Aramco U.S. Retiree Medical Payment Plan

Non-Medicare Eligible PPO Plan and Medicare Eligible Indemnity Coverage for Eligible U.S. Dollar Retirees

January 1, 2025

Notice to Participants

This document describes the pre-Medicare “PPO” and post-Medicare “Indemnity” portions of the medical and prescription plan that the Aramco Shared Benefits Company (“ASBCO”) sponsors for Retired Employees who were on the U.S. Dollar payroll of ASBCO and the Participating Companies (collectively, the “Company”) and their eligible Dependents, as in effect on January 1, 2025, except as herein otherwise noted.

The coverages described in this booklet are offered under the Aramco U.S. Retiree Medical Payment Plan (the “Plan”). This document constitutes the Summary Plan Description (“SPD”) for these portions of the Plan. A separate SPD applies for the Health Reimbursement Arrangement (“HRA”) portion of the Plan, offered to Medicare-eligible U.S. Dollar retirees and dependents.

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.”

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.; and
- Saudi Arabian Oil Company

Effective January 1, 2025, Saudi Arabian Oil Company employees hired on or after January 1, 2025 and their dependents are not eligible for the HRA or post-Medicare “Indemnity” portions of the Plan. Saudi Arabian Oil Company employees hired on or after January 1, 2025 and their dependents may be eligible for the pre-Medicare “PPO” portion of the Plan if they otherwise meet the eligibility requirements specified in this SPD.

Aramco Ventures LLC (“AV”) (formerly known as Saudi Aramco Energy Ventures, LLC) was a Participating Company only with respect to employment before March 1, 2019. No service with AV on and after March 1, 2019, will count toward retiree medical eligibility under the Plan. Employees of AV will not be eligible for benefits under the Plan, with the exception of employees who met all the eligibility requirements prior to March 1, 2019. Motiva Enterprises, LLC 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 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.

What's 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, and how benefits are paid. If you need additional information, there are a variety of resources to help you. Contact information is listed below.

Businessolver Aramco Benefits Center	
For Enrollment and COBRA coverage questions	888-532-4144
Website Member	MyAramcoBenefits.com
Rightway – Healthcare Navigation	305-851-7310
Assistance with:	
Finding Providers	
Billing/Claims Issues	
Aetna International (for Medical Benefits)	
Member Services	
Inside the U.S.	1-866-486-4180
Outside the U.S.	1-813-775-0066
Member Website including	www.aetna.com
Finding In-Network Providers	
Wellness and Health Promotion Topics	
Healthy Living Topics	
Healthy Pregnancy	
Aetna Informed Health Line (Nurse line)	1-800-556-1555
Aetna International Behavioral Health	
For Mental Health and Substance Use Disorder	1-888-238-6232
Express Scripts (for Prescription Drugs)	
Member Services	1-800-711-0917
Member Website	www.express-scripts.com
Aptia365	
Website	https://retiree.aptia365.com/aramco.html
Member Services	1-855-230-2064 (toll-free) 1-515-243-1776 (participants outside of the US) Dial 711 (deaf or hard of hearing individuals) 1-857-362-2999 (fax) retiree.exchange@aptia-group.com
Address	P.O. Box 14401 Des Moines, IA 50306-3401

WEX

For Health Savings Account questions

Website	https://www.wexinc.com/login/benefits-login/
Member Services	866-451-3399
Email	customerservice@wexhealth.com

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Section 1: ELIGIBILITY & ENROLLING IN COVERAGE

The Plan is intended to help pay for eligible medical expenses incurred by Retirees of the Company and their eligible Dependents for Medically Necessary care incurred for the diagnosis and treatment of covered Sickness, Injury and pregnancy and for certain preventive health care. This coverage is available to Retirees and their eligible Dependents who meet the Plan's eligibility requirements and who elect to participate in the Plan (the "Covered Persons").

As a Covered Person under the Plan, you must comply with the provisions of the Plan, which define and determine the benefits you are eligible to receive. You should become familiar with these provisions, because failure to comply may result in additional costs to you, a reduction in benefits, or even in the denial of benefits under the Plan.

A: Eligibility for Coverage

Retiree Eligibility

You are eligible for the PPO or Indemnity coverages under the Plan only if you meet the eligibility conditions described below. In general, a retiree or dependent ceases to be eligible for Plan coverage once the retiree or dependent becomes Medicare-eligible. Medicare-eligible retirees and their dependents generally instead become eligible only for coverage under the Health Reimbursement Arrangement ("HRA"), which became effective July 1, 2018. Please refer to the summary booklet for the HRA for more information.

Retirees and Aramco U.S. Long-Term Disability Plan participants under age 65 may be eligible to enroll themselves and any eligible Dependents for the PPO or Indemnity coverage under the Plan if one of the following eligibility tests is met 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 Retiree Medical Eligibility Service[1], 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 Retiree Medical Eligibility Service[1], 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 Retiree Medical Eligibility Service.[1]

- **You are receiving benefits under the Aramco U.S. Long Term Disability Plan, and you are under age 65.**

- **Certain Participants Who Reach Age 60:** Without regard to your hire date, you are eligible for coverage if, as of the date of your termination of employment, you have attained age 60 but are under age 65, and have completed at least two (2) but less than ten (10) years of Retiree Medical Eligibility Service.[1] (Note: Plan participation terminates for such Retirees and their eligible Dependents on the last day of the month prior to the month in which the Retiree becomes eligible for Medicare; such individuals therefore will not be eligible for the Indemnity coverage nor the HRA under the Plan.)

- **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:

[1] If 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 Retiree Medical Eligibility Service after rehire (in addition to meeting the existing age and Retiree Medical Eligibility 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.

- 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.

Eligibility under the foregoing tests depends in part upon your years of Retiree Medical Eligibility Service. On and after January 1, 2019, your period of employment while on a U.S. Dollar payroll of a Participating Company (and while it is a Participating Company) under the Plan counts as Retiree Medical Eligibility Service. For the avoidance of doubt, periods of employment with an affiliated company that is not a Participating Company and/or while on a non-U.S. Dollar payroll do not count as Retiree Medical Eligibility Service. Effective March 1, 2019, Aramco Ventures LLC ("AV") is not a Participating Company under the Plan.

Prior to January 1, 2019, Retiree Medical Eligibility Service was the same as "Service" under the Retirement Income Plan.

Dependent Eligibility

Eligible Dependents include the following:

- Your legally recognized 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);
- Your or your Spouse's unmarried Child who is under age 25, including a natural Child, stepchild, a legally adopted Child, a Child placed for adoption or a Child for whom you or your Spouse are the legal guardian;
- An unmarried Child of any age who is or becomes disabled and dependent upon you before age 19 while covered under the Plan or the U.S. Dollar Welfare Benefit Plan (Medical Benefits). See the section "**Disabled Child Eligibility**" below for a complete list of eligibility requirements; or

Surviving Spouse and Dependent eligibility 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 your death the surviving Spouse is age 60 or older, the surviving Spouse and eligible Dependents may continue coverage under the Plan. Coverage for the surviving Spouse and eligible Dependents prior to attaining age 60 is determined and services provided under the provisions of the Aramco U.S. Medical Payment Plan.
- 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 and eligible Dependents are eligible to continue coverage 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; or
- If a Surviving Spouse remarries, he or she and all other eligible Dependents cease to be Dependents eligible to be covered under the Plan.

- A Child for whom health care coverage is required under a Qualified Medical Child Support Order or other court or administrative order and who otherwise meets the eligibility requirements under the Plan.

Disabled Child Eligibility

A covered disabled Dependent Child will continue to be eligible to participate in the Plan after age 25 provided such child:

- Is unmarried and became disabled as determined by a physician before age 19 and was covered under the Plan before age 19.
- The Dependent Child was certified as disabled while covered under the Aramco U.S. Medical

Payment Plan and continues to meet the requirements below;

- Is unable to be self-supporting due to a mental or physical handicap or disability;
- Relies primarily on the Retiree or Surviving Spouse for support;
- the Child is unmarried and became disabled and covered under the Plan before age 19. The application for continuing coverage under the Plan is submitted to the Claims Administrator within 31 days following the Dependent's 25th
- birthday; and
- Upon the request of the Plan Sponsor, satisfactory proof of continuing disability is provided. Such proof might include medical examinations at the Plan Sponsor's expense, which will not be requested more than once each Calendar Year. If you fail to supply such requested proof within 31 days following receipt of the request, the Child will cease to be a Covered Dependent.

The following table summarizes your Dependents' eligibility for coverage under the Plan:

Summary of Eligibility Requirements for Dependents of Eligible Retirees		
	Eligible	**Not Eligible**
Your Spouse who is not covered by another medical plan of the Company.	✓	
Your or your Spouse's Children age 19 or older, but under age 25, who are dependent upon you or your Spouse for support and are not employed full-time.	✓	
Your or your Spouse's unmarried Children age 25 or older who were disabled before age 19 while covered under the Plan or under the Aramco U.S. Medical Payment Plan. The claim for this continuing coverage must be submitted to the Claims Administrator within 31 days after the disabled Dependent's 25th birthday.	✓	
Your Children subject to a Qualified Medical Child Support Order (QMCSO), provided that such Children are otherwise eligible for coverage under the Plan.	✓	
If you die while you are an active Employee after having attained age 60 and have at least 2 years of Retiree Medical Eligibility Service (but less than 10 years of Retiree Medical Eligibility Service), your eligible Dependents, until the earlier of the last day of the month prior to the month you would have been eligible to enroll in Medicare, or the loss of eligibility by your surviving Spouse. Coverage for the surviving Spouse and eligible Dependents prior to attaining age 60 is determined and services are provided under the provisions of the Aramco U.S. Medical Payment Plan.	✓	
If you die while you are an active Employee after having attained age 50 and have at least 10 years' Retiree Medical Eligibility Service, your eligible Dependents.	✓	
Your eligible Dependents at your surviving Spouse's death.	✓	

Your grandchildren, if they are your legal Dependents by adoption or guardianship, subject to the same age, employment and marital status limitations for Children as explained above.	✓	
Saudi Arabian Oil Company employees hired on or after January 1, 2025 and their dependents who are Medicare disabled and are under the age of 65 are eligible for the post-Medicare Indemnity coverage portion of the Plan.	✓	
Your or your Spouse's married Children, regardless of age.		✓
Your surviving Spouse and other eligible Dependents following the remarriage of your surviving Spouse.		✓
Your parents, brothers, sisters, grandparents, aunts, uncles, nieces, nephews, brothers-in-law, or sisters-in-law.		✓
Your Dependents actively serving in the armed forces of any country.		✓
Saudi Arabian Oil Company employees hired on or after January 1, 2025 and their dependents who are age 65 or older are not eligible for the HRA or post-Medicare Indemnity coverage portions of the Plan.		✓
Note: No restriction on coverage under the Plan shall exist because of a preexisting condition of an adopted Child who qualifies as an eligible Dependent.		

B: Who Is Not Eligible

You are not eligible to enroll for PPO or Indemnity coverage under the Plan if any 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 Medicare-eligible and are eligible for participation in the HRA plan.
- You have elected to participate in a non-Company sponsored Medicare Advantage plan (Part C) or Medicare Part D prescription drug plan. If you elect to participate in a non-Company sponsored Medicare Advantage plan and later wish to enroll under this Plan, you can do so during Annual Enrollment so long as you have maintained continuous coverage under some combination of this Plan, another employer's plan covering active or retired employees or dependents, or a non-Company sponsored Medicare Advantage plan, assuming you continue to meet the eligibility requirements under the Plan.

Effective July 1, 2018, Medicare-eligible U.S. Dollar retirees and dependents are no longer eligible for medical and prescription drug coverage administered by Aetna and Express Scripts sponsored by ASBCO.

Except as provided below, 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 Aptia365. For more information about this program please refer to the HRA summary plan description located respectively on the Company Intranet, the Businessolver Aramco Benefits Center Website, the Aptia365 Exchange website and Aramco Americas website.

Notwithstanding anything herein to the contrary, Saudi Arabian Oil Company employees hired on or after January 1, 2025 and their dependents are not eligible for the HRA or post-Medicare Indemnity coverage portions of the Plan.

C: Enrolling for Coverage

Initial Enrollment

If you meet the Plan's eligibility requirements, you and/or your eligible Dependents must enroll within the 60-day period following your retirement. If you fail to enroll during the 60-day period you will permanently lose your eligibility to participate in the Plan, unless you qualify for Late Enrollment as defined below.

You must also enroll your Dependents for whom you want coverage under the Plan at that time. Dependent coverage will start on the later of the date your coverage begins under the Plan or, for a newly acquired Dependent, the date you enroll a new Dependent for coverage under the Plan. If you are not enrolled for coverage under the Plan, you may not enroll your Dependents for coverage.

How to Enroll

Following notification to the Company of your intent to retire, you will be provided with contact information for the Businessolver Aramco Benefits Center. If you elect to enroll, you may complete your enrollment by contacting the Businessolver Aramco Benefits Center at 888-532-4144 or online at MyAramcoBenefits.com

If you acquire a new Dependent or Dependents after you retire, you may enroll the Dependent(s) for coverage under the Plan **within 60 days of the date they become your eligible Dependent.**

If your Dependent is eligible for coverage under another medical plan sponsored by the Company, you may defer enrollment of your Dependent in the Plan for up to 60 days after your Dependent is no longer eligible to be covered under that plan.

If you are required by a qualified medical child support order, as defined in the Omnibus Budget Reconciliation Act of 1993 ("OBRA 93"), to provide health benefit coverage for your Children, they may be enrolled as timely enrollees as required by OBRA 93.

If you do not enroll yourself and/or your eligible Dependents at the times stated above, you and your Dependents will permanently lose eligibility to be covered under the Plan, unless you are eligible for Late Enrollment (see below).

Enrolling Your New Dependent(s)

Provided you are covered under the Plan, you may add the following eligible Dependents by notifying the Businessolver Aramco Benefits Center at 888-532-4144 or online at MyAramcoBenefits.com.

Newborns: Your newborn Child will be eligible for benefits under the Plan provided such child is enrolled in the Plan within 60 days of birth.

Adoption and guardianship: You may enroll a Child or other Dependent who is eligible for coverage as defined in **Section 1-A "Eligibility for Coverage"** provided such Child or Dependent is enrolled in the Plan within 60 days after the date of adoption or establishment of guardianship.

Marriage: You may enroll your Spouse who is eligible for coverage as defined under **Section 1-A, "Eligibility for Coverage"**, within 60 days after the date of your marriage. You will be required to provide a copy of the marriage license or marriage certificate. You may elect that coverage become effective as of the date of your marriage or on the first day of the month following the date of your marriage.

NOTE: Any change in your required contributions resulting from the addition of a Dependent will take effect as of the first day of the month in which the Dependent's coverage becomes effective. If a Dependent is enrolled for coverage after the first day of a month you will pay the required contribution for the entire month, unless you elect to have coverage begin on the first day of the following month.

If you do not enroll yourself and/or your eligible Dependents at the times stated above, you and your Dependents will permanently lose eligibility to be covered under the Plan, unless you are eligible for Late Enrollment (see below).

Deferred Enrollment if Covered by Another Plan

You may defer enrolling in the Plan if you or an eligible Dependent is enrolled for coverage in:

1) Another employer-sponsored group medical plan, or

At such time as coverage in the above plans ends for you and/or your eligible Dependent, you and/or your eligible Dependent will be eligible to enroll in the Plan, provided enrollment is completed within 60 days after the date you are no longer covered under the above plans.

Late Enrollment

If you or an eligible Dependent fail to enroll within the 60-day period following 1) your loss of coverage in another employer-sponsored medical plan, or 2) within the 60-day period following original date of eligibility, you or the eligible Dependent may enroll in the Plan during the **next following Annual Enrollment Period only**. If enrollment is not completed during the next following Annual Enrollment Period, your eligibility to enroll yourself and/or your eligible Dependents in the Plan will be permanently lost.

Annual Enrollment Period

Each year during the Annual Enrollment Period, you may make changes to your Plan coverage for yourself and/or your eligible Dependents who are eligible for Late Enrollment.

Changes made during the Annual Enrollment Period will become effective on the first day of the following Plan Year.

When Coverage Begins

Once you have properly enrolled, coverage will begin on the date of your retirement. Coverage for your Dependents will start on the date your coverage begins, provided that they meet eligibility requirements and that you have enrolled them in a timely manner.

