Schlumberger

HEALTH CARE SPENDING ACCOUNT

Summary Plan Description

As in Effect January 1, 2022

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INTRODUCTION TO THE HEALTH CARE SPENDING ACCOUNT

This document is a Summary Plan Description or "SPD" for the Schlumberger Health Care Spending Account (HCSA) Plan (Plan). It describes the Plan's most important features. Some terms that are used frequently in this SPD are capitalized because they have specific meanings. You can find the definitions of those terms in the *Definitions* section at the end of this SPD.

You also can find information on the Plan, including your own enrollment information, 24-hours a day, seven days a week, on *iThrive* at *https://iThrive.slb.com*.

More Important Details

Schlumberger offers a variety of benefit programs, including the HCSA Plan, under its Group Welfare Benefits Plan (the "Group Plan").

The formal document for the Group Plan includes some details that apply to the HCSA Plan, mainly regarding plan administration, that aren't fully described in this SPD. If something in this SPD conflicts with the formal document, the terms of the formal document will govern.

As with all the plans it provides, Schlumberger reserves the right to modify or terminate the Group Plan or the HCSA Plan at any time.

Online Access

You can access your Accounts online via *https://iThrive.slb.com or http://digital.alight.com/schlumberger*.

Once online:

- You have 24/7 access to your Account and funds.
- Provide your email address and/or mobile phone number and you can receive important email updates, text messages and claim status notifications.
- Your transaction activity will enable you to access, review and print your real-time Account information at any time.
- Review your transaction activity and download it real-time.
- Check the complete list of eligible expenses.
- Order additional Alight Smart-Choice debit cards for your family

Customer Care

You can reach the US Benefits Center Customer Care representatives at 1-800-474-4015 from 7:00 a.m. to 7:00 p.m., Central Time, Monday through Friday.

HCSA HIGHLIGHTS

Schlumberger established the Health Care Spending Account (HCSA) to provide its Eligible Employees a convenient and tax-effective way to pay for their family's annual health care costs that are not reimbursed by the Schlumberger Medical and Dental Plans. Participation is strictly voluntary, and you may enroll if you elected the OAP medical option or you declined Schlumberger medical coverage. The major features of the HCSA are described below.

More Important Details
This section of the SPD only describes the *highlights* of the HCSA Plan. You must read all of this SPD for other important details that apply to HCSA Plan benefits.

If you choose to participate, you decide how much you want to contribute to your Health Care Spending Account (your HCSA) on an annual basis, based on the amount of eligible health care expenses you expect to incur during the year.

Your contributions are used to reimburse eligible expenses you and your family incur during the same calendar year that are not covered by any health care coverage you may have. Examples of eligible expenses include your annual deductibles, co-payments and co-insurance for medical and dental expenses, your share of prescription drug and vision care expenses, and other amounts you pay out-of-pocket for your family's health care (see *Eligible Expenses*).

To receive reimbursements from your HCSA, you will file a claim along with supporting documentation proving that you have incurred the eligible expense (see *Claims and Appeals*). Only those expenses incurred in the same calendar year in which your contributions are made are eligible for reimbursement. IRS regulations require that you forfeit any contributions to your HCSA which are not used to reimburse eligible expenses incurred during the same calendar year (see *Contribution Forfeitures*).

When you contribute to the Health Care Spending Account and receive reimbursements as you incur eligible expenses, you are able to spread your family's annual health care costs more evenly over the course of the calendar year. As your out-of-pocket spending increases, your reimbursements from your HCSA increase, helping to offset higher out-of-pocket costs you incur at the beginning of the year before you reach your Annual Deductible amounts. And, because your contributions to your HCSA are made on a pre-tax basis, you also save tax dollars when you pay for your family's eligible health care expenses through your HCSA.

LIMITED PURPOSE SPENDING ACCOUNT HIGHLIGHTS

If you elected the Choice HSA or Saver HSA medical option, your Health Care Spending Account (HCSA) is **limited purpose**. This means that **you only receive reimbursement for dental and vision expenses**. Medical expenses can only be reimbursed after you meet the IRS minimum annual deductible.

The IRS minimum required deductible only applies to medical expenses. Eligible dental and vision expenses that are not reimbursed though any other healthcare plan, may be reimbursed from the HCSA without regard to any minimum deductible.

More Important Details
This section of the SPD only describes the *highlights* of the Limited Purpose Spending Account. You must read all of this SPD for other important details.

If you choose to participate, you decide how much you want to contribute to your limited purpose spending account on an annual basis, based on the amount of eligible health care expenses you expect to incur during the year.

You may contribute to both a Health Savings Account (HSA) and a Limited Purpose Spending Account. If you decide to have both, the money in your limited purpose spending account can be used first to reimburse your Eligible Expenses, allowing you to save the money in your HSA into future years, even into retirement. While you will forfeit any amounts in you limited purpose spending account that are not used by the end of the year. Keep in mind that is not the case with the Health Savings Account, which is yours to keep. Be sure to review the Medical Plan SPD for more information on the HSA.

ELIGIBILITY, ENROLLMENT AND PERIOD OF COVERAGE

Eligibility

Eligible Employees

You're an "Eligible Employee" on the first day you're on the Schlumberger US Payroll, **unless** you're:

- classified by the *Company* as a contractor, or as anything other than an employee (regardless of your legal status);
- covered by a collective bargaining agreement that doesn't provide for your participation in the Plan; or
- employed by a company acquired by Schlumberger that continues to provide benefit programs different from those offered by Schlumberger.

You must be in *Active Service* for your coverage to take effect, as further discussed below under *When Coverage Begins*.

Special Rules for Married Employees
If both you and your Spouse are Eligible Employees, only one of you may enroll in the Plan. If your Spouse works elsewhere, each of you may contribute to your respective employers' plans up to the limits of each plan (see *Contributions*).

Special Rule Depending on Your Medical Plan Option
You may enroll in the HCSA during any period that you're enrolled in the Open Access Plan option under the Schlumberger Medical Plan or if you decline Schlumberger medical coverage.

You may enroll in the Limited Purpose Spending Account during any period that you're enrolled in the Saver HSA option or the Choice HSA option under the Schlumberger Medical Plan.

Enrollment and Election Changes

Regular Enrollment Opportunities

You may elect to enroll in and make contributions to the HCSA, as applicable, during the 31-day period starting on the first day you're an *Eligible Employee*. You also may enroll during any *Annual Enrollment* period.

Limited Midyear Election Changes

In general, the election you make whether or not to contribute to the Plan during *Annual Enrollment* or when you are first eligible can't be changed after the enrollment period closes. Those elections must remain in effect through the end of the *Plan Year* to which the election applies.

However, if you have a qualified change in status, you may add or drop coverage, or change the amount you contribute, in the middle of a Plan Year if your change is on account of a qualified change in status. To make a coverage change, you must make an election within 31 days starting on the date of the event (61 days in order to enroll yourself or your dependent (i) upon termination of coverage under a Medicaid plan or state child health plan due to loss of eligibility or (ii) upon you or your dependent becoming eligible for premium assistance under a Medicaid plan or a state child health plan or (iii) upon receipt of a qualified medical child support order).

Qualified Changes in Status

The events listed below are qualified changes in status that will allow you to make a change to your contribution elections under the Plan.

