

Aramco U.S. Medical Payment Plan

**Preferred Provider Organization Option
High Deductible Health Plan Option**

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

Active Employees

January 1, 2026

Notice to Employees

This document describes the medical and prescription plan that the Aramco Shared Benefits Company (“ASBCO”) sponsors for Employees on the U.S. Dollar payroll of ASBCO and the Participating Companies (collectively, the “Company”) and their eligible Dependents, as in effect on April 1, 2020. Participating Companies under the Plan include Saudi Arabian Oil Company; Aramco Americas Company (formerly known as Aramco Services Company (“ASC”)); Aramco Associated Company; Aramco Overseas Company B.V.; Aramco Capital Company, LLC; Saudi Petroleum International, Inc.; Aramco Ventures LLC (“AV”) (formerly known as Saudi Aramco Energy Ventures, LLC), Aramco Venture Management Consultant Company, LLC; Aramco Training Americas LLC, and Saudi Refining, Inc.

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

The Plan is a component benefit plan under the Aramco U.S. Welfare Benefit Plan. The Plan includes a Preferred Provider Organization option (“PPO Plan”) and a High Deductible Health Plan option (“HDHP”) for certain eligible employees. The PPO Plan and HDHP include different rules, coverage, cost sharing and benefits in certain circumstances. You should carefully review this SPD for the terms applicable to you and your eligible Dependents.

Prior to April 1, 2020, the Plan and the Aramco U.S. Welfare Benefit Plan were sponsored by the Saudi Arabian Oil Company and named as the “Saudi Aramco U.S. Dollar Welfare Benefit Plan (Medical Benefits)” and “Saudi Aramco U.S. Dollar Welfare Benefit Plan,” respectively.

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

Website

MyAramcoBenefits.com

Member Services

888-532-4144

Rightway – Healthcare Navigation

305-851-7310

Assistance with:

Finding Providers

Billing/Claims Issues

Aetna International

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 Program

Aetna Informed Health Line (Nurse line)

1-800-556-1555

Aetna International Behavioral Health

1-888-238-6232

For Mental Health and Substance Use

Disorder

Express Scripts (for prescription drugs)

Member Services

1-800-711-0917

Member Website

www.express-scripts.com

WEX

For Health Savings Account questions

Website

<https://www.wexinc.com/login/benefits-login/>

Member Services

866-451-3399

Email

customerservice@wexhealth.com

As you read this SPD, you will see certain capitalized terms, which are defined in Section 7: *Glossary of Terms*, at the end of this SPD.

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SECTION 1: ELIGIBILITY AND ENROLLING IN COVERAGE

The Plan is intended to help pay for eligible medical expenses incurred by Employees 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 Employees 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 in 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, a reduction in benefits, or even in the denial of benefits under the Plan.

Section 1-A: Eligibility for Coverage

The following table lists the **eligibility requirements** for coverage under the Plan:

Summary of Eligibility Requirements		
Employee Eligibility	Eligible	Not Eligible
Regular full-time salaried Employees of the Company who are employed on a U.S. Dollar Payroll. Salaried employees in the U.S. sub-group of the Expatriate Payroll of Saudi Aramco working as a rotator, as determined by Saudi Aramco. Notwithstanding the foregoing, the High Deductible Health Plan (HDHP) and the Health Savings Account (HSA) are only available to U.S. Dollar Payroll Employees working in the U.S.	✓	
An independent contractor, Leased Employee, consultant, or hourly or daily paid employee.		✓
Employees who are on a Company approved long term disability and are under the age of 65 are eligible for coverage under the Aramco U.S. Retiree Medical Payment Plan.		✓
Dependent Eligibility		
Spouse - your legally-recognized spouse not covered under another Company-sponsored group medical plan.	✓	
Child or Children - your and your Spouse's Children under age 26 (Note 1) , including: - Your natural children, stepchildren, legally adopted children and children for whom you are the legal guardian; - Your foster children, including any children placed with you for adoption; - Children for whom you are responsible under a qualified medical child support order ("QMCSO");	✓	
Your and your spouse's Children age 26 or older who were disabled before age 19 while their coverage under the Plan was in force. The request to enroll for this coverage must be submitted to the Claims Administrator no later than 31 days after the disabled Dependent's 26th birthday.	✓	
If you die in an industrial death while you are an Employee and if you were not retirement eligible at the date of your death, your eligible Dependents, until the earlier of (1) The last day of the month during which your surviving Spouse attains age 60 ; or (2) The last day of the month during which your surviving Spouse remarries.	✓	
If you die in a non-industrial death while you are an Employee and if you were not retirement eligible at the date of your death, your eligible Dependents, until the earlier of (1) The end of the month in which occurs the five-year anniversary of your death; (2) The last day of the month during which your surviving Spouse attains age 60 ; or (3) The last day of the month during which your surviving Spouse remarries.	✓	
If you die after becoming retirement eligible while you are an active Employee, your eligible Dependents, until your surviving Spouse remarries or attains age 60 . After this coverage ends, eligibility of your Spouse and Dependents is determined under the provisions of the Retiree Medical Payment Plan. If you are not married on the date of your death, your covered Dependent Children may continue to be covered	✓	

under COBRA provided they continue to meet all other eligibility requirements of the Plan.		
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.		✓
Note 1: Coverage for Dependents attaining age 26 terminates at the end of the month they reach 26 years of age, at which time they will be eligible to elect COBRA benefits.		

Who is Not Eligible

You are not eligible to participate in the Plan if **any** of the following conditions apply:

- (1) You are employed on any basis other than as a regular full-time salaried Employee of the Company (for example, as an hourly or daily paid employee);
- (2) You provide services to the Company as an independent contractor under a contract between yourself and the Company or under a contract between the Company and a third party; or
- (3) You provide services to the Company under a leasing agreement with the Company.
- (4) You are not eligible to participate in the HDHP and HSA if you work outside of the U.S.

Disabled Child Eligibility Guidelines

You or your Spouse's unmarried, disabled Child is eligible for continued medical coverage under the Plan after your Child reaches age 26 when eligibility would otherwise end **if** the Child is:

- Physically or mentally disabled before age 19 while covered under the Plan;
- Incapable of self-support upon reaching the age eligibility would otherwise end; and
- Dependent on you for financial support.

If you wish to continue coverage for a disabled Child:

You must provide proof of the Child's disability to Aetna within 31 days after your Child reaches age 26. You may be required to provide annual proof of continuing disability.

Dual Company Coverage

If both you and your Spouse work for the Company, neither of you may be covered as both an Employee and a Dependent at the same time under the Plan or another Company sponsored group

medical plan. If your Spouse works for another Participating Company or is eligible for any other Company sponsored medical plan, you may not be covered as an Employee under the Plan and as your Spouse's Dependent under the other Company's medical plan. If both you and your Spouse work for the Company or your Spouse works for another Participating Company and you have one or more Dependent Children, they may be covered by either you or your spouse but cannot be covered as a Dependent by both of you at the same time. If both you and your Spouse work for the Company or your Spouse works for another Participating Company, your Spouse cannot be covered as your Dependent.

Coordinating with Medicare

Active Employees

If you're an active employee, and you or an enrolled dependent is eligible for Medicare due to age or disability, the Medical Plan is generally the primary payor and Medicare is the secondary payor.

Note: If you or your dependent has Medicare coverage because of end stage renal disease, Medicare is primary. However, for the first 30 months of Medicare eligibility, the Medical Plan is the primary payer and Medicare is secondary. After 30 months, Medicare becomes primary. Home dialysis is covered under the Plan, but only if medically necessary and the provider is a Medicare-approved agent.

Disability Leave: If you're receiving Aramco U.S. Long-Term Disability Plan benefits, the government and the Company no longer consider you an active employee covered under this Medical Plan. You will instead be eligible for coverage under the Aramco U.S. Retiree Medical Payment Plan if you are under age 65. If you become eligible for Medicare due to disability, Medicare becomes the primary payor of benefits for you and any Medicare-eligible dependents. You may remain enrolled in the Aramco U.S. Retiree Medical Payment

Plan as long as you maintain eligibility, but you must also enroll in Medicare as soon as you are eligible. The Retiree Medical Payment Plan will assume enrollment in both Medicare Parts A and B and will pay claims as though you have both parts. If you aren't enrolled in Medicare, you will be responsible for a large part of the claims cost.

Retired Employees

When you attain eligibility for Medicare, Medicare will become the primary payor for medical benefits, even if you (and your Medicare-eligible dependents, if applicable) are covered under the Retiree Medical Payment Plan. It's important that

Medicare-eligible family members apply for Medicare Parts A and B three months before

attaining eligibility for Medicare. Home dialysis is covered under the Plan, but only if medically necessary and the provider is a Medicare-approved agent.

Section 1-B: Enrolling for Coverage

How to Enroll

When you enroll you must elect one of the following coverages under the Plan:

- Employee Only; or
- Employee + Spouse; or
- Employee + Child(ren); or
- Employee + Family.

If both you and your Spouse are eligible to enroll in the Plan as Employees and you both wish to be covered:

- Each of you may enroll for "Employee-only". If you have one Child: one of you may enroll for "Employee + Children" and the other may enroll for "Employee Only"; or

NOTE: You must be enrolled for coverage under the Plan in order to enroll your Dependents for coverage.

To enroll, you must contact the Businessolver Aramco Benefits Center within 60 days of the date you become eligible to participate in the Plan.

When to Enroll

Initial Enrollment

You may enroll yourself and your eligible Dependents in the Plan at any time within 31 days after the date you begin employment. If you enroll within 31 days after the date you begin employment (or your eligibility date), you may choose to begin coverage retroactive to your date of employment (or your eligibility date) or you may elect to have coverage begin on the first day of the following month.

Late Enrollment

If you did not enroll yourself and your eligible Dependents for coverage during the initial enrollment period described in the previous Section, or if you were enrolled under the Plan, subsequently canceled your coverage, and wish to re-enroll, **you may enroll yourself and your eligible Dependents only at the following times:**

- Within 60 days after an applicable Qualified Change in family or employment status (for details about Qualified Changes in family or employment status see Section 5: *Events Affecting Coverage*); or
- During the next Annual Open Enrollment Period.

You are not permitted to enroll yourself or eligible Dependents at any other time.

Enrolling Your New Dependent(s)

Newborns: Provided you are covered under the Plan, your newborn Child will be eligible for benefits under the Plan on the same basis as any other covered Dependent, provided you enroll your newborn Child 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 entitled "*Eligibility for Coverage*" on the date the Child is legally adopted or guardianship of the Dependent is established so long as Businessolver is notified 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*", effective as of the date of your marriage or on the first day of the month

following the date of your marriage. You are required to notify Businessolver within 60 days after the date of your marriage. You will be required to provide a copy of the marriage license or certificate.

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.

Annual Open Enrollment Period

Changes if You and Your Dependents Are Currently Covered

Each year during the Annual Open Enrollment Period, you have the opportunity to make changes to your Plan coverage.

The types of changes you can make include the following:

- (a) Changing your or your Dependents' coverage;
- (b) Deleting or adding eligible Dependents; or
- (c) Terminating coverage.

Your changes to coverage will become effective on January 1 following enrollment during the Annual Open Enrollment Period.

Changes if You or Your Dependents Are Not Currently Covered

If you or your Dependents are not covered under the

Plan and you wish to enroll for coverage during the Annual Open Enrollment Period, you may either:

- (a) Enroll for coverage under the Plan; or

Section 1-C: Cost/Funding

The Plan is a self-funded plan. This means that claims are not paid by the insurance company, Aetna International ("Aetna"), under an insurance policy with Aetna, or by Express Scripts under an insurance contract with Express Scripts. Contributions made by the Company and Employees participating in the Plan are used to pay

- (b) Add eligible Dependents as described previously in this Section entitled "*Enrolling Your New Dependent(s)*".

Your changes to coverage will become effective on January 1 following enrollment during the Annual Open Enrollment Period.

Effective Date of Coverage

In Summary

Employee coverage is effective on the employment date or the first day of the following month (at the Employee's election) if the Employee enrolls within 31 days after the employment date or, 60 days if enrollment is due to a Qualified Change as described in Section 5: *Events Affecting Coverage*, on the first day of the following month. Coverage for Dependents enrolled at the date employment begins is effective on the date the Employee becomes covered. Coverage for subsequent Dependents is effective as follows:

- For a Spouse - the date of marriage, or the first day of the following month, as elected by the Employee;
- For a newborn Child - the date of birth;
- For an adopted Child - the date of adoption or placement for adoption.

For any other Child, the date the Child otherwise becomes an eligible Dependent, as described under Section 1-A: *Eligibility for Coverage*.

Newborn Children must be enrolled in the Plan within 60 days following the date of birth to be covered under the Plan from the date of birth.

the claims of Covered Persons.

The Plan Sponsor, on behalf of the Plan, has contracted with Aetna and Express Scripts to act as Claims Administrators to process claims under the Plan and to provide certain other administrative services. The Claims Administrators are paid fees

out of Plan contributions to provide these services.

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 the required contribution rates that will be paid by the Company and by Employees who participate in the Plan. Normally, changes in contribution rates become effective on January 1.

Company Contributions

The Company currently contributes an amount each month toward the required total contribution to the Plan. The Company's contribution is reviewed periodically, and may be increased or decreased based on several factors, including the Company's ability to continue making contributions. The Company reserves the right to withhold, reduce or discontinue its contributions at any time, as permitted under ERISA.