Coverage for a Spouse or eligible Dependent that you acquire by marriage becomes effective on either the date of the marriage or the first day of the month following the date the Businessolver Aramco Benefits Center receives notice of your marriage, provided you notify them **within 60 days** of your marriage. Coverage for Dependent Children acquired through birth, adoption, or placement for adoption is effective the date of the family status change, provided you notify the Businessolver Aramco Benefits Center **within 60 days** of the birth, adoption, or placement.

***Note**:* Any Child under age 18 who is placed with you for adoption will be eligible for coverage on the date the Child is placed with you, even if the legal adoption is not yet final. If you do not legally adopt the Child, all medical Plan coverage for the Child will end when the placement ends. No provision will be made for continuing coverage (such as COBRA coverage) for the Child.

Cost and Required Employer Premiums

Each year, the Plan is reviewed on the basis of total contributions paid into the Plan compared to claims paid plus operating expenses charged to the Plan. Based on this review and projections of future medical costs, the Company determines in its sole discretion the required contribution rates that will be paid by the Company and by participants in the Plan.

Retirees and eligible Dependents who elect to participate in the Plan are required to pay their share of the Plan premiums. Their share of the cost is the difference between the total required contributions required to fund the benefits paid by the Plan less the Company's contributions, if any, to the Plan.

You may pay for your share of the coverage each month by check or by Electronic Funds Transfer from your bank.

You can obtain current contribution rates by calling the Businessolver Aramco Benefits Center at 888-532-4144

D – (i): How the Plan Works Prior to Medicare Eligibility Preferred Provider Organization ("PPO") Information

Prior to a participant's Medicare eligibility, coverage is provided under the Preferred Provider Organization ("PPO") option of the Plan through the Aetna Choice POS II network. Eligible services provided by members of the Aetna Choice POS II network are considered and paid at In-network

Provider rates. For services received from In-Network Providers, the amount Retirees and Dependents pay will generally be less than if the same services are received from Out-of-Network Providers.

In-Network Providers have contracted with Aetna to participate in the Network under agreed terms and conditions, one of which is that In-Network Providers may not charge a Covered Person or Aetna for certain expenses, except as stated below.

An In-Network Provider cannot charge a Covered Person or Aetna for any services or supplies which are not Covered Expenses.

You may choose an In-Network Provider and pay only a Co-Payment for services. Alternatively, you may choose an Out-of-Network Provider, but you will generally pay co-insurance of 30% after satisfying your Annual Deductible.

To assure that proper charges are made by the In-Network Provider and that there is no unnecessary delay in processing your claim, it is your responsibility to present your Plan identification card and identify yourself as a Plan member at the time you visit your Provider.

A directory is available at:
www.aetna.com or call **1-866-486-4180**
for In-Network Providers in your area.

There are many types of providers who participate in the Aetna Network, including, but not limited to, the following:

- Ambulatory Surgical Centers
- Chiropractors.
- Durable Medical Equipment Providers.
- Home Health Care Providers.
- Home IV Providers.
- Hospices.
- Hospitals.
- Mental Health and Substance Use Disorder Treatment Centers.
- Physical Therapists.
- Physicians.
- Podiatrists.
- Rehabilitation Facilities.
- Skilled Nursing Facilities.

In-Network Advantage

The Plan pays 100% of Covered Expenses for In-Network Provider services after the Co-Payment and, if applicable, the deductible is met (see **Section 1 – E: How Deductibles, Co-Payments, and Coinsurance Work**).

Out-of-Network Providers Paid At In-Network Levels

- Radiology, anesthesiology, and pathology services are paid at the In-Network Provider level even when received from an Out-of-Network Provider, provided Services are received in one of the following in-network settings:
  - Inpatient Hospital.
  - Outpatient facility which is part of a Hospital.
  - Ambulatory Surgical Center.
- Emergency Care is payable at the In-Network Provider level, even if services are received from an Out-of-Network Provider.

In-Network Provider Charges That Are Not Covered

A Covered Person may agree with the In-Network Provider to pay any charges for services and supplies which are not Covered Expenses; however, because these charges are not Covered Expenses under the Plan, they will not be reimbursed by Aetna.

In-Network vs. Out-of-Network

Out-of-Network Providers are providers who are not part of the Network and who have not agreed to

accept discounted rates. Retirees and their Dependents may choose to use Out-of-Network Providers, but generally at an increased cost. If you choose an Out-of-Network Provider, you will generally pay co-insurance of 30% after satisfying your Annual Deductible.

D – (ii): How the Plan works following Medicare Eligibility

Covered Persons become eligible for Medicare on the earlier of (1) the first day of the month in which they reach age 65; (2) for Covered Persons whose 65th birthday falls on the first day of the month, on the first day of the preceding month; or (3) the date in which you are approved for Medicare due to disability and are under the age of 65. At that time Medicare becomes the primary insurer (meaning Medicare pays first) and the Plan becomes secondary. Covered Persons who become eligible for Medicare are required to enroll for Medicare Parts A & B. If you do not enroll for Medicare your claims will be paid as if Medicare was the primary insurer and the amount you will receive will be reduced by the amount Medicare would have paid had you timely enrolled for Medicare.

When you become eligible for Medicare and you meet the eligibility requirements for coverage under this Plan, you are moved from the PPO Option of the plan, which offers both In-Network and Out-of-Network coverage, to the Indemnity Plan Option, which does not offer In- Network coverage and is a traditional indemnity plan. Covered Expenses are reimbursed at the applicable Coinsurance percentage once Annual Deductibles have been met and following payment by Medicare of its portion of expenses.

The Indemnity Plan Option generally covers 80% of Medicare allowable charges, after the Covered Person has met the Annual Deductible, reduced by the amount paid by Medicare. When you become Medicare-eligible, the combined total reimbursement from Medicare and the Plan for an eligible expense will be 80% of the Medicare allowable charges. If Medicare pays 80% of a claim the Plan will pay nothing. Home dialysis is covered under the Plan, but only if medically necessary and the provider is a Medicare-approved agent.

Notwithstanding the foregoing, Saudi Arabian Oil Company employees hired on or after January 1, 2025 and their dependents are not eligible for the HRA or post-Medicare Indemnity portions of the Plan.

Medicare Direct

The Plan offers a Medicare cross-over program, called Medicare Direct, for Medicare Part B and Durable Medical Equipment ("DME") claims. If you enroll for this program, you will not be required to file your claims with both Medicare and the Plan.

Once the Medicare Part B and DME carrier[s] have reimbursed your health care Provider, the Medicare carrier will electronically submit the necessary information to Aetna to process the balance of your claim under the Plan.

To participate in the Medicare Direct Program, you should contact Aetna at **1-866-486-4180.** Your Dependents may also enroll for this program if they are eligible for Medicare and this Plan is their only secondary medical coverage. You can verify that Medicare Direct is in place when your copy of the explanation of Medicare benefits states your claim has been forwarded to your secondary carrier. Until such time, you must continue to file secondary claims with Aetna.

The Medicare Direct Program does not apply to expenses that are covered by the Plan but not by Medicare. You should continue to file claims for these expenses with Aetna.

E: How Deductibles, Co-Payments and Coinsurance Work

The following table sets out the Plan's Co-Payments, Co-Insurance, Annual Deductibles, Annual Out-of-Pocket Maximums, and Maximum Benefits.

Plan Features	**Non-Medicare Eligible (Under 65) "PPO Plan"**			**Medicare Eligible**	
	Network	**Non-Network**		**"Indemnity Plan"**	
Co-pay, Coinsurance	**100% coverage after this co-pay amount**	**Company share[1]**	**Your share**	**Company share[1]**	**Your share**
Primary Care Physician Office Visit	**$20**	**70%**	**30%**	**80%**	**20%**
Urgent Care	**$45**	**70%**	**30%**	**80%**	**20%**
Specialist Office Visit	**$40**	**70%**	**30%**	**80%**	**20%**
Emergency Room	**$175**	**$175**	**$175**	**80%**	**20%**
Hospital Inpatient	**$300**	**70%**	**30%**	**80%**	**20%**
Outpatient Surgery performed in a surgical facility	**$50**	**70%**	**30%**	**80%**	**20%**
[1]Following satisfaction of your annual deductibles described below					
Annual Deductibles (per Calendar Year)					
You Only	**$250**	**$800**		**$400**	
You and Family (requires 2 individual Annual Deductibles to be met)	**$500**	**$1,600**		**$800**	
Annual Out-of-Pocket Maximum Prescription Drugs are not counted toward fulfillment of the Out-of-Pocket Maximum.					
You Only	**$3,000**	**$3,000**		**$3,000**	
You and Family **(Two individual limits met)**	**$6,000**	**$6,000**		**$6,000**	
Maximum Benefits					
Lifetime Maximum (includes Medical Benefits and Mental Health and Substance Use Disorder Treatment benefits but not Prescription Drug benefits)	**$ 5 million**				

Out-of-Pocket Expenses

Co-Payment

A Co-Payment is the amount of Covered Expenses the Covered Person must pay to an In-Network Provider in the PPO Plan at the time services or Prescription Drugs are provided.

- Medical Co-Payments are counted toward the Annual Out-of-Pocket Maximum but do not apply to the Annual Deductible that must be satisfied for Out-of-Network claims.
- Prescription Drug Co-Payments are not counted toward the Annual Out-of-Pocket Maximum or the Annual Deductible.
- Covered Expenses which require a Co-Payment are not subject to an Annual Deductible.

Co-Insurance

Co-Insurance is the percentage of the Covered Expenses you are required to pay for services received from an Out-of-Network provider.

After the individual or family Annual Deductible is met, 1) the PPO Plan pays 70% of Covered Expenses incurred at an Out-of-Network Provider, or, 2) the Indemnity Plan pays 80% of Covered Expenses. Applicable Co-Insurance is applied until the individual or family Out-of-Pocket Maximum amounts (as discussed below) have been paid. Thereafter, charges for Out-of-Network Covered Expenses in the PPO Plan and for all Covered Expenses in the Indemnity Plan are reimbursed at 100% for the rest of the Calendar Year. For the PPO Plan, to determine whether a provider is an In-Network Provider, contact Aetna or refer to www.aetna.com. To locate a Network Pharmacy, contact Express Scripts.

Individual Annual Deductible

The individual Annual Deductible is the amount of Covered Expenses a Covered Person must pay before the Plan pays any benefits. The **Annual Deductible** applies to all Hospital and medical expenses (**except** charges for certain In-Network services described in this SPD in the PPO Plan, and charges and Co-Payments for Prescription Drugs).

Once a Covered Person has met his or her Annual Deductible, reimbursement is made by the Plan for Covered Expenses in excess of the Annual Deductible, regardless of whether other Covered Persons have incurred any Covered Expenses or met their respective Annual Deductibles.

Family Annual Deductible

The family Annual Deductible will be satisfied when two individual Annual Deductibles have been satisfied in a Calendar Year. After two individual Annual Deductibles have been met, all other Covered Persons in the family will begin receiving benefits for Covered Expenses without satisfying any additional Annual Deductible for the Calendar Year.

Common Accident Deductible

If two or more covered family members incur Covered Expenses as a result of the same accident, then only one individual Annual Deductible will be applied against those combined Covered Expenses resulting from that accident for the remainder of that Calendar Year.

You will find details on out-of-pocket expenses in **Section 2 – A: What's Covered – Medical Benefits.**

Non-Notification Deductible

The non-notification deductible applies to Covered Expenses if precertification is not obtained when required. See Section 1 – F, The Role of Precertification, for a discussion of precertification and the non-notification deductible.

Annual Out-of-Pocket Maximum Provision

Individual Annual Out-of-Pocket Maximum

The annual Out-of-Pocket Maximum protects you from extreme financial loss in the event of catastrophic medical expenses by limiting the amount of Covered Expenses you must pay in any

Calendar Year. After you have paid any required Annual Deductible(s) and your out-of-pocket Covered Expenses have reached the annual individual or family Out-of-Pocket Maximum, the Plan will pay **100% of all individual or family** Covered Expenses during the remainder of that Calendar Year. Your Annual Deductible(s) are counted in determining your annual individual and family Out-of-Pocket Maximums.

Important: The following out-of-pocket expenses **will not** be applied toward your annual Out-of-Pocket Maximum:

- Covered Expenses used to satisfy the **non-notification deductible** do not count toward any of the Out-of-Pocket Maximums. This deductible still applies even after the applicable Out-of-Pocket Maximum has been reached;
- Expenses for services and supplies not covered under the Plan;
- Expenses you pay for charges in excess of Reasonable and Customary Charges; Co-Payments paid when using the Prescription Drug program; and
- Co-insurance and copays for Prescription Drugs.

Family Annual Out-of-Pocket Maximum

As with the Annual Deductible, the annual Out-of-Pocket Maximum will be determined separately for each Covered Person. The family annual Out-of-Pocket Maximum will be met when two family members satisfy their individual annual Out-of-Pocket Maximum amounts during a Calendar Year. Thereafter, all family member Covered Persons will begin receiving Plan benefits at 100% for Covered Expenses without satisfying any additional Out-of-Pocket Maximum amounts.

You will find details on Out-of-Pocket Maximums in **Section 2 – A: What's Covered – Medical Benefits.**

F: The Role of Precertification

Certain services, inpatient stays, and certain tests, procedures and outpatient surgeries require precertification by Aetna. Precertification is a process that helps you and your Physician determine whether the services being recommended are Covered Expenses under the Plan. It also allows Aetna to help your provider coordinate your transition from an inpatient setting to an outpatient setting (called discharge planning) and to register you for specialized programs or case management.

You do not need to pre-certify services provided by an In-Network Provider. In-Network Providers are responsible for obtaining necessary precertification for you. Since precertification is the In-Network Provider's responsibility, there is no additional out-of-pocket cost to you as a result of an In-Network Provider's failure to pre-certify.

When you go to an Out-of-Network Provider, it is your responsibility to obtain precertification from Aetna for any services or supplies on the pre-certification list below. If you do not pre-certify, your benefits may be reduced, or the Plan may not pay any benefits.

Services and Supplies Which Require Precertification

This may not be an all-inclusive list. Contact Aetna to confirm.

- Stays in a Hospital;
- Stays in a Skilled Nursing Facility;
- Stays in a Rehabilitation Facility;
- Stays in a Hospice facility;
- Organ/tissue transplants;
- Stays in a residential Mental Health and Substance Use Disorder Treatment Center for treatment of mental disorders and substance use disorder;
- Partial hospitalization programs for Mental Health and Substance Use Disorder Treatment;
- Private duty nursing care;

- Intensive outpatient programs for Mental Health and Substance Use Disorder Treatment;
- Amytal interview;
- Applied behavioral analysis;
- Biofeedback;
- Electroconvulsive therapy;

The Precertification Process

Prior to receiving any of the services or supplies listed above which require precertification, certain precertification procedures are required to obtain full benefits under the Plan.

You or a member of your family, a Hospital staff member, or the attending Physician, must notify Aetna and pre-certify the admission to a Hospital or other medical facility, or prior to the receipt of specified medical services and supplies in accordance with the following timelines:

For non-Emergency Care admissions:	You, your Physician or the facility are required to call Aetna and request precertification at least 14 days before the date scheduled for admission.
For an Emergency Care outpatient medical condition:	You or your Physician are required to call Aetna prior to receiving outpatient Emergency Care, treatment or procedures if possible or, if not possible, as soon as reasonably possible thereafter.
For an Emergency Care admission:	You, your Physician or the facility are required to call Aetna within 48 hours or as soon as reasonably possible after admission for Emergency Care.
For an Urgent Care admission:	You, your Physician or the facility are required to call before you are scheduled to be admitted. An Urgent Care admission is a hospital admission by a Physician due to the onset of or change in Sickness; the diagnosis of a Sickness; or an Injury.
For outpatient non-Emergency Care medical services requiring precertification:	You or your Physician must call at least 14 days before medical services are provided or the treatment procedure is scheduled.

Aetna will provide written notification to you and your Physician of the precertification decision. If your precertified expenses are approved, the approval is good for 180 days, provided you remain enrolled in the Plan.

When you have an inpatient admission to a facility, Aetna will notify you, your Physician and the facility about your pre-certified length of stay. If your Physician recommends that your stay be extended, additional days will need to be certified by Aetna. You, your Physician, or the facility will need to call Aetna at the number on your ID card as soon as reasonably possible, but no later than the final pre-certified day. Aetna will review and process the request for an extended stay. You and your Physician will receive a notification of an approval or denial from Aetna.

If precertification determines that the stay or services and supplies are not Covered Expenses, the notification will explain the reasons for the determination and how Aetna's decision can be appealed. You or your provider may request a review of the precertification decision pursuant to the Claims and Appeals section in this SPD.