- ***Changes in Legal Marital Status***: Events that change your legal marital status, including marriage, death of Spouse and divorce.
- ***Changes in Number of Dependents***: Events that change your number of *Account-qualified Dependents*, including birth, death, adoption or placement for adoption.
- ***Changes in Employment Status***: Events that change employment status for you or your Spouse, to the extent that employment change affects eligibility for Plan coverage or for other health coverage.
- ***Changes in Account-qualified Dependent Eligibility***: An event that causes a dependent to satisfy or cease to satisfy the eligibility requirements to be an Account-qualified Dependent, including reaching a certain age.
- ***Entitlement to or Coverage under Medicare or Medicaid***: You, your Spouse, or dependent becomes enrolled under, or loses eligibility under, Medicare Part A or B or Medicaid.
- ***Loss of Coverage under State Child Health Plan***: You or your dependent loses coverage under a state child health plan due to a loss of eligibility.

Period of Coverage

When Coverage Begins

Initial Eligibility
Coverage that you elect when you're first eligible will take effect on the day you become an Eligible Employee if you are in *Active Service* on that day. If you are not in Active Service on that day, coverage will take effect when you have completed one full day of Active Service.

Annual Enrollment
Coverage that you elect during Annual Enrollment takes effect on the following January 1.

Return from Leave of Absence
Coverage that terminates due to you taking an unpaid leave of absence will be reinstated automatically effective on the date you return to *Active Service*.

Status Change
Coverage elected as the result of a qualified change in status (as described above) takes effect on the date you make the election, except that coverage added in connection with birth, adoption or placement for adoption will take effect retroactive to the date of the birth, adoption or placement.

When Coverage Ends

Your coverage will end on the first date one of these events occurs:

- you start an approved *unpaid* leave of absence (unless you are on FMLA leave or military leave and your coverage is required by law to continue);
- your employment with Schlumberger ends, including termination of your employment because you fail to return to work at the end of an approved leave of absence;

- you stop making any required contributions for that coverage, including contributions required while on a leave of absence;
- a new *Plan Year* begins and you waived coverage or failed to elect coverage for that Plan Year;
- the Plan is amended in a way that disqualifies you for further benefits; or
- the Plan is terminated.

If your Plan coverage ends as described above, you may be eligible to temporarily continue that coverage as described in the "*COBRA Rights and Procedures*" section.

Paying for Coverage

Only you make contributions to your Account. Your contributions are made on a pre-tax basis through payroll deductions. This means you don't pay federal and Social Security taxes (and, in most areas, state or local taxes) on your contributions. This can reduce your taxable income and help reduce the cost of your family's health care expenses that are not reimbursed by the Schlumberger Medical and Dental Plans.

YOUR HCSA PLAN BENEFITS

The HCSA Plan is a way for you to pay for your family's annual health care costs that are not reimbursed under your Schlumberger Medical and Dental coverage or other health care coverage, if you meet all of the Plan's *eligibility requirements*.

You make contributions to your Account through payroll deductions on a pre-tax basis and you submit requests for reimbursement from your Account as you incur *Eligible Expenses* throughout the same calendar year. In this way, the HCSA Plan can help you manage the financial impact of your family's annual out-of-pocket health care costs. And, because the HCSA allows you to pay for health care expenses for family members who may not be eligible for coverage under the Schlumberger Medical and Dental Plans, the impact of your contributions in managing your overall health care expenses can be substantial (see Definition of *Account-qualified Dependents*).

Contributions to the HCSA Plan

If you elect coverage under the Plan, you make pre-tax contributions to your Account throughout the entire calendar year by payroll deduction. You decide how much you want to contribute each year, based on the amount of eligible expenses you expect your family to incur during the calendar year.

When deciding how much to contribute to your Account, you should first estimate your out-of-pocket health care expenses for the Plan Year. The Alight Smart-Choice Accounts website (available via *iThrive.slb.com*) includes information on qualified expenses. See *Eligible Expenses*.

Limits on Amounts You Can Contribute

The maximum annual contribution you may make is $2,750. If you are 55 or older, you may contribute an additional $1,000.

Contribution Changes during the Calendar Year

If you elect to contribute to the HCSA, your election will remain in effect for the entire calendar year (or the remainder of the calendar year, if you are enrolling other than at January 1). You may only increase, decrease or discontinue your contribution(s) during an Annual Enrollment period unless you have a qualified change in status (see *Limited Midyear Election Changes*).

Contribution Forfeitures

IRS regulations require that you forfeit any contributions remaining in your Account that are not used to reimburse Eligible Expenses incurred during the same calendar year. Forfeitures will occur on or after March 31 of the year following the year they are contributed. Forfeited amounts will be used to offset the administrative expenses of the Plan.

Because of this forfeiture rule, you should estimate your eligible expenses carefully before deciding on the amount to contribute to your HCSA. In making your estimate, keep in mind that you are not permitted to:

- transfer money between your HCSA and your Dependent Care Spending Account;
- use money from your Account to reimburse expenses incurred before you begin participating in the Plan or after you stop participating;
- use money from your Account to pay for dependent care expenses;
- "carry over" expenses or contributions from one calendar year to the next; or
- use money from your Account to pay premiums for other insurance or health care coverage or

- use money from your Limited Purpose Spending Account to reimburse medical expenses below the IRS minimum required deductible.

Effect of Pre-Tax Contributions

Contributions to your Account are made on a pre-tax basis, so you reduce your taxable income for Federal income tax, Social Security tax and, in most cases, for state and local taxes as well. The chart below shows how your contributions to the Plan reduce your current tax liability.

The Pre-Tax Spending Account Advantage

Assume you are a married taxpayer filing jointly, you earn $50,000 and you expect to spend $1,000 in eligible health care expenses this year. The following table shows the advantage of contributing $1,000 to the Health Care Spending Account on a pre-tax basis vs. paying for these expenses on an after-tax basis.

	Pre-tax Contributions to Your Health Care Spending Account	After-Tax Payments for Health Care Expenses
Your taxable earnings	$50,000	$50,000
Pre-tax contribution	- 1,000	- 0
Taxable income	$49,000	$50,000
Federal income taxes (estimate)*	- 3,301	- 3,451
FICA (7.65%)	- 3,749	- 3,825
Net after-tax income	$41,950	$42.724
After-tax health care expenses	- 0	- 1,000
"Spendable" income	$41,950	$41,724
The Pre-Tax Advantage	$226	$0

* From 2017 federal income tax tables for a married taxpayer, filing jointly with no other income. This assumes a standard deduction of $12,700 (married filing jointly) and 2 exemptions (2 X $4,050 = $8,100) The impact on state and local taxes is not reflected in this chart.

Debit Card

When you enroll in the Plan, you will receive a debit card for you and your family to use. This card can be used like a credit card at approved, in-network locations. The debit card draws from your Account balance to automatically pay your share of expenses. If your HCSA is a Limited Purpose Spending Account, you will need to certify to the Claim Administrator once you exceed the IRS minimum required deductible so that eligible medical expenses may be reimbursed.

You can use your debit card to pay for products and services like:

- Copayments or coinsurance at pharmacies, doctor's or dentist's offices1
- Diabetic supplies
- Eye glasses, contact lenses and contact solutions
- Orthodontic devices such as braces
- Personal protective equipment such as masks, hand sanitizer and disinfecting wipes that are purchased for the primary purpose of preventing the spread of COVID-19 (this change is retroactive to January 1, 2020)

[1]Copayment or coinsurance at pharmacies or doctor's offices may be reimbursed from the limited purpose spending account to the extent they are for preventive services or are incurred **after** you reach the annual IRS minimum required deductible

Please keep in mind that you are responsible for how your HCSA dollars are spent. If you're ever in doubt about the eligibility of a particular product or service, check the Smart-Choice Accounts website via *iThrive*, *visit https://www.irs.gov/publications/p969* or contact a Customer Care representative at 1-800-474-4015. If you accidentally use your debit card for a non-eligible item, contact Alight Smart-Choice Accounts as soon as you become aware of the mistake for instructions on how to reimburse the Account for the ineligible item.