Employee Contributions

Employees who elect to participate in the Plan are required to share in the cost of the Plan. The Employees' share of the cost is the difference

between the total required contributions less the Company's contributions, if any, to the Plan.

Annual Rate Announcements

Contribution rates are announced annually during the Annual Open Enrollment Period.

Future of the Plan

The Plan is a voluntary plan. It is the Plan Sponsor's intention to continue to provide these Plan benefits to participants in the Plan. However, the Plan Sponsor reserves the right to amend, modify, or terminate the Plan, in whole or in part, at any time and for any reason, including but not limited to the Company's ability to continue making contributions, subject to applicable law (see Section 6: *Administration & Other Information*). Any such actions will be effective as of the date designated by the Plan Sponsor.

Section 1-D: PPO Plan and HDHP Information

The PPO Plan and HDHP cover all or a portion of Covered Expenses received from either In-Network Providers (the Aetna Choice POS network) or Out-of-Network Providers. For services received from In-Network Providers the amount the Employee pays will generally be less than if the same services were received from an Out-of-Network 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.
- Physical Therapists.

- Physicians.
- Podiatrists.
- Rehabilitation Facilities.
- Skilled Nursing Facilities.

The PPO Plan and HDHP Covered Expenses are subject to Annual Deductibles, annual Out-of-Pocket Maximums, Copayments and/or Coinsurance unless otherwise stated in the schedule of benefits set forth below.

Under each option, you will:

1. Pay your **Copayment where applicable**
2. Then pay any remaining **Annual Deductible**
3. Then pay your Coinsurance

Your **Copayment** does not apply to any **Annual Deductible**.

In-Network Advantage

The PPO Plan pays 100% of Covered Expenses for In-Network Provider services after the Copayment and, the Annual Deductible is met (see

Section 1-E: *How Deductibles, Copayments and Coinsurance Work*).

The HDHP pays 80% of Covered Expenses for In-Network Provider services after the Copayment and Annual Deductible is met (see Section 1-E: *How Deductibles Copayments, 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

The PPO and the HDHP both use a provider network. You will pay less if you use a provider in the plans' network. You will pay more if you use an out-of-network provider, and you may receive a bill from a provider for the difference between the provider's charge and what your plan pays (Balance Billing).

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.

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

Under the Plan, you may choose an In-Network

Provider and pay only a Copayment for services.

Alternatively, you may choose an Out-of-Network Provider, but under the PPO Plan you will generally pay a Coinsurance of 30% after satisfying your Annual Deductible. Under the HDHP you will generally pay a Coinsurance of 40% 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.

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. Employees may choose to use Out-of-Network Providers, but generally at increased cost to the Employee.

Health Savings Account

The following is a brief summary of the HSA that you could establish to complement your election of the HDHP option. This summary only addresses the HSA and not the HDHP that is associated with the HSA as described elsewhere in this SPD.

The Company has entered into an agreement with WEX (formerly Discovery Benefits) under which WEX will provide certain administrative services to the Plan for those who choose to establish an HSA. The HSA is not a plan that is subject to ERISA and is not a component of the HDHP, the Plan or the Aramco U.S. Welfare Benefit and is not otherwise an arrangement that is established and maintained by the Company. Rather, the HSA is established and maintained by the HSA trustee. This description of the HSA is provided solely for your convenience.

An HSA is a tax-advantaged account that can be used to pay for qualified health care expenses on a tax-free basis that you, or your eligible Dependents, incur. Amounts distributed from the HSA to pay non-qualified health expenses are subject to income tax and may be subject to a 20% excise tax penalty unless an exception applies. To be eligible to participate, you must be enrolled in the HDHP.

Your HSA is funded through your and the Company's contributions. The HSA can help offset

your out-of-pocket health care costs, including your deductible, with tax-free dollars that you set aside each pay period.

HSA contributions:

- Remain in your account until you use them.
- Accumulate over time with interest or investments earnings on a tax free basis.
- Are portable after employment.

You must be covered under the HDHP in order to participate in the HSA. In addition, you must not be:

- Covered by any health plan (including a full health care flexible spending account) that is not a high deductible health plan and which provides coverage for any benefit which is covered under the HDHP (this does not include coverage under an ancillary plan such as vision or dental, or any other permitted coverage as defined by the IRS).
- Enrolled in Medicare.
- Claimed as a dependent on another person's tax return.

Contributions are made by you through pre-tax payroll deductions pursuant to the Aramco U.S. Flexible Benefit Plan. The Company may also contribute into your HSA. The current Company HSA contribution amount is \$750 if you elect employee-only coverage under the HDHP and \$1,500 if you elect family coverage under the HDHP. You must complete the process to open an HSA with WEX to receive the Company's contributions and make voluntary personal contributions. If you do not open your HSA by the deadline designated, you will forfeit any Company HSA contributions for the calendar year. The Company does not provide HSA contributions to COBRA participants. All funds placed into your HSA are owned and controlled by you, subject to any administrative restrictions imposed by the trustee.

The IRS limits how much you can contribute to your HSA for each year, including your contributions and the Company's contributions. Your contribution limits are determined by the level of coverage you've selected in a qualifying, high deductible health plan, such as the HDHP. Monitor your contributions carefully. It is your responsibility to track the total contributions during the year — including your contributions, the Company's contributions, and contributions from other sources. The Company

cannot track your contributions against the maximum annual limit. If you contribute over the limit, you may be subject to taxes and penalties. While the IRS limits how much you can contribute in a year, there is no limit to the balance you are allowed to carry over into the next year, and there's no overall limit to the total balance you can carry in your account.

You are allowed to make an extra \$1,000 in catch-up contributions starting in the calendar year in which you turn age 55. The maximum limits set by the IRS may be found on the IRS website at www.irs.gov.

If you enroll in your HSA within the year (not on January 1) you will still be allowed to contribute the maximum amount set by the IRS. However, you must remain enrolled in a high deductible health plan and HSA until the end of the 12th month from your initial enrollment or you will be subject to tax implications and an additional tax of 10%. Note: Amounts that exceed the contribution maximum are not tax-deductible and will be subject to an excise tax unless withdrawn as an "excess contribution" prior to April 15th of the following year.

If you do not use all of the funds in your HSA during the calendar year, the balance remaining in your HSA will roll-over. If your employment terminates for any reason, the funds in your HSA will continue to be owned and controlled by you, whether or not you elect COBRA coverage for the HDHP. If you choose to transfer the HSA funds from one account to another eligible account, you must do so within 60 days from the date that HSA funds are distributed to you to avoid paying taxes on the funds. If you elect COBRA, the HSA funds will be available to assist you in paying your out-of-pocket costs under the

Plan and COBRA premiums while COBRA coverage is in effect.

The above information is only a summary and additional terms or conditions may apply. You may obtain additional information on your HSA by contacting WEX and online at www.irs.gov. You may also contact your tax advisor.

Section 1-E: How Deductibles, Copayments, and Coinsurance Work

The following table sets out the **PPO Plan's** Copayments, Coinsurance, Annual Deductibles, Out-of-Pocket Maximums, and Maximum Benefits.

Summary of Annual Deductibles, Out-of-Pocket Maximums and Copayments	Amounts In-Network	Out-of-Network or Outside the U.S.
Copayments (In-Network) (Apply toward Out-of-Pocket Maximum but not the Annual Deductible)		
Primary Care Physician Office Visit Copayment - Applies to In-Network primary care Physician visits and applies to all Covered Expenses given in connection with each office visit.	\$20	N/A
Specialist Office Visit Copayment - Applies to In-Network specialist Physician visits including physical therapist's services if the physical therapist bills for his/her services separately from any other charges. It applies to all Covered Expenses given in connection with each office visit.	\$40	N/A
Emergency Room Copayment - Applies to In-Network and Out-of-Network Hospital emergency room services and applies to each visit. Services for Emergency Care are payable only if it is determined that the services are Covered Services and there is not a less intensive or more appropriate place of service, diagnostic treatment or treatment alternative that could have been used in lieu of emergency room services. The emergency room Copayment does not apply if the Covered Person is admitted as a Hospital inpatient.	\$175	
Hospital Inpatient Copayment - Applies to each confinement in an In-Network Hospital or In-Network Rehabilitation Facility.	\$300	N/A
Outpatient Surgery Copayment - Applies to In-Network Hospital services or In-Network Ambulatory Surgical Center services for outpatient surgery. The outpatient surgery Copayment applies to each outpatient surgery admission.	\$50	N/A
Coinsurance (Out-of-Network) (Applies toward Out-of-Pocket Maximum)		
After satisfying the Annual Deductible you share in the cost of most Out-of-Network Covered Expenses. See Section 2-A: <i>What's Covered – Medical Benefits</i> for additional information.	None	30%
Annual Deductibles (per Calendar Year)		
You Only	\$250	\$800
You and Family (requires 2 individual Annual Deductibles to be met)	\$500	\$1,600

Non-Notification Per Person (additional payment only if precertification is required and not notified – does not count toward Annual Deductible or Out-of- Pocket Maximum)	\$200
Annual Out-of-Pocket Maximum (per Calendar Year) (Prescription Drugs are included toward fulfillment of the Out-of-Pocket Maximum)	
You Only	\$3000 (includes the Annual Deductible of \$800)
You and Family	\$6000 (includes the family Annual Deductible of \$1,600)
Maximum Benefits	
Lifetime Maximum (includes Medical Benefits and mental health benefits but not Prescription Drug benefits)	Unlimited

The following table sets out the High Deductible Health Plan's (**HDHP's**) Copayments, Coinsurance, Annual Deductibles, Out-of-Pocket Maximums, and Maximum Benefits.

Summary of Annual Deductibles, Out-of-Pocket Maximums and Copayments	Amounts In-Network	Out-of-Network or Outside the U.S.
Copayments (In-Network) (Apply toward Out-of-Pocket Maximum but not the Annual Deductible)		
Primary Care Physician Office Visit Copayment - Applies to In-Network primary care Physician visits and applies to all Covered Expenses given in connection with each office visit.	N/A	N/A
Specialist Office Visit Copayment - Applies to In-Network specialist Physician visits including physical therapist's services if the physical therapist bills for his/her services separately from any other charges. It applies to all Covered Expenses given in connection with each office visit.	N/A	N/A
Emergency Room Copayment - Applies to In-Network and Out-of-Network Hospital emergency room services and applies to each visit. Services for Emergency Care are payable only if it is determined that the services are Covered Services and there is not a less intensive or more appropriate place of service, diagnostic treatment or treatment alternative that could have been used in lieu of emergency room services. The emergency room Copayment does not apply if the Covered Person is admitted as a Hospital inpatient.	\$150 Copay and 20% after Annual Deductible	
Hospital Inpatient Copayment - Applies to each confinement in an In-Network Hospital or In-Network Rehabilitation Facility.	N/A	N/A
Outpatient Surgery Copayment - Applies to In-Network Hospital services or In-Network Ambulatory Surgical Center services for outpatient surgery. The outpatient surgery Copayment applies to each outpatient surgery admission.	N/A	N/A
Coinsurance (Out-of-Network) (Applies toward Out-of-Pocket Maximum)		
After satisfying the Annual Deductible you share in the cost of most Covered Expenses. See Section 2-A: <i>What's Covered – Medical Benefits</i> for additional information.	20%	40%
Annual Deductibles (per Calendar Year and any combination of members can contribute to satisfy the deductible)		
You Only	\$2,000	\$4,000
You and Family	\$4,000	\$8,000

Non-Notification Per Person (additional payment only if precertification is required and not notified – does not count toward Annual Deductible or Out-of- Pocket Maximum)		\$200	
Annual Out-of-Pocket Maximum (per Calendar Year) (Deductibles, Copays, and Prescription Drugs are included toward fulfillment of the Out-of-Pocket Maximum)			
You Only		\$4,000	\$8,000
You and Family		\$8,000	\$16,000
Maximum Benefits			
Lifetime Maximum (includes Medical Benefits and mental health benefits but not Prescription Drug benefits)		Unlimited	

Out-of-Pocket Expenses

Copayment

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

- Medical Copayments are counted toward the Annual Out-of-Pocket Maximum but do not apply to the Annual Deductible.
- Copayments and Coinsurance for Prescription Drugs do not count toward the Annual Deductible but are included toward fulfillment of the Out-Of-Pocket Maximum under the Plan.
- Covered Expenses which require a Copayment are not subject to an Annual Deductible.

Individual Annual Deductible

The individual Annual Deductible is the amount of Covered Expenses the Employee must pay for a Covered Person 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. It does not include charges and Copayments 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 family member Covered Persons have incurred any Covered Expenses or met their respective Annual Deductibles.

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

PPO Plan Family Annual Deductible

Under the PPO Plan, 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.

HDHP Family Annual Deductible

Under the HDHP, you pay for covered services each year before the plan begins to pay. After the

amount paid for Covered Expenses reaches this family Annual Deductible, the HDHP starts to pay for Covered Expenses for the rest of the year. To satisfy this family Annual Deductible for the rest of the year, the combined Covered Expenses that you and each of your covered eligible Dependents incur toward the individual Annual Deductible must reach this family Annual Deductible in a year. When this happens in a year, the individual Annual Deductibles for you and your covered eligible Dependents are met for the rest of the 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.

