time, in accordance with ERISA.

D. HIPAA Privacy Rights

The Plan is subject to the privacy rules of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), which provides safeguards on your protected health information maintained by Mercer Marketplace 365 and the HRA. These privacy rules are described in the Notice of Privacy Practices previously sent to you. If you would like another copy of the Plan's Notice of Privacy Practices, you may contact the Plan Administrator.

E. Miscellaneous

No Employment or Other Rights

The Plan and this SPD do not create a contract of employment. Eligibility to participate in a plan or program or receipt of benefits does not constitute a promise or right of continued employment or render any person an employee of the Company or any Affiliate or constitute any commitment by the Company to continue any plan or benefit.

No Warranty

The Plan does not provide for payment for all medical care. The Plan Administrator only determines whether your medical care is or is not covered by the Plan, not what medical care is appropriate for you. The ultimate decisions on your medical care must be made by you and your

Physician. The Company and its Affiliates and the Plan do not endorse any provider or represent or warrant the quality of the care they provide. The decision to choose any health plan option or use any provider is the participant's responsibility.

Fraud Against the Plan

It is a crime to knowingly, and with intent to injure, defraud, or deceive the company, provide any fraudulent information, including enrolling an individual whom you know is not eligible to participate in the Plan, continuing to maintain coverage for an individual whom you know is not eligible, or filing a claim that contains any false, incomplete, or misleading information. If you intentionally misrepresent information to, knowingly withhold relevant information from, or deceive or mislead the Company or the Plan, the Plan Administrator may:

- (1) terminate your and/or your beneficiary's participation in the Plan, either retroactively to the date deemed appropriate by the Plan Administrator, or prospectively;
- (2) require you to reimburse the plan for the employer's share of premiums or amounts it paid to you or your beneficiary, including all costs of collection such as attorneys' fees and court costs;

- (3) prohibit you from enrolling in the plan or other benefit plans sponsored by the Company; and/or
- (4) take additional action the Plan Administrator deems appropriate in its sole discretion.

In addition, your employer may terminate your employment or take other legal action. These actions, as well as the submission of materially false information, may result in the rescission of your coverage under the Plan, retroactive to the date of the fraudulent act, and you may be subject to prosecution and punishment under state and/or federal laws. The Plan would terminate coverage of a participant or beneficiary for a reason such as fraud. If you or your beneficiary is terminated from eligibility under any other benefit plan sponsored by the Company because of fraud or misrepresentation, the Plan Administrator may determine that you and/or your beneficiary are not eligible for coverage under the Plan.

Note: The Plan Sponsor has the right to demand that you pay back Benefits the Plan Sponsor paid to you, or which were paid in your name, during the time you were erroneously covered under the Plan. After the first two years, the Plan Sponsor can only demand that you pay back these Benefits if the claim contained a fraudulent misstatement.

Section 6: ERISA RIGHTS

As a participant in the Plan, you are entitled to certain rights and protections under ERISA. The HRA and the Plan are generally subject to ERISA, but ERISA does not apply to the coverages on Mercer Marketplace 365. ERISA provides that all Plan participants are entitled to:

Receive Information About Your Plan & Benefits

- Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites, all Plan documents including insurance contracts and copies of all documents filed by the Plan with the U.S. Department of Labor and the Internal Revenue Service, such as detailed annual reports and Plan descriptions.
- Obtain copies of all Plan documents and other Plan information upon written request to the Plan

Administrator. The Plan 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.
- Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the plan on the rules governing your [COBRA](#) continuation coverage rights.

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 Plan. The people who operate the Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of Plan participants, other Covered Persons and beneficiaries under the Plan.

No one, including the Employer or any other person, may discriminate against a Covered Person in any way to prevent that person from obtaining a benefit or exercising his or her rights under ERISA.

Enforce Your Rights

If a claim for a benefit is denied in whole or in part, a Covered Person must receive a written explanation of the reason for the denial. The Covered Person has the right to appeal the denial and have the Plan review and reconsider the claim.