For some expenses, Alight Smart-Choice Accounts may need additional information, including receipts, to verify that the expense is eligible and it complies with IRS rules. It's important for you to save all of your itemized receipts, and to fax or mail them promptly if Alight Smart-Choice Accounts asks for them. Without proper receipts, Alight Smart-Choice Accounts must consider those expenses ineligible, and you'll have to reimburse your Account. You could also lose access to your debit card.

Reimbursements from the HCSA Plan

You have several ways to access funds in your Health Care Spending Account including:

- Using your Alight Smart-Choice debit card. If you need additional cards, contact Alight Smart-Choice Accounts at 1-800-474-4015.
- Filing a claim online by submitting claims through the Smart-Choice Accounts website at *iThrive*
- Filing a paper claim by fax (1-855-673-6719) or mail.

To receive reimbursements from your Account for expenses when you don't use your debit card, you will file a reimbursement request along with documentation proving that you have incurred an eligible expense as described in the *Claims and Appeals* section. You are eligible to receive reimbursements from your Account at any time during the calendar year up to the maximum amount you have elected to contribute on an annual basis.

To be eligible for reimbursement, you only have to have incurred (not paid for) the expense, so in many cases, you can use your reimbursement to pay for your eligible expenses. However, keep in mind that all payment arrangements are between you and the provider of the services. In some cases the provider may require you to make payment before you have been reimbursed from your Account.

A Closer Look: When to Submit Claims

Examples of expenses eligible for reimbursement through your Account include your annual deductibles, co-payments and co-insurance for medical and dental expenses, your share of prescription drug and vision care expenses, fees in excess of reasonable and customary charges, and other amounts you pay out-of-pocket for your family's health care (see *Eligible Expenses*).

Only your eligible expenses that are incurred in the same calendar year in which your contributions are made will be approved for reimbursement.

Funds Available for Claim Reimbursements

The funds available to reimburse eligible expenses under your Health Care Spending Account at any given time are equal to the annual amount you have elected to contribute less any amounts already reimbursed from your Account.

Maximum Annual Reimbursement

The maximum annual amount you may be reimbursed from your Account in a given calendar year is equal to the lesser of:

- the annual amount you have elected to contribute to your Account; or
- the actual amount of eligible health care expenses that you have incurred during the calendar year and which you have claimed by March 31 of the following year (see *Eligible Expenses*).

The chart below gives an example of how the maximum annual reimbursable amount under your HCSA is calculated.

Calculation of the Maximum Annual Reimbursable Amount

Assume you have elected to contribute $1,200 per year to the Plan. The example below shows the maximum reimbursable amount from your Account during the calendar year if 1) you incur $1,150 in eligible expenses; or 2) if you incur $1,300 in eligible expenses.

	Scenario 1	Scenario 2
Annual contributions	$1,200	$1,200
Total eligible expenses incurred for the year	$1,150	$1,300
Maximum annual reimbursement	$1,150[1]	$1,200[2]
Excess expenses not reimbursed by the Plan	0	$100
Excess annual contributions you forfeit	$50	0

[1] Your maximum reimbursement is limited to the actual amount of eligible expenses you incur during the calendar year.

[2] Your maximum reimbursement is limited to the annual amount you elected to contribute to your Account.

Contributions and Reimbursements during Leave of Absence

If you are absent from work on an approved, paid leave of absence, the pre-tax contributions you were making to your Account will continue without interruption during your period of absence. However, you will be eligible for expenses incurred during this period only if they qualify as *Eligible Expenses*.

If you are absent from work on an approved, unpaid leave, contributions to your Account will stop as of the first day of your approved leave. Any expenses incurred after that date will not be eligible for reimbursement from the Account.

ELIGIBLE EXPENSES

Expenses that are eligible for reimbursement from your Account are any payments that the IRS considers to be deductible health care expenses and that are not reimbursed by any other benefit plan or program. These expenses may be incurred by you and/or your *Account-qualified Dependent*.

Examples of eligible and ineligible expenses are given in the following chart. A more comprehensive listing of eligible expenses can be found on the Smart-Choice Accounts website available through *iThrive or at https://www.irs.gov/publications/p969.*

Examples of Eligible and Ineligible Account Expenses
Eligible expenses for reimbursement through your HCSA are any payments that the IRS considers to be deductible medical expenses and that are not reimbursed by a health insurance plan, as shown in the following examples.
Eligible Expenses[1]
• Deductibles and Co-payments under healthcare plans, including the Schlumberger Medical and Dental Plans
• Out-of-pocket payments for healthcare that exceed reasonable and customary charges
• Out-of-pocket expenses for prescription drugs
• The cost of orthodontia (braces) not covered by an dental plan
• Smoking cessation programs, even if they are not recommended by your doctor
• The cost of eye exams, eyeglasses, contact lenses and lens solutions not covered by any medical insurance
• Laser eye surgery (radial keratotomy)
• Insulin
• The cost of personal protective equipment such as masks, hand sanitizer and disinfecting wipes that are purchased for the primary purpose of preventing the spread of COVID-19)
• Over-the-counter medications
Ineligible Expenses
• Services, treatments, equipment or supplies reimbursed by Medicare or a healthcare plan
• Expenses you deduct on your income tax returns
• Premiums, contributions or other payments for any healthcare plan or insurance policy
• Cosmetic medical or dental services or treatments to improve appearance or general health
• Health club programs
• Household help, even if recommended by your doctor
• Lessons of any type, even if recommended by your doctor
• Marriage counseling
• Vitamins to improve general health
• Nicotine patches and gum
• Weight loss programs, even if recommended by your doctor

- Herbal remedies

Definition of Account-qualified Dependent

Your Account-qualified Dependents are individuals you claim as dependents for Federal income tax purposes.

Examples of Account-qualified Dependents include:

- your spouse;
- your children, including stepchildren, legally adopted children, children who have been placed in your home for adoption, and foster children who live with you for the full calendar year;
- your parents or your spouse's parents;
- grandparents;
- brothers and/or sisters; and
- grandchildren.

CLAIMS AND APPEALS

This section of the SPD explains the process you must follow to file a claim for Plan benefits and to appeal the denial of a claim (or any other adverse benefit decision). It also explains the rules the Plan must follow when making decisions on claims or appeals.

You may authorize another person to represent you in making a claim for a Plan benefit or in appealing the denial of a claim under the Plan.

All deadlines described in this Claims and Appeals section of the SPD are based on calendar days (not business days).

You may not sue for any Plan benefits until you have gone through the first level of appeal described below.

How and When to File a Claim

When you incur an eligible expense, you must use the following procedure to request reimbursement:

- File a claim online by logging in to your Account via *https://iThrive.slb.com or via http://digital.alight.com/schlumberger* and the system will walk you through what is required.
- If you prefer to submit a claim by fax (1-855-673-6719) or mail, go to *https://iThrive.slb.com or http://digital.alight.com/schlumberger* to download a general claim form and follow the instructions on the form for submissions.
- Documentation for the expense includes the nature of the expense, the date the expense was incurred, and the name and address of the service provider. You do not need to pay the expense before you file the claim (unless your provider requires immediate payment), but you must be able to provide proof that you incurred the expense.
- Upload or attach the Explanation of Benefits (EOB) provided by your health plan showing the amount you are responsible to pay to the service provider or attach a bill from your service provider for eligible expenses incurred.
- Submit your claim no later than March 31 of the year following the year in which the expenses were incurred.

