MEDICAL PLAN

Summary Plan Description
As in Effect January 1, 2024

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INTRODUCTION TO THE MEDICAL PLAN

This document is a Summary Plan Description or "SPD" for the SLB Medical Plan. It describes the Medical 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 Medical Plan, including your own enrollment information, 24-hours a day, seven days a week, on iThrive at *https://iThrive.slb.com* .

More Important Details

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

The formal document for the Group Plan includes some details that apply to the Medical 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, SLB reserves the right to modify or terminate the Group Plan or the Medical Plan at any time.

MEDICAL PLAN HIGHLIGHTS

SLB established the Medical Plan to help its *Eligible Employee*s pay for health care services for themselves and their covered dependents.

More Important Details

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

The Medical Plan offers you a choice of three coverage options to help you manage health care while employed with SLB. These options support SLB's basic health care philosophy, which emphasizes:

- protection against the major expenses of serious accidents or health problems;
- prevention, with resources employees and their families can use to build and maintain healthy lifestyles; and
- cost-sharing between employees and SLB to keep health care costs affordable for employees and competitive for SLB.

Under the Choice HSA and Open Access Plus coverage options, the Plan pays 80% of *Negotiated Fees* for services through an in-network provider or 60% of *Maximum Charges* for services through an out-of-network provider after you meet an *Annual Deductible*.

Under the Saver HSA coverage option, the Plan pays 100% of *Negotiated Fees* for services through an in-network provider or 100% of *Maximum Charges* for services through an out-of-network provider after you meet an *Annual Deductible*.

Your total covered Plan costs in a calendar year are limited by the *Annual Out-of-pocket Maximum*.

Each medical option is described below.

Saver HSA and Choice HSA Options

The Saver HSA and Choice HSA each combine comprehensive medical coverage with a special tax-free Health Savings Account, or HSA. The HSA lets you partner with SLB in saving money to pay for out-of-pocket healthcare costs whenever you need it – today, tomorrow or at any time in the future.

The Saver HSA and Choice HSA each offer low employee contributions as well as Company contributions to your HSA. These valuable features help offset the higher Annual Deductible that applies to most medical services under these options – including prescription drugs. Both you and SLB may contribute to the HSA. Company contributions are based on the coverage option and coverage level you elect. Note that Company contributions will be pro-rated if your coverage takes effect after January 1st of the plan year.

You may also make pre-tax contributions to your HSA. When you have an eligible expense, you can pay for it using your HSA, or pay for it out-of-pocket and let the money in your account grow over time. All contributions to your HSA remain in your account from year to year until you need them. You always own all the money in your account – including Company contributions. If you retire or leave SLB, your account goes with you.

> 🙣 **A Closer Look**
> See *Appendix A - Health Savings Account* for more details about how this tax-favored account (which is not a part of the Medical Plan) works.

Open Access Plus (OAP)

Like the Saver HSA and Choice HSA options, the Open Access Plus option provides comprehensive medical coverage.

Employee contributions for the OAP coverage are higher than contributions for the Saver HSA and Choice HSA. However, the Annual Deductible is lower in the OAP and you only pay a *Copay* or Coinsurance for prescription drugs even before you meet the *Annual Deductible*.

You are not eligible for an HSA if you enroll in the OAP but you may elect coverage under the Health Care Spending Account (HCSA) Plan in order to pay some of your expenses on a pre-tax basis. (See the HCSA summary plan description on iThrive.)

Benefits That Come with All Medical Options

Each Medical plan option includes:

- Free preventive care;
- Prescription drug benefits;
- Vision care benefits;
- Health Risk Assessment;
- Cigna 24-Hour Health Information Line (nurse line); and
- Cigna Healthy Rewards Discounts.
- Acupuncture benefits

You also are eligible for the following wellness benefits and services whether or not you enroll in the Plan:

- Employee Assistance Program (EAP) and related work / life resources, including legal, financial and dependent care referrals and concierge services.

ELIGIBILITY, ENROLLMENT AND PERIOD OF COVERAGE

Eligibility

Eligible Employees

You're an "Eligible Employee" on the first day you're on the SLB 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 SLB that continues to provide benefit programs different from those offered by SLB.

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

Eligible Dependents

Your "Eligible Dependents" are your *Spouse* and your eligible dependent children. Eligible dependent children are your child(ren) under age 26 who are your:

- birth children;
- stepchildren;
- legally adopted children, or children legally placed for adoption in your home; or
- children placed under your or your Spouse's exclusive legal guardianship, whose parents have had a court permanently terminate their rights as parents (or whose parents have permanently given up their rights as parents as reflected in a court document).

Your child described above continues to be your eligible dependent child after reaching age 26 if he or she (i) is physically or mentally disabled, (ii) depends on you for support and (iii) became disabled before age 26. You must provide supporting medical information to verify your child's disability within 31 days following the date they would otherwise become ineligible for coverage.

Documentation is required to cover Eligible Dependents under the Plan.

★**Note:** The spouse or children of your covered children are not eligible for coverage.

If Your Spouse Works for SLB

If both you and your *Spouse* are Eligible Employees, each of you may enroll as an employee or one of you may choose to waive coverage and be covered as dependent under your Spouse's coverage.

You cannot be covered under the Plan as both an employee and a dependent, and no one can be considered a dependent of more than one employee. If you are both electing coverage as an employee, you don't have to enroll in the same Plan option. For example, you can elect the Saver HSA and your Spouse can elect the OAP.

Enrollment and Election Changes

Regular Enrollment Opportunities

You may elect to enroll in Medical Plan coverage during the 30-day period starting on the first day you're an *Eligible Employee*. You also may enroll or change coverage during any *Annual Enrollment* period.

During these enrollment periods, you may choose to be covered under any Plan option for which you are eligible, or you may choose not to be covered ("waive" coverage). If you elect a coverage option, you will also elect who to cover. The permitted coverage levels are:

- employee only;
- employee + Spouse;
- employee + 1 or more children; and
- employee + family.

★Default Coverage

If you don't make an election or waive coverage you will automatically be enrolled in the Plan's default coverage. Currently, default coverage (a) for interns, is no coverage, (b) for all other newly eligible employees, is employee only coverage under the Choice HSA, and (c) for employees (except interns) who don't elect or waive coverage during annual enrollment, is the same coverage the employee and the dependents have in the current year.

Limited Midyear Election Changes

In general, Medical Plan coverage elections you make 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 be allowed to change coverage in the middle of a Plan Year if your change is "on account of" and "corresponds with" your 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).

Qualified Changes in Status

The events listed below are qualified changes in status that will allow you to make an election change under the Medical Plan (to the extent the election changes you make is on account of and corresponds with your status change).

- ***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 Eligible Dependents, including birth, death, adoption or placement for adoption.
- ***Changes in Employment Status***: Events that change employment status for you, your *Spouse* or another Eligible Dependent, to the extent that employment change affects eligibility for medical coverage.

- ***Changes in Dependent Eligibility***: An event that causes a dependent to satisfy or cease to satisfy the eligibility requirements for medical coverage under this Plan or another group medical plan (reaching a certain age, change in disability status, or any similar circumstances).

★**Note:** If one of your dependents ceases to satisfy the eligibility requirements for coverage due to a status change, you may only elect to drop coverage for that dependent. Dropping coverage for any other dependent will not "correspond with" the status change.

- ***Changes in Residence***: A change in the place of residence for you, your Spouse or another dependent, if that change affects eligibility for medical coverage.
- ***Court Order for a Dependent's Coverage***: A judgment, decree or court order in a divorce, legal separation, annulment or change in legal custody requires (i) another person to provide medical coverage for your dependent child and that other coverage is, in fact, provided, or (ii) you to provide medical coverage for your dependent child who is an Eligible Dependent.
- ***Changes in Coverage Costs***: Your cost of medical coverage significantly increases or significantly decreases.
- ***Reduction or Loss of Coverage***: You, your Spouse or other dependent has a significant reduction in or loss of overall medical coverage (for example, there is a significant increase in the deductible, the Copay, or the out-of-pocket cost sharing limit, or the applicable benefits package is eliminated).
- ***Changes in Available Coverage Options***: A new medical coverage option is offered, or coverage under an existing option is significantly improved.
- ***Loss of Governmental or Educational Institution Coverage***: You, your Spouse or dependent lose medical coverage under any group health coverage sponsored by a governmental or educational institution.
- ***Eligibility for Premium Assistance***: You or your dependent becomes eligible for premium assistance under a Medicaid plan or state child health plan that provides medical coverage.
- ***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 medical coverage under a state child health plan due to a loss of eligibility.
- ***Changes in Coverage Under Another Employer's Plan***: You, your Spouse or other dependent gain or lose medical coverage under another employer's plan, or make an election change under another employer's medical plan on the basis of a qualified change in status as described above, or make an election under another employer's medical plan for a period of coverage that is different than the calendar year period of coverage offered under this Medical Plan.

★**Note:** If you or any of your dependents become eligible for medical coverage under another employer's plan, you may only elect to drop coverage under this Medical Plan to the extent that coverage is actually added under the other plan. Dropping coverage when replacement coverage is not actually added under another plan will not "correspond with" the status change.

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. Coverage you elect for Eligible Dependent(s) begins the same day your coverage begins.

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*. However, if you return to Active Service in a calendar year after the calendar year in which your leave began, you will automatically be enrolled in the coverages you had prior to your leave and you will have 30 days to call in to make any changes.

Coverage elected as the result of a qualified change in status (as described above) takes effect on the date of the event.

When Coverage Ends

Your coverage will end on the first day of the pay period immediately following one of these events:

- you are on an approved unpaid leave of absence for 31 days (unless you are on FMLA leave or military leave and your coverage is required by law to continue);
- your employment with SLB 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; or
- a new Plan Year begins and you waived coverage for that Plan Year.

Your coverage will end immediately upon one of these events:

- the Plan is amended in a way that disqualifies you for further benefits; or
- the Plan is terminated.

Coverage for your dependents will end on the first day of the pay period immediately following one of these events:

- your dependent no longer meets the Plan's requirements for Eligible Dependents;
- you stop making the required contributions for your dependents; or
- a new Plan Year begins and you waived coverage for that dependent.

Coverage for your dependents will end immediately upon one of these events:

- the Plan is amended in a way that disqualifies your dependent for further benefits; or
- the Plan is terminated.

If your coverage or a dependent's coverage ends under the Medical Plan as described above, you may be eligible to temporarily continue that coverage as described in the "*COBRA Rights and Procedures*" section. If you die while actively employed and your dependents choose to enroll in COBRA medical benefits, they will pay nothing for their continued coverage for the first six months. At the end of the six-month period, your dependents pay the full cost of the coverage for the remainder of the COBRA coverage period.

★Special Rule for Medicare Eligible Retirees or Dependents
Coverage for a retiring employee and any covered dependents will be continued for up to 2 months following retirement if the retiree or any dependent is transitioning to coverage under the SLB *Medicare-Eligible Retirees' Health Reimbursement Arrangement Plan*.