Under ERISA, there are steps a Covered Person can take to enforce the above rights. For instance, if a Covered Person requests materials from the Plan and does not receive them within 30 days, the Covered Person may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay the Covered Person up to \$110 a day until the person receives the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.

If a Covered Person has a claim for benefits which is denied or ignored, in whole or in part, the Covered

Person may file suit in a state or federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if a Covered Person is discriminated against for asserting his or her rights, the Covered Person may seek assistance from the U.S. Department of Labor, or may file suit in a federal court. The court will decide who should pay court costs and legal fees. If the Covered Person is successful, the court may order the person who was sued to pay these costs and fees. If the Covered Person loses, the court may order the Covered Person to pay these costs and fees (for example, if the court finds the Covered Person's claim is frivolous).

Assistance With Your Questions

If a Covered Person has any questions about the Plan, the person should contact the Plan Administrator.

If a Covered Person has any questions about this statement or about their rights under ERISA, that person should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in the telephone directory or on their web site at www.dol.gov/ebsa/. Alternatively a Covered Person may contact 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.

Section 7: GLOSSARY

These definitions apply when these capitalized terms are used in this Summary Plan Description.

- Affiliate**--Any corporation or other entity that is required to be combined with the Plan Sponsor as a single employer under Code Section 414(b) or (c).
- Child or Children**--The natural children or adopted children of a Retiree, as well as natural, foster or adopted children of the Spouse who are living in the Retiree's household, and children over whom the Retiree has legal guardianship. Child or Children does not include persons who are over age 18 at the time of adoption or placement for adoption
- Code**--The U.S. Internal Revenue Code of 1986, as amended.
- Company**--The Aramco Shared Benefits Company,) or any of the Participating Companies under the Plan.
- Covered Person**--The Retiree, the Retiree's covered Spouse, and the Retiree's Children and other eligible Dependents who are covered under the Plan.
- Dependent**--A Spouse, Child or other person listed under **Section 1 – A: Eligibility for Coverage**, who is eligible to be covered under

- the Plan.
7. **Employee**--Regular full-time salaried Employees of the Company or a Participating Company who are employed on a U.S. dollar payroll, working not less than 30 hours per week. An independent contractor, Leased Employee, consultant, or hourly or daily paid employee is not included as an Employee.
 8. **Employer**--The Company or any Participating Company under the Plan which engages the services of Employees.
 9. **ERISA**--The Employee Retirement Income Security Act of 1974, as amended.
 10. **HRA**--The Health Reimbursement Arrangement established pursuant to the Plan for eligible participants.
 11. **Leased Employee**-- Any person who performs services for an Employer on a substantially full-time basis for at least one year pursuant to an agreement with a leasing organization, but only if such services are performed under the primary direction and control of the service recipient.
 12. **Medicare**--The Health Insurance For The Aged and Disabled program under Title XVIII of the Social Security Act.
 13. **Mercer**--Mercer and/or its affiliates that either provide services to the Plan or operate Mercer Marketplace 365 separate from the Plan.
 14. **Participant**-- A Retiree, Spouse, Surviving Spouse, or Dependent who is eligible for and participates in the HRA offered under the Plan.
 15. **Participating Companies**-- Participating Companies include Aramco Services Company; Aramco Associated Company; Aramco Overseas Company B.V.; Aramco Capital Company, LLC; Saudi Petroleum International, Inc.; Aramco Performance Materials; Saudi Arabian Oil Company, and Saudi Refining, Inc., all of which are covered by the Plan.
 16. **Plan** --The Aramco U.S. Retiree Medical Payment Plan, which is a welfare benefit plan established by the Plan Sponsor to provide certain medical, prescription drug, and other benefits to Covered Persons.
 17. **Plan Administrator** --The person(s) identified in **Section 5 – A. Plan Information** responsible for administering the Plan.
 18. **Plan Sponsor**--Aramco Shared Benefits Company.
 19. **Plan Year**--The Plan year is the calendar year.
 20. **Retiree or Retired Employee** --A former U.S. Dollar Employee who meets the Plan’s eligibility requirements as described under **Section 1 – A: Eligibility for Coverage**.
 21. **Retirement Income Plan**--The Aramco U.S. Retirement Income Plan of , as amended from time to time.
 22. **Spouse**-- The individual married to the Retiree in accordance with applicable law.
 23. **Surviving Spouse**--The Spouse of a Retiree who, following the Retiree’s death, is eligible for survivor coverage under the Plan.