How Failure to Precertify Affects Your Benefits

A precertification benefit reduction will be applied to the benefits paid if you fail to obtain a required precertification prior to incurring medical expenses. This means Aetna will reduce the amounts paid, or your expenses may not be covered. You will be responsible for any unpaid balance.

You are responsible for obtaining the necessary precertification from Aetna prior to receiving services from an Out-of-Network Provider. Your Out-of-Network Provider may pre-certify your treatment; however, you should verify with Aetna that the provider has obtained precertification from Aetna prior to undergoing the procedure. If your treatment is not pre-certified by you or your Out-of-Network Provider, the benefit payable may be significantly reduced, or your expenses may not be Covered Expenses under the Plan.

The chart below illustrates the effect on your benefits if required precertification is not obtained.

If precertification is:	Then the expenses are:
• Requested and approved by Aetna.	• Covered
• Requested and denied by Aetna.	• Not covered, denial may be appealed.
• Not requested but would have been approved by Aetna if requested.	• Covered after a pre- certification benefit reduction is applied.
• Not requested, would not have been approved by Aetna if requested.	• Not covered, denial may be appealed.

It is important to remember that any out-of-pocket expenses incurred as a result of failing to obtain required precertification will not count toward your deductible, payment percentage or Out-of-Pocket Maximum.

Section 2: WHAT'S COVERED UNDER THE PLAN

The Plan pays all or a portion of Covered Expenses as described in this Section 2. You should understand what is covered and what you must do before any Covered Expenses are incurred in order to manage your out-of-pocket expenses. You may also find it helpful to refer to **Section 3: WHAT'S NOT COVERED** in order to better understand your Medical Benefits payable under the Plan.

A: What's Covered – Medical Benefits

This table provides an overview of the Plan's coverage levels. It is intended to be a summary of your Medical Benefits and is not all-inclusive. For more detailed descriptions of your Medical Benefits, refer to the explanations that follow the table or call Aetna at 1-866-486-4180 or Express Scripts at 1-800-711-0917.

Summary of Covered Expenses

(The following charts are not intended to be all-inclusive)

Non-Medicare Eligible (Under age 65) "PPO Plan"			
Eligibility Provision			
Retiree	Retired employees of an employer participating in this Plan.		
Dependent	Your legally recognized spouse; unmarried children up to age 25, regardless of student status.		
PLAN FEATURES	**Outside the U.S.**	**In the U.S.**	
		Preferred Benefits (In-Network)	**Non-Preferred Benefits (Out-of-Network)**
Individual Deductible	$800 per calendar year	$250 per calendar year	$800 per calendar year
Family Deductible	$1,600 per calendar year	$500 per calendar year	$1,600 per calendar year
Prior Plan Credit	Prior plan credit accrued within the last calendar year from previous carrier applies to the current year		
Individual Maximum Out- of-Pocket Limit	$3,000 per calendar year	None	$3,000 per calendar year
(Does not include benefit penalties or outpatient Prescription Drugs. Includes deductibles and copays.)			
Family Maximum Out-of- Pocket Limit	$6,000 per calendar year	None	$6,000 per calendar year

(Does not include benefit penalties or outpatient Prescription Drugs. Includes deductibles and copays.)			
Lifetime Maximum	$5,000,000		
Inpatient Per Confinement Deductible *(Maximum of 3 per calendar year)*	None	$300	None
Member Payment Percentages			
Hospital Services			
Inpatient	30% after deductible	No charge after deductible and $300 inpatient per confinement copay	30% after deductible
Outpatient	30% after deductible	No charge after deductible	30% after deductible
Outpatient Surgery performed in a surgical facility	30% after deductible	No charge after $50 copay	30% after deductible
Outpatient Surgery performed in an office	30% after deductible	No charge after applicable copay	30% after deductible
Private Room Limit	The institution's semiprivate rate.		
Pre-certification Penalty	No Penalty	No Penalty	$200
Non-Emergency Use of the Emergency Room	Not Covered	Not Covered	Not Covered
Emergency Room *(copay waived if admitted)*	No charge after $175 copay	No charge after $175 copay	No charge after $175 copay
Emergency Ambulance	No Charge (When emergency transport criteria is met)	No Charge (When emergency transport criteria is met)	No Charge (When emergency transport criteria is met)
Urgent Care	30% after deductible	No charge after $45 copay (Copay waived when no office service is billed)	30% after deductible

Non-Urgent Care	30% after deductible	No charge after $45 copay (Copay waived when no office service is billed)	30% after deductible
Physician Services			
Physician Office Visit	30% after deductible	No charge after $20 copay (Copay waived when no office service is billed)	30% after deductible
Specialist Office Visit	30% after deductible	No charge after $40 copay (Copay waived when no office service is billed)	30% after deductible
Mental Health Services			
Mental Health Inpatient Coverage *Unlimited days per calendar year*	30% after deductible	No charge after deductible and $300 inpatient per confinement copay	30% after deductible
Mental Health Outpatient Coverage	30% after deductible	No charge after $40 copay	30% after deductible
Unlimited visits per calendar year			
Alcohol/Drug Abuse Services			
Substance Use Disorder Inpatient Coverage *Unlimited days per calendar year*	30% after deductible	No charge after deductible and $300 inpatient per confinement copay	30% after deductible
Substance Use Disorder Outpatient Coverage	30% after deductible	No charge after $40 copay	30% after deductible
Unlimited visits per calendar year			
Wellness Benefits			
Routine Children Physical Exams	30% after deductible	No charge	30% after deductible

7 exams in the first 12 months of life, 3 exams in the second 12 months of life, 3 exams in the third 12 months of life, 1 exam per 12 months thereafter to age 22 (includes immunizations)			
Routine Adult Physical Exams	30% after deductible	No charge	30% after deductible
Adults age 22+ & -65: 1 exam/12 months Adults age 65+: 1 exam/12 months includes immunizations			
Routine Gynecological Exams	30% after deductible	No charge	30% after deductible
Includes 1 exam and pap smear per calendar year			
Baseline Mammograms *(1 Baseline from ages 35-40 years)*	30% after deductible	No charge	30% after deductible
Mammograms *(Routine visits age 40+)*	30% after deductible	No charge	30% after deductible
Prostate Specific Antigen (PSA)	30% after deductible	No charge	30% after deductible
Includes 1 PSA per calendar year for males 40+			
Digital Rectal Exam (DRE)	30% after deductible	No charge	30% after deductible
Includes 1 DRE per calendar year for males 40+			
Cancer Screening	30% after deductible	No charge	30% after deductible
Includes 1 flex sigmoid and double barium contrast every 5 years; and at age 45+ 1 colonoscopy every 10 years			
Lung Cancer Screening **(Annually for those at least age 55)**	30% after deductible	No charge	30% after deductible

Routine Hearing Exam *Includes one routine exam per calendar year*	30% after deductible	No charge	30% after deductible
Hearing Aids	30% after deductible	No charge after deductible	30% after deductible
1 hearing aid per ear to $2,500 maximum per ear every 4 years. Covers 1 cleaning of hearing device per calendar year and hearing device repairs are not subject to the dollar limit.			
Vision Care			
Routine Eye Exam	30% after deductible	No charge	30% after deductible
(Covered under medical) Includes one routine exam per calendar year			
Skilled Nursing Facility *(120 Days per calendar year)*	30% after deductible	No charge after deductible and $300 inpatient per confinement copay	30% after deductible
Hospice Care Facility Inpatient *(Unlimited lifetime maximum)*	30% after deductible	No charge after deductible and $300 inpatient per confinement copay	30% after deductible
Home Health Care *(40 visits per calendar year)*	30% after deductible	No charge after deductible	30% after deductible
Private Duty Nursing *(Unlimited visits per calendar year)*	30% after deductible	No charge after deductible	30% after deductible
Spinal Disorder Treatment *(20 visits per calendar year)*	30% after deductible	No charge after $40 copay	30% after deductible
Short-Term Rehabilitation	30% after deductible	No charge after $40 copay	30% after deductible
(Includes coverage for Occupational, Physical and Speech Therapies; 120 combined maximum visits per calendar year) Pervasive Developmental Disorders (including Autism) are covered.			

Diagnostic Outpatient X-ray	30% after deductible	No charge after deductible	30% after deductible
Diagnostic Outpatient Lab	30% after deductible	No charge after deductible	30% after deductible
Refractive Eye Surgery *(Includes lasik, radial keratomy, orthoptic training and PKR) (maximum $3,000 per eye)*	No charge after $40 copay ($3,000 max per eye)		
Bariatric Surgery *(Unlimited per lifetime)*	30% after deductible	Inpatient: No charge after deductible and $300 inpatient per confinement copay Outpatient: No charge after $50 copay	30% after deductible
Allergy Serum and Injection	30% after deductible	No charge after deductible	30% after deductible
Acupuncture	30% after deductible	No charge after $40 copay	30% after deductible
Other Services			
Aetna Assistance Program *($500,000 calendar year maximum)*	No Charge	No Charge	No Charge
International Disease Management	Included	Included	Included
International Maternity	Included	Included	Included
In Touch Care (ITC)	Included	Included	Included
Teladoc	Excluded	Included	Included

Indemnity	
Eligibility Provision	
Retiree	Grandfathered International Retirees, Grandfathered non-Medicare members, LTD/Disabled members under age 65.
Dependent	Your legally recognized spouse; unmarried children up to age 25, regardless of student status.
PLAN FEATURES	**Outside the U.S.**
Individual Deductible	$400 per calendar year
Family Deductible	$800 per calendar year
Prior Plan Credit	Prior plan credit accrued within the last year from previous carrier applies to the current year
Individual Coinsurance Limit	$3,000
(Does not include benefit penalties or outpatient Prescription Drugs. Includes deductibles and copays.)	
Family Coinsurance Limit	$6,000
(Does not include benefit penalties or outpatient Prescription Drugs. Includes deductibles and copays.)	
Lifetime Maximum	$5,000,000
Hospital Services	
Inpatient	20% after deductible
Outpatient	20% after deductible

Private Room Limit	The institution's semiprivate rate
Pre-certification Penalty	No Penalty
Ambulance (When emergency transport criteria is met)	20% after deductible
Non-Emergency Use of the Emergency Room	50% after deductible
Emergency Room	20% after deductible
Non-Urgent Use of Urgent Care Provider	20% after deductible
Urgent Care	20% after deductible
Physician Services	
PCP Office Visit	20% after deductible
Specialist Office Visit	20% after deductible
Mental Health Services	
Mental Health Inpatient Coverage	20% after deductible
Mental Health Outpatient Coverage	20% after deductible
Alcohol/Drug Abuse Services	
Substance Use Disorder Inpatient Coverage	20% after deductible
Substance Use Disorder Outpatient Coverage	20% after deductible

Other Services	
Global Emergency Assistance Program ($500,000 calendar year maximum)	No Charge
Wellness Benefits	
Wellness Care Maximum	20% after deductible
Routine Adult Physical Exams	20% after deductible
1 exam/12 months includes immunizations	
Routine Gynecological Exams	20% after deductible
Includes 1 exam and pap smear per calendar year	
Mammograms *(Covers females age 35-39 – 1 baseline; age 40+ 1 mammogram per calendar year)*	20% after deductible
Prostate Specific Antigen (PSA)	20% after deductible
Includes 1 PSA per calendar year for males 40+	
Digital Rectal Exam (DRE)	20% after deductible
Includes 1 DRE per calendar year for males 40+	
Cancer Screening	20% after deductible
Includes 1 flex sigmoid and double barium contrast every 5 years; and at age 45+ 1 colonoscopy every 10 years	
Routine Hearing Exam *(Includes one routine exam per calendar year)*	20% after deductible

Hearing Aids	20% after deductible
($2,500 per ear every 4 years, covers 1 cleaning of hearing device per calendar year and hearing device repairs not subject to the dollar limit)	
Vision Care	
Routine Eye Exam	20% after deductible
(Covered under medical) Includes one routine exam per calendar year	
Prescription Drug Coverage	
Covered Under Medical Plan	20% after deductible
Other Services	
Skilled Nursing Facility *(120 Days per calendar year)*	20% after deductible
Hospice Care Facility Inpatient	20% after deductible
Hospice Care Facility Outpatient *(Unlimited visits)*	20% after deductible
Home Health Care *(40 visits per calendar year)*	20% after deductible
Private Duty Nursing	20% after deductible
Spinal Disorder Treatment *(20 visits per calendar year)*	20% after deductible
Short Term Rehabilitation	20% after deductible
(120 visits combined maximum per calendar year)	
Diagnostic Outpatient X-ray	20% after deductible

Diagnostic Outpatient Lab	20% after deductible
Base Infertility Services	20% after deductible
Durable Medical Equipment	20% after deductible
Emergency Assistance Program ($500,000 calendar year maximum)	No Charge
International Disease Management	Included
International Maternity Management Program	Included
In Touch Care (ITC)	Included
Teladoc	Included

B: What's Covered - Prescription Drug Benefits

The table below provides an overview of the Plan's Prescription Drug coverage provided through Express Scripts. It includes Co-Payments and Co-Insurance amounts that apply when you have a prescription filled at a retail pharmacy or through the mail order program.

	For Retail Prescriptions (Up to a 30-day supply)	For Express Scripts Mail-Order Delivery (Up to a 90-day supply)
At In-Network Pharmacies, Using Express Scripts ID Card	**You pay:** • **$5** for Generic Drug • **$50** for Brand-Name Drug on Preferred Drug List • **$60** for Brand-Name Drug not on Preferred Drug List	**You pay:** • **$10** for Generic Drug • **$100** for Brand-Name Drug on Preferred Drug List • **$120** for Brand-Name Drug not on Preferred Drug List. **You pay the lesser of $120 or 50% of the Prescription Drug Cost, whichever is less.**
Specialty Drugs Provided through Accredo from Express Scripts only	**You pay:** • **$125** for 30 days • **$250** for 60 days • **$375** for 90 days	Not Applicable
Direct Claims Outside of the United States	Pay the pharmacy's retail price and submit a claim form to Express Scripts for processing and payment. Claim forms can be obtained on the Express Scripts website, www.express-scripts.com. You are responsible for the lesser of 50% of the Prescription Drug Cost or $60.	Not Applicable
At Out-of-Network Pharmacies in the United States	**You pay:** **50%** for Covered Prescriptions	Not applicable

Note: Co-Payments and Co-Insurance for Prescription Drugs do not count toward the Annual Deductible or Out-Of-Pocket Maximum under the Plan.

The Plan provides Prescription Drug coverage both at In-Network Pharmacies and at Out-of-Network Pharmacies and mail-order Prescription Drug coverage is provided for maintenance prescriptions. Certain Prescription Drugs require authorization prior to dispensing, using guidelines approved by Express Scripts. Such prior approval is to be obtained from Express Scripts by the prescribing Physician or the pharmacist. The list of Prescription Drugs requiring prior authorization is subject to periodic review and modification by Express Scripts.

The following is an overview of your Prescription Drug benefits.

In-Network Prescription Drug Purchases

You can fill prescriptions directly at any Express

Scripts In-Network Pharmacy (which includes most major chain pharmacies), as well as at Out-of-Network Pharmacies.

An Express Scripts ID card with your Plan information is issued to all Covered Persons. When you need a prescription filled, present your ID card at an In-Network Pharmacy. Your covered prescription will be filled for up to a 30-day supply.

To find out if a specific pharmacy participates in the Express Scripts Pharmaceutical Network, call 1-800-711-0917

Out-of-Network Prescription Drug Purchases

You also can choose to have your prescription filled at an Out-of-Network Pharmacy. If you do, you'll need to:

Pay the pharmacy's retail price and submit a claim form to Express Scripts for processing and payment. Claim forms can be obtained on the Express Scripts website, www.express-scripts.com.

Mail-Order Prescriptions

The Plan also offers you a money saving alternative to having your prescription filled at a local pharmacy. You may choose to have your maintenance prescriptions for chronic or long-term conditions filled by Express Scripts mail-order Prescription Drug service. With the Express Scripts mail order Prescription Drug service, you can order up to a 90-day supply of maintenance Prescription Drugs. When you use this service, you will pay:

- A **$10** Co-Payment for each Generic Drug;
- A **$100** Co-Payment for each Brand Name Drug on the Preferred Drug List; or
- An **$120** Co-Payment for each Brand Name Drug not on the Preferred Drug List or 50% of the Prescription Drug cost, whichever is less.

Prescriptions filled through Express Scripts will be filled with the Generic Drug equivalent when available and permissible by law, unless your Physician specifically requests a Brand Name Drug.