Requests for reimbursement are processed at regular intervals each month. Only your eligible expenses that are incurred in the same calendar year in which your contributions are made are eligible for reimbursement.

For purposes of approving expenses eligible for reimbursement, an expense is incurred on the date the service or supply is provided.

★**Note:** If you fail to file a claim for eligible expenses by March 31 following the calendar year in which the expenses were incurred, those expenses will not be reimbursed.

Claim Processing

After you file a claim, Alight Smart-Choice Accounts will review the claim and notify you of its decision within a reasonable period of time, which won't be more than 30 days after the claim was received. However, this deadline may be extended for up to 15 days based on special circumstances beyond Alight Smart-Choice Accounts' control (for example, if you don't provide all of the information necessary for a decision). If Alight

Smart-Choice Accounts needs to extend the deadline, it will provide you a written notice that tells you why the extension is required and when it expects to make the decision. If applicable, the notice will specifically describe any additional information that is required, and give you at least 45 days to provide that information.

Denial of a Claim

If any part of your claim is denied, you will be given a written or electronic notice that will include:

- the specific reason(s) for the denial;
- a reference to each of the specific provision(s) of the Plan on which the denial is based;
- a description of any additional material or information you must provide in order for your claim to be complete, and an explanation of why that material or information is necessary;
- if any internal rule, guideline or protocol was relied on in denying the claim, either that specific rule, guideline or protocol, or a statement that a rule, guideline or protocol was relied on in denying the claim and that a copy will be provided to you free of charge on request;
- if the claim denial was based on an exclusion or limit such as "medical necessity" or "experimental treatment," either an explanation of the scientific or clinical judgment for the exclusion or limit as applied to your circumstances, or a statement that such an explanation will be provided to you free of charge upon request;
- an explanation of the appeal procedures described below, including information on how to file an appeal and the time limits that apply; and
- a statement that you can file a lawsuit under ERISA if your claim is denied on final appeal.

Appealing a Denied Claim

If any part of your claim is denied, you can appeal that denial to:

Claims and Appeals Management
P.O. Box 1407
Lincolnshire, IL 60069-1407

Your appeal must be made in writing within 180 days after the date you receive the claim denial. You may give Alight Smart-Choice Accounts written comments and any other information that you want to have considered on appeal. You can also make a written request to see (and get a free copy of) any Plan policy statement or guideline that relates to your denied benefit (even if that policy statement or guideline was not relied on in denying the claim) as well as other information relevant to your claim for benefits.

Appeal Processing

Alight Smart-Choice Accounts will reconsider any denied claim that you appeal by the deadline, including all information you provide relating to the claim. The review won't give deference to the original claim denial and won't be made by the person who made the original claim denial (or a subordinate of that person).

Alight Smart-Choice Accounts will notify you of its decision on your appeal within a reasonable time frame after the claim is received, which won't be more than 30 days. However, this deadline may be extended for up to 15 days if Alight Smart-Choice Accounts determines special circumstances exist that require an extension. If Alight Smart-Choice Accounts needs to extend the deadline, it will provide you a written notice that tells you why the extension is required and when it expects to make the decision. If applicable, the

notice will specifically describe any additional information that is required and give you at least 45 days to provide that information.

Denial of an Appeal

If any part of your claim is denied on appeal, you will be given a written or electronic notice that will include:

- the specific reason(s) for the denial;
- a reference to each of the specific provision(s) of the Plan on which the denial is based;
- if any internal rule, guideline or protocol was relied on in denying the claim on appeal, either that specific rule, guideline or protocol, or a statement that a rule, guideline or protocol was relied on in denying the claim and that a copy will be provided to you free of charge on request;
- if the claim denial on appeal was based on an exclusion or limit such as "medical necessity" or "experimental treatment," either the scientific or clinical judgment for the exclusion or limit as applied to your circumstances, or a statement that such an explanation will be provided to you free of charge upon request;
- a statement that you are entitled, upon request, to see all documents, records, and other information relevant to your claim for benefits and to get free copies of that information;
- a statement describing any further appeal procedures offered by the Plan, including information on how to file a further appeal and the time limits that apply, and your right to obtain further information; and
- a statement of your right to file a lawsuit under ERISA.

Voluntary Second Appeal

If Alight Smart-Choice Accounts denies your claim on appeal, you may make a second appeal to the Plan Administrator. This, second appeal is entirely optional on your part (and only applies after you have followed the appeal procedure described above). You do not have to make this second appeal before filing a lawsuit under ERISA for Plan benefits (although you must follow the first appeal procedure described above before filing suit). Your decision whether or not to file a voluntary, second appeal will have no effect on your rights to any other Plan benefits.

If you choose to make a voluntary, second appeal under the Plan, the Plan Administrator will review all of the information you provide and give you a written decision on the appeal within a reasonable time after it is received. This typically will not be more than 30 days from the date the appeal is received. You will not be charged any fees or costs as part of this second appeal, and any deadline (or "statute of limitations") that applies to pursuing your claim in court will be extended (or "tolled") by the length of time the voluntary appeal process takes.

Authority of Alight Smart-Choice Accounts

Alight Smart-Choice Accounts has been delegated the discretionary authority and responsibility for determining benefits under the Plan, all as described above in this section of the SPD. In processing claims and appeals, Alight Smart-Choice Accounts has the discretionary authority to interpret the provisions of the Plan and to interpret the facts and circumstances of claims for benefits. No benefits will be paid under the Plan unless Alight Smart-Choice Accounts decides in its sole discretion you are entitled to them. Any decision made by Alight Smart-Choice Accounts on appeal (or on a second voluntary appeal if you choose to file one) is final and binding, unless you file suit under ERISA.

Requirements before Filing Suit

You cannot bring any legal action against the Plan, the Plan Administrator, or Alight Smart-Choice Accounts for any reason unless you first complete all the steps in the first appeal process described in this document. After completing that process, if you want to bring such a legal action, you must do so within one year of the date you are notified of the final decision on your appeal, or you lose any rights to bring such an action.

Your Repayment Obligation

If you are paid more than you should have been reimbursed for a claim or if a claim is paid for ineligible expenses, you must repay the Plan. In addition, Alight Smart-Choice Accounts may deduct the overpayment from future claims payments due to you under the Plan.

OTHER HCSA PLAN CONSIDERATIONS

Account Statements

If you elect to participate in the Plan, you will receive a quarterly statement from Alight Smart-Choice Accounts showing your annual contribution amount, year-to-date contributions made, year-to-date reimbursements and current available balance. In addition, a statement of your account is always available on the Smart-Choice Accounts website, which you can access from *https://iThrive.slb.com.*

Effect on Social Security Benefits

Your pre-tax contributions to the Plan are not counted as income for Social Security purposes. This means that your future Social Security benefits may be reduced unless your income after contributions to your Account exceeds the annual amount taxable by Social Security each year (the Social Security wage base).

Tax Implications

When you pay your eligible health care expenses through the HCSA Plan, you lower your federal income tax, Social Security tax and, in most cases, your state and local income taxes. However, in certain states, your state and/or local tax liability may not be reduced by amounts you contribute to your Account. You should check your own state income tax requirements to determine whether or not these contributions are subject to state and/or local tax.

Another way to lower your federal income tax liability is to take a tax deduction for your eligible health care expenses when you file your income tax return. In general, eligible health care expenses that exceed 10% of your gross income may be deductible on your federal income tax return; however, you may not include any amounts that were reimbursed through the HCSA when determining if your expenses exceed 10% of gross income.