Coinsurance

Coinsurance is the percentage of the Covered Expenses you are required to pay. After the Annual Deductible is met, the PPO Plan begins paying its share of Covered Expenses. The PPO Plan pays 70% if an Out-of-Network Provider is used, until the individual or family Out-of-Pocket Maximum amounts (as discussed below) have been paid. Thereafter, the Plan pays 100% of Covered Expenses for the rest of the Calendar Year.

After the Annual Deductible is met, the HDHP pays 80% if an In-Network Provider is used, 60% if an Out-of-Network Provider is used, until the individual or family Out-of-Pocket Maximum amounts have been paid.

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 or refer to www.express-scripts.com

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

Examples of In-Network Services

PPO

Maternity

Initial office visit when pregnancy is diagnosed	Applicable copay
Physician's prenatal care, delivery and postnatal care	Up to \$250 deductible

Facility charges for delivery	\$300 inpatient deductible
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Outpatient Surgery in a Surgery Center

Physician/surgeon charges	Up to \$250 deductible
Surgery center/facility charges	\$50 copay

HDHP

Maternity

Initial office visit when pregnancy is diagnosed	20% per visit after deductible
Physician's prenatal care, delivery and postnatal care	20% per visit after deductible

Facility charges for delivery	20% per admission after deductible
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Outpatient Surgery in a Surgery Center

Physician/surgeon charges	20% per visit after deductible
Surgery center/facility charges	20% per visit after deductible

Labs and X-Rays

In most cases, the deductible would apply to labs and x-rays. The exception is if labs or x-rays are done in a physician office with an exam/consult, and billed by the provider as part of the office visit.

Physician Services

Physician services where no exam/consult is involved, such as allergy injections would be subject

to the 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 credited toward your annual Out-of-Pocket Maximum or be paid at 100% after you reach your 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; and Expenses you pay for charges in excess of Reasonable and Customary Charges.

Family Annual Out-of-Pocket Maximum

PPO - 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.

HDHP – After the amount of the cost share and deductible paid during the year for covered services meets the family Out-of-Pocket Maximum, the Plan will pay 100% of the eligible charge for covered services that would apply toward the limit for the rest of the year. For the purposes of the Maximum Out-of-Pocket limit provision:

- The individual maximum Out-of-Pocket applies

to a person enrolled for employee only coverage.

- The family maximum Out-of-Pocket applies to a person enrolled with one or more dependents.

You will find details on Out-of-Pocket Maximums in

Section 2-A: What's Covered – Medical Benefits.

Section 1-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 personally precertify 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 precertify.

Services and Supplies Which Require Precertification

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

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 precertification list below. If you do not precertify, your benefits may be reduced, or the Plan may not pay any benefits.

- 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 Mental Health and Substance Use Disorder Residential Treatment Center for treatment of mental disorders and substance use disorders;
- 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 being hospitalized or receiving Other Services and Supplies 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 precertify the admission to a Hospital or other medical facility 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 precertified 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 precertified 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 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 precertify 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 precertified 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 additional 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 Maximum. 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.

Section 2-A: What's Covered – Medical Benefits

This table provides an overview of the **PPO 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.

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	\$3,000 per calendar year	\$3,000 per calendar year
<i>(Does not include benefit penalties. Includes deductibles, copays, and Prescription Drugs.)</i>			
Family Maximum Out-of-Pocket Limit	\$6,000 per calendar year	\$6,000 per calendar year	\$6,000 per calendar year
<i>(Does not include benefit penalties. Includes deductibles, copays, and Prescription Drugs.)</i>			
Lifetime Maximum	Unlimited		
Inpatient Per Confinement Deductible <i>(Maximum of 3 per calendar year)</i>	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 \$50 copay	30% after deductible
Outpatient Surgery performed in a surgical facility	30% after deductible	No charge after applicable 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 <i>(copay waived if admitted)</i>	No charge after \$175 copay	No charge after \$175 copay	No charge after \$175 copay
Non-Urgent Use of Urgent Care Provider	30% after deductible	No charge after \$45 copay (Copay waived when no office service is billed)	30% after deductible
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 <i>Unlimited days per calendar year</i>	30% after deductible	No charge after deductible and \$300 inpatient per confinement copay	30% after deductible
Mental Health Outpatient Coverage <i>Unlimited visits per calendar year</i>	30% after deductible	No charge after \$20 copay	30% after deductible
Substance Use Disorder Services			

Substance Use Disorder Inpatient Coverage <i>Unlimited days per calendar year</i>	30% after deductible	No charge after deductible and \$300 inpatient per confinement copay	30% after deductible
Substance Use Disorder Outpatient Coverage <i>Unlimited visits per calendar year</i>	30% after deductible	No charge after \$20 copay	30% after deductible
Wellness Benefits			
Routine Children Physical Exams	30% after deductible	No charge	30% after deductible
<i>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 calendar year thereafter to age 22 (includes immunizations)</i>			
Routine Adult Physical Exams	30% after deductible	No charge	30% after deductible
<i>Adults age 22+ & -65: 1 exam/12 months Adults age 65+: 1 exam/per calendar year includes immunizations</i>			
Routine Gynecological Exams <i>Includes 1 exam and pap smear per calendar year</i>	30% after deductible	No charge	30% after deductible
Baseline Mammograms <i>(1 Baseline from ages 35-40 years)</i>	30% after deductible	No charge	30% after deductible
Mammograms <i>(Routine visits age 40+)</i>	30% after deductible	No charge	30% after deductible
Prostate Specific Antigen (PSA)	30% after deductible	No charge	30% after deductible
<i>Includes 1 PSA per calendar year for males 40+</i>			
Digital Rectal Exam (DRE)	30% after deductible	No charge	30% after deductible
<i>Includes 1 DRE per calendar year for males 40+</i>			
Cancer Screening	30% after deductible	No charge	30% after deductible
<i>Includes 1 flex sigmoid and double barium contrast every 5 years; and at age 45 + 1 colonoscopy every 10 years</i>			

Routine Hearing Exam <i>Includes one routine exam per calendar year</i>	30% after deductible	No charge	30% after deductible
Hearing Aids	30% after deductible	No charge after deductible	30% after deductible
<i>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.</i>			
Vision Care			
Routine Eye Exam	30% after deductible	No charge	30% after deductible
<i>(Covered under medical) Includes one routine exam per calendar year</i>			
Other Services			
Skilled Nursing Facility <i>(120 Days per calendar year)</i>	30% after deductible	No charge after deductible and \$300 inpatient per confinement copay	30% after deductible
Hospice Care Facility Inpatient <i>(Unlimited lifetime maximum)</i>	30% after deductible	No charge after deductible and \$300 inpatient per confinement copay	30% after deductible
Hospice Care Facility Outpatient <i>(Unlimited lifetime maximum)</i>	30% after deductible	No charge after deductible	30% after deductible
Home Health Care <i>(40 visits per calendar year)</i>	30% after deductible	No charge after deductible	30% after deductible
Private Duty Nursing <i>(Unlimited visits per calendar year)</i>	30% after deductible	No charge after deductible	30% after deductible
Spinal Disorder Treatment <i>(20 visits per calendar year)</i>	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
<i>(Includes coverage for Occupational, Physical and Speech Therapies; 120 combined maximum visits per calendar year, except if associated with any MH/SUD and PDD conditions as required by MHPAEA)</i>			
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 <i>(Includes lasik, radial keratotomy, orthoptic training and PKR)</i>	No charge after \$40 copay (\$3,000 max per eye)		
Bariatric Surgery <i>(Unlimited per lifetime)</i>	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 (Copay waived when no office service is billed)	30% after deductible
Other Services			
Aetna Assistance Program <i>(\$500,000 calendar year maximum)</i>	No charge	No charge	No charge
International Employee Assistance Program (IEAP)	Included	Included	Included
<i>Includes up to 5 counseling sessions per issue per year per enrolled member. Access benefits by calling the member service number on ID card: 800-231-7729 or collect 813-775-0190. Services include: Cultural adjustment assistance, Marital/Family Stress, Child care and behavioral concerns, Social adaptation needs, Alcohol/Substance Use Disorder, Work/Life Balance and Depression.</i>			
International Disease Management	Included	Included	Included
International Maternity	Included	Included	Included
In Touch Care (ITC)	Included	Included	Included
Teladoc	Excluded	Included	Included

This table provides an overview of the **High Deductible Health Plan's (HDHP'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.

PLAN FEATURES	Outside the U.S.	In the U.S.	
		Preferred Benefits (In-Network)	Non-Preferred Benefits (Out-of-Network)
Individual Deductible	\$4,000 per calendar year	\$2,000 per calendar year	\$4,000 per calendar year
Family Deductible	\$8,000 per calendar year	\$4,000 per calendar year	\$8,000 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	\$8,000 per calendar year	\$4,000 per calendar year	\$8,000 per calendar year
<i>(Does not include benefit penalties. Includes deductibles, copays, and Prescription Drugs.)</i>			
Family Maximum Out-of-Pocket Limit	\$16,000 per calendar year	\$8,000 per calendar year	\$16,000 per calendar year
<i>(Does not include benefit penalties. Includes deductibles, copays, and Prescription Drugs.)</i>			
Lifetime Maximum	Unlimited		
Inpatient Per Confinement Deductible <i>(Maximum of 3 per calendar year)</i>	None	None	None
Member Payment Percentages			
Hospital Services			
Inpatient	40% after deductible	20% after deductible	40% after deductible
Outpatient	40% after deductible	20% after deductible	40% after deductible
Outpatient Surgery performed in a surgical facility	40% after deductible	20% after deductible	40% after deductible

Outpatient Surgery performed in an office	40% after deductible	20% after deductible	40% 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 <i>(copay waived if admitted)</i>	\$150 copay then 20% after Annual Deductible	\$150 copay then 20% after Annual Deductible	\$150 copay then 20% after Annual Deductible
Non-Urgent Use of Urgent Care Provider	40% after deductible	20% after deductible	40% after deductible
Urgent Care	40% after deductible	20% after deductible	40% after deductible
Physician Services			
Physician Office Visit	40% after deductible	20% after deductible	40% after deductible
Specialist Office Visit	40% after deductible	20% after deductible	40% after deductible
Mental Health Services			
Mental Health Inpatient Coverage <i>Unlimited days per calendar year</i>	40% after deductible	20% after deductible	40% after deductible
Mental Health Outpatient Coverage <i>Unlimited visits per calendar year</i>	40% after deductible	20% after deductible	40% after deductible
Substance Use Disorder Services			
Substance Use Disorder Inpatient Coverage <i>Unlimited days per calendar year</i>	40% after deductible	20% after deductible	40% after deductible
Substance Use Disorder Outpatient Coverage <i>Unlimited visits per calendar year</i>	40% after deductible	20% after deductible	40% after deductible

Wellness Benefits			
Routine Children Physical Exams	40% after deductible	No charge	40% after deductible
<i>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)</i>			
Routine Adult Physical Exams	40% after deductible	No charge	40% after deductible
<i>Adults age 22+ & -65: 1 exam/12 months Adults age 65+: 1 exam/12 months includes immunizations</i>			
Routine Gynecological Exams <i>Includes 1 exam and pap smear per calendar year</i>	40% after deductible	No charge	40% after deductible
Baseline Mammograms <i>(1 Baseline from ages 35-40 years)</i>	40% after deductible	No charge	40% after deductible
Mammograms <i>(Routine visits age 40+)</i>	40% after deductible	No charge	40% after deductible
Prostate Specific Antigen (PSA)	40% after deductible	No charge	40% after deductible
<i>Includes 1 PSA per calendar year for males 40+</i>			
Digital Rectal Exam (DRE)	40% after deductible	No charge	40% after deductible
<i>Includes 1 DRE per calendar year for males 40+</i>			
Cancer Screening	40% after deductible	No charge	40% after deductible
<i>Includes 1 flex sigmoid and double barium contrast every 5 years; and at age 45 + 1 colonoscopy every 10 years</i>			
Routine Hearing Exam <i>Includes one routine exam per calendar year</i>	40% after deductible	No charge	40% after deductible
Hearing Aids	40% after deductible	20% after deductible	40% after deductible
<i>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.</i>			
Vision Care			

Routine Eye Exam	40% after deductible	No charge	40% after deductible
<i>(Covered under medical) Includes one routine exam per calendar year</i>			
Other Services			
Skilled Nursing Facility <i>(120 Days per calendar year)</i>	40% after deductible	20% after deductible	40% after deductible
Hospice Care Facility Inpatient <i>(Unlimited lifetime maximum)</i>	40% after deductible	20% after deductible	40% after deductible
Hospice Care Facility Outpatient <i>(Unlimited lifetime maximum)</i>	40% after deductible	20% after deductible	40% after deductible
Home Health Care <i>(40 visits per calendar year)</i>	40% after deductible	20% after deductible	40% after deductible
Private Duty Nursing <i>(Unlimited visits per calendar year)</i>	40% after deductible	20% after deductible	40% after deductible
Spinal Disorder Treatment <i>(20 visits per calendar year)</i>	40% after deductible	20% after deductible	40% after deductible
Short-Term Rehabilitation	40% after deductible	20% after deductible	40% after deductible
<i>(Includes coverage for Occupational, Physical and Speech Therapies; 120 combined maximum visits per calendar year, except if associated with any MH/SUD and PDD conditions as required by MHPAEA)</i>			
Diagnostic Outpatient X- ray	40% after deductible	20% after deductible	40% after deductible
Diagnostic Outpatient Lab	40% after deductible	20% after deductible	40% after deductible
Refractive Eye Surgery <i>(Includes lasik, radial keratotomy, orthoptic training and PKR)</i>	20% after deductible (\$3,000 max per eye)	20% after deductible (\$3,000 max per eye)	20% after deductible (\$3,000 max per eye)
Bariatric Surgery <i>(Unlimited per lifetime)</i>	40% after deductible	20% after deductible	40% after deductible
Allergy Serum and Injection	40% after deductible	20% after deductible	40% after deductible
Acupuncture	40% after deductible	20% after deductible	40% after deductible

Other Services			
Aetna Assistance Program (\$500,000 calendar year maximum)	No charge	No charge	No charge
International Employee Assistance Program (IEAP)	Included	Included	Included
<i>Includes up to 5 counseling sessions per issue per year per enrolled member. Access benefits by calling the member service number on ID card: 800-231-7729 or collect 813-775-0190. Services include: Cultural adjustment assistance, Marital/Family Stress, Child care and behavioral concerns, Social adaptation needs, Alcohol/Substance Use Disorder, Work/Life Balance and Depression.</i>			
International Disease Management	Included	Included	Included
International Maternity	Included	Included	Included
In Touch Care (ITC)	Included	Included	Included
Teladoc	Excluded	Included	Included

Outpatient Cognitive Therapy, Physical Therapy, Occupational Therapy and Speech Therapy Rehabilitation Benefits

Coverage is subject to the limits, if any, shown on the Summary of Covered Expenses. Inpatient rehabilitation benefits for the services listed will be paid as part of your inpatient Hospital and Skilled Nursing Facility benefits.