Section 8: APPENDICES

Appendix A - International and Non-Medicare Eligible Administration

These individuals remain on the Aetna-administered Indemnity Plan coverage offered under the Aramco U.S. Retiree Medical Payment Plan (the “Plan”).

- I. **October 1, 2009 Grandfathered** – Retirees and/or dependents that resided internationally and were not enrolled in Medicare Part A and/or B as of September 30, 2009. The Indemnity Plan pays primary on claims both inside and outside the US. These individuals pay the higher PPO premium because the Indemnity Plan is paying primary on their claims.
- II. **July 1, 2018 Grandfathered (Retirees, spouses, and surviving spouses residing internationally as of 6/01/2018)**

These individuals are covered under the Indemnity Plan while residing internationally. These individuals are not eligible for the Health Reimbursement Account (HRA).

- a. **Age 65 or older and enrolled in Medicare Part A and B**
 - i. Payment for medical claims incurred in the United States (US) while still residing internationally, but visiting the US, will coordinate with Medicare.
 - ii. Individuals relocating to the US will lose eligibility for the Indemnity Plan and will be required to enroll in a plan through Mercer Marketplace 365 (MM365). They will also become eligible for the HRA. Individuals that fail to enroll in a plan through MM365 upon relocation to the US are not eligible for the HRA. The dependents lose eligibility if the retiree does not enroll.
- b. **Age 65 or older and eligible for, but not enrolled in, Medicare Part A and B**
 - i. Payment for medical claims incurred in the US while still residing internationally, but visiting the US, will be paid as if Medicare was the primary insurer and the amount paid will be reduced by the amount Medicare would have paid had the individual been enrolled in Medicare.
 - ii. **Individuals eligible to purchase Medicare Part A and B who relocate to the US must do the following:**
 1. Notify the Aramco Benefits Center of their new US address so that they will be reported on the file to Mercer to initiate the mailing of the MM365 Welcome Kit.
 2. They should enroll in Medicare Part A and B and may choose to either:
 - a. Participate in the HRA by enrolling in a plan through MM365; or
 - b. Remain on the Indemnity Plan. Payment for medical claims incurred in the US will be coordinated with Medicare.
 3. These individuals are also eligible for an additional HRA subsidy to assist with the cost of purchasing Medicare Part A. The current subsidy amount is 80% reimbursement of the premium costs, up to a maximum reimbursement of \$500 per month.
- c. **Individuals relocating to the US who are not eligible to purchase Medicare Part A and B will remain on the Indemnity Plan.** There will be no assumed Medicare offset provided they submit supporting documentation from Social Security or Medicare specifically stating they are ineligible to purchase Medicare Part A and B. These individuals pay the higher PPO premium because the Indemnity Plan is paying primary on their claims.
- d. **Under Age 65**
 - i. Required to enroll in Medicare Part A and B, if eligible when they become eligible. Payment for medical claims incurred in the US while still residing internationally,

but visiting the US, will coordinate with Medicare whether or not the individual enrolled in Medicare Part A and B as instructed.

- ii. Individuals relocating to the US (whether before or after reaching age 65) will lose post-65 eligibility for the Indemnity Plan and instead will be eligible only for the HRA in conjunction with Mercer Marketplace 365 (MM365). Individuals who are eligible for, but fail to enroll in, a plan through MM365 are not eligible for the HRA. Any dependents also lose eligibility if the retiree does not enroll.