Paying for Coverage

You and SLB share the cost of the coverage you elect. The amount you pay will depend on:

- which medical coverage option you elect; and
- who you choose to cover.

Your contributions for Plan coverage 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 your cost for coverage. For information on the current cost of coverage, visit iThrive.

Spousal Surcharge
If your *Spouse* has other coverage available through his or her full-time employer, but you choose to cover your Spouse under the SLB Medical Plan instead of your Spouse's medical plan, a spousal surcharge will apply. This surcharge represents an additional employee paid contribution you are required to pay for coverage.

Government Assistance for Children's Coverage
If your dependent child who is an *Eligible Dependent* qualifies for health coverage under the federal Children's Health Insurance Program (CHIP), you may qualify for a government subsidy of the cost of covering the child under the Plan. If this applies to your child, please contact the US Benefits Center at 1-800-474-4015.

HOW BENEFITS ARE CALCULATED

This section of the SPD describes the way that benefits are calculated when you or a covered dependent receives services that are covered under the Plan. The amount the Plan will pay depends on several factors including:

- whether the care is considered preventive care (for which the Plan generally pays 100% with no *Annual Deductible* if the care is provided in-network);
- whether you receive non-preventive services from an in-network provider (for which the Plan generally pays 80%) or an out-of-network provider (for which the Plan generally pays 60% of the *Maximum Charge*);
- whether you have already had covered expenses for the year that equal or exceed your *Annual Deductible*;
- whether you have already had expenses for the year that equal or exceed your *Out-of-Pocket Maximum*; and
- in some cases, where you receive the services.

Each of these concepts is explained later in this section, and all explanations apply to all three medical coverage options unless noted otherwise.

Understanding the Value of Networks

Health care is more affordable for you and for SLB when it is provided by a member of Cigna's network. The Plan provides benefits whether or not the provider you choose participates in a network. But there are substantial differences in the amount of benefits the Plan pays for in-network and out-of-network services which are described in detail below.

Advantages of In-Network Providers

When you receive care from an in-network provider:

- you pay nothing (no *Annual Deductible* or cost-sharing) for preventive care, family planning and tobacco cessation counseling;
- you pay less for covered services because your Annual Deductible is one-half of the Annual Deductible that applies to out-of-network providers, and you take advantage of *Negotiated Fees*;
- under the Choice HSA and OAP, you also pay less for covered services because the reimbursement rate after you meet your Deductible is 80% as compared to 60% of the *Maximum Charge* for out-of-network services; and
- you do not need to file a benefit claim form in most cases.

Network Deficiencies

If you can't find at least one Cigna network provider within 25 miles of your home to provide a particular service, Cigna may authorize you to receive in-network benefits for services from an out-of-network provider, subject to the *Maximum Charge* limit. (For all locations other than Alaska, this only applies to specialists.)

For assistance finding a provider, call Cigna at 800-668-1506. If Cigna customer service can't find a network provider, they will transfer your call to Cigna's Health Care Facilitation Centers. A nurse will assist you by looking further for a network provider and by authorizing you to see an out-of-network provider at

the in-network benefit level if none can be found. This authorization will be provided to you in a letter identifying the services that will be covered as in-network services. If the authorized provider refers you to another provider or to a facility, you are responsible for ensuring that the other provider or facility is in the network.

Not all services are eligible for this special network deficiency provision. Examples of services that are not covered include:

- extended care;
- skilled nursing facilities/acute rehab;
- transplant related services;
- urgent/emergent care;
- telemedicine; and
- services provided by a tertiary facility (these centers provide highly specialized medical care performed by medical specialists in state-of-the-art facilities).

★**Note:** A provider's network status may change. Cigna updates its network regularly, so you should periodically check the status of the providers you and your covered dependents use at myCigna.com. You are responsible for determining if your providers participate in the network before using their services.

Disadvantages of Out-of-Network Providers

When you receive care from an out-of-network provider:

- you are responsible for filing claims with the Plan in order to receive reimbursement;
- you pay more for covered services because the *Annual Deductible* you must pay before the Plan begins to pay any benefits is two times the Deductible amount that applies when you use a network provider, and only your out-of-network expenses count toward this out-of-network Deductible;
- under the Choice HSA and OAP, you also pay more for covered services because the reimbursement rate after you meet your Annual Deductible is 60% of the *Maximum Charge* as compared to 80% for in-network services;
- if you receive care at an out-of-network hospital or other facility, you must pay an extra $1,000 deductible (a penalty amount); and
- *Negotiated Fees* don't apply, which leaves you at risk for paying excessive charges as described in the box below.

Your Risk of Excess Charges

The Plan pays out-of-network benefits based on the *Maximum Charge* for the specific service or supply. If an out-of-network provider charges more than the Maximum Charge, the provider may require you to pay 100% of the amount above the Maximum Charge limit (in addition to your *Annual Deductible* and Coinsurance). If the provider does not require payment from you, the service or supply will not be covered by the Plan at all. See "*Warning About Providers Who Waive Your Cost-Sharing*."

Providers Assigned to You at Network Hospitals

If you receive services from an out-of-network doctor or other health care professional while being treated at a network hospital through no fault of your own (for example, the radiologist who reads your x-ray), benefits will be paid at the in-network level.

Emergencies and Urgent Care
Emergency room treatment for a true emergency (treatment for a sudden, unexpected and life-threatening illness or injury) is always paid at the in-network level of benefits. All urgent care treatment is also provided at the in-network level.

Out-of-Network Area Coverage

If you live in a rural area, the Cigna network may not be available. You can contact Cigna to find out if you live in a network area.

If you don't live in a Cigna network area, after you meet your *Annual Deductible*, the Plan will pay the 80% in-network rate for covered services, but the payment will be based on *Maximum Charges* (since no *Negotiated Fees* apply). In addition, you must file a claim form each time you receive care. When the Cigna network is extended to your area, you'll need to use in-network providers to continue receiving benefits at the higher reimbursement rate.

Cost Sharing

You and SLB share in the cost of the medical care you receive. Amounts you are required to pay include:

- the *Annual Deductible*;
- *Copays*;
- *Coinsurance*;
- all amounts that exceed *Maximum Charges* for out-of-network services; and
- all amounts for services that are not covered under the Plan.

Each of these is discussed below. Where cost-sharing is different under the three medical options, those differences are noted.

Annual Deductible and Annual Out-of-Pocket Maximum

The amount of your Annual Deductible and Out-of-Pocket Maximum depends on whether you choose the Saver HSA, Choice HSA or OAP.

Under the Saver HSA and Choice HSA, the deductible applies to medical services and prescription drugs. You may meet the deductible with any combination of medical and prescription drug costs.

Under the OAP, the deductible applies to medical services only. Your prescription drug costs do not count toward the deductible.

Under the OAP, the medical out-of-pocket maximum applies to medical costs only; prescription drug costs do not count toward this limit. Prescription drugs have their own separate out-of-pocket maximum; your medical costs do not count toward this separate limit.

See iThrive for the current deductibles and out-of-pocket maximums.

Expenses that Don't Count Toward Deductible or Out-of-Pocket Maximum

The following items do **not** apply to your Annual Deductible or your Annual Out-of-Pocket Maximum:
- vision care expenses and copays;

- prescription drug expenses if you are covered under the OAP option (these expenses are subject to a separate Out-of-Pocket limit);
- expenses not covered by the Plan;
- fees over the Maximum Charge; and
- penalties for not complying with precertification rules.

Copays (other than vision copays) count toward the Out-of-Pocket Maximum, but do not count toward the Annual Deductible.

Annual Deductible

The Annual Deductible is an amount you must pay each calendar year before the Plan pays benefits for certain services. The Plan has different Annual Deductibles depending on whether you have employee-only coverage or you cover one or more dependents.

If you elect employee-only coverage, you meet your deductible when your covered expenses for the calendar year equal the employee deductible. If you elect any other coverage level (employee + Spouse, employee + children, employee + family) the "All Other" deductible applies and this amount generally can be met by any combination of covered expenses incurred by any family members.

The Plan has separate Annual Deductible amounts for in-network and out-of-network services. To encourage you to use network providers, both in-network and out-of-network covered expenses will count toward the in-network Annual Deductible. However, only out-of-network expenses count toward the out-of-network Annual Deductible.

Special OAP Rules

If a family member covered by the OAP meets the employee-only deductible before the "All Other" deductible is met, the Plan will begin paying benefits for that person. When the "All Other" deductible is met by any combination of family members covered by the OAP, the Plan will begin paying benefits for the entire family. However, no family member can contribute more than the amount of the employee-only deductible to the "All Other" family deductible under the OAP. (See *Expenses That Don't Count Toward Deductible or Out-of-Pocket Maximum* for more important details.)

Copays

A Copay is the amount you pay each time you receive certain covered health services. The Copay is a flat dollar amount and is paid at the time of service or when billed by the provider (regardless of whether the *Annual Deductible* has been met). If the eligible expense is less than the Copay, you are only responsible for paying the eligible expense and not the Copay.

> ★**Note:** Copays only apply to prescription drug and vision care expenses. See the *Prescription Drug Coverage* and *Vision Coverage* sections for more information.

Coinsurance

Coinsurance is the percentage of a covered expense that you must pay after you meet the Annual Deductible and before you meet your Annual Out-of-Pocket Maximum. In most cases, the Plan will pay 80% of *Negotiated Fees* for in-network services and 60% of the *Maximum Charge* for out-of-network services. The remaining 20% in-network or 40% out-of-network is your Coinsurance amount. There are a few exceptions, including the amount the Plan pays for preventive care, emergency and urgent care and second surgical opinions. If an exception to the usual 80% or 60% Plan payment provision applies, it is noted where that specific benefit is discussed in this SPD.

Annual Out-of-Pocket Maximum

The Annual Out-of-Pocket Maximum is the maximum amount you will pay in a calendar year for covered health services. A separate Annual Out-of-Pocket Maximum applies to in-network and out-of-network services.

Once your eligible out-of-pocket expenses in a calendar year equal the Annual Out-of-Pocket Maximum, the Plan pays 100% of eligible expenses for covered health services through the end of the calendar year. The Annual Out-of-Pocket Maximum applies to all covered medical services under the Plan. See *Expenses That Don't Count Toward Deductible or Out-of-Pocket Maximum* for more important details.

★Warning About Providers Who Waive Your Cost-Sharing
Some providers "forgive" or "waive" the cost sharing obligations the Plan requires you to pay (*e.g.* your Annual Deductible and/or Coinsurance and/or amounts over the Maximum Charge). If the provider waives any part of the cost-sharing that applies to you under the Plan, no benefits will be payable under the Plan for the service they provide. See *Excluded Expenses, Services and Supplies* for additional information.

Example of Savings Using In-Network Providers

This example illustrates why it is important to use in-network providers.

Let's assume you have minor outpatient surgery, where the *Maximum Charge* is $5,000.