- Physical therapy is covered for non-chronic conditions and acute **Sicknesses and Injuries**, provided the therapy expects to significantly improve, develop or restore physical functions lost or impaired as a result of an acute **Sickness, Injury** or surgical procedure. Physical therapy does not include educational training or services designed to develop physical function.
- Occupational therapy (except for vocational rehabilitation or employment counseling) is covered for non-chronic conditions and acute **Sicknesses and Injuries**, provided the therapy expects to significantly improve, develop or restore physical functions lost or impaired as a result of an acute **Sickness, Injury** or surgical procedure, or to relearn skills to significantly improve independence in the activities of daily

living. Occupational therapy does not include educational training or services designed to develop physical function.

- Speech therapy is covered for non-chronic conditions and acute **Sicknesses and Injuries**, provided the therapy expects to restore the speech function or correct a speech impairment resulting from **Sickness or Injury**; or for delays in speech function development as a result of a gross anatomical defect present at birth. Speech function is the ability to express thoughts, speak words and form sentences. Speech impairment is difficulty with expressing one's thoughts with spoken words.
- Cognitive therapy associated with physical rehabilitation is covered when the cognitive deficits have been acquired as a result of neurologic impairment due to trauma, stroke, or encephalopathy, and when the therapy is part of a treatment plan intended to restore previous cognitive function.
- Pervasive Developmental Disorders (including Autism) are covered. Refer to the *Summary of Covered Expenses* in this Section 2-A for the maximum number of visits covered under the Plan. **Covered Expenses** include charges for

two therapy visits each in a 24-hour period.

The therapy should follow a specific treatment plan that:

- Details the treatment, and specifies frequency and duration; and
- Provides for ongoing reviews and is renewed only if continued therapy is appropriate.

Refer to the *Summary of Covered Expenses* in this Section 2-A for details about the short-term rehabilitation therapy maximum benefit.

Unless specifically covered above, *not* covered as Medical Benefits under this Section 2-A are charges for:

- Therapies for the treatment of delays in development are not covered, unless resulting from acute Sickness or Injury or therapies related to congenital defects amenable to surgical repair (such as cleft lip and cleft palate). Examples of non-covered diagnoses include Down's Syndrome and Cerebral Palsy, as they are considered both developmental and/or chronic in nature;
- Any services which are covered expenses in whole or in part under any other group plan sponsored by another employer;
- Any services unless provided in accordance with a specific treatment plan;
- Services provided during a stay in a Hospital, Skilled Nursing Facility, or Hospice except as stated above;
- Services not performed by a **Physician** or under the direct supervision of a **Physician**;
- Treatment covered as part of a spinal manipulation treatment;
- Services provided by a **Physician** or physical, occupational or speech therapist who resides in your home; or who is a member of your family or a member of your Spouse's family; Special education to instruct a person whose speech has been lost or impaired, to function without that ability. This includes lessons in sign language.

Explanation of Medical Benefits

Medical Benefits are payable for Covered Expenses incurred by Covered Persons under the

Plan.

Covered Expenses are the actual costs to the Covered Person which are the Reasonable and Customary Charges for Covered Expenses. Aetna, in its discretion, will determine the amount of Covered Expenses following evaluation and validation of all In-Network Provider and Out-of-Network Provider billings in accordance with:

- The methodologies in the most recent edition of the Current Procedural Terminology.
- The methodologies as reported by generally recognized professionals and publications.

Covered Expenses must be incurred for the care of Sickness or Injury. A Covered Expense is incurred on the date that it is performed or given.

Once the Covered Person has satisfied the Copayments and Annual Deductibles set forth in Section 1-E: *How Deductibles, Copayments, and Coinsurance Work*, the Medical Benefits payable are those Covered Expenses shown in this Section 2.

Covered Expenses

A Covered Person and his or her Physician decide upon which medical services and supplies are given, but the Plan only pays for expenses which are determined to be Covered Expenses by Aetna.

Covered Expenses are those expenses listed below which are given for the diagnosis or treatment of Sickness or Injury or which are incurred for Mental Health and Substance Use Disorder Treatment, subject to the limitations and exclusions under the Plan.

1. Acupuncture

If administered by a Physician.

2. Ambulatory Surgical Center Services

When given within 72 hours before or after a surgical procedure. The services must be given in connection with the procedure.

3. Anesthetics

4. Chemotherapy

5. Chiropractor Services (See Spinal Manipulations)

6. Durable Medical Equipment

Equipment meeting all of the following conditions:

- for repeated use and not a consumable or disposable item.
- used primarily for a medical purpose.
- appropriate for use in the home.

Some examples of Durable Medical Equipment are:

- Appliances which replace a lost body organ or part, or which help an impaired one to work.
- Orthotic devices such as arm, leg, neck and back braces.
- Hospital-type beds.
- Equipment needed to increase mobility, such as a wheelchair.
- Respirators or other equipment for the use of oxygen.
- Monitoring devices.

Aetna makes the determination of whether the Durable Medical Equipment should be purchased or rented.

7. Foot Care and Treatment

Only if needed due to severe systemic disease. Routine care such as removal of warts, corns, or calluses, the cutting and trimming of toenails, foot care for flat feet, fallen arches, and chronic foot strain is a Covered Expense only if needed due to severe systemic disease.

8. Hearing Aids

Diagnosis of hearing deficiencies including audiometry and initial placement of necessary hearing aid devices.

New hearing aids or replacement of existing hearing aids not more frequently than once every four years. Hearing aid Covered Expenses are limited to \$2,500 per hearing aid.

Covered Expenses include one audiogram and one cleaning per Calendar Year and hearing device repairs not subject to the dollar limit.

9. Home Health Care Services (See Precertification requirements later in this Section 2).

NOTE: Home Health Care Services are limited to 40 visits per Calendar Year for each Covered Person. Each period of Home Health Care Services of up to four hours given in the same day counts as one visit. Each visit by any member of the Home Health Care Services team will count as one visit.

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 aide.
- Physical therapy.
- Occupational therapy.
- Speech therapy.

10. Hospice Care

- Room and Board.
- Other Services and Supplies.
- Part-time nursing care by or supervised by a registered nurse (R.N.).
- Home Health Care Services as shown above. The limit on the number of visits shown under Home Health Care Services does not apply to Hospice patients.
- Counseling for the patient, Spouse and Dependents.
- **Bereavement counseling** for the surviving Spouse and Dependents. Bereavement counseling services must be received within **six months** before and/or after the patient's death.

Covered Expenses are limited to a total of 15 bereavement counseling visits for each family (including the patient, Spouse and Dependents).

Note: The following conditions apply to bereavement counseling services:

- Counseling must be given by a Licensed Counselor or pastoral counselor.
- Services for the patient must be given in an inpatient Hospice facility or in the patient's home.
- The Physician must certify that the patient is terminally ill with six months or less to live.

- Any counseling services given in connection with a terminal illness will not be considered a Mental Health and Substance Use Disorder Treatment.

11. Hospital Services (See Precertification requirements later in this Section 2).

- Room and Board.

Covered Expenses for a private room are limited to the regular daily charge made by the Hospital for a semi-private room.

- Other Services and Supplies included as Covered Expenses.
- Emergency room services.

Emergency room services are Covered Expenses only if it is determined that there is not a less intensive or more appropriate place of service, diagnostic or treatment alternative that could have been used in lieu of emergency room services. If Aetna, in its discretion, determines that a less intensive or more appropriate treatment could have been given, then no Medical Benefits are payable.

12. Infertility Treatment

Diagnosis and treatment of infertility, including surgery and drug therapy.

13. Laboratory Tests and X-rays

X-rays or tests for diagnosis or treatment.

14. Medical Supplies

- Surgical supplies (such as bandages and dressings). Supplies given during surgery or a diagnostic procedure are included in the overall cost for that surgery or diagnostic procedure.
- Blood or blood derivatives only if not donated or replaced.
- The following Medically Necessary supplies:
 - Colostomy supplies.
 - Elastic stockings.
 - Stump socks.
 - Supportive hose and leotards.
 - Surgical stockings.

15. 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 the nearest other 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 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.

16. Mental Health Benefits

Covered Expenses for Mental Health and Substance Use Disorder Treatment as described in Section 2-C.

17. Nurse-Practitioner Services

Services of a licensed or certified Nurse-

Practitioner acting within the scope of that license or certification.

18. Oral Surgery and Dental Services

Oral Surgery if needed as a necessary, but incidental, part of a larger service in treatment of an underlying medical condition.

The following services and supplies are covered only if needed because of Injury to natural teeth:

- Oral Surgery.
- Full or partial dentures.
- Fixed bridge work.
- Prompt repair to natural teeth.
- Crowns.

19. Oral and Maxillofacial Treatment (Mouth, Jaw and Teeth)

Covered Expenses include charges made by a Physician or Hospital for:

- Non-surgical treatment of infections or diseases of the mouth, jaw joints or supporting tissues.

Services and supplies for treatment of or related conditions of the teeth, mouth, jaws, jaw joints or supporting tissues (including bones, muscles, and nerves), for surgery needed to:

- Treat a fracture, dislocation, or wound.
- Cut out cysts, tumors, or other diseased tissues.
- Cut into gums and tissues of the mouth.
This is only covered when not done in connection with the removal, replacement or repair of teeth.
- Alter the jaw, jaw joints, or bite relationships by a cutting procedure when appliance therapy alone cannot result in functional improvement.
- Hospital services and supplies received for a stay required because of a covered condition.

Oral Surgery and Dental Services and orthodontic treatment needed to remove, repair or reposition:

- Natural teeth damaged, lost or removed; or
- Other body tissues of the mouth fractured or cut due to Injury.

- Any such teeth must have been free from decay or in good repair and firmly attached to the jawbone at the time of Injury.

- The treatment must be completed in the Calendar Year of the accident or in the next Calendar Year.

If crowns, dentures, bridges, or in-mouth appliances are installed due to Injury, Covered Expenses only include charges for:

- The first denture or fixed bridgework to replace lost teeth;
- The first crown needed to repair each damaged tooth; and
- An in-mouth appliance used in the first course of orthodontic treatment after the Injury.

20. Organ/Tissue Transplants

Precertification must be notified at least 7 working days (or as soon as reasonably possible) before the scheduled date of any of the following:

- The evaluation.
- The donor search.
- The organ procurement/tissue harvest.
- The transplant procedure.

The medical care and treatment and transportation and lodging provisions described in this Section apply only to the following qualified procedures that are performed at a Designated Transplant Facility (as defined by Aetna otherwise expenses will be treated as out-of-network). Services and supplies for necessary organ or tissue transplants are Covered Expenses under the Plan.

Donor Charges for Organ/Tissue Transplants

- In the case of an organ or tissue transplant, donor charges are considered Covered Expenses only if the recipient is a Covered Person under the Plan. If the recipient is not a Covered Person, no benefits are payable for donor charges.
- The search for bone marrow/stem cells from a donor who is not biologically related to the patient is not considered a Covered Expense unless the search is made in connection with a transplant procedure arranged by a Designated Transplant Facility.

- The Medical Care and Treatment and Transportation and Lodging provisions described below apply to any of the following procedures which are Covered Expenses, provided they are performed at a Designated Transplant Facility.

Qualified Procedures

- Heart Transplants.
- Lung transplants.
- Heart/Lung transplants.
- Liver transplants.
- Kidney transplants.
- Pancreas transplants.
- Kidney/Pancreas transplants.
- Bone Marrow/Stem Cell transplants.
- Other transplant procedures when Aetna determines that it is Medically Necessary, provided that the procedure is performed at a **Designated Transplant Facility**.