This Generic Drug substitution will result in added savings to you, since your Co-Payment for a supply of Generic Drugs may be substantially less than the Co-Payment for a supply of Brand Name Drugs.

Examples of chronic or long-term conditions include:

- High blood pressure
- High cholesterol
- Ulcers
- Arthritis
- Heart or thyroid conditions
- Emphysema
- Diabetes
- Glaucoma

New Provisions Affecting Prescription Drug Coverage after 2015

Cholesterol Care Value Program

Beginning January 1, 2016, Express Scripts' Cholesterol Care Value Program will be implemented in the Plan. Under this program, certain types of cholesterol medications will be managed within the Plan to assure proper usage according to medical necessity.

Compound Management Exclusion Program

Beginning January 1, 2016, if you are using a compounded medication, the medication will no longer be covered without a Prior Authorization. Approval for a Prior Authorization will require clinically sound studies proving the effectiveness of the medication.

C: What's Covered - Mental Health and Substance Use Disorder

	Non-Medicare Eligible PPO Plan		Indemnity Plan
SERVICE	**IN-NETWORK**	**OUT-OF-NETWORK[1]**	
	You Pay:	**You Pay:**	**You Pay:**
Substance Use Disorder – Inpatient Care	0% after $300 inpatient per confinement deductible	30% after deductible	20% after deductible
Mental Health Inpatient	0% after $300 inpatient per confinement deductible	30% after deductible	20% after deductible
Mental Health and Substance Use Disorder Outpatient Care Benefits	0% after $40 Co-Payment	30% after deductible	20% after deductible
Precertification	Required	Failure to pre-certify will result in payment at Out-of-Network benefit levels	Required

Explanation of Benefits

Mental Health and Substance Use Disorder ("MH/SA") Treatment is intended to provide Covered Persons with the resources necessary to get efficient and appropriate care for problems including, but not limited to:

- depression,
- drug and alcohol abuse,
- marital or family problems,
- anxiety,
- stress, or
- grief or loss.

Mental Health and Substance Use Disorder Program

Contact Aetna Behavioral Health Call toll-free

1-866-486-4180

In the PPO Plan, Aetna Behavioral Health has contracted with In-Network Providers through whom care will be provided at reduced cost and at higher levels of coverage.

Whenever care is required for inpatient MH/SA problems your provider must precertify benefits with Aetna Behavioral Health in order to have coverage under the Plan and utilize the Mental Health and Substance Use Disorder treatment.

If you use an Out-of-Network Provider for outpatient services, you are not subject to precertification, but claims will be reviewed to determine if the treatment was Medically Necessary. However, treatment at an Out-of-Network inpatient facility requires precertification with Aetna Behavioral Health. In order for the Out-of-Network facility to be considered an eligible provider of in-patient treatment, Aetna Behavioral Health must determine that the following requirements are met:

1. A behavioral health provider must be onsite 24 hours per day/7 days a week.
2. The patient must be admitted by a Physician.
3. The facility must provide access to at least weekly sessions with a psychiatrist or Psychologist for individual psychotherapy.
4. Services must be managed by a licensed behavioral health provider who must, (1) meet the Aetna credentialing criteria as an individual practitioner, and (2) function under the direction/supervision of a licensed Psychiatrist or Psychologist.

Aetna Services

If a Covered Person has a MH/SA problem and

needs help, he or she can call Aetna Behavioral Health toll-free at 1-866-486-4180 24 hours a day. Aetna's trained professionals will assist in emergency and crisis situations, precertify care, help design a treatment plan and monitor ongoing care and progress. In addition, the Covered Person can call Aetna if he or she is not comfortable with their Provider or has any questions about MH/SA coverage or MH/SA Treatment.

In-Network Benefits

In the PPO Plan, to qualify for the higher In-Network level of benefits for Mental Health and Substance Use Disorder Treatment you must:

1) Call Aetna Behavioral Health for precertification before the treatment begins;
2) Use the In-Network Provider to whom you are referred; and
3) Follow the Aetna-approved course of treatment.

In general, In-Network Providers charge less for *the same level and quality of care* than do Out-of-Network Providers.

Precertification

In order to be eligible for In-Network benefits in the PPO Plan, all Mental Health and Substance Use Disorder Treatment must be pre-certified through Aetna.

Precertification begins when the Covered Person calls Aetna Behavioral Health. He or she will speak with an Aetna intake counselor who will refer him or her to a qualified In-Network Provider. The In-Network Provider will work to design a MH/SA Treatment plan that is tailored to the Covered Person's MH/SA needs. Aetna will monitor progress and, working with the In-Network Provider, adjust care over time, as needed.

Only Mental Health and Substance Use Disorder Treatment that is determined to be Medically Necessary is covered under the Plan.

Inpatient Care

Inpatient care for Mental Health and Substance Use Disorder Treatment with In-Network Providers requires precertification and is reimbursed in the PPO Plan at a higher level than Out-of-Network Providers and generally involves less Out-of-Pocket Expenses to you. The fact that an Out-of-Network Provider prescribes or recommends treatment, or services will not result in that treatment or those services being covered by the Plan unless they are found by Aetna to be Medically Necessary.

Outpatient Care

For a comparison of coverages for Mental Health and Substance Use Disorder Treatment provided by In- Network Providers and Out-of-Network Providers, refer to the Summary Chart at the beginning of this Section 2.

Mental Health Benefits Reminder

If you or your dependents are accessing mental health care benefits in the U.S., it is important that, to minimize your out-of-pocket expenses, you use in-network facilities and providers and obtain pre-authorization for any in-patient treatment you seek. Facilities and their anticipated treatment plans are required to meet the Plan's provisions regarding medical necessity, and the facility itself must meet certain requirements for coverage under the Plan to apply.

Facilities and services that do not meet the Plan's requirements are not covered under the Plan. Residential treatment for behavioral or substance use disorder issues is only covered to the extent medically necessary. This means that medical professionals have determined that inpatient care by medical professionals is necessary in order to treat the illness.

For example, if you have a dependent with behavioral or substance use disorder issues, it is critical to make sure that the facility at which your dependent seeks treatment meets Plan requirements for coverage. There are many residential programs which combine a very small amount of "covered" medical care (which might include, for example, psychotherapy or counseling) with other "activities" and components that are not considered medically necessary and are not provided by a medical professional (such as horseback riding, camping, climbing, etc.). These "camp," "school," or "treatment" facilities that provide these types of experiences are not covered as the treatment does not constitute medically necessary services provided by a medical professional. You are

advised to confirm that both the facility and treatment plan meet the standards for Plan coverage before you incur expenses that may not be payable under the Plan.

Emergency Care

In a MH/SA Emergency Care situation, your priority is to get help as quickly as possible. Therefore, in the event of an emergency, you should go to the nearest emergency medical facility.

An emergency is any situation in which a failure to get immediate care may result in serious harm or danger to you, the patient or to others. If you are unsure whether or not you are facing a "true" emergency, call Aetna for immediate assistance. Aetna counselors are trained to identify and help people in crisis situations. An Aetna counselor can be reached 24 hours a day, 7 days a week.

Whenever a Covered Person receives emergency Mental Health and Substance Use Disorder Treatment, he or she is required to call Aetna Behavioral Health as soon as possible, but no later than 48 hours after admission. Failure to contact Aetna will result in reduction or loss of Medical Benefits.

Out-of-Network Benefits

Out-of-Network MH/SA benefits are payable for Covered Expenses from an Out-of-Network Provider with the requirement that to be covered under the Plan Out-of-Network care must be provided only by psychiatrists, Psychologists and certified or licensed clinical social workers.

You may be uncomfortable calling Aetna Behavioral Health or getting treatment from someone other than your own health care professional who may not be an Aetna In-Network provider. However, you should keep in mind that Out-of-Network benefits have higher charges and a lower level of coverage. In addition, both In-Network and Out-of-Network inpatient care and Emergency Care require that you call Aetna to avoid any loss of Medical Benefits.

As mentioned above, treatment at an Out-of-Network inpatient facility requires precertification with Aetna Behavioral Health. For an Out- of-Network Mental Health and Substance Use Disorder Treatment Center to be considered an eligible provider of in-patient treatment, Aetna Behavioral Health must determine that the following requirements are met:

1. A behavioral health provider must be onsite 24 hours per day/7 days a week;
2. The patient must be admitted by a Physician;
3. The facility must provide access to at least weekly sessions with a psychiatrist or Psychologist for individual psychotherapy; and
4. Services must be managed by a licensed behavioral health provider who must, (1) meet the Aetna credentialing criteria as an individual practitioner, and (2) function under the direction/supervision of a licensed psychiatrist or Psychologist.

D: The Role of Medicare

When a Covered Person becomes eligible for Medicare, the Plan pays Medical Benefits in accordance with the Medicare Secondary Payer requirements under Federal law, regardless of whether or not you have elected Medicare.

When The Plan Pays Primary to Medicare

The Plan pays **primary** to Medicare for Covered Persons who are eligible for Medicare due to end stage renal disease under the conditions and for the time periods specified under Federal law and employees and dependents who are disabled.

When The Plan Pays Secondary to Medicare

The Plan pays **secondary** to Medicare for Covered Person(s) who become eligible for Medicare regardless of whether such Covered Person(s) have elected Medicare.

Important! - Medicare Enrollment Requirements

Covered Persons are responsible for enrolling in Medicare Parts A and B when they become eligible to enroll. Benefits available under Medicare are deducted from the amounts payable under the Plan, whether or not the Covered Person has enrolled with Medicare.

If the Covered Person does not enroll with Medicare when he or she first becomes eligible, the Covered Person must enroll during the Annual Enrollment Period which applies when the Covered Person stops being eligible for coverage under the Plan as provided under **Section 6: EVENTS AFFECTING**

COVERAGE.

How The Plan Pays When Medicare Is Primary

When Medicare is the primary payer, the Plan pays benefits up to the amount of Medicare eligible expenses as described below with respect to any Covered Person who becomes eligible under Medicare.

First, the Plan determines the Medical Benefits payable under the Plan. The amount of Covered Expenses is based on the maximum amount of charges allowed under Medicare rules instead of under the Reasonable and Customary Charges determination made by the Plan. The Plan subtracts the amount payable under Medicare from Plan Medical Benefits. The Plan pays only the difference (if any) between Plan Medical Benefits and Medicare benefits.

The amount payable under Medicare which is subtracted from the Plan's Medical Benefits is determined as the amount that would have been payable under Medicare when Medicare is primary even if:

- The Covered Person is not enrolled for Medicare. Medicare benefits are determined as if the Covered Person was enrolled and covered under Medicare Parts A and B.
- The Covered Person is enrolled in a Medicare+ Choice plan (Medicare Part C or Medicare Risk HMO) and receives non-covered Out-of-Network services because the Covered Person did not follow all the rules of that plan. Medicare benefits are determined as if the services were covered under Medicare Parts A and B.
- The Covered Person receives services from a provider who has elected to opt-out of Medicare. Medicare benefits are determined as if the services were covered under Medicare Parts A and B and the provider had agreed to limit charges to the amount of charges allowed under Medicare rules.
- The services are provided in a Veterans Administration facility or other facility of the Federal government. Medicare benefits are determined as if the services were provided by a non-governmental facility and covered under Medicare Parts A and B.
- The Covered Person is enrolled under a plan with a Medicare Medical Savings Account. Medicare benefits are determined as if the Covered Person was covered under Medicare Parts A and B.

Government Plans (other than Medicare and Medicaid)

If the Covered Person is also covered under a Government Plan (defined as any plan, program, or coverage — other than Medicare or Medicaid — which is established under the laws or regulations of any government, or in which any government participates other than as an employer), the Plan does not cover any services or supplies to the extent that those services or supplies, or benefits for them, are available to that Covered Person under the Government Plan.

This provision does not apply to any Government Plan which by law requires the Plan to pay primary.

E: Examples of How the Plan Works

The following examples illustrate how Annual Deductibles, Copays, Out-of-Pocket Maximums, Lifetime Maximum Benefits and Coinsurance work in practice.

Non-Medicare Eligible

In this example, let's say Gary has individual coverage under the Plan, and he is not yet Medicare eligible. He has not met his non-Network Annual Deductible and needs to see a Physician. The flow chart below shows what happens when he visits an In-Network Physician versus an Out-of-Network Physician.

In-Network Benefits

1. Gary goes to see an In-Network Physician and presents his ID card.
2. He receives treatment from the Physician. The Plan's Eligible Expense for the In-Network office visit equals $125.
3. On his way out, Gary pays a $20 Copay. Since In-Network Physician office visits are covered at 100% after the Copay, Gary has met his financial obligations for this office visit.
4. The Plan pays the In-Network Provider $105 ($125 Eligible Expense minus $20 Copay) and applies it toward Gary's Lifetime Maximum Benefit.

Out-of-Network Benefits

1. Gary goes to see an Out-of-Network Physician and presents his ID card.
2. He receives treatment from the Physician. The Plan's Eligible Expense for his visit is $175, however the Physician's fee is $225.
3. The Physician's office requests no payment, informing Gary that it will bill Aetna directly. Aetna processes the claim and determines that because Gary has not met his annual $800 deductible nothing will be paid by Aetna.
4. Gary is responsible for paying the Eligible Expense of $175 directly to the Physician, because he has not yet met his Annual Deductible.
5. Gary receives a bill from the Physician and pays the Physician directly.
6. The Physician's office, at its discretion, might bill Gary for the remaining $50:

$225	-	$175	=	$50
(Physician's fee)		(Eligible Expense)		

Gary's $50 payment does not apply to his Annual Deductible or Out-of-Pocket Maximum.

7. Aetna applies the $175 toward Gary's Annual Deductible and Out-of-Pocket Maximum.

Medicare Eligible

Assume that Gary is Medicare eligible and has individual coverage under the Plan and has met his Annual Deductible. The following example illustrates how the Coinsurance and Out-of-Pocket Maximum and Lifetime Maximum work in practice.

1. Gary goes to see a Physician who accepts Medicare and presents his ID card.

I

2. He receives treatment from the Physician. The Medicare eligible expense for this visit is $175.

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3. The Physician's office requests no payment, informing Gary that it will bill Medicare directly.

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4. Medicare pays $140, which is 80% of the Medicare eligible expense. A copy of the Medicare Explanation of Benefits (EOB) is provided to Aetna.

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5. Aetna processes the claims as the secondary payer, but because Medicare paid 80% of the Medicare-eligible expense Aetna pays nothing.

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6. Gary is responsible for paying his Coinsurance, $35, which is 20% of the $175 Eligible Expense.

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7. Gary receives a bill from the Physician for $35 and pays the Physician directly. The $35 is applied to Gary’s annual Out-of-Pocket Maximum and Lifetime Maximum.

Section 3: WHAT'S NOT COVERED

What the Plan Does Not Cover

The Plan does not cover any expenses incurred for services, supplies, medical care or treatment relating to, arising out of, or given in connection with, the following:

1. Services or supplies received before a Retiree, his or her Spouse or his or her Dependent becomes covered under the Plan.

2. Expenses incurred by a Dependent if the Dependent is covered as an Employee for the same services under the Plan or under a Company sponsored medical program.

3. Abdominoplasties.

4. Chelation therapy, except to treat heavy metal poisoning.

5. Charges for completion of claim forms or missed appointments.

6. Cosmetic or reconstructive surgery or treatment. This is surgery or treatment primarily to change appearance. It does not matter whether or not it is for psychological or emotional reasons. See **Section 2 – A: What's Covered – Medical Benefits** under Physician Services for limited coverage of certain reconstructive surgery.

7. Custodial care which meets one of the following conditions:

   - Care furnished mainly to train or assist in personal hygiene or other activities of daily living, rather than to provide medical treatment.

   - Care that can safely and adequately be provided by persons who do not have the technical skills of a health care provider.

   Care that meets one of these conditions is excluded custodial care regardless of any of the following:

   - Who recommends, provides or directs the care.

   - Where the care is provided.

   - Whether or not the patient or another caregiver can be or is being trained to care for himself or herself.

8. Ecological or environmental medicine, diagnosis or treatment.

9. Education, training and room and board while confined in an institution which is mainly a school or other institution for training, a place of rest, a place for the aged or a nursing home.

10. Expenses incurred or arising from elective abortions.

11. Eyeglasses, contact lenses, cochlear implants, unless required due to an Injury or cataract surgery.

12. Herbal medicine, holistic or homeopathic care, including drugs.

13. Services, supplies, medical care or treatment given by one of the following members of the Retiree's immediate family:

    - The Retiree's Spouse.