In this example, the in-network surgeon charges a Negotiated Fee that is $500 less than the Maximum Charge (or $4,500), and the Plan pays 80% of this discounted amount (or $3,600). You pay the remaining 20%, which is $900.

On the other hand, the out-of-network surgeon charges double the Maximum Charge for this surgery (or $10,000), and the Plan only pays 60% of the Maximum Charge (or $3,000). You are responsible for paying your 40% share of the Maximum Charge ($2,000), plus the entire $5,000 in excess charges, for a total of $7,000. In addition, if the outpatient surgical center where you have your surgery is not in the network, you will pay an extra $1,000 deductible for using an out-of-network facility.

As you see, if you use a surgeon outside the network, you won't receive any discount on charges for services you receive, and you are responsible for excessive charges because all amounts over the Maximum Charge are your responsibility. In this example, you would pay $900 for in-network services and as much as $7,000 for out-of-network services (plus an extra $1,000 if the facility is also out-of-network).

Illustration of Savings Using In-Network Providers		
	In- Network Example	Out-of-Network Example
Maximum Charge	$5,000	$5,000
In-network discount	$500	–
Charges billed by the provider	$4,500	$10,000
Plan pays	$3,600	$3,000
You pay		
• 20% of discounted charge	$900	---
OR		
• 40% of Maximum Charge PLUS	---	$2,000
• 100% of charges over Maximum Charge	---	$5,000
TOTAL YOU PAY	**$900**	**$7,000**

PROGRAMS TO HELP SAVE YOU MONEY

The Plan contains several provisions to help ensure you receive the most cost-effective care possible. These include precertification, case management and alternatives to long-term hospitalization.

Precertification Requirements

Precertification is the process of determining in advance whether a procedure, treatment or service will be covered under the Plan. It also helps ensure you get the right care in the right setting - potentially saving you from costly and unnecessary services. You (or your doctor) should obtain precertification as soon as possible after one of the services listed below is recommended (but *before* you receive treatment). Typically, you must notify Cigna within 48 hours of an emergency hospital admission (including maternity).

Important: If you or a covered dependent do not obtain a required precertification as described below for an out-of-network service, your benefits for covered expenses will be reduced by $500.

Your doctor is responsible for getting the required precertification for in-network services. You're responsible if you choose to see an out-of-network doctor. To get precertification, call Cigna at 800-668-1506. You'll need the name of the doctor or facility, the procedure or procedure code and the date of service when you call. Remember, when you go out-of-network, your out-of-pocket costs will be higher and your coverage may be reduced by $500 if you don't get precertification

Examples of Services that Must Be Pre-certified to Avoid $500 Penalty	
Inpatient Services	**Outpatient Services**
• All inpatient admissions and non-obstetric observation stays such as: o Acute hospitals o Skilled nursing facilities o Rehabilitation facilities o Long-term acute care facilities o Hospice care o Transfers between inpatient facilities • Experimental and investigational procedures • Blepharoplasty and Rhinoplasty when medically necessary • Maternity stays longer than 48 hours (vaginal delivery) or 96 hours (Cesarean section)	• Outpatient surgical procedures • High-tech radiology (examples include MRI, CAT scans, PET scans) • Injectable drugs (other than self-injectables) • Durable medical equipment (examples include insulin pumps, specialty wheelchairs, etc.) • Home health care/home infusion therapy • Dialysis • External prosthetic appliances • Speech therapy • Cosmetic or reconstructive procedures • Infertility treatment • Radiation therapy

Case Management

If you (or one of your family members) has a potentially complex medical condition that is eligible for case management, you will be contacted by a nurse case manager. The case manager will evaluate your current health care needs and the quality and cost of the care you are receiving, and may recommend alternatives

to your current course of treatment. The case manager will work with you, your doctor and other providers to coordinate and monitor services to best meet your medical needs.

When you or your spouse participate in *Case Management* for cardiac, back, joint or bariatric surgery, you earn $500 cash cards that can help offset your Annual Deductible or Coinsurance.

Second Surgical Opinion

The Plan pays 100% of *Negotiated Fees* (in-network) or 60% of *Maximum Charges* (out-of-network) for a second—or even a third—surgical opinion. If surgery is suggested for you, take advantage of this network opportunity. **If you are enrolled in the Saver HSA or Choice HSA, your deductible will apply.**

Telehealth Services

Under Cigna's telehealth services you have access to in-network telehealth services via MDLive. Here you can access U.S. board-certified doctors 24/7/365 to resolve many of your medical issues through phone, video, or email consultations.

MD Live is a convenient and affordable way to get quality care. You may choose to use MDLive when:

- you have a non-emergency medical issue (especially as an alternative to the emergency room or urgent care center);
- your doctor is not available on your schedule; or
- you are traveling and need medical care.

The telehealth doctors can treat many medical conditions, such as cold and flu symptoms, allergies, bronchitis, urinary tract infections, respiratory and sinus infection. And, they will share information about your consultation with your primary care physician if you like.

To use the telehealth services you must register online or by phone at:

- MDLiveforCigna.com or (888) 726-3171

Once your account is set up, you can request a consult anytime you need care, 24 / 7 / 365. Consults can be conducted by telephone or by online video.

Cigna Health Information Line

The Cigna Health Information Line offers 24 / 7 / 365 access to trained nurses who can provide personalized assistance to help you make informed decisions about your care. They can advise on:

- Self-help and home care
- Whether you should seek professional care
- Available online tools to locate care.

The service is provided at no cost to you. Call 1-800-564-9286 to get started.

Claims Review Award

To help control healthcare costs, you are encouraged to check all hospital bills of less than $20,000 for mistakes (Cigna audits bills over $20,000). If you find any over-payments, SLB may pay you 50% of the over-payment amount, up to a maximum payment of $500.

If you find an error, please report it promptly to your medical provider. Once a revised, itemized bill is agreed upon, submit it to Cigna. After Cigna reviews the claim, submit proof of both bills by contacting the US Benefits Center at 1-800-474-4015. The Plan Administrator will review both bills and certify your eligibility for the award.

Centers of Excellence

Each year, Cigna reviews and identifies top-performing, in-network hospitals for common inpatient conditions and procedures, like heart conditions, hip replacements and surgeries. These hospitals typically provide lower costs and improved patient outcomes over other hospitals.

Centers of Excellence are available for:

- cardiac surgery (bypass surgery, defibrillator implant, pacemaker implant, heart valve replacement);
- elective cardiac surgery (cardiac catheterization, angioplasty with and without stent);
- gastroenterology (bariatric surgery);
- general heart conditions (heart attack, heart failure, irregular heartbeat);
- general surgery (abdominal hysterectomy, colon surgery, laparoscopic gall bladder removal, prostate cancer, kidney cancer)'
- infertility (outpatient);
- neurology (stroke, head and neck endarterectomy);
- obstetrics (Cesarean section, vaginal delivery, uterine cancer, mastectomy or lumpectomy for breast cancer);
- orthopedic back surgery (disk surgery, spinal fusion);
- orthopedics (total hip and/or knee replacement); and
- pulmonology (COPD, adult pneumonia).
- To find a Center of Excellence, go to *mycigna.com*.

★**Note:** If you or your spouse is covered by the Saver HSA or Choice HSA and use a Center of Excellence for a cardiac, orthopedic or bariatric surgery, you will earn a $500 *cash card*.

Alternatives to Long-term Hospitalization

If you need longer-term care, there may be less expensive, more convenient and comfortable yet equally effective alternatives to a long hospital stay. If appropriate, the Plan will cover:

Home Health Care Services

These are services provided by a licensed Home Health Care Agency that are approved in writing by your attending physician and in lieu of an inpatient hospital stay. Covered services and supplies include:

- professional nursing services by a registered nurse (RN) or licensed practical nurse if an RN is not available;
- visits for medical care by home health aides;
- medical supplies;
- necessary laboratory services; and
- physical and speech therapy.

Care in a Skilled Nursing Facility

The Plan covers inpatient care at a licensed skilled nursing facility that is supervised by a physician or registered nurse and that provides 24-hour professional nursing services under the direction of a full-time registered nurse.

Covered services and supplies include:

- semi-private room and board, or a private room up to the cost of the facility's average charge for a semi-private room;
- general medical and nursing services;
- x-ray and laboratory examinations;
- use of special treatment rooms;
- physical or speech therapy;
- drugs, biologicals, solutions, dressings, casts; and
- other required medical services customarily provided by convalescent facilities.

Hospice Care

Hospice care involves medical, psychological, and nursing care provided to terminally ill patients, as well as supportive services to their families.

When medical necessity criteria are met, hospice services may include:

- physician services
- intermittent skilled nursing services
- home health aide services
- physical and/or occupational therapy
- speech therapy services for dysphagia/feeding therapy
- medical social services
- counseling services (e.g., dietary and bereavement)
- short-term inpatient care
- prescription drugs
- consumable medical supplies (e.g., bandages, catheters) used by the hospice team

RESOURCES TO HELP YOU STAY HEALTHY

To encourage prevention and early detection of health risks and diseases, the Medical Plan offers a choice of preventive care benefits on favorable cost-sharing terms, as follows:

- You may receive periodic physical exams or preventive screenings through doctors of your choice. When you choose in-network doctors under the Choice or OAP plans, these exams are provided to you free of charge. Under the Saver Plan, these exams are free for both in and out of network providers.
- Instead of a physical exam through your doctor, you may elect the Comprehensive Physical exam offered through EHE International.

Each option is discussed below.

Periodic Physical Exams and Preventive Screenings

Your benefits depend on which medical plan you are in and whether you use in or out-of-network providers.

- **In-Network** - The Plan provides **free** preventive care when you use in-network providers under all three plans (Saver, Choice, OAP) for a periodic physical exam, routine lab work and a wide range of preventive health screenings, including those for certain cancers and cardiovascular conditions, diabetes, osteoporosis and various obstetric, pediatric, vision and hearing disorders.
- **Out-of-Network** - If you use out-of-network providers and are under the Choice or OAP plans, your exam, screenings and related services are treated as any other out-of-network medical expenses. In this case, the out-of-network *Annual Deductible* will apply before the Plan begins paying benefits. Once you reach the Annual Deductible, the Plan will reimburse 60% of the cost of services, subject to *Maximum Charge* limits. You are responsible for all other costs, including any charges that exceeds the Maximum Charge.
- In order to ensure that your claim is processed as preventive care, your visit must be coded by your provider as wellness, preventive or screening. Services for treatment of any illness or injury will not be processed as preventive.

Coverage includes a physical exam and/or preventive screenings for:

- Cervical cancer (routine gynecological exam, including pap smear);
- Breast cancer (one baseline mammogram for women age 35-39, then annually for women 40 or older);
- Colon cancer (age 50 and older)
- Prostate cancer (men ages 50 and older or age 40 with risk factors)
- Osteoporosis (age 65 and older or under age 65 with risk factors)
- High Blood Pressure
- Cholesterol (age 40 and older)
- Blood glucose and type 2 diabetes (age 40-70 with risk factors)
- Sexually Transmitted Infections
- routine well baby/well child exams including immunizations; and
- routine hearing screening for ages 2 months – 21 years old

Comprehensive Physical Exam

During Annual Enrollment, you and/or your Spouse (between the ages of 18 and 40) may elect a Comprehensive Physical exam every two years, or annually if over age 40. The exam will include the tests and procedures outlined in the chart below, according to your age.