To find out more about the tax implications of participating in the HCSA Plan, you should consult a qualified tax advisor.

Assignment of Benefits

In general, your interest in your HCSA Plan may not be sold, used as collateral for a loan, given away or otherwise transferred. Also, your creditors may not attach, garnish or otherwise interfere with your benefits under the HCSA Plan.

In Case of Your Death

If you die, reimbursement for eligible and approved expenses incurred before your death will be made to your survivors or to the executor of your estate, as long as your executor or survivors file a claim for reimbursement by March 31 following the year in which the expenses were incurred.

ADMINISTRATIVE AND ERISA INFORMATION

Plan Name

The formal name of the Group Plan is the Schlumberger Group Welfare Benefits Plan. The portion of the Group Plan that provides pre-tax reimbursement of eligible medical expenses is commonly known as the Schlumberger Health Care Spending Account.

Plan Sponsor and Other Employers Participating in Plan

The Plan sponsor is:

Schlumberger Technology Corporation
3600 Briarpark Drive, 3rd floor
Houston, TX 77042.

You and other participants and beneficiaries may obtain information about other employers that participate in the Group Plan by writing to the Plan Administrator.

Employer Identification Number

22-1692661

ERISA Plan Number

502

Type of Plan

The Group Plan is a welfare benefit plan providing various benefits including pre-tax reimbursement of qualified health care expenses.

Plan Administrator/Agent for Legal Process

Administrative Committee
Schlumberger Group Welfare Benefits Plan
3600 Briarpark Drive, 3rd floor
Houston, TX 77042
Telephone: 713-789-9600

The Administrative Committee is a group of *Company* employees appointed by the Company to serve as Plan Administrator. The Plan Administrator has full discretionary authority to control and manage the operation of the Group Plan, to construe and interpret the terms of the Group Plan and to delegate and allocate responsibilities for the operation and administration of the Group Plan to others.

Legal process may be served on the Plan Administrator.

Claims Administrator/Appeals Fiduciary

The Plan Administrator has delegated the authority and discretion to Alight Smart-Choice Accounts to process, investigate and decide claims and manage the daily administration of the Plan. The Plan Administrator also has delegated discretionary authority to Alight Smart-Choice Accounts to process, investigate and decide appeals under the Plan.

Alight Smart-Choice Accounts
P.O. Box 64009
The Woodlands, TX 77387-4009
1-800-474-4015

Claims and Appeals Management
P.O. Box 1407
Lincolnshire, IL 60069-1407

Plan Contributions

Plan contributions are either (i) used immediately to pay or insure Group Plan benefits or (ii) held in the Schlumberger Master Welfare Benefits Trust. The Trustee for the Schlumberger Master Welfare Benefits Trust is:

The Northern Trust Company
50 South LaSalle Street
Chicago, IL 60675

Plan Funding

Benefits may be paid from the Schlumberger Master Welfare Benefits Trust or from the general assets of the *Company*.

Right to Change or Terminate Plan

Schlumberger Technology Corporation ("STC") intends to continue the HCSA Plan, but reserves the right to change or end all or part of the Group Plan including the HCSA Plan at any time for any reason, with respect to any employer or all employers participating in the Group Plan. STC has given the Plan Administrator the authority to change the Group Plan.

An employer's participation in the Group Plan will end automatically if it ends affiliation with STC. If the Group Plan terminates, any plan assets that are held in trust will be used to pay plan expenses and benefits through the date of termination. Any plan assets remaining after these expenses and benefits are paid may be transferred to a successor plan or, if there is no successor plan, may be refunded to plan participants.

In general, no Group Plan assets may ever revert to or be paid to the *Company*. If the Group or the HCSA Plan terminates, benefits in pay status may continue or may terminate as provided in the document(s) by which the plan is terminated.

Plan Year

Plan financial records are kept on a calendar year basis (January 1 - December 31).

Qualified Medical Child Support Order

The HCSA Plan will comply with all the terms of a qualified medical child support order (QMCSO). A QMCSO is an order or judgment from a court or administrative body that directs the Plan to cover a child of a participant. Under federal law, a medical child support order must meet certain form and content requirements to be a qualified medical child support order. When an order is received, each affected participant and each child (or the child's representative) covered by the order will be notified and sent a copy of the Group Plan's procedure for determining if the order is valid. Coverage under the Group Plan under a medical child support order will not become effective until the Plan Administrator determines that the order is a QMCSO. If you have any questions or would like to receive a copy of the written procedure for determining whether a QMCSO is valid, please contact the US Benefits Center at 1-800-474-4015.

Problem Resolution Procedure

If you have questions or problems with your benefits you should first contact the US Benefits Center at 1-800-474-4015.

If your question or problem is not resolved by the US Benefits Center, write to the *Plan Administrator*.

YOUR ERISA RIGHTS

As a participant in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA).

Receive Information about Your Plan and Benefits

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 and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.
- Receive a summary of the plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.
- Continue health care coverage for yourself, your *Spouse* or other dependents if coverage is lost due to a Qualifying Event. You or your dependents may have to pay for such coverage. Review the *COBRA Rights and Procedures* section of this SPD for the rules governing your *COBRA* continuation of coverage rights.

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of a Plan document or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court (after you have followed all of the claims and appeals procedures provided for under the Plan). If it should happen that plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court.

The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your plan, you should contact the US Benefits Center at 1-800-474-4015.

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

DEFINITIONS USED IN THIS SPD

Account

Your "Account" is a bookkeeping account established to record your contributions to and reimbursements from the HCSA Plan.

Account-qualified Dependent

Your HCSA-qualified Dependents are individuals you claim as dependents for Federal income tax purposes. Examples include:

- your spouse;
- your children, including stepchildren, legally adopted children, children who have been placed in your home for adoption, and foster children who live with you for the full calendar year;
- your parents or your spouse's parents;
- grandparents;
- brothers and/or sisters; and
- grandchildren.

Active Service

You are in "Active Service" on a day which is one of your regularly scheduled work days if:

- you are performing your regular job for the *Company*. You must be working at your regular work location, one of the Company's usual places of business, or at some location to which the Company business requires you to travel; **or**
- the day is a scheduled holiday or vacation day and you were performing your regular job on the preceding scheduled work day.

You're in "Active Service" on a day which is not one of your scheduled work days only if you were in Active Service on the preceding scheduled work day.

Annual Enrollment

"Annual Enrollment" is a time period each year when you can make benefit elections or changes for the upcoming calendar year.

Claims Administrator

The "Claims Administrator" is Alight Smart-Choice Accounts. See "*Claims Administrator/Appeals Fiduciary*" for contact information.

COBRA

"COBRA" is a federal law that allows you and/or your covered dependents to continue health care coverage on an after-tax basis (under certain circumstances) when coverage would otherwise have ended.

COBRA Administrator

The “COBRA Administrator” is Alight Smart-Choice Accounts. The contact information is:

Alight Smart-Choice Accounts
P.O. Box 64009
The Woodlands, TX 77387-4009
1-800-474-4015

Company (also referred to as Schlumberger)

The “Company” is Schlumberger Technology Corporation and any of its subsidiaries.

Eligible Employee

An “Eligible Employee” is a person who meets the requirements of the *Eligible Employees* section.

Explanation of Benefits

The Explanation of Benefits (EOB) is a statement you receive from your coverage provider showing the name of the service provider, the date and cost of the services or supplies you received and the benefit payable under the Plan. The EOB also shows the amount you are responsible for paying.