    - The Child, brother, sister, parent or grandparent of either the Retiree or the Retiree's Spouse.

14. Charges for procedures which facilitate a pregnancy, but which do not treat the cause of infertility, including in vitro fertilization, artificial insemination, embryo transfer, gamete intrafallopian transfer, zygote intrafallopian transfer and tubal ovum transfer.

15. Medical, surgical, diagnostic, psychiatric, substance use disorder or other health care services, technologies, supplies, treatments, procedures, drug therapies or devices that, at the time Aetna makes a determination

regarding coverage in a particular case, are determined to be:

- Not approved by the U.S. Food and Drug Administration ("FDA") to be lawfully marketed for the proposed use and not identified in the American Hospital Formulary Service, or the United States Pharmacopoeia Dispensing Information, as appropriate for the proposed use; or

- Subject to review and approval by any institutional review board for the proposed use; or

- The subject of an ongoing clinical trial that meets the definition of a Phase 1, 2 or 3 clinical trial as set forth in FDA regulations, regardless of whether the trial is actually subject to FDA oversight; or

- Any service that does not fall within the definition of Covered Expenses.

If a Covered Person has a "life-threatening" Sickness (one which is likely to cause death within one year of the request for treatment) Aetna may determine that an Experimental, Investigational or Unproven Service meets the definition of a Covered Expense for the Sickness or condition. For this to take place, Aetna must determine that such Service uses a specific research protocol that meets standards equivalent to those defined by the National Institutes of Health.

16. Services and supplies for which the Covered Person is not legally required to pay.

17. Liposuction.

18. Surgical correction or other treatment of malocclusion.

19. Services or supplies which are not Covered Expenses including any confinement or treatment given in connection with a service or supply which is not covered under the Plan.

20. Membership costs for health clubs, weight loss clinics and similar programs.

21. Nutritional counseling, except for services related to management of diabetes is a medically necessary preventive service for children and adults who are obese, and for adults who are overweight and have other cardiovascular disease risk factors (hypertension, dyslipidemia, impaired fasting glucose, or the metabolic syndrome), when it is prescribed by a physician and furnished by a provider (e.g., licensed nutritionist, registered dietician, or other qualified licensed health professionals such as nurses who are trained in nutrition) recognized under the plan.

22. Occupational Injury or Sickness which is covered under a workers' compensation act or similar law.

    For Covered Persons for whom coverage under a workers' compensation act or similar law is optional because they could elect coverage, or could have coverage elected for them, Occupational Injury or Sickness includes any Injury or Sickness that would have been covered under the workers' compensation act or similar law had that coverage been elected.

23. Examinations or treatment ordered by a court in connection with legal proceedings unless such examinations or treatment otherwise qualify as Covered Expenses.

24. Services given by a pastoral counselor, except for bereavement counseling.

25. Personal convenience or comfort items including, but not limited to, TVs, telephones, first aid kits, exercise equipment, air conditioners, humidifiers, saunas and hot tubs.

26. Private duty nursing services while confined in a facility.

27. Services for, or related to, the removal of an organ or tissue from a person for transplantation into another person, unless the transplant recipient is a Covered Person under the Plan and is undergoing a covered transplant.

28. Reversal of sterilization.

29. Sensitivity training, educational training therapy or treatment for an education requirement.

30. Gender affirmation surgery.

31. Charges made by a Hospital for confinement in a special area of the Hospital which provides non-acute care, by whatever name called, including but not limited to the type of care given by the facilities listed below.

    - Adult or child day care center.
    - Ambulatory Surgical Center.
    - Birth Center.
    - Half-way house.
    - Hospice.
    - Skilled Nursing Facility.
    - Mental Health and Substance Use Disorder Treatment Center.
    - Vocational rehabilitation center.

    If otherwise covered under the Plan, then benefits for the covered facility listed above which is part of a Hospital, as defined, are payable at the coverage level for that facility, not at the coverage level for a Hospital.

32. Stand-by services required by a Physician.

33. Care of or treatment to the teeth, gums or supporting structures such as, but not limited to, periodontal treatment, endodontic services, extractions, implants or any treatment to improve the ability to chew or speak. See **Section 8- Glossary of Terms, Item 50: Oral Surgery**.

34. Telephone consultations.

35. Tobacco dependency.

36. Services or supplies received as a result of active participation in any insurrection or active war.

37. Weight reduction or control (unless there is a diagnosis of morbid obesity).

38. Special foods, food supplements, liquid diets, diet plans or any related products.

39. Wigs or toupees (except for loss of hair resulting from treatment of a malignancy or permanent loss of hair from an accidental Injury), hair transplants, hair weaving or any drug if such drug is used in connection with baldness.

40. Services given by volunteers or persons who do not normally charge for their services.

41. Pregnancy of Dependent Children.

42. Hospice Limitations

    Unless specified above, Hospice expenses not covered under the Plan include charges for:

    - Daily room and board charges over a semi-private room rate.
    - Funeral arrangements.
    - Pastoral counseling.
    - Financial or legal counseling. This includes estate planning and the drafting of a will.
    - Homemaker or caretaker services. These are services which are not solely related to Hospice care. These include but are not limited to the following: sitter or companion services; transportation; and home maintenance.

43. Compounded medications, unless the compounded medication has prior authorization.

Section 4: COORDINATION OF BENEFITS AND SUBROGATION

A: Coordination of Benefits ("COB")

Coordination of benefits applies when a Covered Person has health coverage under the Plan and one or more Other Plans, as defined below. The rules in this Section specify which plan will be primary and which plan will be secondary.

Whenever there is more than one plan, the total amount of benefits paid in a Calendar Year under all plans cannot be more than the Allowable Expenses charged for that Calendar Year.

Note: COB does not apply to Prescription Drug Benefits.

Definitions

"Other Plans" are any of the following types of plans which provide health benefits or services for medical care or treatment:

- Group medical or health policies or plans, whether insured or self-insured. This does not include school accident-type coverage.
- Group coverage through HMOs and other prepayment, group practice and individual practice plans.
- Group-type plans obtained and maintained only because of membership in or connection with a particular organization or group.
- Government or tax supported programs excluding Medicare or Medicaid.

"Primary Plan": A plan that is primary will pay benefits first. Benefits under the Primary Plan will not be reduced due to benefits payable under Other Plans.

"Secondary Plan": Benefits under a plan that is secondary may be reduced if benefits are payable under Primary Plans.

"Allowable Expenses" means the necessary,

Reasonable and Customary Charges for health care when the expense is covered in whole or in part under at least one of the plans.

The difference between the cost of a private Hospital room and the cost of a semi-private Hospital room is not considered an Allowable Expense unless the patient's stay in a private Hospital room is necessary either in terms of generally accepted medical practice or as defined under the Plan.

When any plan provides benefits in the form of services, instead of a cash payment, the reasonable cash value of each service rendered will be considered both an Allowable Expense and a benefit paid.

How Coordination Works

When the Plan is the Primary Plan, full benefits are paid according to the Plan provisions as if the Secondary Plan or Secondary Plans did not exist. The Secondary Plan(s) pays the remainder, if any, after the Primary Plan and all other plans primary to the Secondary Plan have paid, up to the maximum allowable under the provisions of the Secondary Plan(s).

When the Plan is a Secondary Plan, its benefits are reduced so that the total benefits paid or provided by all plans during a Calendar Year are not more than total Allowable Expenses. The amount by which the Plan's benefits have been reduced shall be used by the Plan to pay Allowable Expenses which were incurred during the Calendar Year by the Covered Person for whom the claim is made, and which were not otherwise paid. As each claim is submitted, the Plan determines its obligation to pay for Allowable Expenses based on all claims which were submitted up to that point in time during the Calendar Year.

Benefits under the Plan will only be reduced when the sum of all benefits that would be payable as Allowable Expenses under the Other Plans, in the absence of

provisions like those of these **Coordination of Benefits** provisions, whether or not claims are made, exceeds Allowable Expenses in a Calendar Year.

When the benefits of the Plan are reduced as described above, each benefit is proportionately reduced and is then charged against any applicable benefit limit of the Plan.

Which Plan is the Primary Plan

In order for claims to be paid, the Claims Administrator must determine which is the Primary Plan and which are Secondary Plans.

When two or more plans provide benefits for the same Covered Person, benefits will be paid in the following order:

- A plan with no COB provision will pay its benefits before a plan that has a coordination provision.
- The benefits of the plan which covers the person other than as a Dependent are determined before those of the plan which covers the person as a Dependent.
- The benefits of the plan covering the person as a Dependent are determined before those of the plan covering that person as other than a Dependent, if the person is also a Medicare beneficiary and both of the following are true:
    - Medicare is secondary to the plan covering the person as a Dependent.
    - Medicare is primary to the plan covering the person as other than a Dependent (for example, as a Retiree).
- When the Plan and another plan cover the same Child as a Dependent of parents who are not separated or divorced, the benefits of the plan of the parent whose birthday falls earlier in a year are determined before those of the plan of the parent whose birthday falls later in that year. This is called the "Birthday Rule." The year of birth is ignored.

If both parents have the same birthday, the benefits of the plan which covered one parent longer are determined before those of the plan which covered the other parent for a shorter period of time.

If the Other Plan does not have a birthday rule, but instead has a rule based on the gender of the parent, and if, as a result, the plans do not agree on the order of benefits, the rule in the Other Plan will determine the order of benefits.

- If two or more plans cover a person as a Dependent Child of divorced or separated parents, benefits for the Child are determined in this order:
    - First, the plan of the parent with custody for the Child.
    - Second, the plan of the Spouse of the parent with the custody of the Child.
    - Finally, the plan of the parent not having custody of the Child.
- However, if the specific terms of a court decree state that one of the parents is responsible for the health care expenses of the Child, and the entity providing plan benefits has actual knowledge of those terms, the benefits of that plan are determined first. The plan of the other parent will be the Secondary Plan. This rule does not apply with respect to any claim for which any benefits are actually paid or which are provided before the entity has that actual knowledge.
- If the specific terms of a court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the Child, the plans covering the Child shall follow the order of benefit determination rules that apply to Dependents of parents who are not separated or divorced.
- The benefits of a plan which covers a person as an employee who is neither laid off nor retired are determined before those of a plan which covers that person as a laid off or retired employee. The same rule applies if a person is a Dependent of a person covered as a retiree or an employee. If the Other Plan does not have this rule, and if as a result, the plans do not agree on the order of benefits, this rule is ignored.

If none of the above rules determines the order of benefits, the benefits of the plan which covered an employee, member or subscriber for the longer period are determined before those of the plan which

covered that person for the shorter period.

Right to Exchange Information

In order to coordinate benefit payments, the Claims Administrators (Aetna and Express Scripts) need certain information. They may get needed facts from or give them to any other organization or person. The Claims Administrators need not tell, or obtain the consent of, any person to do this.

A Covered Person must give the Claims Administrators information about Other Plans. If the Covered Person cannot furnish all the information the Claims Administrator needs, the Claims Administrator has the right to get this information from any source. If any other organization or person needs information to apply its COB provision, the Claims Administrators have the right to give that organization or person such information. Information can be given or obtained without the consent of any person.

Facility of Payment

It is possible that benefits may be paid by the wrong plan. For example, Aetna may pay the plan, organization or Covered Person the amount of benefits that Aetna determines it should have paid. That amount will be treated as if it was paid under the Plan. The Plan will not have to pay that amount again to the Covered Person.

B: Recovery Provisions

Right of Recovery

The Claims Administrator may pay benefits that should be paid by another plan, organization or person. The Plan may recover the amount paid from the Other Plan, organization or person.

Benefits may be paid that are in excess of what should have been paid under the Plan. The Plan has the right to recover any excess payments.

Refund to the Plan of Overpayments of Benefits

If benefits are paid under the Plan for Covered Expenses incurred by a Covered Person, such Covered Person or any Other Plan, organization or person that was paid must make a refund to the Plan if:

- All or some of the expenses were paid to a Covered Person, Other Plan or organization or person when there was no legal obligation to do so;
- All or some of the payments made under the Plan exceeded the benefits payable under the Plan.

The refund will equal the amount of benefits paid in excess of the amount of benefits that should have been paid under the Plan.

If the refund is due from any Other Plan, organization or person, upon request the Covered Person will help the Plan seek to obtain a refund.

If the Covered Person, Other Plan, organization or person that was erroneously paid or overpaid does not promptly refund the full amount of the erroneous payment or overpayment, the Plan may reduce the amount of any future benefits that are payable to such person. The Plan may also reduce future benefits under any other group benefits plan administered by Aetna for the Company. The reductions will equal the amount of the erroneous payment or overpayment. The Plan may have other rights in addition to this right to reduce future benefits.

Subrogation

In the event a Covered Person suffers an Injury or Sickness as a result of an allegedly negligent or wrongful act or omission of a third party, Aetna will have rights of subrogation and will succeed to the Covered Person's right of recovery against the third party where and to the extent permitted by law. Aetna may exercise these rights to the extent of the benefits paid under the Plan. The amount of the recovery will be reduced by a proper share of the legal fees and expenses incurred to obtain the recovery.

The Covered Person agrees to help the Plan exercise these rights of subrogation upon the request of the Plan.

Section 5: CLAIMS & APPEALS PROCEDURES

You must file an initial claim for reimbursement and any appeal in accordance with these Claims and Appeals Procedures. You must follow and exhaust these Claims and Appeals Procedures before you may be eligible to bring a lawsuit relating to benefits under the Plan.

A: How to File a Claim

Claims must be filed in writing to the appropriate Claims Administrator:

- Aetna Member Services for medical and mental health and substance use disorder claims; and,
- Express Scripts for Out-of-Network Pharmacy and coordination of benefit Prescription Drug claims.

The Claims Administrator will provide you with an explanation of benefits which informs you of your entitlement to benefits and any amounts payable to the provider or to you.

The following categories of claims for benefits apply to the Plan, and according to the type of claim submitted, your claim will be reviewed and responded to within a designated response time. If additional time (an extension) is needed to decide on your claim because of special circumstances, you will be notified within the claim response period.

If you have questions regarding an In-Network or Out-of-Network claim, contact Aetna or Express Scripts Member Services.

- Urgent care claims are any claims for medical care or treatment with respect to which the time periods for making non-urgent care determinations: (1) could seriously jeopardize the life or health of the Covered Person or the ability of the Covered Person to regain maximum function, or, (2) in the opinion of a physician with knowledge of the Covered Person's medical condition, would subject the Covered Person to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.
- With respect to Prescription Drug claims, if the Covered Person's situation meets the definition of a claim involving urgent care as described above, an urgent Prescription Drug claim may be requested and will be conducted as soon as possible, but no later than 72 hours from receipt of request. If the Covered Person or provider believes that the Covered Person's situation is urgent, the expedited review must be requested by phone or fax. Prescription Drug claims and appeals submitted by mail will not be considered for urgent processing unless a subsequent phone call or fax identifies the appeal as urgent.
- Pre-service claims are claims for benefits where the Plan provisions require precertification before medical care or prescriptions are obtained.
- Post-service claims are claims for benefits where the Plan provisions do not require precertification before medical care or prescriptions are obtained. These claims are made after medical care or prescriptions treatment is received and apply to claims under the Plan. Most claims are post-service claims.

Type of Claim	Response Time	Extension
Urgent Care claims	**Aetna** 36 hours **Express Scripts** 72 hours	Not applicable. However, if additional information is needed, the claims fiduciary must request the additional information 24 hours after receiving the claim. You must then respond with this additional information within 48 hours of the request. Failure to submit this additional information may result in a claim denial. If a claim involves urgent ongoing treatment, and the claim was filed at least 24 hours before the treatment period expires, the response time is 24 hours.
Pre-service claims	**Aetna** 15 days **Express Scripts** 15 days (retail) 5 days (home delivery)	An additional 15 days. However, if an extension is necessary due to incomplete information, you must provide the additional information within 45 days from the date of receipt of the extension notice.
Post-service claims	**Aetna** 30 days **Express Scripts** 30 days	An additional 15 days. However, if an extension is necessary due to incomplete information, you must provide the additional information within 45 days from the date of receipt of the extension notice.

Timely Filing Limit

If you see an In-Network Provider OR In-Network Pharmacy, that provider or pharmacy will usually send the detailed bill for services to the appropriate Claims Administrator. If you see an Out-of-Network Provider or Out-of-Network Pharmacy, you may receive the bill (proof of loss) directly. This bill forms the basis of your post-service claim. If you receive the bill directly, you or your provider must send the bill within 12 months of the date you received services for medical, mental health, and substance use disorder benefit claims submitted to Aetna and 18 months of the date Prescription Drugs are dispensed to you for Prescription Drug claims submitted to Express Scripts. These time limits apply unless you are unable to notify us due to circumstances outside of your control. You must send the bill with the appropriate claim form. Claim forms may be located on the Claims Administrators' websites or by contacting Members Services.