Medical Care and Treatment

Covered Expenses for services and supplies provided in connection with a transplant procedure include:

- Pre-transplant evaluation for one of the procedures listed above.
- Organ acquisition and procurement.
- Hospital and Physician fees.
- Transplant procedures.
- Follow-up care for up to one year after the transplant.
- Search for bone marrow/stem cell from a donor who is not biologically related to the patient. If a separate charge is made for bone marrow/stem cell search, a maximum Plan benefit of \$25,000 is payable for all charges made in connection with the search.

Transportation and Lodging

Precertification will assist the patient and family with travel and lodging arrangements. Covered Expenses include travel, lodging and meals for the transplant recipient and a companion as follows:

- Transportation of the patient and one

companion who is traveling on the same day(s) to and from the site of the transplant for the purpose of evaluation, the transplant procedure or necessary post-discharge follow-up.

- Reasonable and necessary expenses for lodging and meal expenses for the patient (while not confined) and one companion. Benefits are paid at a per diem rate of up to \$50 for one person or up to \$100 for two people.
- Travel and lodging expenses are only available if the transplant recipient resides more than 50 miles from the Designated Transplant Facility.
- If the patient is a covered Dependent minor Child, the transportation expenses of two companions will be covered and lodging and meal expenses will be reimbursed at the \$100 per diem rate.
- There is a combined overall lifetime maximum of \$10,000 per Covered Person for all transportation, lodging and meal expenses incurred by the transplant recipient and companion(s) incurred in connection with all transplant procedures of that Covered Person.

21. Orthoptic Training (Eye Muscle Exercise)

Training by a licensed optometrist or an orthoptic technician. Covered Expenses are limited to a lifetime maximum of 20 visits for each Employee or Spouse and to a lifetime maximum of 30 visits for each Child.

22. Outpatient Occupational Therapy

Services of a licensed occupational therapist, provided the following conditions are met:

- The therapy must be ordered and monitored by a Physician.
- The therapy must be given in accordance with a written treatment plan approved by a Physician. The occupational therapist must submit progress reports at the intervals stated in the treatment plan.

Covered Expenses are limited to 120 combined outpatient cognitive therapy, physical therapy, occupational therapy and speech therapy visits per Covered Person per Calendar Year except if associated with any MH/SUD and PDD conditions as required by MHPAEA.

23. Outpatient Physical Therapy

Services of a licensed physical therapist, provided the following conditions are met:

- The therapy must be ordered and monitored by a Physician.
- The therapy must be given in accordance with a written treatment plan approved by a Physician. The physical therapist must submit progress reports at the intervals stated in the treatment plan.

Covered Expenses are limited to 120 combined outpatient cognitive therapy, physical therapy, occupational therapy and speech rehabilitation visits per Covered Person per Calendar Year, except if associated with any MH/SUD and PDD conditions as required by MHPAEA.

24. Physician Services

Medical Care and Treatment

- Hospital, office and home visits.
- Emergency room services.

Surgery

- Services for surgical procedures.
- Second and third surgical opinions by a licensed Physician.
- Stand-by services by a Physician.

Reconstructive Surgery (See Precertification requirements later in this Section).

- Reconstructive surgery to improve the function of a body part when the malfunction is the direct result of one of the following:
 - Birth defect.
 - Sickness.
 - Surgery to treat a Sickness or Injury.
- Reconstructive breast surgery following a Medically Necessary mastectomy.
- Reconstructive surgery to remove scar tissue on the neck, face, or head if the scar tissue is due to Sickness or Injury.
- Cosmetic procedures are excluded from coverage. Procedures that correct a congenital anomaly without improving or restoring physiologic function are considered cosmetic procedures. The fact that a Covered Person may suffer

psychological consequences or socially avoidant behavior as a result of an Injury, Sickness or congenital anomaly does not result in the classification of surgery or other procedures done to relieve such consequences or behavior as a reconstructive procedure.

Notify Aetna 5 business days before receiving services relating to reconstructive services. Aetna can verify that the services are covered reconstructive procedures rather than excluded cosmetic procedures.

Assistant Surgeon Services

Covered Expenses for assistant surgeon services are limited to 20% of the amount of Covered Expenses for the surgeon's charge for the surgery. An assistant surgeon must be a Physician. Surgical assistant's services are not Covered Expenses.

Multiple Surgical Procedures

Multiple surgical procedures mean more than one surgical procedure performed during the same operative session. Covered Expenses for multiple surgical procedures are limited as follows:

- Covered Expenses for a secondary procedure are limited to 50% of the Covered Expenses that would otherwise be considered for the secondary procedure had it been performed during a separate operative session.
- Covered Expenses for any subsequent procedure are limited to 25% of the Covered Expenses that would otherwise be considered for the subsequent procedure had it been performed during a separate operative session.

25. Pregnancy

Covered Expenses incurred as a result of pregnancy are only available to the Employee and Spouse when covered under the Plan. Benefits are not available for pregnancies of other Dependents.

Pregnancy benefits are paid in the same way as other Covered Expenses.

Covered Expenses relating to pregnancy include a minimum of:

- 48 hours of inpatient care for the mother and newborn Child following a normal vaginal delivery.
- 96 hours of inpatient care for the mother and newborn Child following a Cesarean section.

The Hospital or other provider is required to get precertified by Aetna for the time periods stated above.

Federal law does not prohibit the mother's or newborn Child's attending Physician, after consulting with the mother, from discharging the mother or her newborn Child earlier than 48 hours (or 96 hours, as applicable).

An Office Visit Copayment is not imposed for pre-natal and post-natal office visits (after the initial diagnosis of pregnancy) to In-Network Providers (obstetricians and gynecologists) who are primarily responsible for the Covered Person's maternity care.

Additional Covered Expenses specific to pregnancy are listed below. These additional Covered Expenses are subject to the same requirements, limitations and exclusions as other Covered Expenses.

Additional Covered Services and Supplies

Birth Center Services

- Room and Board.
- Other Services and Supplies.
- Anesthetics.

Nurse-Midwife's Services

- Services of a Nurse-Midwife.

Routine Well Baby Care

The following medical services and supplies given during a newborn Child's initial Hospital confinement:

- Hospital services for nursery care.
- Other Services and Supplies provided by the Hospital.
- Services of a surgeon for circumcision.
- Physician services.

Not Covered

- Any expenses incurred in connection with an abortion chosen by the Covered Person.
- Dependent Child pregnancy.

Exclusions and limitations that apply to pregnancy are listed in Section 3: *What's Not Covered*.

26. Prescription Drugs and Medicines

- Administered by Express Scripts: Prescription Drugs and medicines are described in Section 2-B.
- Allergy serums, if administered at a Physician's office.
- Insulin and the following diabetic supplies: insulin syringes with needles; blood testing strips - glucose; urine testing strips glucose; ketone testing strips and tablets; lancets and lancet devices.

27. Private Duty Nursing Care

Private duty nursing care given on an outpatient basis by a licensed nurse (R.N., L.P.N., or L.V.N.).

28. Psychologist Services

Services rendered by 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, who specializes in clinical psychology. Refer to Section 2-C: *Mental Health and Substance Use Disorder* for coverages.

29. Radial Keratotomy

Radial keratotomy, PRK and Lasik.

30. Radiation Therapy

31. Rehabilitation Therapy

Inpatient

- Services of a Hospital or Rehabilitation Facility for Room and Board, care and treatment during a confinement.
- Inpatient rehabilitation therapy is a Covered Expense only if intensive and multidisciplinary rehabilitation care is necessary to improve the patient's ability to function independently.

Covered Expenses are limited to a combined total of 120 days of confinement in a Hospital, Skilled Nursing Facility and Rehabilitation

Facility each Calendar Year.

Outpatient

- Services of a Hospital or **Comprehensive Outpatient Rehabilitative Facility**.
- Covered Expenses are limited to 20 days of rehabilitation therapy per Calendar Year. A day of therapy includes all services given by or visits to the Hospital or comprehensive outpatient Rehabilitation Facility in any one day.
- Covered Expenses for each day of therapy reduces the number of visits under Covered Expenses for outpatient physical therapy, outpatient occupational therapy and speech therapy. This reduction only applies to days of such therapy during which the therapy includes services given by a physical therapist, occupational therapist or speech therapist.

32. Skilled Nursing Facility Services

Room and Board and Other Services and Supplies will be counted as Covered Expenses. Covered Expenses for Room and Board are limited to the facility's regular daily charge for a semi-private room.

NOTE: Skilled Nursing Facility charges are Covered Expenses only for the first 120 days of confinement each Calendar Year.

33. Speech Therapy

Services of a licensed speech therapist.

These services must be given to restore speech lost or impaired due to one of the following:

- Surgery, radiation therapy or other treatment which affects the vocal cords.
- Cerebral thrombosis (cerebral vascular accident).
- Brain damage due to Injury or organic brain lesion (aphasia).

Covered Expenses are limited to 120 combined outpatient cognitive therapy, physical therapy, occupational therapy and speech rehabilitation visits per Covered Person per Calendar Year, except if associated with any MH/SUD and PDD conditions as required by MHPAEA.

Speech Therapy for Children Services of a licensed speech therapist for treatment given to

a Child due to medical necessity whose speech is impaired due to one of the following conditions:

- Infantile autism.
- Developmental delay or cerebral palsy.
- Hearing impairment.
- Major congenital anomalies that affect speech such as, but not limited to, cleft lip and cleft palate.

Covered Expenses are limited to 120 combined outpatient cognitive therapy, physical therapy, occupational therapy and speech therapy visits per Covered Person per Calendar Year except if associated with any MH/SUD and PDD conditions as required by MHPAEA.

34. Spinal Manipulations

Services of a Physician given for the detection or correction (manipulation) by manual or mechanical means of structural imbalance or distortion in the spine.

Covered Expenses are limited to 20 visits per Calendar Year.

35. Vision Care

Eye refraction exam and refraction service. Covered Expenses are limited to one exam and service per Calendar Year for each Covered Person.

Exclusions and limitations that apply to vision care benefits are listed in Section 3: *What's Not Covered*.

36. Family Planning Benefits

Covered Expenses include family planning expenses incurred by a Covered Person under the Plan.

Family planning benefits are covered at 100% with no Copayment when provided by an In-Network Physician.

After coverage under the Plan stops there are no extended family planning benefits. See Section 5: *Events Affecting Coverage*.

Covered Services and Supplies

Contraceptive Prescription Drugs, Services and Devices

Contraceptive Prescription Drugs, services and

devices, including but not limited to:

- Intrauterine devices and related Physician services.
- Physician services related to a diaphragm fitting.
- Voluntary sterilization by either vasectomy or tubal ligation.
- Surgical implants for contraception, such as Norplant.

Charges for the diaphragm and oral contraceptives are included under Section 2- B: *Prescription Drug Benefits*.

Exclusions and limitations that apply to family planning benefits are listed in Section 3: *What's Not Covered*.

37. Preventive Health Care

Preventive health care benefits are included as Covered Expenses when provided to a Covered Person by a Physician. Preventive health care benefits are covered at 100% with no Copayment when provided by an In-Network Physician.

Preventive health care benefits are Covered Expenses payable at the Out-of-Network level as shown in Section 1-D if Covered Expenses are received from an Out-of-Network Physician.

After coverage under the Plan stops there are no extended preventive health care benefits. See Section 5: *Events Affecting Coverage*.

Covered Preventive Health Care Services and Supplies:

- Routine physical exams for the Employee and Spouse, including tests and immunizations as set out below:
 - Covered tests for adults include the following: (1) Abdominal Aortic Aneurysm one-time screening for men of specified ages who have ever smoked; (2) Alcohol Misuse screening and counseling; (3) Aspirin use to prevent cardiovascular disease for men and women of certain ages; (4) Blood Pressure screening; (5) Cholesterol screening for adults of certain ages or at higher risk; (6) Colorectal Cancer screening for adults over 50; (7) Depression Screening; (8)

Diabetes (Type 2) screening for adults with high blood pressure; (9) nutritional counseling for adults at higher risk for chronic disease; (10) HIV screening for everyone ages 15 to 65, and other ages at increased risk; (11) Obesity screening and counseling; (12) Sexually Transmitted Infection (STI) prevention counseling for adults at higher risk; (13) Syphilis screening for adults at higher risk; (14) Tobacco Use screening for all adults and cessation interventions for tobacco users; (15) Annual lung cancer screening for those at least age 55 ; and (16) Hepatitis C virus infection screening for adults at high risk, or one-time screening for those born 1945 through 1965.