If you elect the Comprehensive Physical exam you pay an annual contribution per exam in addition to your regular contributions for medical coverage.

If you elect to participate in the Comprehensive Physical exam, you may not reverse enrollment within the same year or carry-over your contribution into the next year if you fail to take your exam. In addition, if you fail to take your exam or leave the *Company* for any reason before you have received your exam, the contributions you made before termination will not be refunded to you.

Your exam will be performed by a physician you select from among an established group of physicians contracted by EHE International (EHE) to perform these physicals. You may choose to take your Comprehensive Physical exam at any of the EHE-owned facilities in the US or at one of several in-network locations nationwide. Before you enroll, you should call EHE or refer to the network listing on the EHE website to find the location nearest you, as the network may change from year to year and a facility may not be available in your area.

After your exam, you will receive a written narrative report from the doctor, including any findings that should be followed-up with your personal physician.

The chart below includes a partial listing of included services.

Age at December 31 of the Year in Which Exam Takes Place			
Service	**Under age 40**	**40-49**	**50 and over**
Medical and family history	Every two years	Annual	Annual
Physical exam	Every two years	Annual	Annual
Electrocardiogram	Every two years	Annual	Annual
Blood and urine tests	Every two years	Annual	Annual
Pap smear	Every two years	Annual	Annual
Prostate specific antigen test	n/a	n/a	Annual
Cardiac stress test	n/a	Once every three years	One every two years
Mammogram	Baseline exam given once between ages 35-39	Annual	Annual

Colonoscopy	When medically indicated	Annual	Annual

Cigna Diabetes Prevention Program – Omada

Cigna Diabetes Prevention Program in collaboration with Omada is a program to help you avoid the onset of diabetes, as well as health risks that might lead to heart disease or a stroke. This benefit is available at no cost to employees enrolled in an SLB medical plan and any covered dependents 18 years or older.

The program is covered by your health plan at the preventive level, just like for your wellness visit. Program participants have access to a professional virtual health coach, an online support group, interactive lessons, and a smart-technology scale. The program will help you make small changes in your eating, activity, sleep, and stress to achieve healthy weight loss through a series of 16 weekly lessons and tools to help you maintain weight loss over time.

You will also be offered the opportunity to join a gym for a low monthly fee and no enrollment fee.

Additional information is available at *https://go.omadahealth.com/slb* or by phone at 1-888-409-8687.

Hinge Health

Hinge health is a digital program for back and joint pain available at no cost to employees enrolled in an SLB medical plan and any covered dependents 18 years or older.

Hinge Health provides support for back, muscle, and joint problems.

Call 1-855-902-2777 or visit *www.hingehealth.com/slb* for more information.

Other Support Services

The Plan also offers the following programs and services.

Health Risk Assessment (HRA)

You and your covered *Spouse* can take the Health Risk Assessment to help you learn about your current health risks and find ways to reduce or eliminate them.

When you participate in the HRA, you receive an instant, confidential report based on your answers to an online questionnaire. Your report addresses general issues such as how you interact with your health care providers, as well as your unique health concerns, such as chronic conditions you may have (like diabetes or asthma) and/or lifestyle practices (like smoking) that may affect your health. Your report will also highlight the Medical Plan resources available to help you reduce your health risks.

Cigna HealthCare Healthy Rewards

Cigna HealthCare Healthy Rewards offers discounts on many wellness products and services not covered by the SLB Medical Plan, including:

- selected weight-loss programs
- eyeglasses and contact lenses
- certain chiropractic care and therapeutic massage
- acupuncture
- laser vision correction
- herbal and vitamin supplements; and
- non-prescription health and beauty products
- active and fit program (add details)

For more information on the program and to locate Cigna HealthCare Healthy Rewards in-network providers in your area, visit *myCigna.com.*

Cigna Lifestyle Management Programs

Cigna Lifestyle Management Programs are convenient and flexible programs that are free to employees who are enrolled in an SLB medical plan. Through these programs, you can work with a Cigna coach, either online or by phone, for support with weight management, tobacco cessation or stress management. These programs offer one-on-one coaching, evening and weekend hours, educational materials and interactive tools.

Weight Management

Reach your goal of maintaining a healthy weight – all without the fad diets. Create a personal healthy-living plan that will help you build your confidence, be more active and eat healthier. And, you'll get the support you need to stick with it.

Tobacco Cessation

Get the help you need to finally quit tobacco. Create a personal quit plan with a realistic quit date. And, get the support you need to kick the habit for good. You'll even get free over-the-counter nicotine replacement therapy (patch or gum).

Stress Management

Get help lowering your stress levels and raising your happiness levels. Learn what causes you stress in your life and develop a personal stress management plan. And, get the support you need to help you cope with stressful situations – both on and off the job.

More information on these programs or to sign up, go to www.mycigna.com.

COVERED MEDICAL SERVICES AND SUPPLIES

This section provides information on the major categories of services covered by the Plan. After you meet your *Annual Deductible*, all in-network services are paid at 80% of the *Negotiated Fee*, or at 60% of the *Maximum Charge* for out-of-network services, unless otherwise noted.

Physician's Services

The Plan covers physician's fees for medically necessary services performed by a legally qualified physician, podiatrist, chiropractor, or osteopath, including fees for obstetrical procedures, in-hospital visits, office visits, consultations, and diagnosis. This includes telephone, video or email consultations for nonemergency conditions with MDLIVE's board-certified physicians. The Plan also covers physician's charges for inpatient and outpatient surgery, including charges for an assistant surgeon, anesthetist, pathologist, or radiologist. Periodic physical exams are covered as provided under the Preventive Care Benefits provision (see *Resources to Help You Stay Healthy*).

In-Hospital Services and Supplies

The Plan covers hospital charges for semi-private room and board or for a private room, up to the cost of the hospital's rate for a semi-private room. The Plan also covers hospital charges for general nursing services; intensive care units; use of operating, delivery and treatment rooms; equipment; drugs; medicines; x-rays; lab tests; blood; plasma; oxygen; electrocardiograms and fluoroscopy.

> ★ **Note:** When two or more surgical procedures are performed at one time the maximum amount payable will be the amount payable for the most expensive procedure and 1/2 of the amount payable for all other surgical procedures.

Therapy, Tests and Procedures

The Plan covers a variety of therapies, tests and procedures, including:

- diagnostic x-rays and laboratory tests;
- oxygen and anesthesia;
- x-ray, radium, and radioactive therapy;
- dental or cosmetic treatment or surgery resulting from a congenital abnormality or arising out of a non-occupational accident or injury;
- dental care for accidental injury of teeth, including charges for dental implants, office visit, inpatient/outpatient care and physician's services;
- outpatient short term rehabilitation, including physical therapy, speech therapy, occupational therapy or chiropractic therapy;
- speech therapy for normal speech which is lost because of illness or injury;
- treatment for TMJ (but not for TMJ appliances or orthodontic treatment);
- all medically appropriate, non-experimental organ transplants, including the inpatient facility and physician's services;

- treatment of autism disorders (including autism or autistic disorder, Asperger's syndrome, pervasive developmental disorder, childhood disintegrative disorder ("Heller's syndrome) and Rett's disorder), including:
  - office visits;
  - lab, imaging and other diagnostic testing to rule out other underlying conditions;
  - speech therapy, occupational therapy, and / or physical therapy;
  - behavioral therapy and early intensive behavior intervention programs, such as Applied Behavioral Analysis (ABA) therapy;
  - pharmacologic treatment to manage behavioral issues; and
  - psychotherapy to manage behavioral issues; and
- when reviewed and determined to be medically necessary:
  - bariatric surgery for employees with at least six months of Company service (or their *Spouses*);
  - gender reassignment surgery;
  - breast reduction;
  - rhinoplasty; and
  - panniculectomy.

★ **Note:** The Plan will pay 100% of the covered expenses (after the Annual Deductible) for an organ transplant when performed at a Cigna LifeSource Center**.**

Family Planning, Maternity, Pre- and Post-natal Care

The Plan covers family planning, including tests and counseling occurring during office visits, and surgical sterilization procedures for vasectomy and tubal ligations (but not reversals). This includes services of a physician, and an inpatient or outpatient facility.

The Plan also provides maternity coverage, including initial visits to determine pregnancy, all subsequent prenatal visits, postnatal visits, delivery, hospital and birthing center services. The minimum hospital stay the Plan must cover for a vaginal delivery is 48 hours (96 hours for a cesarean) after giving birth. Precertification is not required for the minimum hospital stay; however, longer stays do require it. You have the right to leave the hospital before completion of the minimum stay. Midwives are covered if they are licensed by the state and if the midwife is associated with a physician.

Nursery charges and physician expenses for newborns are covered from date of birth, if the baby is enrolled in the Plan within 31 days after birth.

Abortion (elective and non-elective) is covered for any eligible family member, and may be performed at an inpatient facility or outpatient surgical facility.

Services offered through WINFertility are available to employees enrolled in an SLB medical plan and any covered dependents 18 years or older.

SLB employees are provided the following benefits:

Fertility Benefit: Eligible employees and covered dependents enrolled in the Cigna medical plan are provided a 3-cycle lifetime maximum benefit toward certain eligible expenses related to fertility treatment and prescription injectable medications.

Adoption & Surrogacy Benefit: Eligible employees enrolled in the Cigna medical plan are provided a $10,000 lifetime maximum reimbursement for eligible expenses associated with adoption and surrogacy agreements.

Infertility and Conception Services

Coverage will be provided for the following services:

• Testing and treatment services performed in connection with an underlying medical condition.

• Testing performed specifically to determine the cause of infertility.

• Treatment and/or procedures performed specifically to restore fertility (e.g. procedures to correct an infertility condition).

• Treatment and/or procedures performed to enable conception with or without an infertility condition.

• Artificial Insemination /Intrauterine insemination, regardless of an infertility condition, In-vitro, GIFT, ZIFT, etc.

• Access to reproductive services for the purpose of pre-implantation genetic diagnosis (PGD) and embryo selection when parent(s), though fertile, are known carriers of genes associated with birth defects.• charges made for services related to diagnosis of infertility and treatment of infertility once a condition of infertility has been diagnosed, charges made for intrauterine insemination / artificial insemination services related to enabling conception regardless of an infertility diagnosis; access to harvesting of sperm and oocytes for the purposes of cryopreservation and short term storage of sperm, oocytes, and embryos [when an infertility condition is imminent] ; access to reproductive services for the purpose of pre-implantation genetic diagnosis (PGD) and embryo selection when parent(s), though fertile, are known carriers of genes associated with birth defects. Services include, but are not limited to: infertility drugs which are administered or provided by a Physician; cryopreservation, storage, and thawing of [sperm] and [eggs] and [embryos]; approved surgeries and other therapeutic procedures that have been demonstrated in existing peer-reviewed, evidence-based, scientific literature to have a reasonable likelihood of resulting in pregnancy; laboratory tests; sperm washing or preparation; artificial insemination; diagnostic evaluations; gamete intrafallopian transfer (GIFT); in vitro fertilization (IVF); zygote intrafallopian transfer (ZIFT); and the services of an embryologist.