B: Denied Claims and Right to Appeal

If a claim for benefits is completely or partially denied (also referred to as an adverse benefit determination), you, your beneficiary, or designated representative (as duly designated under the terms of this Plan and in accordance with the procedures established by the Plan Administrator) will receive written notice of the decision. The notice will describe:

- 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 (also referred to as an adverse benefit determination on review).
- 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.

You should be aware that the Claims Administrators

have the right to request repayment if a claim is overpaid for any reason.

Questions and Appeals

All appeals are filed with the applicable Claims Administrator. The Claims Administrator is Aetna for medical and mental health and substance use disorder mandatory appeals and Express Scripts for all Prescription Drug mandatory and voluntary appeals. The ASBCO Plan Administrative Committee is the Claims Administrator for voluntary appeals. You may contact the Claims Administrator as follows:

Medical, Mental Health & Substance Use Disorder Mandatory Appeals:	Aetna P.O. Box 14463 Lexington, KY 40512- 4463
Prescription Drug Mandatory and Voluntary Appeals	Clinical appeal requests: Express Scripts Attn: Clinical Appeals Department P.O. Box 66588 St. Louis, MO 63166-6588 Fax: 877-852-4070 Administrative appeal requests: Express Scripts Attn: Administrative Appeals Department P.O. Box 66587 St. Louis, MO 63166-6587 Fax: 877-328-9660
Medical Voluntary Appeals:	ABSCO Plan Administrative Committee Aramco U.S. Benefits Retiree Medical Payment Plan Attn: Managing Director, Two Allen Center 1200 Smith Street Floor 32 Houston, TX 77002-4313

If any of your appeals are denied, you will receive written notice of the adverse benefit determination. The notice will set forth:

- The specific reason(s) for the adverse determination and the Plan provisions upon which the adverse determination 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 final adverse benefit determination.
- A statement of the procedure to further appeal the final adverse benefit determination and your right to obtain information about such procedure.
- A statement of your right to bring an action under section 502(a) of the Employee Retirement Income Security Act (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.”

Filing Appeals

Medical, Mental Health & Substance Use Disorder Claims Appeal Process

First-Level Mandatory Appeal

If your claim for medical, mental health or substance use disorder benefits is denied, or your coverage under the Plan is otherwise affected by an adverse benefit determination, including any rescission of coverage, you, your beneficiary, or your designated representative (as duly designated under the terms of this Plan and in accordance with the procedures established by the Plan Administrator) are required to appeal the decision to Aetna before taking any other action. Your written appeal should include the patient's name, member ID, phone number, 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. In the case of an Urgent Care claim, you may request an expedited appeal orally or in writing. You must submit your first-level written appeal to Aetna within 180 days from the date of the notice of denial of your claim. The review of your appeal will provide a full and fair review of your claim, taking 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 from Aetna within a designated response time as follows:

Claim Type	Response Time
Urgent Care claims	36 hours
Pre-service claims	15 days
Post-service claims	30 days

If additional time is needed to review your mandatory appeal because of special circumstances, you will be notified within the claim response period.

Second-Level Mandatory Appeal

If your first-level appeal is denied and you disagree with the response, you may request a second-level appeal. To begin this process, you must send a written request along with any additional relevant information for consideration to the Claims Administrator within 60 days after you receive the first-level appeal denial. You will receive a response to the appeal within the designated response time in the chart above.

Voluntary External Review Program

If a final determination is made to deny benefits, you may choose to participate in Aetna's voluntary external review programs within 120 days from the second-level appeal denial. This program only applies if the denial of benefits is based on either of the following:

- Medical judgment.
- The exclusion of Experimental, Investigational or Unproven Services
- A rescission.

The voluntary external review program is not available if the coverage determinations are based on explicit benefit exclusions or defined benefit limits.

Contact Aetna at the telephone number shown on your ID card for more information on the voluntary external review program.

(**NOTE:** In this Questions and Appeals Section the terms "you" and "your" include any Covered Person.)

Prescription Drug Claim Appeal Process

First-Level Mandatory Appeal

When an initial claim has been denied, also referred to as an adverse benefit determination, a request for appeal may be submitted to Express Scripts by you, your beneficiary, or your designated representative (as duly designated under the terms of this Plan and in accordance with the procedures established by the Plan Administrator) within 180 days from receipt of notice of the initial adverse benefit determination. To initiate an appeal, required information must be submitted by fax or mail to the appropriate department of Express Scripts for clinical or administrative review requests. Required information should include the patient's name, member ID, phone number, the drug name for which benefit coverage has been denied, description of why you disagree with the initial adverse benefit determination, and any additional information that

may be relevant to the appeal, including prescriber statements/letters, bills or any other documents.

Second-Level Mandatory Appeal

When a first-level appeal has been denied, also called an adverse benefit determination, a request for a second-level appeal may be submitted to Express Scripts by you, your beneficiary, or your designated representative (as duly designated under the terms of this Plan and in accordance with the procedures established by the Plan Administrator) within 90 days from receipt of the first-level appeal adverse benefit determination. To initiate a second-level appeal, all required information must be submitted by mail or fax to the appropriate department for clinical or administrative review requests. Required information may include your information, the drug name for which benefit coverage has been denied, description of why you disagree with the first-level appeal adverse benefit determination, and any additional information that may be relevant to the appeal, including prescriber statements/letters, bills or any other documents.

Voluntary External Review

The right to request an independent external review may be available for an adverse benefit determination involving medical judgment, rescission or a decision based on medical information, including determinations involving Experimental, Investigational or Unproven Services. Generally, all internal appeal rights must be exhausted prior to requesting an external review. The external review will be conducted by an independent review organization (IRO) with medical experts that were not involved in the prior determination of the claim.

The voluntary external review programs are not available if the coverage determinations are based on explicit benefit exclusions or defined benefit limits.

Contact Express Scripts at the telephone numbers shown on your ID card for more information on the voluntary external review programs.

(**NOTE**: In this Questions and Appeals section the terms “you” and “your” include any Covered Person.)

Voluntary Appeal to ASBCO Plan Administrative Committee

If your mandatory internal appeals are denied and you have made a timely request for Voluntary External review, if eligible, and that has also been denied, you may submit a final voluntary appeal to the ASBCO Plan Administrative Committee (PAC). All levels of internal appeal and voluntary external review must be exhausted prior to submitting a written voluntary appeal to the ASBCO PAC. Your voluntary appeal to the PAC must be submitted within 30 days of the denial of your second-level mandatory internal appeal, or voluntary external review, if eligible. The 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 voluntary 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 ASBCO PAC receives the voluntary appeal. The ASBCO PAC 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. The decision of the ASBCO PAC is final.

C: Authorized Representative

A member may designate a designated representative through the Plan Administrator 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 which 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.

D: Non-Assignment of Benefits or Claims

Assignment of claims by a member or any other covered individual under this Plan to any third party

or provider is not permitted. No employee, 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.

E: Legal Actions and Statute of Limitations

You may not bring any legal action against the Plan Administrator, Aetna or Express Scripts unless you first complete the mandatory internal appeal process described in this SPD. After completing that process, if you want to bring a legal action against the Plan Administrator, Aetna or Express Scripts, you must do so within one year of the date on which your final mandatory internal appeal was decided.

The above does not apply if claims and appeals procedures are not established or followed by the Plan Administrator. In such a case you will be deemed to have exhausted the administrative remedies under the Plan and will be able to pursue legal action against the Plan Administrator, Aetna or Express Scripts. However, you will bear the burden of proving to the satisfaction of the court that the Plan Administrator failed to establish or follow the administrative procedures under the Plan.

The statute of limitations or other defense based on timeliness is suspended during the time that a voluntary appeal of that decision is pending.

Section 6: EVENTS AFFECTING COVERAGE

A: Changing Coverage

Qualified Change

You cannot terminate coverage, or add or remove Dependents during the calendar year, unless you have an applicable **"Qualified Change"** in:

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

Change in Your Coverage

Changes in your benefit coverage on any date other than January 1 will only be permitted if the change is directly related to a Qualified Change in family or employment status.

If you have a Qualified Change in family or employment status, you may change your coverage only if:

- You submit your request to change your coverage within 60 days after the date of the Qualified Change; and
- The requested change in coverage is consistent with the Qualified Change in family or employment status.

For example, the birth of a Child would allow you to change to family coverage under the Plan. However, you would not be allowed to cancel your coverage under the Plan upon the birth of a child, since cancellation of coverage is not related to acquiring a Dependent.

The change in coverage becomes effective on the date of a Qualified Change in family or employment status, or in the event of marriage, on the first day of the following month if the Retiree so elects.

When Coverage Ends

Loss of Eligibility

Coverage for you or your eligible Dependent will end on the last day of the month in which you or that Dependent no longer meets the eligibility requirements. However, you may be able to continue coverage. (For details, see **Section 6-B, Extension of Medical Benefits**).

Failure to Pay Retiree or Covered Person's Contribution

If you fail to pay the Employee's contribution to the Plan, your coverage will end on the last day of the month for which you last made a contribution.

Your entitlement to Medical Benefits automatically ends on the date that coverage ends, even if you are hospitalized or are otherwise receiving medical treatment on that date.

When your coverage ends, the Plan Sponsor will still pay claims for Covered Health Services that you

received before your coverage ended. However, once your coverage ends, Benefits are not provided for health services that you receive after coverage ended, even if the underlying medical condition occurred before your coverage ended.

Your coverage under the Plan will end on the earliest of:

- the end of the month in which you stop being an eligible Retiree;
- the date you stop making the required contributions; or the date Aetna receives written notice from the Plan Sponsor to end your coverage, or the date requested in the notice, if later.
- the date the Plan ends.

Coverage for your eligible Dependents will end on the earliest of:

- the date your coverage ends;
- the date you stop making the required contributions;
- the date Aetna receives written notice from the Plan Sponsor to end your coverage, or the date requested in the notice, if later; or
- the end of the month your Dependents no longer qualify as Dependents under this Plan; or
- the date the Plan ends.

The Plan will provide written notice to you that your coverage has ended if any of the following occur:

- you authorize another person to use your ID card or you use another person's ID card, intending to defraud the Plan; or
- you knowingly give Aetna false material information including, but not limited to, giving false material information relating to another person's eligibility or status as a Dependent or filing or authorizing another person to file materially false claims with the intent of defrauding the Plan.
- you commit an act of physical or verbal abuse that constitutes a threat to the Plan Sponsor's staff, Aetna's staff, Express Scripts' staff, Businessolver staff, or a Provider; or
- you violate any terms of 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.

Death

Should you die while covered under the Plan, your Dependent(s) medical coverage under the Plan may continue with the same benefits and provisions that your Dependent(s) enjoyed while you were alive. For more details, see **Section 6-C: Other Extensions of Medical Benefits**.

Divorce

In the case of your divorce, your former Spouse who was covered under the Plan will no longer be eligible for coverage, but he or she will have the option to extend his or her coverage (see Section 6-B, *Extension of Medical Benefits).* A court order requiring you to provide medical coverage for your former Spouse will not give you or your former Spouse rights to continue coverage under the Plan beyond those described in **Section 6 – B, Extension of Medical Benefits**. Coverage for your Children, however, may be subject to provisions of a Qualified Medical Child Support Order (see **Section 6 - D, Qualified Medical Child Support Orders***).*

Coverage for a Disabled Child

See **Section 1 – A: Eligibility for Coverage**.

B: Extension of Medical Benefits

Continuation of Coverage under COBRA

Under the Consolidated Omnibus Reconciliation Act of 1985 (known as "COBRA"), your covered Dependents may extend your 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.

Qualifying Event	
Eligible Dependents	• Your divorce or legal separation • Your Dependent's eligibility for coverage ends, or • The birth or adoption of a Child during the Retiree's period of continued coverage

Continued Coverage

Coverage may be continued for up to **36 months** from the date coverage ends in connection with the Qualifying Event. Continued coverage will be identical to the coverage provided to Retirees. You will have the same rights as a Covered Person, including the right to enroll eligible Dependents at annual enrollment or under special enrollment rules.

COBRA Qualifying Event	How Long Coverage May Continue	
	You	Dependents
You and your Spouse divorce or legally separate	N/A	36 months
Your Child is no longer eligible for coverage	N/A	36 months

Second Qualifying Events

Your total coverage under COBRA is limited to a maximum of 36 months from the date of the first Qualifying Event. You may be eligible for an additional period of coverage (within this 36-month period) if a second Qualifying Event occurs while you are receiving continuation coverage under COBRA. This does not apply if you become entitled to Medicare. You must notify the Businessolver Aramco Benefits Center in writing within 60 days after the second Qualifying Event.

Notification

If your covered Dependent loses coverage under the Plan due to **divorce, legal separation, or loss of Dependent eligibility**, it is your responsibility to notify the Businessolver 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 Businessolver Aramco Benefits Center will inform you, your Spouse or your Dependent within 14 days of the right to obtain continuation coverage under COBRA.

Enrollment

You will have 60 days from the date of the Qualifying Event (or the date you receive written notification of your right to continue these Plan benefits, if later) to elect to continue coverage under the Plan.

If you decline your COBRA coverage option, Plan benefits will terminate in accordance with the terms of the Plan.

Businessolver provides administration services for COBRA benefits under the Plan. To reach Businessolver, call 888-532-4144.

Cost of Coverage

In order to continue your coverage under COBRA, you must pay the full monthly cost (your contribution and the Company's contribution), plus 2% of these costs to cover administration expenses.

If the Covered Person is disabled as determined by

the Social Security Administration at the time he or she becomes eligible for COBRA coverage and if he or she remains disabled after 18 months of COBRA coverage, your cost for continued coverage beyond the first 18 months is 150% of the Company's total cost for Retirees.

The initial COBRA premium payment must be made within 45 days of your election to continue coverage. Subsequent payments are due on the first of the month. A 30-day grace period will apply to all late payments. **If payment is not made within the 30-day grace period, coverage under COBRA will terminate.**

Termination of COBRA Coverage

Continuation coverage under COBRA cannot be terminated by the Plan before the end of the 36-month period, unless:

(1) Your required contributions are not paid when due (or within the 30-day grace period);

(2) The Covered Person becomes eligible for Medicare;

(3) The Covered Person becomes covered under a group health plan of another employer (if the other employer's medical plan contains an exclusion or limitation with respect to any preexisting condition, you or the Covered Person may continue COBRA coverage under the Plan to cover only the exclusion or preexisting condition);

(4) The Company terminates Plan coverage for all its Retirees; or

(5) In the case of extended coverage due to disability, the disabled person ceases being eligible for SSDI benefits.

C: Other Extensions of Medical Benefits

In addition to the option to continue coverage under COBRA, certain extensions of benefits are available upon a Retiree's death. However, PPO coverage under the Plan terminates upon eligibility for Medicare, at which point you may instead be eligible for coverage under the HRA.

Total Disability

Coverage for Covered Persons Receiving Long-Term Disability Benefits

If you are receiving benefits under the Aramco U.S. Long-Term Disability Plan ("LTD Plan") you will continue to be eligible for coverage under the Plan, provided you make required premium payments. Premiums will be those paid by Retiree Medical Plan participants, as applicable. Your eligibility for coverage will end on the earlier of the last day of the month in which you receive your final LTD Plan benefit payment or the first day of the month in which you attain age 65, unless you meet one of the eligibility requirements for continued coverage under the Plan.

At such time as you begin to receive LTD Plan benefits, you will no longer be considered to have "active employment status" with the Company, as defined by Federal law and determined by the Company.

- In order to maintain your eligibility for coverage in the Plan you must apply for Social Security disability benefits as soon as possible following the date of your disability.

- If approved for Social Security disability benefits, you must also enroll in Medicare Parts A and B at which time you will be moved to the Indemnity coverage under this Plan in order to coordinate with Medicare.

- Your coverage under the Retiree Medical Plan will be secondary to Medicare.

- If you do not enroll for Medicare when you become eligible for such coverage, benefits under the Retiree Medical Plan will be determined as if you were enrolled and covered under Medicare Parts A and B.

- If you are an LTD participant and you die prior to meeting one of the other eligibility requirements for continued coverage under the Plan, your covered Dependents' eligibility for coverage will end the last day of the month in which your death occurs. However, such

Dependents may elect to continue coverage under the Plan through COBRA.