- Immunization vaccines which are covered for adults – with doses, ages and recommended populations varying – include Hepatitis A; Hepatitis B; Herpes Zoster; Human Papillomavirus; Influenza (Flu Shot); Measles, Mumps, Rubella; Meningococcal; Pneumococcal; Tetanus, Diphtheria, Pertussis; and Varicella.
- Covered tests for Children include the following: (1) Alcohol and Drug Use assessments for adolescents; (2) Autism screening for children at 18 and 24 months; (3) Behavioral assessments for children at various ages; (4) Blood Pressure screening for children at various ages; (5) Cervical Dysplasia screening for sexually active females; (6) Depression screening for adolescents; (7) Developmental screening for children under age 3; (8) Dyslipidemia screening for children at higher risk of lipid disorders; (9) Fluoride Chemoprevention supplements for children without fluoride in their water source; (10) Gonorrhea prevention medication for the eyes of all newborns; (11) Hearing screening for all newborns; (12) Height, Weight and Body Mass Index measurements for children at various ages; (13) Hematocrit or Hemoglobin screening for children; (14) Hemoglobinopathies or sickle cell

screening for newborns; (15) HIV screening for adolescents at higher risk; (16) Hypothyroidism screening for newborns; (17) Iron supplements for children ages 6 to 12 months at risk for anemia; (18) Lead screening for children at risk of exposure;

(19) Medical history for all children throughout development; (20) Obesity screening and counseling; (21) Oral Health risk assessment for young Children ages 0 to 11 months, 1 to 4 years and 5 to 10 years;

(22) Phenylketonuria (PKU) screening for this genetic disorder in newborns; (23) Sexually Transmitted Infection (STI) prevention counseling and screening for adolescents at higher risk; (24) Tuberculin testing for children at higher risk of tuberculosis; and (25) Vision screening for all Children.

- Immunization vaccines which are covered for Children from birth to age 18 – with doses, ages and recommended populations varying – include Diphtheria, Tetanus, Pertussis; Haemophilus influenza type b; Hepatitis A; Hepatitis B; Human Papillomavirus; Inactivated Poliovirus; Influenza (Flu Shot); Measles, Mumps, Rubella; Meningococcal; Pneumococcal; Rotavirus; and Varicella.

- Preventive health services for women include the following: (1) Anemia screening; (2) Breast Cancer Genetic Test Counseling (BRCA) for women at higher risk of breast cancer; (3) Breast Cancer Mammography Screenings every 1 to 2 years for women over 40; (4) Breast Cancer Chemoprevention counseling for women at higher risk; (5) Breastfeeding comprehensive support and counseling from trained providers, and access to breastfeeding supplies, for pregnant and nursing women; (6) Cervical Cancer screening for sexually active women; (7) Chlamydia infection screening for younger

women and other women at higher risk; (8) Contraception: Food and Drug Administration-approved contraceptive methods, sterilization procedures, and patient education and counseling, as prescribed by a health care provider for women with reproductive capacity (not including abortifacient drugs); (9) Domestic and interpersonal violence screening and counseling; (10) Folic Acid supplements for women who may become pregnant; (11) Gestational diabetes screening for women 24 to 28 weeks pregnant and those at high risk for developing gestational diabetes; (12) Gonorrhea screening for all women at higher risk; (13) Hepatitis B screening for pregnant women at their first prenatal visit; (14) HIV screening and counseling for sexually active women; (15) Human Papillomavirus (HPV) DNA test every 3 years for women with normal cytology results who are 30 or older; (16) Osteoporosis screening for women over age 60 depending on risk factors; (17) Rh Incompatibility screening for all pregnant women and follow up testing for women at higher risk; (18) Sexually transmitted infections counseling for sexually active women; (19) Syphilis screening for all pregnant women or other women at increased risk; (20) Tobacco Use screening and interventions for all women, and expanded counseling for pregnant tobacco users; (21) Urinary tract or other infection screening for pregnant women; (22) Well- woman visits to get recommended services for women under 65; and (23) Breast cancer preventive medication (e.g. generic tamoxifen) for women with increased risk.

See <https://www.healthcare.gov/coverage/preventive-care-benefits/> for a complete and up-to-date list of Preventive Health Care Services and Supplies which are Covered Expenses under the Plan.

Exclusions and limitations that apply to preventive health care services are listed in Section 3: *What's Not Covered*.

Section 2-B: What's Covered – Prescription Drug Benefits

The table below provides an overview of the **PPO Plan's** Prescription Drug coverage provided through Express Scripts. It includes Copayments that apply when you have a prescription filled at a pharmacy or through the mail order program.

Summary of Prescription Drug Benefits		
	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	You 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
GLP-1 Prescriptions for Weight Loss	20% coinsurance	
At Out-of-Network Pharmacies in the United States	You pay the following Coinsurance: • 50% for Covered Prescriptions	Not applicable

Note: Copayments and Coinsurance for Prescription Drugs do not count toward the Annual Deductible but are included toward fulfillment of the Out-Of-Pocket Maximum under the PPO Plan. Coverage is provided for methadone maintenance and medication assisted treatment which includes treatment coverage for pain management for multiple sclerosis conditions and methadone maintenance of opioid use disorder (MH/SUD).

The table below provides an overview of the **HDHP's** Prescription Drug coverage provided through Express Scripts. It includes Copayments that apply when you have a prescription filled at a pharmacy or through the mail order program.

Summary of Prescription Drug Benefits		
	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 **provided through Accredo from Express Scripts only	You pay: • \$5 after deductible for Generic Drug • 20%, \$15 minimum after deductible for Brand-Name Drug on Preferred Drug List • 30%, \$30 minimum after deductible for Brand-Name Drug not on Preferred Drug List • 30%, \$30 minimum after deductible for Specialty Drug **	Not applicable
At Out-of-Network Pharmacies	You pay: • 50% after deductible for Covered Prescriptions after the following Annual Deductibles are satisfied: • \$2,000 Individual • \$4,000 Family	Not applicable
Through Express Scripts' Mail Order Program	Not applicable	You pay: • \$10 after deductible for Generic Drug • 20%, \$30 minimum after deductible for Brand-Name Drug on Preferred Drug List • 30%, \$60 minimum after deductible for Brand-Name Drug not on the Preferred Drug List

Note: Copayments and Coinsurance for Prescription Drugs count towards the Annual Deductible and are included toward fulfillment of the Out-Of-Pocket Maximum under the HDHP. Coverage is provided for methadone maintenance and medication assisted treatment which includes treatment coverage for pain management for multiple sclerosis conditions and methadone maintenance of opioid use disorder (MH/SUD).

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:

PPO Plan:

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

HDHP:

- A **\$10** Copayment **after deductible** for each Generic Drug;
- **20%, \$30** Copayment **after deductible** for each Brand Name Drug on the Preferred Drug List; or
- **30%, \$60** Copayment **after deductible** for each Brand Name Drug not on the Preferred Drug List.

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 Copayment for a supply of Generic Drugs may be substantially less than the Copayment 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

Express Scripts' Cholesterol Care Value Program manages certain types of cholesterol medications within the Plan to assure proper usage according to medical necessity.

Compound Management Exclusion Program

Compounded medications are not covered without a Prior Authorization. Approval for a Prior Authorization requires clinically sound studies

proving the effectiveness of the medication.

Section 2-C: What's Covered – Mental Health and Substance Use Disorder

Aetna Behavioral Health manages all aspects of the Mental Health and Substance Use Disorder ("MH/SUD") Treatment coverage.

Summary Mental Health and Substance Use Disorder Benefits				
SERVICE	IN-NETWORK		OUT-OF-NETWORK	
	PPO	HDHP	PPO	HDHP
Substance Use Disorder – Inpatient Care	No charge after deductible and \$300 inpatient per confinement copay	20% after deductible	30% after deductible	40% after deductible
Mental Health Inpatient	No charge after deductible and \$300 inpatient per confinement copay	20% after deductible	30% after deductible	40% after deductible
Mental Health and Substance Use Disorder Outpatient Care Benefits	No charge after \$ 20 copay	20% after deductible	30% after deductible	40% after deductible
Utilization Review: In-Network 1) Precertification required for all inpatient MH/SUD Services is obtained by your In-Network Provider. 2) Emergency admissions -- notification must be received within 48 hours or as soon as reasonably possibly after admission.		Utilization Review: Out-of-Network 1) Precertification required for all inpatient MH/SUD Services is obtained by you. 2) Emergency admissions, notification must be received within 48 hours or as soon as reasonably possible after admission.		

Explanation of Benefits

The MH/SUD Treatment program is intended to provide Covered Persons with the resources necessary to get efficient and appropriate care for problems including, but not limited to:

Mental Health and Substance Use Disorder Program
Contact Aetna Behavioral Health Call

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

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 inpatient care is required for MH/SUD conditions, including care at a Mental Health and Substance Use Disorder Residential Treatment Center, Aetna Behavioral Health must precertify coverage under the Plan and 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.

Expenses incurred for Mental Health and Substance Use Disorder Treatment, either In-Network or Out-of- Network, do not count toward any Out-of- Pocket Maximum limits.

Aetna Services

If a Covered Person has a MH/SUD problem and needs help, he or she can call Aetna Behavioral Health toll-free at 888-238-6232 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/SUD coverage or MH/SUD Treatment.

In-Network Benefits

Your In-Network Provider is required to contact Aetna Behavioral Health for precertification before the treatment begins and must 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. 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 precertify.

Precertification

Your In-Network Provider will work to design a MH/SUD Treatment plan that is tailored to the Covered Person's MH/SUD needs.

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 is reimbursed 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.

Emergency Care

In a MH/SUD 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 within 48 hours or as soon as reasonably possible after admission. Failure to contact Aetna will result in reduction or loss of Medical Benefits.

Out-of-Network Benefits

Out-of-Network MH/SUD 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.

Out-of-Network inpatient care and Emergency Care requires that Aetna be called to avoid any loss or reduction of Medical Benefits. 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.

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 be sure to 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. 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 you seek treatment meets Plan requirements for coverage, as there are many programs which combine a very small amount of “covered” medically necessary care (such as psychotherapy or counseling) with other “activities” and components that are not considered medically necessary, such as, wilderness therapy, health resorts, recreational programs, outdoor skills programs, relaxation or lifestyle programs and services provided in conjunction with (or as a part of) those programs including horseback riding, camping, climbing, etc. These “camp,” “school,” or “treatment” facilities that provide these types of experiences are not covered. You are advised to confirm that the facility and treatment plan meet the standards for Plan coverage before you incur expenses that may not be payable under the Plan.

Section 2-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.

When The Plan Pays Primary to Medicare

The Plan pays **primary** to Medicare for:

- Employees who become eligible for Medicare due to attaining age 65.
- Dependents who become eligible for Medicare due to attaining age 65.
- Employees and Dependents who are eligible for Medicare due to end stage renal disease under the conditions and for the time periods specified under Federal law.
- Employees and dependents who are disabled.

When The Plan Pays Secondary to Medicare

The Plan pays **secondary** to Medicare for:

- Employees who become eligible to receive benefits under the Aramco U.S. Long-Term Disability Plan and who DO NOT have “current employment status” with the Company, as defined by Federal law and determined by the Company (See also “Coverage for Employees

Receiving Long- Term Disability Benefits” in Section 5-C: *Other Extensions of Medical Benefits*).

- Employees and Dependents for whom Federal law allows Medicare to be primary, including those with end stage renal disease, but only under the conditions and/or time periods specified under Federal law.

Important! - Medicare Enrollment Requirements

When the Plan pays **secondary** to Medicare, the Covered Person is responsible for enrolling in Medicare Parts A and B. 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 Open Enrollment Period which applies when the Covered Person stops being eligible for coverage under the Plan as provided under Section 5: *Events Affecting Coverage*.

How The Plan Pays When Medicare Is Primary

If 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.

If you or your Covered Dependent Children are eligible for Medicaid or the Children's Health Insurance Program ("CHIP") and you are also eligible for health insurance from your employer, your State may have a premium assistance program that can help pay for coverage. You can contact your State Medicaid or CHIP office or dial 1-877- KIDS NOW or www.insurekidsnow.gov to find out how to apply. If you

qualify, you can ask the State if it has a program that might help you pay premiums under the Plan. If you are eligible for premium assistance under Medicaid or CHIP, as well as eligible under the Plan, the Plan

Administrator must permit you to enroll in the Plan if you are not already enrolled. This is a “special enrollment” opportunity, and you **must request coverage within 60 days of being determined to be eligible for premium assistance.** If you have questions about enrolling in the Plan, you can contact the Department of Labor at www.askebsa.dol.gov or by calling toll-free 1- 866-444-EBSA (3272).

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 an Employee, 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. Abdominoplasty.
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 primarily 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. Eye glasses, 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 Employee's immediate family:
 - The Employee's Spouse.
 - The Child, brother, sister, parent or grandparent of either the Employee or the Employee'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 as required under Mental Health Parity and Equity Act.
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. 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.

31. Stand-by services required by a Physician.
32. 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 2-A, Item 18: *Oral Surgery and Dental Services* for limited coverage of certain oral surgery and dental services.
33. Tobacco dependency.
34. Services or supplies received as a result of

active participation in any insurrection or active war.

35. Weight reduction or control (unless there is a diagnosis of morbid obesity).
36. Special foods, food supplements, liquid diets, nutritional plans or any related products.
37. 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.
38. Services given by volunteers or persons who do not normally charge for their services.
39. Pregnancy of Dependent Children.
40. 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.

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

SECTION 4: CLAIMS INFORMATION

Section 4-A: How to File a Claim

Filing 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
 - 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 prescription 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 72 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.

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 they overpay a claim 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 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. Medical Payment Plan Attn: Managing Director, Two Allen Center 1200 Smith Street Floor 31 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 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	72 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 Claims Appeal Process

First-Level 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 may include the your information, 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 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 number 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.

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.

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.

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 4-B: 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 retired Employee).

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.