Group Plan

The “Group Plan” is the Schlumberger Group Welfare Benefits Plan.

Account-qualified Dependent

Your HCSA-qualified Dependents are individuals you claim as dependents for Federal income tax purposes. Examples include:

- your spouse;
- your children, including stepchildren, legally adopted children, children who have been placed in your home for adoption, and foster children who live with you for the full calendar year;
- your parents or your spouse's parents;
- grandparents;
- brothers and/or sisters; and
- grandchildren.

Health Care Spending Account Plan (also referred to as the HCSA Plan or Plan)

The “Health Care Spending Account Plan” is the health flexible spending account program offered under the Schlumberger Group Welfare Benefits Plan that is described in this SPD.

IRS Minimum Required Deductible

The IRS annual minimum required deductible applies to participants in the HCSA who must incur eligible medical expenses up to the minimum required deductible before medical expenses may be reimbursed from their limited purpose spending account.

iThrive

"iThrive" is the U.S. benefits web site available at *https://iThrive.slb.com*.

Plan (also referred to as the HCSA Plan or the Health Care Spending Account Plan)

The "Plan" is the health flexible spending account benefits program offered under the Schlumberger Group Welfare Benefits Plan that is described in this SPD.

Plan Year

The "Plan Year" is the 12-month period on which Plan records are kept, beginning on January 1 and ending on December 31.

Schlumberger (also referred to as the Company)

"Schlumberger" is Schlumberger Technology Corporation and any of its subsidiaries.

Spouse

Your "Spouse" is your legal spouse, as recognized under the laws of the state in which you were married at the time you were married, including same-sex and common-law spouses.

APPENDIX A - CONTINUATION OF COVERAGE

COBRA Rights and Procedures

Introduction to COBRA

The Consolidated Omnibus Budget Reconciliation Act, commonly referred to as "COBRA", requires most employers sponsoring group health plans to offer employees and their families the opportunity to temporarily extend their health coverage at group rates in certain cases where their coverage would otherwise end. This notice is intended to summarize your rights and obligations with respect to this continued coverage (referred to as "COBRA coverage") if you qualify for COBRA coverage in the future.

Eligibility for COBRA Coverage

If you are a Schlumberger employee and are enrolled in the Schlumberger US Medical or Dental Plan (and in certain cases, the Health Care Spending Account) which are referred to jointly in this Appendix as the "Schlumberger Plans", you have a right to COBRA coverage if you lose your current coverage due to one of the following events ("qualifying events"):

- a reduction in your hours of work; or
- termination of your employment (for reasons other than gross misconduct on your part).

If you are the Spouse of a Schlumberger employee and you are covered by a Schlumberger Plan, you have the right to elect COBRA coverage if you lose your coverage due to any of the following events ("qualifying events"):

- death of your spouse;
- termination of your spouse's employment for reasons other than gross misconduct;
- reduction in your spouse's hours of employment with Schlumberger;
- divorce or legal separation from your spouse; or
- your spouse becomes entitled to Medicare.

Dependent children of a Schlumberger employee who are covered by a Schlumberger Plan have the right to COBRA coverage if they lose coverage under either of these plans due to any of the following events ("qualifying events"):

- death of a parent-employee;
- termination of a parent-employee's employment for reasons other than gross misconduct;
- reduction in a parent-employee's hours of employment with Schlumberger;
- divorce or legal separation of a parent-employee;
- the parent-employee becomes entitled to Medicare; or
- the dependent child ceases to be a "dependent child" under the applicable Schlumberger Plan.

Similar rights may apply to certain retirees, spouses, and dependent children if Schlumberger commences a Chapter 11 bankruptcy proceeding and they lose coverage.

The Plan Administrator reserves the right to terminate your COBRA Coverage retroactively to the extent allowed by law if you are determined to be ineligible.

Alternatives to COBRA Coverage

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Or, you may qualify for coverage under a spouse's plan under certain special enrollment rules. You can learn more about many of these options at *www.healthcare.gov*.

Required Notices

You are responsible for informing the Plan Administrator of any divorce, legal separation or child losing dependent status under the Schlumberger Plans. You must notify the Plan Administrator within 60 days of the event (or 60 days of the date coverage would be lost, if later). You may notify the Plan Administrator via *iThrive* or by calling the US Benefits Center at 1-800-474-4015. Notice provided in any other manner will not be considered sufficient notice.

Important

You will forfeit COBRA coverage if you fail to give notice of an event within the 60-day period described above or fail to elect COBRA coverage within the 60-day period described below.

Schlumberger is responsible for notifying the Plan Administrator of an employee's death, termination, reduction in hours of employment or Medicare entitlement.

Upon notification that one of these events has occurred, the Plan Administrator will inform you (within 14 days of receiving notice) of your right to elect COBRA coverage. Under the law, you then have 60 days from (1) the date you would lose coverage on account of the event or (2) the date on which you received notice from the Plan Administrator, whichever is later, to elect COBRA coverage.

If you do not elect COBRA coverage within the 60-day period, you lose your right to continue coverage.

What COBRA Coverage Is

If you choose COBRA coverage, you are entitled to continue coverage that is in effect under the Schlumberger Medical Plan, Dental Plan and in some cases the Health Care Spending Account at the time the qualifying event occurred.

If Schlumberger changes or ends group health coverage under the Schlumberger Plans for similarly situated active employees, your coverage will also change or end.

If you marry while you are on COBRA coverage, you are allowed to change your coverage status to include your spouse. If you have a newborn child or adopt a child or have a child placed with you for adoption while you are on COBRA coverage, you are allowed to change your coverage status to include your dependents. If COBRA coverage is dropped at any time, coverage may not be reinstated.

Period of Coverage

Generally

The maximum COBRA coverage period for the Health Care Spending Account ends on the last day of the plan year in which the qualifying event occurred, COBRA coverage for the Health Care Spending Account cannot be extended under any circumstances.

Paying for COBRA

You pay a monthly premium for COBRA coverage. The amount you pay is different than the active employee rates. You will be notified of the amount you must pay at the time you elect COBRA. The initial premium payment is due within 45 days following the date you elect COBRA coverage. After the initial premium payment, there is a grace period of 30 days for full payment of the regularly scheduled premium.

Special Rules for Health Care Spending Account (HCSA)

The rules for continuing participation in the Health Care Spending Account (HCSA) are different than those described above for the Schlumberger Medical and Dental Plans. If you terminate employment and the contributions you have made to the HCSA are greater than the amount you have been reimbursed for during the year, you (or a qualified beneficiary) may continue to make contributions to the HCSA on an after-tax basis through the end of that calendar year. If you elect to continue your contributions under COBRA, eligible expenses incurred through the end of the year may be submitted for reimbursement through the HCSA. Re-enrollment is not permitted in any subsequent year.

If you terminate employment and your contributions to the HCSA for the year are equal to or less than what has been reimbursed to you, your participation will end as of the date you terminate employment. No offer to extend participation will be provided.

More Information on COBRA Coverage

If you have any questions about COBRA, please contact the US Benefits Center at 1-800-474-4015. For more information about your rights under COBRA, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at *www.dol.gov/ebsa*. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

Keep Your Plans Informed of Address Changes

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan Contact Information

Plan Administrator for all of the COBRA Plans

Administrative Committee
Schlumberger Group Welfare Plan
3600 Briarpark Drive, 3rd floor
Houston, TX 77042
Telephone: 713-789-9600

COBRA Administrator

Alight Solutions
Smart-Choice Account
P.O. Box 64009
The Woodlands, TX 77387-4009
1-800-474-4015

Information regarding the COBRA Plans and COBRA continuation coverage can be obtained upon request to the COBRA Administrator.