Infertility is defined as:

• the inability of opposite-sex partners to achieve conception after at least one year of unprotected intercourse;

• the inability of opposite-sex partners to achieve conception after six months of unprotected intercourse, when the female partner trying to conceive is age 35 or older;

• the inability of a woman, with or without an opposite-sex partner, to achieve conception after at least six trials of medically supervised artificial insemination over a one-year period; and

• the inability of a woman, with or without an opposite-sex partner, to achieve conception after at least three trials of medically supervised artificial insemination over a six-month period of time, when the female partner trying to conceive is age 35 or older.

This benefit includes diagnosis and treatment of both male and female infertility.

The following are specifically excluded infertility services:

• reversal of male and female voluntary sterilization;

• infertility services when the infertility is caused by or related to voluntary sterilization;

• donor charges and services;

• pre-implantation genetic screening (PGS) and genetic screening of parents/donors beyond what is covered as by the medical plan; and

• any experimental, investigational or unproven infertility procedures or therapies.

Adoption & Surrogacy Benefit

The SLB Adoption & Surrogacy program is administered by WINFertility and is offered to eligible employees who choose to build their families through adoption and/or surrogacy. The program helps to cover a portion of the expenses associated with adopting a child eighteen years or younger or when using a surrogate to assist in carrying and giving birth to a child.

Eligible employees enrolled in the Cigna medical plan are provided up to a $10,000 lifetime maximum reimbursement for certain eligible expenses associated with adoption and surrogacy agreements that are legally finalized on or after January 1, 2023 and eligible expenses incurred on or after January 1, 2023.

Before you begin the adoption/surrogacy process, contact WINFertility for information about all aspects of the Program, including details about eligibility and covered expenses. You can reach a WINFertility Service Team Member at: 833-506-3475, Monday - Friday 9:00 a.m. - 7:30 p.m. EST. More details are also available at *https://managed.winfertility.com/slb*

Durable Medical Equipment and Prosthesis

The Plan covers rental or purchase (whichever is less costly) of durable medical or surgical equipment. Coverage for repair, replacement or duplicate equipment is provided only when required due to anatomical change and/or reasonable wear and tear. All maintenance and repairs that result from a person's misuse are the person's responsibility.. Breast prosthesis or breast implants needed as a result of disease are covered but removal and/or replacements may not be covered, based on medical necessity. The Plan also covers hearing aids, external prosthetic appliances as well as myoelectrical devices.

Clinical Trials

The Plan covers charges made for routine patient services associated with cancer clinical trials when the following criteria are met:

- the cancer clinical trial is listed on the NIH web site *www.clinicaltrials.gov* as being sponsored by the federal government;
- the trial investigates a treatment for terminal cancer and the person has failed standard therapies for the disease and/or cannot tolerate standard therapies for the disease and/or no effective non-experimental treatment for the disease exists;
- the person meets all inclusion criteria for the clinical trial and is not treated "off-protocol"; and
- the trial is approved by the Institutional Review Board of the institution administering the treatment.

Routine patient services do not include, and reimbursement will not be provided for:

- the investigational service or supply itself;
- any services or supplies listed in this SPD under *Excluded Expenses, Services and Supplies*;
- services or supplies related to data collection for the clinical trial (i.e., protocol-induced costs); or
- services or supplies which, in the absence of private health care coverage, are provided by a clinical trial sponsor or other party (e.g., device, drug, item or service supplied by manufacturer and not yet FDA approved) without charge to the trial participant.

Emergency Services

This Plan covers air ambulance and ambulance service to the first hospital where treatment is given in cases of emergency, as well as emergency care by a doctor's office, hospital emergency room, outpatient facility, urgent care facility, air ambulance or ambulance. Air ambulance and ambulance services used as non-emergency transportation (e.g., transportation from hospital back home) generally are not covered.

Mastectomy-Related Services

For individuals receiving mastectomy-related benefits, the Plan will provide coverage for:

- all stages of reconstruction of the breast on which the mastectomy was performed;
- surgery and reconstruction of the other breast to produce a symmetrical appearance;
- prostheses; and
- treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same Annual Deductibles and Coinsurance applicable to other medical and surgical benefits provided under the Plan.

EXCLUDED EXPENSES, SERVICES AND SUPPLIES

Some of the services, procedures and supplies that are *not* covered under the Plan are listed below. Other exclusions may apply. Contact Cigna at 800-668-1506 for more information.

The Plan does not pay benefits for:

- anything that is not ordered by a physician or that is not necessary for medical care, unless it is specifically listed as being covered elsewhere in this SPD;
- charges over the *Maximum Charge*;
- charges which you are not legally required to pay as further explained in *Detailed Warning About Providers Who Waive Your Cost-Sharing* below;
- unusual, unnecessary or excessive charges, as determined by Cigna;
- experimental or investigational procedures and any treatments not approved by the American Medical Association, Federal Drug Agency or other regulatory certifying agency unless eligible under the Clinical Trial requirements;
- cosmetic surgery, unless it is required due to a congenital abnormality, or it qualifies as re-constructive surgery following medically necessary surgery, or it arises out of a non-occupational injury;
- medical expenses due to an occupational accident or sickness;
- any injury resulting from, or in the course of, any employment for wage or profit;
- charges made by a hospital owned or operated by the U.S. government, if the charges are directly related to a sickness or injury connected to military service;
- the services of a person who is a member of your family or your dependent's family, or who normally lives in your home or your dependent's home;
- expenses incurred due to an altercation in which you were the aggressor;
- care in a nursing home for the aged, or custodial care or maintenance care;
- dental treatment, unless due to a non-occupational injury;
- eyeglasses or examinations except as provided under the *Vision Care* benefits or for the first pair of lenses or glasses after cataract surgery;
- surgical treatment for correction of refractive errors, including radial keratotomy;
- routine foot care including, but not limited to, the removal of calluses and corns or the trimming of nails, unless medically necessary;
- charges made by a co-surgeon in excess of the surgeon's allowable charge (an allowable charge is the amount payable to the surgeon before any reductions due to your cost-sharing);
- assistant surgeon's charges in excess of 20% of the surgeon's allowable charge;
- speech therapy other than speech therapy as described in *Therapy, Test and Procedures*;
- reversal of voluntary sterilization procedures;
- charges for in-vitro fertilization, artificial insemination or any other similar procedure; and
- amniocentesis, ultrasound or any other procedures requested solely to determine a baby's sex, unless medically necessary to determine the existence of a sex-linked genetic disorder;
- routine health checkups, except as covered under the *Resources to Help You Stay Healthy* section.

⚐Detailed Warning About Providers Who Waive Your Cost-Sharing.

The Plan will not pay any Charges which you are not legally obligated to pay, or for which you are not billed, or for which you would not have been billed except that they were covered under this Plan. For example, if the Claims Administrator determines that a provider has waived, reduced, or forgiven any portion of its charges, and/or any portion of Copay, Deductible, and/or Coinsurance amount(s) you are required to pay for a covered service without the Claims Administrator's express consent, then the Claims Administrator in its sole discretion shall have the right to (1) deny the payment of all benefits in connection with the covered service, or (2) reduce the benefits in proportion to the amount of the Copay, Deductible, and/or Coinsurance amounts waived, forgiven or reduced. This is true regardless of whether the physician or other provider represents that you remain responsible for any amounts that the Plan does not cover. In the exercise of that discretion, the Claims Administrator will have the right to require you to provide proof sufficient to the Claims Administrator that you have made your required cost sharing payment(s) prior to authorizing any Plan payment. This exclusion from Plan payment includes, but is not limited to, charges of an out-of-network provider who has agreed to charge you (or has charged you) at an in-network benefits level or some other benefits level not otherwise applicable to the services received.

EMPLOYEE ASSISTANCE PROGRAM

The Plan offers short-term assistance free of charge if you need help with personal issues. **You and members of your household, can use the EAP's services even if you're not enrolled in the Medical Plan**.

Employee Assistance Plan

The EAP, offered through Cigna Behavioral Health, is a confidential counseling and referral service that is available 24 hours a day, 365 days a year. The EAP offers a wealth of resources and can help you deal with a wide range of personal challenges, including:

- managing stress and anxiety;
- handling relationship issues;
- balancing work and life;
- caring for children or aging parents;
- working through grief and loss;
- job related concerns; and
- quitting tobacco, alcohol or drug use.

★ The EAP is completely confidential. No information about the nature of the personal problem is shared with the *Company*, unless you provide written approval for the EAP to do so.

Services Available

Cigna has a network of professional staff comprised of psychologists, social workers, and marital and family therapists. You or your eligible family member can call Cigna 24 hours a day, seven days a week at 1-877-622-4327. You'll have the option of meeting with an EAP counselor for an initial confidential assessment to determine the nature of the problem and possible resolutions.

Confide Navigator

EAP & Confide Navigator provides concierge-level support with services such as finding a therapist, connecting with a financial consultant or locating a daycare. Services include:

- Help with finding in-network providers or referrals to licensed counselors in the Confide network for up to 8 sessions per issue – at no additional cost

- Coordination with your insurance carrier, whether that is Cigna or another carrier to help you find in-network providers

- Follow up with you after our first conversation to make sure you're getting the support you need and find out if there is anything else you need

- 24/7/365 support by phone, virtual or face to face

Cost of Services

If EAP counseling is the most appropriate treatment, then up to eight sessions will be provided at no cost. If long-term counseling is needed, the EAP counselor will refer you to a qualified provider.

If you are enrolled in the Medical Plan and you have a mental health or substance use issue, the Plan will pay a portion of the expenses you incur, the same as any other covered medical expense. If you have another type of problem that requires long-term counseling, you must pay for the services you receive.

If you waived coverage under the SLB Medical Plan, you must pay all additional costs for long-term counseling beyond the initial five sessions.

PRESCRIPTION DRUG COVERAGE

Prescription drug benefits are included as part of your medical coverage.

See iThrive for current prescription drug costs, deductibles, and out-of-pocket maximums.

Prescription Drug Benefits, 30-day Supply

If your prescription is for no more than a one-month supply (or 100 units, whichever is less), you may obtain your prescription through any retail pharmacy. Benefits vary according to whether a generic or non-generic drug is dispensed.

Refills of 30-day Prescriptions

If your prescription is for a 30-day supply or less, you can fill your prescription directly through any pharmacy. If your doctor has written a prescription that includes one or more refills, you may obtain a refill when you have used 75% of the current prescription.