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: EVENTS AFFECTING COVERAGE

Section 5-A: Changing Coverage

Qualified Change

You cannot increase or decrease your level of coverage, terminate coverage or change your premium contribution during the year, unless you have an applicable **“Qualified Change”** in:

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

A **“Qualified Change”** in your family status includes:

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

A **“Qualified Change”** in employment status includes:

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

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 (via the [Aramco Benefits Center](#)) 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 case of marriage on the first day of the following month if the Employee so elects. Failure to timely drop an ineligible dependent may result in company discipline, up to and including termination, and any medical expenses paid on behalf of an ineligible dependent may be charged back to you, or the assessment of COBRA premiums for the period from the date the dependent became ineligible to the date their coverage was subsequently cancelled.

Absences with Full or Partial Pay

During any Company-approved absence with full or partial pay, your contributions will continue to be deducted from your paycheck, and your Plan coverage will remain in force.

Absences without Pay

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

Disability and Extended Disability

For existing coverage, benefits are payable to a Totally Disabled Covered Person for up to three months. Extended benefits are only payable for Covered Expenses incurred during the three-month period after the Totally Disabled Covered Person's coverage ends.

The Covered Person must be continuously Totally Disabled due to the same cause from the date coverage ends until the date Covered Expenses are given.

Benefits are only payable for Covered Expenses

incurred for Sickness causing Total Disability.

The Employer has the right to continue a person's employment and coverage under the Plan during a period in which the person is away from work due to disability. The period of continuation is determined by the Employer based on the Employer's general practice for an Employee in the person's job class.

Family and Medical Leave Act

The Family and Medical Leave Act of 1993 ("FMLA") requires employers to provide up to a total of 12 weeks of unpaid, job-protected leave during any 12-month period to Employees for certain family and medical reasons. This provision is intended to comply with the FMLA and any pertinent regulations, and its interpretation is governed by them. Contact ASC Benefits to find out details about whether and, if so, how this continuation coverage applies to you.

Reasons for Taking Leave

FMLA leave must be granted for any of the following reasons:

- Care of a Child after birth.
- Care of a Child after placement of that Child with the Employee for adoption or foster care.
- Care of the Employee's Spouse, Child or parent (but not a parent-in-law) who has a serious health condition.
- A serious health condition that makes the Employee unable to work.
- Military care-giver leave, which allows Employees who are family members or the next of kin of a covered military service member to take up to 26 work weeks of leave in a single 12-month period to care for a covered service member with a serious illness or injury incurred in the line of duty.
- Qualifying exigency leave of up to 12 weeks in a single 12-month period for Employees who are family members of a covered military service member serving in the National Guard or Reserve. Exigency leave may be used for "any qualifying exigency" which arises from the fact that the military member is on active duty or is called to active duty in support of military operations. "Qualifying exigencies" include a broad number of activities, including short-notice deployment, military events and related activities, child care and school activities, counseling, financial and legal arrangements,

rest and recuperation, and post-deployment activities.

Employee Eligibility

To be eligible for FMLA benefits, all of the following must be true:

- The Employee must work for a covered Employer in the U.S.
- The Employee must have worked for the Employer for at least 12 months.
- The Employee must have worked at least 1,250 hours over the previous 12 months.
- The Employee must work at a location where at least 50 employees are employed by the Employer within 75 miles.

Advance Notice and Medical Certification

The Employee must provide advance notice and medical certification to be eligible for FMLA leave. Leave may be denied if requirements are not met.

- The Employee ordinarily must provide 30 days advance notice when the leave is "foreseeable".
- If the need for the leave is unforeseen, notice must be given as soon as practicable.
- An Employer may require medical certification to support a request for leave because of a serious health condition, and may require a second or third opinion (at the Employer's expense) and a fitness for duty report to return to work.

Continuation of Health Coverage, Job Benefits and Protection

For the duration of a FMLA leave, the Employer must allow the Employee to maintain coverage under the Plan. The Employee may continue the Plan benefits for himself or herself and his or her Dependents on the same terms as if the Employee had continued to work. The Employee must pay the same contributions toward the cost of the Plan coverage that he or she made while working. If the Employee fails to make the required contributions on a timely basis, the Employer, after giving the Employee written notice, can end Plan coverage during FMLA leave if payment of Employee contributions is more than 30 days late.

- Upon return from FMLA leave, most Employees must be restored to their original or equivalent

positions with equivalent pay, benefits and other terms of employment.

- The use of a FMLA leave cannot result in the loss of any employment benefit that accrued prior to the start of an Employee's leave.

Intermittent Leave

Under some circumstances, an Employee may take FMLA leave intermittently which means taking a leave in blocks of time, or by reducing his or her normal weekly or daily work schedule.

- Where FMLA leave is for the birth of a Child or for placement of a Child for adoption or foster care, use of intermittent leave is subject to the Employer's approval.
- A FMLA leave may be taken intermittently whenever it is Medically Necessary to care for a seriously ill family member, or because the Employee is seriously ill and unable to work.

Substitution of Paid Leave

Subject to certain conditions, Employees or Employers may choose to use accrued **paid** leave (such as sick leave or vacation leave) to cover some or all of the FMLA leave. The Employer is responsible for designating if paid leave used by the Employee counts as FMLA leave, based on information provided by the Employee. In no case can an Employee's paid leave be credited as FMLA leave **after** the leave has been completed.

Spouses Who Work for the Same Employer

Spouses employed by the same Employer are jointly entitled to a **combined** total of 12 work weeks of family leave for the birth of a Child, placement of a Child for adoption or foster care and to care for such Child or to care for a parent who has a serious health condition.

Re-enrollment after a FMLA Leave

If any or all of an Employee's Plan coverage ends while the Employee is on FMLA leave, the Employee can re-enroll in the Plan when he or she returns to work after FMLA leave. The Employee and any Dependents will be considered timely enrollees if the Employee re-enrolls within 60 days after the date he or she returns to work. Any waiting period will be applied as if there had been no break in coverage.

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 this Section 5-A, *How to Continue Coverage*.)

Layoff or Termination of Employment

Plan coverage will end if you are laid off due to lack of work or if your employment is terminated; however, you may be able to continue coverage. (For details, see Section 5-B: *Extension of Medical Benefits*.)

Failure to Pay Employee'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.

How to Continue Coverage

If You Retire – Coverage under the Retiree Medical Payment Plan

If you retire and are Retiree Medical Payment Plan Eligible, you may elect to continue to receive medical benefits under the Retiree Medical Payment Plan. Alternatively, if you retire at or after normal retirement age with 2 or more years of service, you will be eligible for continued coverage under the Retiree Medical Payment Plan until age 65. If you are not eligible for coverage under the Retiree Medical Payment Plan, coverage for you and your Dependents will terminate upon your retirement. At that time, you are eligible to obtain continuation coverage under COBRA. (For details, see Section 5-B, *Extension of Medical Benefits*.)

Canceling Coverage

You may cancel your Plan coverage by notifying your HR service center in writing. The cancellation will become effective on January 1 following the annual enrollment period or when a Qualified Change in family or employment status occurs.

If you cancel your coverage, you may rejoin the Plan at a later date, either during the next Annual Open Enrollment Period or within 60 days following a Qualified Change.

Plan coverage will not be cancelled or rescinded unless you or a Covered Dependent engages in fraud or intentionally misrepresents a material fact. Rescission of coverage is defined as the cancellation or discontinuance of coverage with retroactive effect, except to the extent attributable to your failure to timely pay premiums.

Total Disability

If you or your Dependent is permanently and Totally Disabled on the date your Plan coverage terminates, the provisions under *Other Extensions of Benefits* applicable to *Total Disability* will apply.

If You Die

In the event of your death, special provisions apply to your Covered Dependents, as explained under Section 5-C, *Other Extensions of Medical Benefits*.

Divorce

In the case of 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 5-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 5-B, Extension of Medical Benefits*. Coverage for your Children, however, may be subject to provisions of a Qualified Medical Child Support Order (see Section 5-D, *Qualified Medical Child Support Orders*).

Section 5-B: Extension of Medical Benefits

Continuation of Coverage under COBRA

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

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

	Qualifying Event
You, the Employee	- Termination of the Employee's employment, except for gross misconduct (unless the Employee is Retiree Medical Payment Plan Eligible) - Reduction in hours resulting in loss of coverage (before Employee becomes Retiree Medical Payment Plan Eligible), except for gross misconduct
Eligible Dependents	- Termination of the Employee's employment (unless the Employee is Retiree Medical Payment Plan Eligible), except for gross misconduct - Reduction in the Employee's hours worked that results in loss of coverage - The Employee's death - Your entitlement to Medicare - Your divorce or legal separation - Your Dependent's eligibility for coverage ends, or - The birth or adoption of a Child during the Employee's period of continued coverage

Continued Coverage

Depending on the Qualifying Event, coverage may be continued for up to **18, 29 or 36 months** from the date coverage ends. Continued coverage will be identical to the coverage provided to Employees. You will have the same rights as a Covered Person, including the right to enroll eligible Dependents.

COBRA Qualifying Event	How Long Coverage May Continue	
	You	Dependents
You terminate employment (except for gross misconduct)	18 months (may be extended an additional 11 months – if you or your Dependent is determined to be disabled)	18 months (may be extended an additional 11 months – if you or your Dependent is determined to be disabled)

	under the Social Security Act).	under the Social Security Act).
Your hours are reduced, resulting in a loss of coverage	18 months (may be extended an additional 11 months – if you or your Dependent is determined to be disabled under the Social Security Act).	18 months (may be extended an additional 11 months – if you or your Dependent is determined to be disabled under the Social Security Act).

COBRA	How Long Coverage May Continue	
Qualifying Event	You	Dependents
You die	N/A	36 months
You become entitled to Medicare	N/A	36 months (special rules apply)
You and your spouse divorce or legally separate	N/A	36 months
Your child is no longer eligible	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 your Benefits Representative or local HR service center in writing within 60 days after the second Qualifying Event.

Notification

If you or a covered Dependent loses coverage under the Plan due to **divorce, legal separation, or loss of Dependent eligibility**, it's your responsibility to notify your Benefits Representative or local HR service center within 60 days after the occurrence of the Qualifying Event.

Upon notification that a Qualifying Event has occurred, your Benefits Representative or local area HR service 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.

Disability

You and your Dependents may be eligible to extend your COBRA coverage an additional 11 months, if you or your Dependent qualifies for Social Security Disability Insurance ("SSDI") benefits at any time during the first 60 days of continuation coverage under COBRA. To receive this extension, you must notify your Benefits Representative or local HR service center in writing within 60 days after first receiving your SSDI determination, but before the end of the original 18-month period of COBRA coverage. The 11-month extension will continue so long as you or your Dependent remains eligible for SSDI benefits, but not beyond a total of 29 months of coverage from the date of the Qualifying Event.

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

If you receive a determination from the Social Security Administration that you or your Dependent is no longer considered disabled, you must notify Businessolver Solutions within 30 days of this determination. COBRA benefits will cease the first day of the month beginning 30 days after the date of determination from the Social Security Administration that you or your Dependent are no longer considered disabled, if the date of

determination is after the original 18-month COBRA period.

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 active Employees.

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 applicable 18-, 29- or 36-month, 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 active and retired Employees; or
- 5) In the case of extended coverage due to disability, the disabled person ceases being eligible for SSDI benefits.

Section 5-C: Other Extensions of Medical Benefits

In addition to the option to continue coverage under

COBRA, certain extensions of benefits are available due to an Employee's death or Total Disability.

Total Disability

Coverage for Employees Receiving Aramco U.S. Long-Term Disability Plan Benefits

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

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 enrolled in the Retiree Medical Payment Plan Indemnity coverage.
- Your coverage under the Retiree Medical Payment 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 Payment Plan will be determined as if you were enrolled and covered under Medicare Parts A and B.

Covered Dependents of Deceased Active Employees

Upon the industrial death of an Employee who IS NOT eligible for retirement under the Retirement Income Plan at the date of death - The surviving Spouse and covered Dependents continue to be eligible to participate in the Plan until the earlier of (1) the last day of the month in which the surviving Spouse reaches age 60, or in the case of Dependent Children, until they reach age 26 and continue to meet the eligibility requirements of the Plan; or (2) The last day of the

month in which the surviving Spouse remarries. If the Employee is not married on the date of death, covered Dependent Children will be eligible for coverage under COBRA.

Upon the non-industrial death of an Employee who IS NOT Retiree Medical Payment Plan Eligible at the date of death – The surviving Spouse and covered Dependents continue to be eligible to participate in the Plan until the earlier of (1) The last day of the month in which occurs the five-year anniversary of the Employee's death; (2) The last day of the month in which the surviving Spouse reaches age 60, or in the case of Dependent Children, the last day of the month in which they reach age 26 and continue to meet the eligibility requirements of the Plan; or (3) The last day of the month during which the surviving Spouse remarries. If the Employee is not married on the date of death, covered Dependent Children will be eligible for coverage under COBRA.

Upon the death of an Employee who IS Retiree Medical Payment Plan Eligible at the date of death – The surviving Spouse continues to be eligible to participate in the Plan until the earlier of (1) the last day of the month in which the surviving Spouse reaches age 60; or (2) The last day of the month during which the surviving Spouse remarries. After age 60, a surviving Spouse who has not remarried is eligible to participate in the Retiree Medical Payment Plan, if all other eligibility requirements of the Retiree Medical Payment Plan are met. Covered Dependent Children continue to be eligible to participate in the Plan until they reach age 26 if they continue to meet the other eligibility requirements of the Plan. If the surviving Spouse is a participant in the Retiree Medical Payment Plan, covered Dependent Children may be eligible to continue coverage under the terms of the Retiree Medical Payment Plan until they reach age 25, provided they meet the eligibility requirements of the Retiree Medical Payment Plan. If the Employee is not married on the date of death, covered Dependent Children may continue to be covered under COBRA provided they continue to meet all other eligibility requirements of the Plan.