Covered Dependents of Deceased Retirees

Upon the death of a Retiree who is enrolled in the Plan at the date of death and who met the age and service requirements applicable to such Retiree under the Plan on the date of his or her retirement from the Company - The surviving Spouse and covered Dependents continue to be eligible to participate in the Plan until the surviving Spouse dies or remarries, or in the case of covered Dependent Children, for so long as they continue to meet the eligibility requirements of the Plan. If the Retiree is not married on the date of death, covered Dependent Children will continue to be covered under the Plan for so long as they continue to meet all other eligibility requirements of the Plan.

Upon the death of a Retiree who is enrolled in the Plan at the date of death and who had attained at least age 60 and completed at least 2 but fewer than 10 years of service - The surviving Spouse and covered Dependents will be eligible to continue coverage under the terms of the Plan until the last day of the month preceding the date the deceased Retiree would have attained age 65, if they continue to meet all other eligibility requirements of the Plan.

In each of the above situations, the Dependents of the deceased Retiree will be required to pay the monthly premiums required for participation in the Plan and will cease to be eligible for PPO coverage under the Plan upon eligibility for Medicare.

Remarriage of a Surviving Spouse

Should the surviving Spouse of a deceased Retiree remarry, eligibility for Plan coverage for the surviving Spouse and Dependents ends no later than the last day of the month in which the marriage occurs.

D: Qualified Medical Child Support Orders ("QMCSOs")

If you are legally separated or in the process of getting divorced, coverage for your Dependent Children may be continued for so long as they otherwise satisfy the eligibility requirements as Dependent Children. However, there may be a domestic relations order that *requires* you to provide medical coverage for your Children, regardless of whether;

(1) They are currently covered under the Plan,

(2) They are dependent on you for financial support, or

(3) You have legal custody of the Children.

A domestic relations order is any judgment, decree, order, or court-approved property settlement agreement that deals with child support, alimony payments, or marital property rights and is issued pursuant to a state domestic relations law. Sometimes a domestic relations order will make you responsible for the medical coverage of your Children.

However, the Plan Administrator is not required to comply with the order unless the domestic relations order is a QMCSO.

A QMCSO is a domestic relations order that creates or recognizes the right of a Child to be covered under your Company-sponsored group medical plan to the extent he or she would otherwise be eligible for participation under the provisions of the Plan. If the Child is not already covered under the Plan, you will be allowed to enroll the Child in the Plan as directed under the QMCSO, and the Plan's late enrollment provisions will not apply. Enrollment of this type is considered to result from a Qualified Change in family status.

A QMCSO must meet specific legal requirements, as outlined in the Plan's written procedures for QMCSOs. If you are going through a legal separation or divorce, you should ask your attorney to obtain a copy of the Plan's QMCSO procedures, which can be helpful in drafting the order. Your attorney can send a draft of your proposed domestic relations order to the Plan Administrator for review, before approval by the state court. This will allow your attorney to know in advance whether the domestic relations order meets the requirements for

a QMCSO under the Plan and will avoid having to go back to the court to amend the domestic relations order to so qualify.

You should send a copy of the final court-approved QMCSO to the Plan Administrator.

Under current law, a QMCSO cannot require the Plan to pay a greater benefit than the benefit that would otherwise be payable by the Plan if no QMCSO existed. However, current law requires benefits to be paid directly to the Child or the Child's custodial parent or legal guardian, instead of to the Covered Person, who usually is the only person entitled to receive the payment of benefits under the Plan.

Section 7: 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 32 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 32 Houston, TX 77002-4313 (713) 432-4132 (800) 343-4272 The Employee Benefits Committee has delegated the authority to determine voluntary appeals to the ASBCO Plan Administrative Committee.
PPO and Indemnity Plan Group Number	476729 ESI Prescription Drug Group Number 4986
Claims and Appeals Administrators	Medical: Aetna Prescription Drug: Express Scripts
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	Third party administered by Aetna (medical) and Express Scripts (prescription drug)
Plan Year	Calendar year
Funding	The Plan is self-insured. Company contributions to the Plan may be paid from the Company or Employer's general assets or 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. No one has any right to any Plan assets.

B: Amendment Authority

The Company 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 the 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.

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

Plan Expenses

Expenses of administering the Plan may be paid by the Plan and taken into account in setting Company and participant contributions. These expenses include, but are not limited to, amounts paid to the Plan's third-party administrators, claims administrators, and other service providers, as well as other expenses that may be incurred and paid by the Company or Employer and later reimbursed by the Plan.

Plan Document

The Plan Document for the Aramco U.S. Retiree Medical Payment 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 PPO and Indemnity Plan coverages 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: 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.

E: ERISA Rights

As a participant in the Plan, you are entitled to certain rights and protections under ERISA. 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.

F: Other Legal Notices

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 the Plan including Aetna and Express Scripts. 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.

Women's Health and Cancer Rights Act of 1998

If a Covered Person has a mastectomy and at any time thereafter decides to have breast reconstruction, based on consultation with her Physician, the following benefits will be subject to the same Co-payment and deductibles which apply to other Plan benefits:

- Reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Services for physical complications in all stages of mastectomy, including lymphedema.

The above benefits will be provided subject to the same deductibles, Co-payments and limits applicable to other Covered Expenses.

Section 8: GLOSSARY OF TERMS

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

1. Allowable Expenses

The necessary, Reasonable and Customary Charges for health care when the expense is covered in whole or in part under the Plan.

2. Ambulatory Surgical Center

A specialized facility which is established, equipped, operated and staffed primarily for the purpose of performing surgical procedures and which fully meets one of the following two tests:

- It is licensed as an Ambulatory Surgical Center by the regulatory authority having responsibility for licensing under the laws of the jurisdiction in which it is located.
- Where licensing is not required, it meets all of the following requirements:
    - It is operated under the supervision of a licensed doctor of medicine (M.D.) or doctor of osteopathy (D.O.) who is devoting full time to supervision and it permits a surgical procedure to be performed only by a duly qualified Physician who, at the time the procedure is performed, is privileged to perform the procedure in at least one Hospital in the area.
    - In all cases except those requiring only local infiltration anesthetics, it requires that a licensed anesthesiologist administer the anesthetic or supervise an anesthetist who is administering the anesthetic and that the anesthesiologist

      or anesthetist remain present throughout the surgical procedure.
    - It provides at least one operating room and at least one post-anesthesia recovery room.
    - It is equipped to perform diagnostic X-ray and laboratory examinations or has an arrangement to obtain these services.
    - It has trained personnel and necessary equipment to handle emergency situations.
    - It has immediate access to a blood bank or blood supplies.
    - It provides the full-time services of one or more registered nurses (R.N.s) for patient care in the operating rooms and in the post- anesthesia recovery room.
    - It maintains an adequate medical record for each patient, the record to contain an admitting diagnosis including, for all patients except those undergoing a procedure under local anesthesia, a preoperative examination report, medical history and laboratory tests and/or X-rays, an operative report and a discharge summary.

3. Annual Deductible

The amount of Covered Expenses the Retiree must pay before the Plan pays any benefits.

4. Annual Enrollment Period

The annual period designated each year by the Company prior to the start of the Plan Year during which all Retirees and their eligible Dependents can be enrolled for coverage under the Plan.

5. Balance Billing

When a provider bills you for the difference between the provider's charge and the allowed amount. For example, if the provider's charge is $100 and the allowed amount is $70, the provider may bill you for the remaining $30. A preferred provider may not balance bill you for covered services.

6. Benefits Representative

Person(s) authorized by the Company to give information on the Plan and to receive enrollment information.

7. Birth Center

A specialized facility which is primarily a place for delivery of children following a normal uncomplicated pregnancy and which fully meets one of the following two tests:

- It is licensed by the regulatory authority having responsibility for the licensing under the laws of the jurisdiction in which it is located.

- It meets all of the following requirements:
    - It is operated and equipped in accordance with any applicable state law.
    - It is equipped to perform routine diagnostic and laboratory examinations such as hematocrit and urinalysis for glucose, protein, bacteria and specific gravity.
    - It has available trained personnel and necessary equipment available to handle foreseeable emergencies, including but not limited to oxygen, positive pressure mask, suction, intravenous equipment, equipment for maintaining infant

      temperature and ventilation, and blood expanders.
    - It is operated under the full-time supervision of a licensed Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.) or Registered Nurse (R.N.).
    - It maintains a written agreement with at least one Hospital in the area for immediate acceptance of patients who develop complications.
    - It maintains an adequate medical record for each patient, the record to contain prenatal history, prenatal examination, any laboratory or diagnostic tests and a postpartum summary.
    - It is expected to discharge or transfer patients within 24 hours following delivery.

A Birth Center which is part of a Hospital, as defined herein, will be considered a Birth Center for the purposes of the Plan.

8. Brand Name Drug

A Prescription Drug which is (1) manufactured and marketed under a trademark or name by a specific drug manufacturer; and (2) identified as a Brand Name Drug by Express Scripts.

9. Calendar Year

A period of one year beginning on January 1 and ending on December 31.

10. 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.

11. Claims Administrators

The Aetna Insurance Company, Hartford, Connecticut is the Claims Administrator for Medical Benefits (except for Prescription Drug benefits) under the Plan. Express Scripts is the Claims Administrator for Prescription Drug benefits under the Plan. The Claims Administrators do not insure the benefits described in this SPD.

12. Clinical Policy Bulletin

Aetna Clinical Policy Bulletins are detailed and technical documents that explain how Aetna makes coverage decisions for Covered Persons under the Plan. Clinical Policy Bulletins spell out what medical, dental, pharmacy and behavioral health technologies and services may or may not be Covered Expenses under the Plan.

Clinical Policy Bulletins are based on evidence from objective, credible sources, such as:

- Scientific literature
- Technology reviews
- Consensus statements
- Expert opinions
- Guidelines from national professional health care organizations
- Public health agencies

13. Coinsurance

The percentage of costs of a covered health care service you pay (20%, for example) after you've paid your deductible.

14. Company

Company means Aramco Shared Benefits Company or any of the Participating Companies under the Plan.

15. Comprehensive Outpatient Rehabilitation Facility

A facility which is primarily engaged in providing diagnostic, therapeutic and restorative services to outpatients for the rehabilitation of persons who have suffered Sickness or Injury, and which fully meets one of the following two tests:

- It is approved by Medicare as a Comprehensive Outpatient Rehabilitation Facility.
- It meets all of the following tests:
  - It provides at least the following comprehensive outpatient rehabilitation services:
    - Services of Physicians who are available at the facility on a full or part-time basis.
    - Physical therapy.
    - Social or psychological services.
  - It has policies established by a group of professional personnel (associated with the facility), including one or more Physicians, to govern the comprehensive outpatient rehabilitation services it furnishes, and it provides for the carrying out of such policies by a full or part-time Physician.
  - It has a requirement that every patient must be under the care of a Physician.
  - It is established and operated in accordance with the applicable licensing regulations and laws.

16. Copayment

A fixed amount you pay for a covered health care service after you've paid your deductible.

Let's say your health insurance plan's allowable cost for a doctor's office visit is $100. Your copayment for a doctor visit is $20.

- If you've paid your deductible: You pay $20, usually at the time of the visit.
- If you haven't met your deductible: You pay $100, the full allowable amount for the visit.

Copayments (sometimes called "copays") can vary for different services within the same plan, like drugs, lab tests, and visits to specialists.

Generally, plans with lower monthly premiums have higher copayments. Plans with higher monthly premiums usually have lower copayments.

17. Covered Expenses

Covered Expenses are those health services, supplies or equipment provided for the purpose of preventing, diagnosing or treating a Sickness or Injury or Mental Health and Substance Use Disorder, or symptoms relating thereto. Covered Services and Supplies must be provided:

- When the Plan is in effect;
- Prior to the date that any of the individual termination conditions set forth in this SPD; and
- Only when the person who receives services is a Covered Person and meets all eligibility requirements specified in the Plan.

A Covered Expense for services must meet each of the following criteria:

- It is supported by national medical standards of practice.
- It is consistent with conclusions of prevailing medical research that demonstrate that the health service has a beneficial effect on health outcomes and is based on trials that meet the following designs:
  - Well-conducted randomized controlled trials. (Two or more treatments are compared to each other, and the patient is not allowed to choose which treatment is received.)
  - Well-conducted cohort studies. (Patients who receive study treatment are compared to a group of patients who receive standard therapy. The comparison group must be nearly identical to the study treatment group.)
  - It is the most cost-effective method and yields a similar outcome to other available alternatives.

It is a health service that is described in this section, and which is not excluded under general exclusions. Decisions about whether to cover new technologies, procedures and treatments will be consistent with conclusions of prevailing medical research, based on well-conducted randomized trials or cohort studies, as described.

18. Covered Person

The Retiree, the Retiree's covered Spouse, and the Retiree's Children and other eligible Dependents who are covered under the Plan.

19. Dependent

A Spouse, Child or Children or other person listed under **Section 1 – A: Eligibility for Coverage**, who is eligible to be covered under the Plan.

20. Designated Transplant Facility

A facility designated by Aetna to render and provide

necessary services and supplies for

qualified transplant procedures which are included as Covered Expenses under the Plan.

21. Direct Claim

Direct claims are those that the member paid out of pocket and then submits the paper claim form or submits online to be reimbursed.

22. Emergency Care

Medical care and treatment provided after the sudden onset of a medical condition manifesting itself by acute symptoms, including severe pain, which are severe enough that the lack of immediate medical attention could reasonably be expected to result in any of the following:

- The patient's health would be placed in serious jeopardy.
- Bodily function would be seriously impaired.
- There would be serious dysfunction of a body organ or part.

In addition, Emergency Care includes immediate Mental Health and Substance Use Disorder Treatment when the lack of the treatment could reasonably be expected to result in the patient harming himself or herself or other persons.

23. Emergency Medical Transportation

Ambulance services for an emergency medical condition.

24. 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.

25. Employer

The Company or any Participating Company under the Plan which engages the services of Employees.

26. Experimental, Investigational or Unproven Services

Medical, surgical, diagnostic, psychiatric,

substance use disorder or other health care services, technologies, supplies, treatments, procedures, drug therapies or devices that, at the time Aetna or Express Scripts makes a determination regarding coverage in a particular case, are determined to be:

- Not approved by the U.S. Food and Drug Administration ("FDA") to be lawfully marketed for the proposed use and not identified in the American Hospital Formulary Service, or the United States Pharmacopoeia Dispensing Information, as appropriate for the proposed use; or
- Not reviewed and approved by any institutional review board for the proposed use; or
- The subject of an ongoing clinical trial that meets the definition of a Phase 1, 2 or 3 clinical trial set forth in the FDA regulations, regardless of whether the trial is actually subject to FDA oversight; or
- Not demonstrated through prevailing peer-reviewed medical literature to be safe and effective for treating or diagnosing the condition or illness for which its use is proposed.

Aetna or Express Scripts, in its judgment, may deem an Experimental, Investigational or Unproven Service covered under the Plan for treating a life-threatening Sickness or condition if it is determined by Aetna or Express Scripts that the Experimental, Investigational or Unproven Service at the time of the determination:

- Is proved to be safe with promising efficacy; and
- Is provided in a clinically controlled research setting, and
- Uses a specific research protocol that meets standards equivalent to those defined by the National Institutes of Health.

For the purpose of this definition, the term "life-threatening" is used to describe a Sickness or condition which is more likely than not to cause death within one year of the date of the request for treatment.

27. Explanation of Benefits

A statement provided by Aetna to you, your Physician, or another health care professional that explains:

- the Benefits provided (if any);
- the allowable reimbursement amounts;
- deductibles;
- coinsurance;

- any other reductions taken;
- the net amount paid by the Plan; and
- if applicable, the reason(s) why services or supplies were not covered by the Plan.

28. Generic Drug

A Prescription Drug which is: (1) chemically equivalent to a Brand Name Drug whose patent has expired; and (2) identified as a Generic Drug by Express Scripts.

29. Home Health Care Agency

An agency or organization which provides a program of home health care and which meets one of the following three tests:

- It is approved under Medicare.
- It is established and operated in accordance with applicable licensing regulations and laws.
- It meets all of the following tests:
  - It has the primary purpose of providing a home health care delivery system bringing supportive services to the home.
  - It has a full-time administrator.
  - It maintains written records of services provided to the patient.
  - Its staff includes at least one registered nurse (R.N.) or it has nursing care by a registered nurse (R.N.) available.
  - Its employees are bonded and it maintains malpractice insurance.