Prescription Drug Benefits, 90-day Supply

Up to a three-month (90-day) supply of prescription maintenance drugs (with 3 refills) is available by mail order or at your retail pharmacy. Benefits vary according to whether a generic or non-generic drug is dispensed.

Refills of Maintenance Drugs

You can apply for up to three refills of the same medication with a prescription written for a 90-day supply.

If your doctor has written a prescription that includes one or more refills, you may obtain a refill when you have used 75% of the current prescription.

If you take any medication for more than one year, you must file a new prescription each year, even if you haven't used up all your refills. Other state or governmental requirements may apply to how often you will need a new prescription for certain medications.

Annual OAP Rx Out-of-Pocket Maximum

The Annual OAP Rx Out-of-Pocket Maximum is the maximum amount you will pay in a calendar year for covered prescription drugs if you are enrolled in the Open Access Plus medical plan. Once your eligible out-of-pocket expenses for prescription drugs in a calendar year equal the Annual OAP Rx Out-of-Pocket Maximum, the Plan pays 100% of eligible expenses for covered prescription drugs and supplies through the end of the calendar year.

Special Rule for Certain Preventive Drugs or Condition-Based Drugs

Certain Patient Protection and Affordable Care Act (PPACA) Preventive Medications covered under the SLB Medical Plan and required as part of preventive care services (detailed information is available at www.healthcare.gov) and certain other preventive care medications as recommended by Cigna are payable at 100% with no Copayment or Deductible, when purchased from a Network Pharmacy. A written prescription is required.

Note: SLB will allow a one-year supply of mail order or retail drugs for employees who are out of the country due to a work assignment.

Applicable to Saver and Choice Plans - Tier 1 and Tier 2 generic and preferred brand insulin and diabetic supplies are covered at $0 copay and excluded from the deductible at retail and mail order.

Applicable to the OAP Plan - Tier 1 and Tier 2 generic and preferred brand insulin and diabetic supplies are covered at $0 copay for retail and mail order.

	Saver HSA	**Choice HSA**	**OAP**
	You pay the full cost of the prescriptions until you meet your plan deductible. After the deductible, you pay:	You pay the full cost of the prescriptions until you meet your plan deductible. After the deductible, you pay:	Prescriptions do not apply to your plan deductible. You pay:
Tier 1 drugs	$0	$10	$10
Tier 2 drugs	$0	25% ($35 min, $75 max)	25% ($35 min, $75 max)
Tier 3 drugs	$0	40% ($50 min, $120 max)	40% ($50 min, $120 max)
Medications under the Patient Protection and Affordable Care Act (**PPACA)**'s preventive service requirement	No deductible, you pay: $0	No deductible, you pay: $0	$0
Preventive Drug Program Tier 1	No deductible, you pay: $0	No deductible, you pay: $0	Not applicable
Preventive Drug Program Tier 2	No deductible, you pay: 25% ($35 min, $75 max)	No deductible, you pay: 25% ($35 min, $75 max)	Not applicable
Preventive Drug Program Tier 3	No deductible, you pay: 40% ($50 min, $120 max)	No deductible, you pay: 40% ($50 min, $120 max)	Not applicable
Log in to the myCigna App or myCigna.com to see how your plan covers specific medications. Click on the "Find Care & Costs" tab and select "Price a Medication." If you have questions about your prescription drug coverage, call Cigna at 800.668.1506.			

Clinical Programs that Apply to All Plan Options

Exclusive Specialty Home Delivery Program

In order to have specialty medications covered under the Plan, you must fill them through Cigna Specialty Pharmacy Services – a convenient home delivery pharmacy. You are not allowed to have any specialty medication filled at a retail pharmacy. If you fill a specialty medication at a retail pharmacy, you will be required to pay 100% of the cost of the drug. If you have the prescription filled through Cigna Specialty Pharmacy Services, your usual cost sharing will apply.

Cigna Pharmacy will notify you by mail to call a special telephone number where information will be given about the specialty pharmacy to use for future fills of the drug.

Prior Authorization and Step Therapy Requirements

Coverage for certain prescription drugs and related supplies requires your doctor to obtain authorization prior to the Plan covering the drug. The drugs subject to step therapy prior authorization are marked PA on the prescription drug list for the Plan which can be accessed at *myCigna.com*.

Prior authorization may also include a "step therapy" requirement. This means you must try certain therapeutically equivalent drug products or supplies appropriate for treatment of a specific condition before more expensive drugs or supplies will be covered by the Plan. If your doctor wishes to request coverage for prescription drugs or supplies for which prior authorization is required, your doctor may call Cigna or complete the appropriate prior authorization form and fax it to Cigna. Your doctor should make this request before writing the prescription.

If the request is approved, your doctor will receive a confirmation. The length of the authorization will depend on your diagnosis and the prescription drugs or supply. When your doctor advises you that coverage for has been approved, you should contact the pharmacy to fill the prescription.

If the request is denied, you and your doctor will be notified that coverage for the prescription drug supply is not authorized. If you disagree with a coverage decision, you may appeal that decision by submitting a written request stating why the prescription drug or supply should be covered. The appeal procedure is described in detail.

If you have questions about a specific prior authorization request, you should call Cigna at 800-668-1506.

Quantity Limits

Some medications have quantity limits. This means coverage is available for a limited amount of a specific medication.

Penalty for Choosing Brand Name Drugs

Some prescription medications have a choice between a brand name drug and its generic equivalent. Generic drugs offer the same strength and active ingredients as the brand name – but often cost much less. In most cases, when you take your prescription for a brand name medication to the pharmacy, your prescription will be filled with the generic equivalent. However, if you ask for the brand name medication instead of the available generic equivalent, even though your doctor has approved the generic for you, you

will pay your cost share for the brand drug plus the difference in cost between the brand drug and the generic.

Covered Prescription Drugs

The Medical Plan covers approved charges for the following drugs:

- drugs that bear the legend "Caution: Federal Law prohibits dispensing without a prescription";
- drugs that are a compound medication of which at least one ingredient is a prescription drug, provided that compound medications are subject to a dollar limit and bulk chemicals are not covered;
- FDA-approved contraceptives (oral, transdermal, intravaginal, injectable and emergency);
- needles and syringes (both diabetic and other);
- injectable insulin, which, under many state laws does not require a prescription;
- blood- and glucose-related agents such as testing strips, lancets, auto injectors and alcohol-impregnated swabs (excludes blood glucose monitors, which are covered under the medical plan);
- drugs that require a prescription by a physician to dispense and that are approved by the U.S. Food and Drug Administration for general use in treating the sickness or injury for which they are prescribed;
- drugs that may be dispensed under authorization by a physician under any state law; and
- drugs that are purchased from a physician, dentist or any other person or organization licensed to dispense drugs.

Prescription Drug Exclusions

The following drugs and services are not covered under the Plan:

- covered drugs that are consumed at the time and place the prescription is filled, unless dispensed by a licensed public pharmacy;
- drugs that are deemed experimental in terms of generally accepted medical standards;
- the administering of drugs or insulin;
- use of tretinoin products for any covered person age 46 or older without Cigna approval and written documentation from a physician stating that the drug is being used for medical reasons;
- a quantity more than the amounts normally prescribed by a physician or dentist (in no event more than a 30-day supply or a three month supply for a maintenance drug);
- more refills than your physician or dentist has specified, or any refill dispensed after one year from the date of the prescription order;
- medication covered under Worker's Compensation (for any occupational injury or sickness) or under any municipal, state or federal program; and
- any drug or medication not listed as a covered prescription drug on the Prescription Drug List maintained by Cigna for purposes of the Plan, even if it is dispensed as a written or oral prescription from a physician.

VISION COVERAGE

Basic vision care benefits are included as part of your medical coverage. Basic coverage includes an annual eye examination, and corrective eyeglass lenses and frames or contact lenses once every other calendar year. However, lenses will be replaced after 12 months instead of after 24 months if (a) your lens prescription shows an axis change of 20 degrees or a .50 diopter cylinder change, and (b) a new prescription would improve your visual acuity by at least one line on the standard eye chart.

If you would like additional coverage, you may elect Supplemental Vision Care coverage. When Supplemental coverage is added to Basic coverage, you are eligible for the annual eye exam and two sets of eyeglasses or contact lenses each year (or one set of each). Blended, progressive, and multi-focal lenses are covered with Supplemental coverage.

Additionally, all covered Active Employees are eligible for safety glasses and Video Display Terminal (VDT) benefits, including glasses if necessary, for use while working at a computer VDT screen. These features are a supplement to your "standard" or "first pair" vision benefit and are designed to provide glasses if necessary, for employees who use a VDT screen or require safety glasses. VDT and safety glasses are not available for dependents.

In-Network Providers and Out-of-Network Providers

Vision care benefits are administered by Cigna. The benefits the Plan pays depend on whether you choose an eye doctor who participates in the Cigna network or an out-of-network provider to deliver the service. To locate a Cigna provider in your area, call Cigna at 800-668-1506 or check *myCigna.com*.

Once you find a Cigna provider, call and make an appointment. You'll need to provide the Social Security number of the covered employee and your SLB group name, so the provider can verify your coverage. When you use a Cigna provider, the Plan reimburses the doctor directly for all covered expenses. You pay only the *Copays* and the cost of any cosmetic items you choose

If you choose an eye doctor who does *not* participate in the Cigna network, you will pay the full charge for your eye exam and any required lenses and/or frames. You will then send your itemized receipt (or an HCFA-1500 form used by most eye doctors) to Cigna for reimbursement. **VDT benefits are not covered if you use a non-Cigna provider.**

See iThrive for additional vision cost and coverage details.

PAYMENTS FROM OTHER SOURCES

How Coverage Works Under Multiple Plans

If you or your covered dependent(s) are covered under more than one health plan, benefits payable from all the plans will be "coordinated" as described in this section

In cases of coverage under more than one plan, the SLB Medical Plan will pay up to the Plan's coverage limits based on whether it is the primary or secondary payer. For example, if your Spouse has coverage under both the SLB Medical Plan and another employer's plan, and both plans cover a certain bill at 80%, the SLB Plan will not pay an additional benefit after the other plan pays. Alternatively, if the other employer's plan covers a certain bill at 80% and the SLB Medical Plan covers the same bill at 100%, then the SLB Plan will pay the additional 20% of the covered charges (if you have met the *Annual Deductible*).

> **A Closer Look**
> This provision is important for employees who are paying for dependent coverage in cases where their dependent also has coverage under another plan. If this applies to you, you should carefully evaluate the costs and benefits available under both plans to determine whether it is financially advantageous for you to continue to pay for both of them. **Coverage under the SLB Medical Plan in addition to coverage under another plan will not guarantee 100% reimbursement of covered medical claims.**

Coordination of Benefits

Definition of a Plan
For purposes of this Coordination of Benefits section, "plan" means any of the following:

- group, blanket or franchise insurance coverage;
- service plan contracts, group or individual practice or other pre-payment plans;
- coverage under any labor-management trust plans, union welfare plans, employer organization plans, or employee benefit organization plans; or
- coverage under federal, state, or local government plans, or programs including Medicare.