USERRA RIGHTS and PROCEDURES

The Uniformed Services Employment and Reemployment Rights Act (USERRA) protects the job rights of individuals who voluntarily or involuntarily leave employment positions to undertake military service as defined in USERRA. This includes the right to elect to continue your existing employer-based health plan coverage for you and your dependents for up to 24 months while in the military, if that coverage would otherwise terminate.

These rights under USERRA are similar, but not identical to, your rights under COBRA. If these rights apply, any election that you make pursuant to COBRA will also be an election under USERRA, and COBRA and USERRA will both apply with respect to the continuation elected. If COBRA and USERRA give you (or your spouse or dependents) different rights or protections, then the law that provides the greater benefits will apply. The administrative policies and procedures described in the preceding COBRA Rights and Procedures Summary above (for example, the procedures for electing COBRA and for paying premiums) also apply to USERRA coverage, unless compliance with the procedures is precluded by military necessity or is otherwise impossible or unreasonable under the circumstances.

You may contact the *COBRA Administrator* for more information regarding your rights and elections in connection with military leave and under USERRA.

APPENDIX B - NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Schlumberger Technology Corporation ("Schlumberger") sponsors certain group health plan(s) (collectively, the "Plan") to provide benefits to our employees, their dependents and other participants. The Plan provides this coverage through various relationships with third parties that establish networks of providers, coordinate your care, and process claims for reimbursement for the services that you receive. This Notice of Privacy Practices (the "Notice") describes the legal obligations of Schlumberger and the Plan regarding your protected health information held by the Plan under HIPAA, and your legal rights under HIPAA regarding that protected health information. Among other things, this Notice describes how your protected health information may be used or disclosed to carry out treatment, payment, or health care operations, or for any other purposes that are permitted or required by law.

The Plan is required to provide this Notice to you pursuant to HIPAA. The HIPAA Privacy Rule protects only certain medical information known as "protected health information." Generally, protected health information is individually identifiable health information, including demographic information, collected from you or created or received by a health care provider, a health care clearinghouse, a health plan, or your employer on behalf of a group health plan, which relates to:

(1) your past, present or future physical or mental health or condition;
(2) the provision of health care to you; or
(3) the past, present or future payment for the provision of health care to you.

Contact Information

If you have any questions about this Notice or about our privacy practices, please contact the Schlumberger US Benefits Team at *https://esm.slb.com/hr* **or 713-789-9600** or contact the Schlumberger HIPAA Privacy Officer at:

Attention: HIPAA Privacy Officer
Schlumberger US Benefits Department
3600 Briarpark, 3rd Floor, MD-4
Houston, Texas 77042

Effective Date

This Notice as revised is effective November 24, 2015.

Our Responsibilities

The Plan is required by law to:

- maintain the privacy of your protected health information;
- provide you with certain rights with respect to your protected health information;
- provide you with a copy of this Notice of the Plan's legal duties and privacy practices with respect to your protected health information; and
- follow the terms of the Notice that is currently in effect.

The Plan reserves the right to change the terms of this Notice and to make new provisions regarding your protected health information that the Plan maintains, as allowed or required by law. If the Plan makes any material change to this Notice, the Plan will provide you with a copy of the revised Notice of Privacy Practices. You may also obtain a copy of the latest revised Notice by contacting the Schlumberger US Benefits Team or the Plan's Privacy Officer at the contact information provided above. Except as provided within this Notice, the Plan may not disclose your protected health information without your prior authorization.

How the Plan May Use and Disclose Your Protected Health Information

Under the law, the Plan may use or disclose your protected health information under certain circumstances without your permission. The following categories describe the different ways that the Plan may use and disclose your protected health information. For each category of uses or disclosures the Plan will explain what is meant and present some examples. Not every use or disclosure in a category will be listed. However, all of the ways the Plan is permitted to use and disclose protected health information will fall within one of the categories.

For Treatment

The Plan may use or disclose your protected health information to facilitate medical treatment or services by providers. The Plan may disclose medical information about you to providers, including doctors, nurses, technicians, medical students, or other hospital personnel who are involved in taking care of you. For example, we might disclose information about your prior prescriptions to a pharmacist to determine if a pending prescription is inappropriate or dangerous for you to use.

For Payment

The Plan may use or disclose your protected health information to determine your eligibility for Plan benefits, to facilitate payment for the treatment and services you receive from health care providers, to determine benefit responsibility under the Plan, or to coordinate Plan coverage. For example, the Plan may tell your health care provider about your medical history to determine whether a particular treatment is experimental, investigational, or medically necessary, or to determine whether the Plan will cover the treatment. The Plan may also share your protected health information with a utilization review or precertification service provider. Likewise, the Plan may share your protected health information with another entity to assist with the adjudication or subrogation of health claims or to another health plan to coordinate benefit payments.

For Health Care Operations

The Plan may use and disclose your protected health information for other Plan operations. These uses and disclosures are necessary to run the Plan. For example, the Plan may use medical information in connection with conducting quality assessment and improvement activities; underwriting, premium rating, and other activities relating to Plan coverage; submitting claims for stop-loss (or excess-loss) coverage; conducting or arranging for medical review, legal services, audit services, and fraud & abuse detection programs; business planning and development such as cost management; and business management and general Plan administrative activities. The Plan is prohibited from using or disclosing protected health information that is genetic information about an individual for underwriting purposes.

To Business Associates

The Plan may contract with individuals or entities known as Business Associates to perform various functions on our behalf or to provide certain types of services. In order to perform these functions or to

provide these services, Business Associates will receive, create, maintain, use and/or disclose your protected health information, but only after they agree in writing with us to implement appropriate safeguards regarding your protected health information. For example, the Plan may disclose your protected health information to a Business Associate to administer claims or to provide support services, such as utilization management, pharmacy benefit management or subrogation, but only after the Business Associate enters into a Business Associate Agreement with us.

As Required by Law

The Plan will disclose your protected health information when required to do so by federal, state or local law. For example, the Plan may disclose your protected health information when required by national security laws or public health disclosure laws.

To Avert a Serious Threat to Health or Safety

The Plan may use and disclose your protected health information when necessary to prevent a serious threat to your health and safety, or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat. For example, the Plan may disclose your protected health information in a proceeding regarding the licensure of a physician.

To Plan Sponsors

For the purpose of administering the Plan, the Plan may disclose to certain employees of the Employer protected health information. However, those employees will only use or disclose that information as necessary to perform Plan administration functions or as otherwise required by HIPAA, unless you have authorized further disclosures. Your protected health information cannot be used for employment purposes without your specific authorization.

Special Situations

In addition to the above, the following categories describe other possible ways that the Plan may use and disclose your protected health information. For each category of uses or disclosures, the Plan will explain what is meant and present some examples. Not every use or disclosure in a category will be listed. However, all of the ways the Plan is permitted to use and disclose information will fall within one of the categories.

Organ and Tissue Donation

If you are an organ donor, the Plan may release your protected health information to organizations that handle organ procurement or organ, eye, or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

Military and Veterans

If you are a member of the armed forces, the Plan may release your protected health information as required by military command authorities. The Plan may also release protected health information about foreign military personnel to the appropriate foreign military authority.