30. Home Health Care Services

Services given by a Home Health Care Agency for the following:

- Temporary or part-time nursing care by or supervised by a registered nurse (R.N.).
- Temporary or part-time care by a home health care aide.
- Physical therapy.
- Occupational therapy.
- Speech therapy.

31. Hospice

An agency that provides counseling and incidental medical services for a terminally ill individual. Room and Board may be provided. The agency must meet one of the following three tests:

- It is approved by Medicare as a Hospice.
- It is licensed in accordance with applicable state laws and regulations.
- It meets the following criteria:
  - It provides 24 hour-a-day, 7 day-a-week Hospice services.
  - It is under the direct supervision of a duly qualified Physician.
  - It has a nurse coordinator who is a registered nurse (R.N.) with four years of full-time clinical experience. Two of these years must involve caring for terminally ill patients.
  - The main purpose of the agency is to provide Hospice services.
  - It has a full-time administrator.
  - It maintains written records of services given to the patient.
  - It maintains malpractice insurance coverage.

A Hospice which is part of a Hospital will be considered a Hospice for the purposes of the Plan.

32. Hospital

An institution which is engaged primarily in providing medical care and treatment of persons suffering from Sickness and Injury on an inpatient basis at the patient's expense and which fully meets one of the following three tests:

- It is accredited as a Hospital by the Joint Commission on Accreditation of Healthcare Organizations.
- It is approved by Medicare as a Hospital.
- It meets all of the following tests:
  - It maintains on the premises diagnostic and therapeutic facilities for surgical and medical diagnosis and treatment of Sick and injured persons by or under the supervision of a staff of duly qualified Physicians.
  - It continuously provides on the premises 24-hour-a-day nursing service by or under the supervision of registered nurses (R.N.s).
  - It is operated continuously with organized facilities for operative surgery on the premises.

33. Injury

Bodily damage from trauma other than Sickness, including all related conditions and recurrent symptoms.

34. In-Network Pharmacy

A pharmacy which has (1) entered into an agreement with Express Scripts or its designee to provide Prescription Drugs to Covered Persons; (2) has agreed to accept specified reimbursement rates for dispensing Prescription Drugs; and (3) has been designated by Express Scripts as an In-Network Pharmacy. An In-Network Pharmacy can be either a retail or a mail service pharmacy.

35. In-Network Provider

A health care provider who has:

- Entered into an agreement with the Claims Administrator or an affiliate; and
- Agreed to accept specified reimbursement rates for Covered Expenses.

36. 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.

37. Licensed Counselor

A person who specializes in Mental Health and Substance Use Disorder Treatment and is licensed as a licensed professional counselor or licensed clinical social worker by the appropriate licensing authority.

38. Lifetime Maximum Benefit

The most the Plan will pay for Benefits during the entire period you are enrolled in this Plan.

39. Medical Benefits

Plan payments provided for the purpose of preventing, diagnosing or treating Sickness, Injury, mental illness, substance use disorder, or their symptoms.

40. Medical Transportation Services

Eligible health services include emergency transport by a licensed air or ground ambulance when your condition is unstable and requires medical supervision and rapid transport services:

Ground Ambulance

- To and from a hospital to provide emergency services.
- Transportation from one hospital to another (to the nearest hospital qualified to provide the required treatment) if the first hospital cannot provide the emergency services needed.
- From your home to a hospital, if an ambulance is the only safe way to transport you. Transport is limited to 100 miles.

Air/water transportation

Air or water ambulance is covered when all of the conditions below are met:

- Professional ground ambulance is not available.
- Your condition is unstable and requires medical supervision and rapid transport.
- You are traveling from one hospital to another (nearest qualified to provide the required treatment), and the first hospital cannot provide the emergency services needed and the two conditions above are met.

The following are not covered: Ground/air/water transportation services or charges that are:

- Non-emergency air transportation by an out-of-network provider
- For routine transportation to receive outpatient or inpatient services
- Separate charges for waiting time, extra attendants, ambulance supplies, supplementary equipment or physician direction of emergency medical systems or any other non-transportation charge. These are considered incidental to the primary ambulance service billed.
- For member convenience or for non-clinical reasons.

41. Medically Necessary or Medical Necessity

Health care services and supplies which are determined by Aetna or Express Scripts to be

medically appropriate, and

(1) necessary to meet the basic health needs of the Covered Person;

(2) rendered in the most cost-efficient manner and type of setting appropriate for the delivery of the service or supply;

(3) consistent in type, frequency and duration of treatment with scientifically based guidelines of national medical, research, or health care coverage organizations or governmental agencies that are accepted by Aetna or Express Scripts;

(4) consistent with the diagnosis of the condition;

(5) required for reasons other than the convenience of the Covered Person or his or her Physician;

(6) demonstrated through prevailing peer-reviewed medical literature to be either:

  (a) safe and effective for treating or diagnosing the condition, Sickness or Injury for which their use is proposed, or,

  (b) safe with promising efficacy

    (i) for treating a life threatening condition, Sickness or Injury;

    (ii) in clinically controlled research setting;

    (iii) using a specific research protocol that meets standards equivalent to those defined by the National Institutes of Health.

For the purpose of this definition, the term "life-threatening" is used to describe a condition, Sickness or Injury which is more likely than not to cause death within one year of the date of the request for treatment.

The fact that a Physician has performed or prescribed a procedure or treatment or the fact that it may be the only treatment for a particular Injury, Sickness, mental illness or pregnancy does not mean that it is a Medically Necessary service or supply as defined above. The definition of Medically Necessary as used in this SPD relates only to determination of coverage under the Plan and differs from the way in which a Physician engaged in the practice of medicine may define “medically necessary”.

42. Medicare

The Health Insurance For The Aged and Disabled program under Title XVIII of the Social Security Act.

43. Medicare Secondary Payer

The term used by Medicare when Medicare is not responsible for paying first.

44. Mental Health and Substance Use Disorder Treatment

Mental Health and Substance Use Disorder Treatment is treatment for the following:

- Any Sickness which is identified in the current edition of the Diagnostic and Statistical Manual of Mental Disorders (“DSM”), including a psychological and/or physiological dependence or addiction to alcohol, drugs or medications, regardless of any underlying physical or organic cause; and
- Any Sickness where the treatment is primarily the use of psychotherapy or other psychotherapist methods.

All inpatient services, including Room and Board, given by a Mental Health and Substance Use Disorder Treatment Center or area of a Hospital which provides Mental Health and Substance Use Disorder Treatment for a Sickness identified in the DSM, are considered Mental Health and Substance Use Disorder Treatments, except in the case of multiple diagnoses.

If there are multiple diagnoses, only the treatment for the Sickness which is identified in the DSM is considered a Mental Health and Substance Use Disorder Treatment.

Detoxification services given prior to and independent of a course of psychotherapy or substance use disorder treatment is not considered a Mental Health and Substance Use Disorder Treatment.

Prescription Drugs used for Mental Health and Substance Use Disorder Treatment are addressed under the terms of the Plan applicable to Prescription Drugs.

45. Mental Health and Substance Use Disorder Treatment Center

A facility which provides a program of effective Mental Health and Substance Use Disorder Treatment and which meets all of the following requirements:

- It is established and operated in accordance with

any applicable state law.

- It provides a program of treatment approved by a Physician and Aetna.
- It has or maintains a written, specific and detailed regimen requiring full-time residence and full-time participation by the patient.
- It provides at least the following basic services:
  - Room and Board (if inpatient benefits are provided at a Mental Health and Substance Use Disorder Treatment Center).
  - Evaluation and diagnosis.
  - Counseling.
  - Referral and orientation to specialized community resources.

A Mental Health and Substance Use Disorder Treatment Center which qualifies as a Hospital is covered as a Hospital and not as a Mental Health and Substance Use Disorder Treatment Center.

46. Network

A network of Physicians, medical facilities and other health care providers who have agreed to provide their services at discounted rates (In-Network Providers).

47. Nurse-Midwife

A person who is licensed or certified to practice as a Nurse-Midwife and fulfills both of these requirements:

- The person is licensed by a board of nursing as a registered nurse (R.N.); and
- The person has completed a program approved by a state licensing body for the certification or practice of Nurse-Midwives.

48. Nurse-Practitioner

A person who is licensed or certified to practice as a Nurse-Practitioner and fulfills both of these requirements:

- The person is licensed by a board of nursing as a registered nurse (R.N.); and
- The person has completed a program approved by a state licensing body for the certification or practice of Nurse-Practitioners.

49. Office Visit Co-Payment

The fixed dollar amount the Covered Person pays for an In-Network Provider visit.

50. Oral Surgery

A procedure that deals with the diagnosis and treatment of oral conditions of the jaw and mouth structures that require surgical intervention.

51. Other Services and Supplies

Services and supplies furnished to a Covered Person and required for medical treatment, other than the professional services of any Physician and any private duty or special nursing services (including intensive nursing care by whatever name called).

52. Out-of-Network Benefits

The benefits received from an Out-of-Network Provider.

53. Out-of-Network Hospital

A Hospital which does not participate in the Network.

54. Out-of-Network Pharmacy

A pharmacy that is not an In-Network Pharmacy.

55. Out-of-Network Provider

A provider which does not participate in the Network.

56. Out-of-Pocket Maximum

The amount at which a Covered Person's required Medical Co-Payments and Deductibles stop during the Calendar Year.

57. Participating Companies

Participating Companies include Aramco Shared Benefits Company; Aramco Services Company; Aramco Associated Company; Aramco Overseas Company B.V.; Aramco Capital Company, LLC; Saudi Arabian Oil Company; Saudi Petroleum International, Inc.; and Saudi Refining, Inc., all of which are covered by the Plan.

58. Physician

A legally qualified:

- Doctor of Medicine (M.D.).
- Doctor of Chiropody (D.P.M.; D.S.C.).
- Doctor of Chiropractic (D.C.).
- Doctor of Dental Surgery (D.D.S.).
- Doctor of Medical Dentistry (D.M.D.).

- Doctor of Osteopathy (D.O.).
- Doctor of Podiatry (D.P.M.).

59. Plan or Medical Plan

The Aramco U.S. Retiree Medical Payment Plan, which is a welfare benefit plan established by the Plan Sponsor to provide certain Medical Benefits, Prescription Drug benefits, and other benefits to Covered Persons.

60. Plan Administrator

The person(s) identified in **Section 7 – A. Plan Information** as responsible for administering the Plan.

61. Plan Sponsor

The Plan Sponsor is Aramco Shared Benefits Company.

62. Plan Year

The Plan year is the calendar year.

63. Preferred Drug List

A list which identifies those Prescription Drugs which are preferred by Express Scripts for dispensing to Covered Persons when appropriate. This list is subject to periodic review and modification by Express Scripts and contains Generic Drugs and Brand Name Drugs. The Preferred Drug List is also known as a drug formulary. You may obtain a copy of the current Preferred Drug List by contacting Express Scripts.

64. Prescription Drug Cost

Express Scripts' contracted reimbursement rate, including any sales tax, with the Network Pharmacy where a Prescription Drug is dispensed. The Prescription Drug Cost does not include any manufacturer's refunds or incentive payments which may be received by Express Scripts.

65. Prescription Drugs

A medication, product or device which has been approved by the Food and Drug Administration and which can, under Federal or state law, be dispensed only pursuant to a Prescription Order or Prescription Refill.

66. Prescription Order or Prescription Refill

The directive to dispense a Prescription Drug issued by a duly licensed health care provider whose scope of practice permits issuing such a directive.

67. Primary Care Physician

A physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine) who directly provides or coordinates a range of health care services for a patient.

68. Psychologist

A person who specializes in clinical psychology and fulfills one of these requirements:

- A person licensed or certified as a psychologist;

  or

- A Member or Fellow of the American Psychological Association, if there is no government licensure or certification required.

69. Reasonable and Customary Charge

As to charges for services rendered by or on behalf of an In-Network Physician, an amount not to exceed the amount determined by Aetna in accordance with the applicable fee schedule.

As to all other charges, an amount measured and determined by Aetna by comparing the actual charge for the services or supplies with the prevailing charges made for similar services or supplies. Aetna determines the prevailing charges, taking into account all pertinent factors including:

- The complexity of the services provided.
- The range of services provided.
- The prevailing charges for similar services and supplies in the geographic area where the provider is located and other geographic areas having similar medical cost experience.

70. Rehabilitation Facility

A facility accredited as a rehabilitation facility by the Commission on Accreditation of Rehabilitation Facilities.

71. Retiree or Retired Employee

A former US Dollar Employee who meets the Plan's eligibility requirements as described under **Section 1– A: Eligibility for Coverage**.

72. Retiree Medical Eligibility Service

On and after January 1, 2019, your period of employment while on a U.S. Dollar payroll of a Participating Company (and while it is a Participating Company) under the Plan counts as Retiree Medical Eligibility Service. For the avoidance of doubt, periods of employment with an affiliated company that is not a Participating Company and/or while on a non-U.S. Dollar payroll do not count as Retiree Medical Eligibility Service. Effective March 1, 2019, Aramco Ventures LLC ("AV") is not a Participating Company under the Plan.

Prior to January 1, 2019, Retiree Medical Eligibility Service was the same as "Service" under the Retirement Income Plan.

73. Retirement Income Plan

The Aramco U.S. Retirement Income Plan, as amended from time to time.

74. Review or Review Process

A review and determination that the services and supplies are (or are not) Covered Expenses.

75. Room and Board

Room, board, general duty nursing, intensive nursing care by whatever name called, and any other services regularly furnished by the Hospital as a condition of occupancy of the class of accommodations provided by the Hospital but not including professional services of Physicians or special nursing services rendered outside of an intensive care unit by whatever name called.

76. Sickness

Physical illness, disease or pregnancy. The term "Sickness" used in connection with newborn Children includes congenital defects and birth abnormalities, including premature births.

77. Skilled Nursing Facility

A facility approved by Medicare as a Skilled Nursing Facility is covered by the Plan.

If not approved by Medicare, the facility will be covered if it is determined by Aetna to meet the following tests:

- It is operated under the applicable licensing regulations and laws.
- It is under the supervision of a licensed Physician or registered nurse (R.N.) who is devoting full time to supervision.
- It is regularly engaged in providing Room and Board and continuously provides 24-hour-a-day skilled nursing care of sick and injured persons at the patient's expense during the convalescent stage of an Injury or Sickness.
- It maintains a daily medical record of each patient who is under the care of a licensed Physician.
- It is authorized to administer medication to patients on the order of a licensed Physician.
- It is not, other than incidentally, a home for the aged, the blind or the deaf, a hotel, a domiciliary care home, a maternity home, or a home for alcoholics or drug addicts or the mentally ill.

A Skilled Nursing Facility which is part of a Hospital will be considered a Skilled Nursing Facility for the purposes of the Plan.

78. Specialist

A physician specialist focuses on a specific area of medicine or a group of patients to diagnose, manage, prevent or treat certain types of symptoms and conditions. A non-physician specialist is a provider who has more training in a specific area of health care.

79. Specialized Facility

A facility which is an Out-of-Network facility which holds a license that is not the same type held by any In-Network Provider.

80. Specialized Provider

A provider who is a Non-Network Provider but who also holds a health care professional license that is not the same type held by any Network Provider in the service area where the services are received by the Covered Person.

81. Spinal Disorder Treatment

The detection or correction, by manual or mechanical means, of bone or joint dislocation(s) (subluxation) in the body to remove nerve interference or its effects. The nerve interference must be the result of, or related to, distortion, misalignment or subluxation of, or in, the vertebral column.

82. Spouse

The individual married to the Retiree in accordance

with applicable law.

83. Substance Use Disorder

A condition of psychological or physiological dependence or addiction to alcohol or psychoactive drugs or medications, which results in functional (physical, cognitive, mental, affective, social or behavioral) impairment.

84. Surviving Spouse

The Spouse of a Retiree who, following the Retiree's death, is eligible for survivor coverage under the Plan.

85. Total Disability or Totally Disabled

- A Retiree's inability to perform all of the substantial and material duties of his or her regular employment or occupation.
- A Dependent's inability to perform the normal activities of a person of like age and gender.

86. Urgent Care

Treatment of an unexpected Sickness or Injury that is not life threatening but requires outpatient medical care that cannot be postponed. An urgent situation requires prompt medical attention to avoid complications and unnecessary suffering, such as high fever, a skin rash, or an ear infection.

87. Urgent Care Center

A facility which provides Urgent Care services. In general, Urgent Care Centers:

- Do not require an appointment;
- Are open outside of normal business hours, so you can get medical attention for minor illnesses that occur at night or on weekends; and
- Provide an alternative if the Covered Person needs immediate medical attention.