The term "plan" does not include coverage under individual policies or individual contracts.

How Coordination Works
The SLB Medical Plan coordinates benefits with other plans, as follows:

- the plan with primary liability pays the full benefit amount payable under that plan; then
- the other plan(s) is/are the secondary payer and may pay any difference between amounts paid by the primary plan and the amount payable for the same covered expenses under its own plan.

When benefits from all plans have been paid, total benefits may be less than or equal to 100% of covered medical expenses, however benefits paid will not exceed 100% of covered medical expenses. The SLB Medical Plan pays benefits as a secondary payer so that benefits from both the primary and the secondary plan combined will equal no more than that which the claimant would have received if the SLB plan was primary.

When benefits from a plan are in the form of services, such as those provided by a Health Maintenance Organization, the reasonable cash value of each service will be deemed to be a benefit paid. Benefits

payable from all other plans include the benefits that would have been payable had a proper claim been made.

The Plan reserves the right to release or obtain from any insurance company, organization or person any information which, in the opinion of the Plan Administrator, is needed for the purpose of applying these Coordination provisions.

When payments are made by another plan that should have been paid by the SLB Medical Plan, reimbursements will be made to the other plan. Such reimbursements will be considered as if they were paid to the employee. If an overpayment is made under the SLB Medical Plan, the Plan Administrator has the right to recover that payment from the person or organization paid.

Rules that Apply to Coverage under More than One Group Plan

The following rules apply if there is coverage under more than one group plan:

1. An employee's claim is primary on his or her group plan. Coverage for a Spouse's claim is secondary under the SLB Medical Plan.

2. A plan that covers the person as an Active Employee, will be considered primary before a plan that covers the person as a retired or laid-off employee.

3. Dependent children's claims are primary for the plan that covers the parent whose birth month is first in the calendar year. The following exceptions apply to this rule 3:

   - if there is a court decree that establishes financial responsibility for medical, dental or other health care of the child, the plan that covers the child as a dependent of the parent who is responsible will be primary; otherwise
   - the plan that covers the child as a dependent of the parent with custody is primary over a plan that covers the child as a dependent of a step-parent or a parent without custody; otherwise
   - the plan that covers the child as a dependent of a step-parent is primary over a plan that covers the child as a parent without custody.

When the preceding rules do not establish the order of payment, the benefits of the plan that has covered the claimant for the longer period of time will be primary.

Rules that Apply to Coverage under Medicare

The following rules apply if there is coverage under Medicare as well as this Plan:

1. The SLB Medical Plan is the primary payer for Active Employees and / or covered Spouses age 65 and over who are entitled to Medicare benefits. The Plan provides the same benefits to all Active Employees and their Spouses, regardless of their age. Medicare is the secondary payer.

2. The SLB Medical Plan is the primary payer for disabled Active Employees and covered dependents who are entitled to Medicare. Medicare is the secondary payer.

3. The SLB Medical Plan is the primary payer for employees and covered dependents with end-stage renal disease for a period of 18 months. The 18-month period begins the month the individual becomes entitled to Medicare, even if a timely application has not been filed.

4. For all other individuals covered under this Plan and entitled to Medicare, the SLB Medical Plan will be a secondary payer to Medicare. This includes former employees and their dependents who are eligible for Medicare and whose coverage is continued for any reason under this Plan.

For individuals who are eligible for Medicare benefits but who have not applied, the Plan will assume the amount payable under Medicare Part A or B to be the amount the individual would receive if he or she had applied. In this case, the Plan will only pay covered expenses above the assumed Medicare benefits for former employees and their dependents. Therefore, it is important that former employees and their dependents enroll in Medicare when first eligible. A former employee and/or dependent is considered eligible for Medicare on the earliest date any coverage under Medicare could become effective for him or her.

Subrogation and Right of Recovery

Definition

The following special terms are used in this section:

A "condition" includes an injury, illness, sickness, or other condition.

A "third party" can be:

- a person or entity which may be responsible in any way for your condition;
- any liability insurance or other insurance (such as homeowner's insurance) that covers you or a third party, or otherwise may be responsible to pay benefits relating to your condition;
- your employer in worker's compensation;
- your own motorist insurance coverage, including uninsured motorist, underinsured motorist insurance, no-fault insurance and medical payments or personal injury protection coverage; or
- school insurance.

How Subrogation and Right of Recovery Work

The Plan has certain special rights, called rights of "subrogation" and "recovery" which are described in more detail below. Subrogation and recovery apply to all benefits offered by the Plan. Subrogation and recovery generally mean that the Plan has the right to reimbursement if it has paid claims on your behalf that you are able to recover from a third party. When the Plan is "subrogated to" your rights to recover from a third party, it means the Plan has the right to be paid first from any recovery you obtain from a third party as a result of your condition.

The Plan may pay or owe benefits relating to a condition for which you may be entitled to compensation from a third party, including payments to you. If this occurs, the Plan is subrogated to all of your rights against, claims against and partial or full recoveries from that third party, up to the amount paid (or owed) by the Plan. This is true regardless of whether the Plan actually has paid the benefits described above, and regardless of whether you have been fully compensated or "made whole" for the condition.

The Plan will have an immediate and first lien on all sums you recover related to a condition for which it pays (or may owe) benefits, up to the amount of the Plan payments, regardless of whether the amounts recovered are obtained by a settlement agreement, judgment, court order, arbitration, mediation or otherwise. The Plan may seek relief from anyone who receives settlement proceeds or amounts collected related to the condition for which it pays (or may owe benefits). This relief may include, but is not limited to, the imposition of a constructive trust and/or an equitable lien.

In addition, if you receive a partial or full recovery from a third party relating to a condition, the Plan is entitled to an independent right of immediate and first reimbursement from that recovery (before anyone else is paid anything from that recovery, including you), up to the amount paid (or owed) by the Plan for that condition. This is true regardless of whether the Plan actually has paid the benefits described above,

regardless of whether you have been fully compensated or "made whole" for that condition, regardless of your fault or negligence, and regardless of how you obtained that recovery from the third party (for example, by a settlement agreement, court order, judgment, arbitration, mediation or otherwise) and no matter how the recovery is captioned or characterized.

You will be responsible for payment of the legal fees and costs associated with your rights of recovery against a third party. The Plan is not required to help you pursue your claim for damages or personal injuries, or participate in or pay any of your associated costs, including attorneys' fees. The Plan's rights of subrogation and recovery described in this section apply to all amounts that you recover (rather than only the amounts remaining after payment of any legal fees and costs). This is true even if the law of the state in which you are pursuing recovery from the third party provides otherwise. The Plan's rights of reimbursement and subrogation apply to the first monies that you are paid or receive, without deductions of any type, including costs or attorney's fees that you incur in order to obtain a payment from a third party with respect to a condition. No so-called "Fund Doctrine" or "Common Fund Doctrine" or "Attorney's Fund Doctrine" or other defenses will apply.

As a condition of paying any benefits, the Plan requires that you do anything that may be necessary or helpful, in the Plan Administrator's or claims processor's discretion, related to the Plan's rights described in this section, including signing (or obtaining signatures on) relevant documents. No benefits are payable from this Plan unless and until such properly executed forms are received by either the Plan Administrator or the claims processor. However, should the Plan pay benefits before the receipt of these documents, the Plan shall have full rights to subrogation and recovery described in this section regardless of whether these documents are ever properly executed and provided to the Plan. Neither may you, any member of your family, your representative, nor anybody else at your direction do anything to harm the Plan's rights to subrogation and recovery. If you or they do not comply with any reasonable Plan request in this regard, the Plan may withhold benefits that otherwise may be due under the Plan, and you will be responsible to reimburse the Plan, in the Plan Administrator's discretion, for any costs incurred.

If you or any beneficiary accepts payment from the Plan or have Plan benefits paid on your (or their) behalf, that person does so subject to the provisions of the Plan, including the provisions described in this Subrogation and Recovery section. You, as well as any legal guardian or representative, will be considered a constructive trustee with respect to any recovery received or that may be received from any third party, which was paid in consideration of any condition for which the third party was responsible and for which you have received a benefit payment. You must hold any such funds in trust until the Plan's lien is satisfied, either in a separate bank account in your name or in your attorney's trust account.

The Plan's rights to subrogation and recovery shall apply regardless of whether you are disabled or incapacitated and shall apply to:

- any funds held by a third party in any form;
- any funds held by a trustee (including any type of special needs trust or any other type of trust arrangement); and
- any funds converted to an annuity or any other type or form of payment.

These rights to subrogation and recovery shall apply regardless of whether you have possession or control of the funds. The Plan shall have a constructive trust and equitable lien over the funds.

You must promptly notify the Plan Administrator of the possibility of obtaining a recovery from a third party for a condition for which the Plan has provided benefits (or may be responsible for providing benefits). This is true regardless of whether that recovery may be obtained by a settlement agreement, judgment, court

order, arbitration, mediation or otherwise. You must not agree to a settlement regarding that condition without first obtaining the written consent of the Plan Administrator, which may be provided through a designee. If you settle a claim with a third party in a way that results in the Plan being reimbursed less than the amount of Plan benefits related to a condition, or in any way that relieves the third party of future liability for medical costs, the Plan may refuse to pay additional benefits for that condition unless the Plan Administrator approves the settlement in writing.

The Plan may enforce its subrogation and recovery rights in any of the following ways:

- The Plan may file suit in your name or require you to assert a claim and take appropriate action to assert its rights under this section.
- The Plan may require you to make a claim against any insurance coverage under which you may be entitled to a recovery for a condition or to appear at medical examinations and legal proceedings, such as depositions and hearings.
- The Plan may intervene in any legal action you bring against a third party related to a condition.
- The Plan may bring a legal action against (a) you, (b) the attorney for you, or anyone else, and (c) any party holding any proceeds recovered by or with respect to you for a condition.

If you fail to cooperate with the Plan, the Plan may terminate your benefits, deny future benefits and/or set off from any future benefits the value of benefits paid on your behalf to which the Plan has a subrogation or recovery right.

More Important Information

The provisions of this section are written to be read by you, the covered employee. They apply equally to all of your covered dependents. In the case of a covered dependent who is a minor child, the child's parent or guardian must sign any required documents on behalf of the child.

Recovery

The Plan is also entitled to recover any amounts paid that exceed amounts actually owed under the Plan. These excess Plan payments may be recovered from you, your covered dependent, any other persons with respect to whom the payments were made, the person who received the benefit payment, any insurance companies, and any other organization or any other beneficiary of the Plan. The Plan may also, at its option, deduct the amount of any excess Plan payments from any subsequent Plan benefits payable to, or on behalf of, you or your covered dependent.

Automobile Insurance

No payment will be made for medical expenses incurred by you or any one of your dependents to the extent that benefits are paid or payable for those expenses under the mandatory part of any auto insurance policy written to comply with:

- a "no fault" insurance law; or
- an Uninsured Motorist insurance law.