Workers' Compensation

The Plan may release your protected health information for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks

The Plan may disclose your protected health information for public health actions. These actions generally include the following:

- to prevent or control disease, injury, or disability;
- to report births and deaths;
- to report child abuse or neglect;
- to report reactions to medications or problems with products;
- to notify people of recalls of products they may be using;
- to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;
- to notify the appropriate government authority if the Plan believes that a patient has been the victim of abuse, neglect, or domestic violence. The Plan will only make this disclosure if you agree, or when required or authorized by law.
-

Health Oversight Activities

The Plan may disclose your protected health information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes

If you are involved in a lawsuit or a dispute, the Plan may disclose your protected health information in response to a court or administrative order. The Plan may also disclose your protected health information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement

The Plan may disclose your protected health information if asked to do so by a law enforcement official—

- in response to a court order, subpoena, warrant, summons or similar process;
- to identify or locate a suspect, fugitive, material witness, or missing person;
- about the victim of a crime if, under certain limited circumstances, the Plan is unable to obtain the victim's agreement;
- about a death that the Plan believes may be the result of criminal conduct;
- about criminal conduct; and
- in emergency circumstances to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime.

Coroners, Medical Examiners and Funeral Directors

The Plan may release protected health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. The Plan may also release medical information about patients to funeral directors as necessary to carry out their duties.

National Security and Intelligence Activities

We may release your protected health information to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

Inmates

If you are an inmate of a correctional institution or are in the custody of a law enforcement official, the Plan may disclose your protected health information to the correctional institution or law enforcement official if necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

Research

The Plan may disclose your protected health information to researchers when:

(1) the individual identifiers have been removed; or
(2) when an institutional review board or privacy board has (a) reviewed the research proposal; and (b) established protocols to ensure the privacy of the requested information, and approves the research.

Required Disclosures

The following is a description of disclosures of your protected health information the Plan is required to make.

Government Audits

The Plan is required to disclose your protected health information to the Secretary of the United States Department of Health and Human Services when the Secretary is investigating or determining our compliance with the HIPAA privacy rule.

Disclosures to You

When you request, the Plan is required to disclose to you the portion of your protected health information that contains medical records, billing records, and any other records used to make decisions regarding your health care benefits. The Plan is also required, when requested, to provide you with an accounting of most disclosures of your protected health information if the disclosure was for reasons other than for payment, treatment, or health care operations, and if the protected health information was not disclosed pursuant to your individual authorization.

Notification of a Breach.

The Plan is required to notify you in the event that the Plan (or one of the Plan's Business Associates) discovers a breach of your unsecured protected health information, as defined by HIPAA.

Other Disclosures

Personal Representatives

The Plan will disclose your protected health information to individuals authorized by you, or to an individual designated as your personal representative, attorney-in-fact, etc., so long as you provide us with a written notice/authorization and any supporting documents (i.e., power of attorney). Note: Under the HIPAA

privacy rule, the Plan does not have to disclose information to a personal representative if the Plan has a reasonable belief that:

(1) you have been, or may be, subjected to domestic violence, abuse or neglect by such person;
(2) treating such person as your personal representative could endanger you; or
(3) in the exercise or professional judgment, it is not in your best interest to treat the person as your personal representative.

Spouses and Other Family Members

With only limited exceptions, the Plan will send all mail to the employee. This includes mail relating to the employee's spouse and other family members who are covered under the Plan, and includes mail with information on the use of Plan benefits by the employee's spouse and other family members and information on the denial of any Plan benefits to the employee's spouse and other family members. If a person covered under the Plan has requested Restrictions or Confidential Communications (see below under "Your Rights"), and if the Plan has have agreed to the request, the Plan will send mail as provided by the request for Restrictions or Confidential Communications.

Authorizations

Other uses or disclosures of your protected health information not described above, including the use and disclosure of psychotherapy notes and the use or disclosure of protected health information for fundraising or marketing purposes, will not be made without your written authorization. You may revoke written authorization at any time, so long as your revocation is in writing. Once the Plan receives your written revocation, it will only be effective for future uses and disclosures. It will not be effective for any information that may have been used or disclosed in reliance upon the written authorization and prior to receiving your written revocation. You may elect to opt out of receiving fundraising communications from us at any time.

Your Rights

You have the following rights with respect to your protected health information:

Right to Inspect and Copy

You have the right to inspect and copy certain protected health information that may be used to make decisions about your health care benefits. To inspect and copy your protected health information, submit your request in writing to the Privacy Officer at the address provided above under Contact Information. If you request a copy of the information, the Plan may charge a reasonable fee for the costs of copying, mailing, or other supplies associated with your request. The Plan may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to your medical information, you may have a right to request that the denial be reviewed and you will be provided with details on how to do so.

Right to Amend

If you feel that the protected health information the Plan has about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for the Plan. To request an amendment, your request must be made in writing and submitted to the Privacy Officer at the address provided above under Contact Information. In addition, you must provide a reason that supports your request. The Plan may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, the Plan may deny your request if you ask to amend information that:

- is not part of the medical information kept by or for the Plan;
- was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
- is not part of the information that you would be permitted to inspect and copy; or
- is already accurate and complete.

If the Plan denies your request, you have the right to file a statement of disagreement with us and any future disclosures of the disputed information will include your statement.

Right to an Accounting of Disclosures

You have the right to request an "accounting" of certain disclosures of your protected health information. The accounting will not include (1) disclosures for purposes of treatment, payment, or health care operations; (2) disclosures made to you; (3) disclosures made pursuant to your authorization; (4) disclosures made to friends or family in your presence or because of an emergency; (5) disclosures for national security purposes; and (6) disclosures incidental to otherwise permissible disclosures. To request this list or accounting of disclosures, you must submit your request in writing to the Privacy Officer at the address provided above under Contact Information. Your request must state a time period of no longer than six years and may not include dates prior to your request. Your request should indicate in what form you want the list (for example, paper or electronic). The Plan will attempt to provide the accounting in the format you requested or in another mutually agreeable format if the requested format is not reasonably feasible. The first list you request within a 12-month period will be provided free of charge. For additional lists, the Plan may charge you for the costs of providing the list. The Plan will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to Request Restrictions

You have the right to request a restriction or limitation on your protected health information that the Plan uses or discloses for treatment, payment, or health care operations. You also have the right to request a limit on your protected health information that the Plan discloses to someone who is involved in your care or the payment for your care, such as a family member or friend. For example, you could ask that the Plan not use or disclose information about a surgery that you had. The Plan is not required to agree to your request. However, if the Plan does agree to the request, it will honor the restriction until you revoke it or the Plan notifies you. To request restrictions, you must make your request in writing to the Privacy Officer at the address provided above under Contact Information. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure, or both; and (3) to whom you want the limits to apply—for example, disclosures to your spouse.

Right to Request Confidential Communications

You have the right to request that the Plan communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that the Plan only contact you at work or by mail. To request confidential communications, you must make your request in writing to the Privacy Officer at the address provided above under Contact Information. The Plan will not ask you the reason for your request. Your request must specify how or where you wish to be contacted. The Plan will consider all reasonable requests and must accommodate your request if you clearly provide information that you will be in danger if the Plan does not accommodate your request.

Right to a Paper Copy of This Notice

You have the right to a paper copy of this notice. You may ask the Plan to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy

of this notice. To obtain a paper copy of this notice, telephone or write the Privacy Officer as provided above under Contact Information.

Complaints

If you believe that your privacy rights have been violated, you may file a complaint with the Plan or with the Office for Civil Rights of the United States Department of Health and Human Services. To file a complaint with the Plan, contact the Privacy Officer as provided above under Contact Information. You will not be penalized, or in any other way retaliated against, for filing a complaint with the Office of Civil Rights or with us. You should keep a copy of any notices you send to the Plan Administrator or the Privacy Officer for your records.