III. **Individuals residing either in the US or internationally who do not meet the Medicare eligibility requirements and are not eligible to purchase Medicare Part A and B (e.g. full career in KSA)**

- a. Supporting documentation from the Social Security Administration or Medicare advising of the individual's ineligibility to purchase Medicare must be provided to the Aramco Benefits Center. There will be no assumed Medicare offset.
- b. These individuals pay the higher PPO premium because the Indemnity Plan is paying primary on their claims.
- c. Should the individual later become eligible for Medicare Part A and B, enrollment in Medicare is required and the individual will become ineligible for the Indemnity Plan. Instead, the individual is eligible only for the HRA in conjunction with MM365. The individual also would be eligible for Medicare Part A subsidy assistance should there be a premium payment associated with the enrollment in Medicare Part A.
- d. If the retiree does not maintain coverage under the Indemnity Plan or MM365 whichever is applicable, the dependents do not qualify for coverage.

IV. **Coverage/Eligibility Requirements**

- a. In all scenarios, an eligible dependent may enroll in coverage only if and while the retiree is covered, either on the Indemnity Plan or through the HRA/MM365.
- b. In all scenarios, a retiree, spouse or surviving spouse may be asked annually to provide proof of international residence or Medicare ineligibility as applicable.

Appendix B – Retirees Not Eligible for Post-65 Retiree Medical and whose Spouse is Older

- I. Retirees reaching age 65 and becoming Medicare eligible must meet the eligibility tests outlined Under *Section 1: Eligibility and Coverage* of the Health Reimbursement Arrangement (HRA) for Medicare-Eligible U.S. Dollar Retirees and Dependents Summary Plan Description (SPD) in order to be eligible for the HRA. If a retired employee is ineligible for post-65 coverage (for example, because the retiree terminates employment before age 65 and with fewer than 10 years of service), and the retiree’s spouse will attain age 65 and become Medicare eligible prior to the retiree, then the spouse will be HRA eligible until the beginning of the month in which the retiree turns 65 and loses eligibility under the Plan. At that time, the retiree will no longer be eligible for continued coverage under the Indemnity Plan and, because the retiree is not eligible for post-65 coverage, neither will be eligible for coverage under the HRA either.

Appendix C – Implementation of Hearing Aids Exception

- I. Hearing aids are covered under the Aetna-administered Indemnity Plan offered under the Aramco U.S. Retiree Medical Payment Plan (the “Plan”) at 80% after the deductible up to \$2,500 per ear every four years. During the implementation of Mercer Marketplace 365, the Company implemented an exception to the four year rule to allow retirees and/or dependents that were covered under the Plan prior to July 1, 2018 and had not purchased hearing aids in the 18 months prior to July 1, 2018, to purchase hearing aids. In order to take advantage of the exception, the hearing aids had to be purchased prior to July 1, 2018.

Appendix D- Retirees Enrolled in Medicare Advantage and Supplemental Plans

- I. During the implementation of the HRA, an exception was made to allow retirees that were already enrolled in a Medicare Advantage or Supplemental plan prior to the implementation of the Mercer Marketplace 365 Exchange to remain in their existing plan which was purchased outside of the Mercer Marketplace 365 Exchange and retain eligibility for the Healthcare Reimbursement Arrangement (HRA).

Appendix E – TRICARE and CHAMPVA Exception

- I. Retirees and dependents must meet the eligibility requirements under Section 1 Eligibility and Coverage of the Health Reimbursement Arrangement (HRA) for Medicare-Eligible U.S. Dollar Retirees and Dependents Summary Plan Description (SPD, in order to be eligible for the HRA subsidy. As one of the requirements, retirees and dependents must be eligible to enroll and actively enrolled in individual medical coverage through the Mercer Marketplace 365 exchange. The requirement to be enrolled in individual medical coverage through Mercer Marketplace 365 is waived if the retiree or dependent is enrolled and participating in a TRICARE or CHAMPVA Plan.