Upon the death of an Employee who IS eligible for retirement under the Retirement Income Plan at the date of death as the result of having attained at least age 60 and who has 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

Retiree Medical Payment Plan until the last day of the month preceding the date the deceased

Employee would have attained age 65, provided they continue to meet all other eligibility requirements of the Retiree Medical Payment Plan.

In each of the above situations, the Dependents of the deceased Employee will be required to pay the monthly premiums paid by Employees of Aramco Americas Company.

Remarriage of a Surviving Spouse

Should the surviving Spouse of a deceased Employee remarry, eligibility for Plan coverage for the surviving Spouse and Dependents ends on the last day of the month in which the marriage occurs.

Section 5-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 5-E: Uniformed Services Employment and Reemployment Rights Act

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

The term "Uniformed Services" means the U.S. Armed Forces, the Army National Guard and the Air National Guard when engaged in active duty for training, inactive duty training, or full-time National Guard duty, the commissioned corps of the Public Health Service, and any other category of persons designated by the President in time of war or national emergency.

If qualified pursuant to USERRA, Employees may elect to continue coverage under the Plan by notifying the Plan Administrator in advance and providing payment of any required contribution for Plan coverage. This may include the amount the Company normally pays on behalf of an Employee. If an Employee's military service is for a period of less than 31 days, the Employee may not be required to pay more than the regular contribution amount, if any, for continuation of Plan coverage.

An Employee may continue Plan coverage under USERRA for up to the lesser of:

- The 24 month period beginning on the date of the Employee's absence from work; or
- The day after the date on which the Employee fails to apply for, or return to, a position of employment.

Regardless of whether an Employee continues Plan coverage, if the Employee returns to a position of employment, the Employee's Plan coverage and that of the Employee's covered Dependents will be reinstated under the Plan. No exclusions or waiting period may be imposed on an Employee or the Employee's covered Dependents in connection with this reinstatement, unless a Sickness or Injury is determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, the performance of military service.

You should call the Plan Administrator if you have questions about your rights under USERRA.

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 Copayment 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, Copayments and limits applicable to other Covered Expenses.

SECTION 6: ADMINISTRATION & OTHER INFORMATION

Administration

The Company has entered into an Administrative Services Only (“ASO”) Contract with the Claims Administrators. The Claims Administrators make all payments of benefits under the Plan. The Claims Administrators do not insure the payment of benefits described in this SPD.

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.

The Plan is governed by ERISA.

The Plan Sponsor reserves the right to change or discontinue the Plan or to reduce or eliminate benefits at any time.

This SPD does not create a contract of employment.

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.

Name of Plan:

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

Name and Address of the Plan Sponsor:

Aramco Shared Benefits Company
Two Allen Center
1200 Smith Street Floor 32
Houston, TX 77002-4313

Employer Identification Number of Plan Sponsor (EIN):

84-4364434

Agent for Service of Legal Process: Aramco Shared Benefits Company

P.O. Box 4536
Houston, Texas 77210-4536
Attention: General Counsel
Phone: 713-432-4000

Plan Number (PN):

501

Aetna Group Number

706367

Other Information

Summary Plan Description for Aramco U.S. Medical Benefits Plan, a component benefit plan under the Aramco U.S. Welfare Benefit Plan.

This is your Summary Plan Description (“SPD”) for purposes of the Employee Retirement Income Security Act of 1974 (“ERISA”). It describes your rights and obligations under the employee welfare benefit plan established by the Plan Sponsor, provided that you elect to participate in the Plan.

This SPD describes the benefits available under the Plan, as well as the Plan's limitations and exclusions. As a Covered Person under the Plan, you may be asked to comply with certain provisions of the Plan which could affect the benefits you receive. Please acquaint yourself with these provisions, because a failure to comply may result in additional costs or in a reduction of benefits.

Plan Type:

The Plan described in this SPD is a Welfare Benefit Plan providing group health plan benefits for purposes of ERISA.

Plan Years:

The financial records of the Plan are kept on a Calendar Year basis.

Plan Administrator:

The Plan Sponsor named above through its Employee Benefits Committee. The Employee Benefits Committee has delegated the authority to determine final voluntary appeals to the Plan Administrative Committee.

Telephone Number of Plan Administrator:

(713) 432-4000

(800) 343-4272

Plan Trustee:

JPMorgan Chase Bank, N.A. TX3-8215 221 West Sixth St, 2nd Floor
Austin, Texas 78701-3400

Type of Administration

Third party administered by Aetna (medical) and Express Scripts (prescription drug)

Medical Benefits (except for prescription benefits) are paid from funds provided by the Company on behalf of the Plan in accordance with a contract with Aetna International.

Prescription benefits are paid from funds provided by the Company on behalf of the Plan in accordance with a contract with Express Scripts.

Source of Contributions and Funding:

The Plan is funded by a combination of contributions from the Company and contributions from Employees who elect to participate in the Plan.

The Employees' contributions toward the total cost of the Plan are determined by the Company.

Plan Details:

The Plan's provisions relating to eligibility to participate and termination of eligibility to

participate as well as a description of the benefits provided by the Plan are described in this SPD.

Future of the Plan/Plan Termination:

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. Any benefits, rights or obligations of

Covered Persons and beneficiaries under the Plan following termination are described in detail in this SPD.

How to Appeal a Claim:

If a Covered Person's claim for a welfare benefit is denied or ignored, in whole or in part, he or she has a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. For instructions on how to appeal denial of a claim, please refer to Section 4: *Claims Information*.

A Covered Person's Rights under the Employee Retirement Income Security Act of 1974 (ERISA)

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:

- 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.

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 terminate a Covered Person or otherwise discriminate against a Covered Person in any way to prevent that person from obtaining a benefit or exercising his or her rights under ERISA.

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 material 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).

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, or if that person needs assistance in obtaining documents from the Plan Administrator, 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. Certain publications about rights and responsibilities under ERISA may also be obtained by calling the publications hotline of the Employee Benefits Security Administration.

Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected by federal law from surprise billing or balance billing. What is "balance billing" (sometimes called "surprise billing")? When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, and/or a deductible. You may have other costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network. "Out-of-network" describes providers and facilities that haven't signed a contract with your health plan. Out-of-network providers may be permitted to bill you for the difference between what your plan agreed to pay and the full amount charged for a service. This is called "balance billing." This amount is likely more than in-network costs for the same service and might not count toward your annual out-of-pocket limit. "Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in network facility but are unexpectedly treated by an out-of-network provider. You are protected from balance billing for: Emergency services If you have

an emergency medical condition and get emergency services from an out-of-network provider or facility, the most the provider or facility may bill you is your plan's in-network cost sharing amount (such as deductibles, copayments and coinsurance). You can't be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balance billed for these post-stabilization services. Certain services at an in-network hospital or ambulatory surgical center When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers may bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers can't balance bill you and may not ask you to give up your protections not to be balance billed. If you get other services at these in-network facilities, out-of-network providers can't balance bill you, unless you give written consent and give up your protections. You're never required to give up your protections from balance billing. You also aren't required to get care out-of-network. You can choose a provider or facility in your plan's network. When balance billing isn't allowed, you also have the following protections:

- You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay out-of-network providers and facilities directly.
- Your health plan generally must:
 - o Cover emergency services without requiring you to get approval for services in advance (prior authorization).
 - o Cover emergency services by out-of-network providers.
 - o Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
 - o Count any amount you pay for emergency services or out-of-network services toward your deductible and out-of-pocket limit.

If you believe you've been wrongly billed, you may contact the Department of Labor or your medical vendor. Visit the Department of Labor's website (www.dol.gov/ebsa) or call the Employee Benefits Security Administration (EBSA) Toll-Free Hotline at 1-866-444-EBSA (3272) for more information about your rights under federal law.

SECTION 7: 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 anesthesiologist who is administering the anesthetic and that the anesthesiologist or anesthesiologist 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 Employee must pay before the Plan pays any benefits.

Under the PPO Plan and with a \$250 per individual Annual Deductible, for example, you pay the first \$250 of Covered Expenses yourself. Under the HDHP and with \$2,000 per individual Annual Deductible, for example, you pay the first \$2,000 of Covered Expenses yourself.

After you pay your Annual Deductible, you usually pay only a Copayment or Coinsurance for Covered Expenses. The Plan pays the rest.

4. Annual Open Enrollment Period

The annual period designated each year by the Company prior to the start of the Plan Year during which all Employees 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. An In-Network preferred provider may not Balance Bill you for Covered Expenses.

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 the Employee, as well as natural, foster or adopted children of the Spouse who are living in the Employee's household, and children over whom the Employee has legal guardianship.

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 the 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 Annual Deductible.

14. Company

Company means Aramco Shared Benefits Company or one 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.

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 Employee, the Employee's Spouse, the Employee's Child or Children and other eligible Dependents who are covered under the Plan.

19. Dependent

A Spouse, Child 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 a 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. High Deductible Health Plan (HDHP)

A plan with a higher deductible than a traditional insurance plan. The monthly premium is usually lower, but you pay more health care costs yourself before the insurance company starts to pay its share (your deductible). A high deductible plan (HDHP) can be combined with a health savings account (HSA), allowing you to pay for certain medical expenses with money free from federal taxes.

The HDHP In-Network Annual Deductible is \$4,000 per individual per calendar year and \$8,000 per family per calendar year. The HDHP Out-of-Network Annual Deductible is \$8,000 per individual per calendar year and \$16,000 per family per calendar year.

30. 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.

31. 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.

32. 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.

33. 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.

34. 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.

35. Injury

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

36. 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; 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.

37. 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.

38. 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.

39. 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.

40. Medical Benefits

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

41. 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.

42. 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 a 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".

43. Medicare

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

44. Medicare Secondary Payer

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

45. 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 or other methods.

All inpatient services, including Room and Board, given by a Mental Health and Substance Use Disorder Residential 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 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.

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

47. 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).

48. Nurse-Midwife

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

- A person licensed by a board of nursing as a registered nurse (R.N.).
- A person who has completed a program approved by the state for the certification or practice of Nurse-Midwives

49. Nurse Practitioner

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

- A person licensed by a board of nursing as a registered nurse (R.N.).
- A person who has completed a program approved by the state for the certification or practice of Nurse-Practitioners
approved by the state for the certification or practice of Nurse-Practitioners.

50. Office Visit Copayment

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

51. Oral Surgery

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

52. 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).

53. Out-of-Network Benefits

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

54. Out-of-Network Hospital

A Hospital which does not participate in the Network.

55. Out-of-Network Pharmacy

A pharmacy that is not an In-Network Pharmacy.

56. Out-of-Network Provider

A provider which does not participate in the Network.

57. Out-of-Pocket Maximum

The amount at which a Covered Person's required Medical Copayments or Annual Deductibles stops during the Calendar Year.

58. Participating Companies

Participating Companies include Aramco Americas Company; Aramco Associated Company; Aramco Overseas Company B.V.; Aramco Capital Company, LLC; Saudi Arabian Oil Company, Aramco Ventures LLC, Aramco Venture Management Consultant Company, LLC, Saudi Petroleum International, Inc.; and Saudi Refining, Inc., all of which are covered by the Plan.

59. Physician

A legally qualified:

- Doctor of Medicine (M.D.).
- Doctor of Chiropractic (D.P.M.; D.S.C.).
- Doctor of
(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.).

60. Plan or Medical Plan

The Aramco U.S. Medical Payment Plan, which is an employee welfare benefit plan established by the Plan Sponsor to provide certain Medical Benefits, Prescription Drug benefits, and other benefits to Covered Persons as described in this SPD. The Plan is a component benefit plan under the Aramco U.S. Welfare Benefit Plan.

61. Plan Administrator

The Plan Administrator is the Aramco Shared Benefits Company.

62. Plan Sponsor

The Plan Sponsor is the Aramco Shared Benefits

Company.

63. Plan Year

The Plan Year is the calendar year.

64. 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.

65. 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 and will be retained by Express Scripts.

66. 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.

67. 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.

68. 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.

69. 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.

70. Reasonable and Customary Charge

As to charges for services rendered by or on behalf of a 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.

71. Rehabilitation Facility

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

72. Retirement Income Plan

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

73. Retiree Medical Payment Plan

The Aramco U.S. Retiree Medical Payment Plan, as amended from time to time.

74. Retiree Medical Payment Plan Eligible

Means an Employee or Dependent who meets the eligibility requirements for coverage under the terms and conditions of the Retiree Medical Payment Plan as applicable to such Employee or Dependent.

75. Review or Review Process

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

76. 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.

77. Sickness

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

78. 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 individuals receiving treatment for substance use disorders or mental health conditions.

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

79. 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.

80. 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.

81. 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.

82. 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.

83. Spouse

The individual married to the Employee in accordance with applicable law.

84. 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.

85. Surviving Spouse

The Spouse of an Employee who, following the Employee's death, is eligible for survivor coverage under the terms of the Plan.

86. Total Disability or Totally Disabled

- An Employee'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.

87. 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.

88. 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.