The Plan Administrator will take into account any adjustment option chosen under that mandatory part of insurance by you or any one of your dependents.

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 appealing the denial of a claim under the Plan, but only as described in the *Authorized Representative* section below.

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

You can contact Cigna regarding a claim or appeal as follows:

Medical, Prescription and Dental	Vision
Cigna P.O. Box 188011 Chattanooga, TN 37422 Phone: 800-668-1506 Fax: 877-815-4827	Cigna Vision P.O. Box 385018 Birmingham, AL 35238-5018 Phone: 800-668-1506

How and When to File a Claim

When you receive medical services from an in-network provider, the provider usually will submit claims on your behalf. You must submit claims for out-of-network services to Cigna. In-network users may also need to file a claim in some instances, such as when the Plan is their secondary coverage. Claim forms are available by contacting Cigna.

A Closer Look: When to Submit Claims
To help ensure your claims are processed quickly and accurately, you should submit your claims to the Cigna as soon as possible after you receive the services or supplies. Cigna will consider claims for coverage under our plans when proof of loss (a claim) is submitted within 365 days for Out-of-Network benefits after services are rendered

Types of Claims and Appeals

This section provides some different rules for the following three different types of claims and appeals:

1. A "**Post-Service Claim**" is a claim for a benefit that the Plan does not require you to have pre-approved (approved before you obtain the medical care) in order to obtain the maximum Plan benefit. Most claims under the Plan will be Post-Service Claims. A "Post-Service Appeal" is an appeal of a Post-Service Claim that has been denied.

2. A "**Pre-Service Claim**" is a claim for a benefit that the Plan does require you to have pre-approved (approved before you obtain the medical care) in order to obtain the maximum Plan benefit. This includes

things like required notification, precertification, care coordination, case management or utilization review, and requests to extend a course of treatment that has previously been pre-approved. The other provisions of this Summary will tell you when these types of approval are required in order for you to obtain the maximum benefit. A "Pre-Service Appeal" is an appeal of a Pre-Service Claim that has been denied.

3. An "**Urgent Care Claim**" (or an "**Urgent Care Appeal")** is a Pre-Service Claim (or appeal of a Pre-Service Claim) where delaying a decision on the claim (or appeal) until the usual deadline (i) could seriously jeopardize your life or health or your ability to regain maximum function, or (ii) would, in the opinion of a physician who has knowledge of your medical condition, subject you to severe and unmanageable pain. The Plan will treat a claim or appeal as an Urgent Care Claim or Appeal if the physician treating you tells the Plan that it meets the criteria for an Urgent Care Claim or Appeal as defined above. Whether a claim or appeal meets the Urgent Care criteria is determined at the time that the claim or appeal is being considered. For example, a denied Urgent Care Claim may no longer meet the Urgent Care criteria when it is being considered on appeal if your condition has improved.

Claim Processing

After you file a Post-Service Claim, Cigna 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. For a Pre-Service claim, you will be notified of the decision within a reasonable period not to exceed 15 days, and for an Urgent Care Claim, you will be notified of the decision as soon as possible taking into account your medical condition, but not longer than 24 hours after the claim is received unless you did not provide sufficient information for Cigna to process the claim. In no event will the decision for an Urgent Care Claim be provided later than 72 hours after the claim is received.

However, the deadline may be extended for up to 15 days for a Pre- or Post-Service Claim based on special circumstances beyond Cigna's control (for example, if you don't provide all of the information necessary for a decision). If Cigna 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 after you receive the notice to provide that information. The 15-day extension does not apply to Urgent Care Claims.

Some Special Rules for Urgent Care and Pre-Service Claims

Improperly Filed Claims

In some cases, if you try to make an Urgent Care Claim or other Pre-Service Claim and you don't make the claim the right way (as required by these claims procedures), Cigna will notify you that you didn't file the claim properly and will let you know how you can file the claim properly. (You may be notified orally. If you are notified orally, you may request a written notice.) You will only be notified if (i) you made the improper claim to someone at the Company who is customarily responsible for handling benefit matters, or to Cigna, or to a case management, utilization review, care coordination or similar company that provides services to the Plan, and (ii) your improper claim included your name, the specific medical condition or symptom, and the specific proposed treatment, service or product that you are trying to get approved. If you meet these requirements, you will be notified as soon as possible that you didn't properly file your claim, but not later than 24 hours after the improperly filed Urgent Care Claim is received or not later than 5 days after any other improperly filed Pre-Service Claim is received.

Incomplete Urgent Care Claims

If you make an Urgent Care Claim, but you don't provide Cigna with all of the information that it needs to make a decision on your claim, Cigna will notify you of the specific information needed to complete your claim within 24 hours after receiving the incomplete claim. You will be given a reasonable period of time (which can't be less than 48 hours) to provide the information. Cigna must notify you of its decision as soon as possible, but in no event later than 48 hours after it receives the specified information (or 48 hours after the deadline for you to provide the specified information, if that is earlier).

Extensions and Terminations of Pre-Approved Benefits

If an ongoing course of treatment has been pre-approved as an Urgent Care Claim or other Pre-Service Claim, you may want an extension or Cigna may determine that the benefit should no longer be continued. If either case, some special deadlines may apply which are described below.

If you make an Urgent Care Claim that is a request to extend a previously approved course of treatment, Cigna must notify you of its decision on that request within 24 hours after the request is received. However, this special rule will only apply if you request the extension at least 24 hours before the end of the previously approved course of treatment. (Any other request to extend previously approved treatment will be treated like any other new Urgent Care Claim or a new Pre-Service Claim, as applicable.)

If Cigna determines that benefit payments for a previously approved course of treatment should be stopped before the scheduled end of that approved treatment, Cigna must give you a notice (which will be treated as a claim denial) and must allow you adequate time to appeal that claim denial and receive a determination on the appeal before the Plan stops paying benefits for that treatment. The rules and deadlines that apply to appeals of claim denials are described below; however, Cigna is only required to give you a reasonable period of time to appeal this type of claim denial (rather than 180 days as described below for other appeals).

Written Approval Notices Required for Urgent Care and Pre-Service Claims

In general, the Plan is not required to provide you with a written notice if a claim is approved; however, the Plan must give you a written or electronic notice by the deadline indicated above if an Urgent Care Claim or other Pre-Service Claim is approved.

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 and External Appeals Review Procedures described below, including information on how to file an appeal or Request for External Review and the time limits that apply;
- a statement that you can file a lawsuit under ERISA or request an external review if your claim is denied on final appeal;
- if your denied claim was an Urgent Care Claim, a description of the faster appeals process that applies to Urgent Care Appeals and Urgent External Reviews; and
- a statement regarding the availability of any applicable office of health insurance consumer assistance or ombudsman established to help claimants with Plan claims and appeals and External Reviews, including contact information.

If your denied claim was an Urgent Care Claim, the information described above may first be provided to you orally, and a written or electronic notice will be given to you within 3 days after the oral notice.

Appealing a Denied Claim

If any part of your claim is denied, you can appeal that denial to Cigna. Your appeal must be made in writing within 180 days after the date you receive the claim denial. You may give Cigna 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.

Special Rule for Urgent Care Appeals

If you are making an Urgent Care Appeal, you may appeal by calling Cigna at 800-668-1506. No written appeal will be required for an Urgent Care Appeal. In addition, all communications between you and the Plan regarding your Urgent Care Appeal may be by telephone, facsimile, or any other available expedited method of communication. In certain circumstances you may be eligible to seek an Expedited External Review of a denial of an Urgent Care Claim. See the External Appeals Review Procedures below for further details.

Appeal Processing

Cigna will reconsider any denied claim that you appeal by the deadline, including all information you provide relating to the claim even if this information was not submitted or considered in the original claim decision. 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).

In connection with your appeal, you have the right to review your claim file and to present evidence and testimony regarding your claim. The Plan must provide you, free of charge, with any new or additional evidence that it considered or generated in connection with the claim as soon as possible so that you have an opportunity to respond before the date the decision is required on your appeal. Similarly, the Plan cannot deny an appeal based on a new or additional rationale until you have been provided with the rationale, free of charge. This must be done as soon as possible so that you have an opportunity to respond before the date the decision is required on your appeal. In addition, the Plan must continue to provide coverage until your appeal has been decided.

If Cigna is deciding an appeal of a claim denial that is based in any way on a medical judgment (including things like whether a treatment is experimental or not medically necessary), Cigna must get advice from a health care professional who has training and experience in that area of health care. Upon request, you will be provided the names of any experts who were consulted in connection with your claim denial, even if the advice was not relied upon in making the denial. The health care professional consulted can't be a person who was consulted by the reviewer in connection with the original claim denial (or a subordinate of the person who was consulted in the original claim).

Cigna will notify you of its decision on your Pre-Service or Post-Service Appeal within a reasonable time frame after the claim is received, which won't be more than 60 days for a Post-Service Appeal or 30 days for a Pre-Service Appeal. For an Urgent Care Appeal, Cigna will notify you of its decision as soon as possible after the appeal is received, but not later than 72 hours after the appeal is received.

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:

- information identifying the claim - including the date or dates of service, the health care provider, the claim amount (if applicable), the diagnosis code and its meaning, and the treatment code and its meaning;
- the specific reason(s) for the denial - including the denial code and its meaning and a description of any standard used to deny the claim;
- 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 or file a request for an external review if your claim is denied on final appeal, including information on how to file a request for an external review and the time limits that apply; and
- a statement regarding the availability of any applicable office of health insurance consumer assistance or ombudsman established to help claimants with Plan claims and appeals and Outside Reviews, including contact information.

If your denied appeal was an Urgent Care Appeal, the information described above may first be provided to you orally, and a written or electronic notice will be given to you within 3 days after the oral notice.

External Appeals Review

You can request an external review by an Independent Review Organization (IRO) as an additional level of appeal before, or instead of, filing a civil action with respect to your claim under Section 502(a) of ERISA. Generally, to be eligible for an independent external review, you must exhaust the internal claim review process described above, unless your claim and appeals were not reviewed in accordance with all of the legal requirements relating to benefit claims and appeals or your appeal is urgent. In the case of an urgent appeal, you can submit your appeal to both the Plan and request an external independent review at the same time, or alternatively you can submit your urgent appeal for the external independent review after you have completed the internal appeal process.

To file for an independent external review, you must provide Cigna your external review request within 4 months after you receive the denial of your claim. (If the date that is four months from that date is a Saturday, Sunday or Federal holiday, the deadline is the next business day) at the address listed in the *Administrative and ERISA Information* section.

Preliminary Review

Cigna will conduct a preliminary review of your request for an external review within 5 business days after the request was received. The preliminary review will determine whether:

- You were covered by the Plan at all relevant times;
- The basis for the denial was failure to meet the Plan's eligibility requirements;
- You exhausted the appeal process (or the internal review process is "deemed" complete because of the Plan's failure to meet all of the requirements set forth above in this Claims Procedure); and
- You submitted all required information or forms that are necessary for processing the external review.

If the Plan determines that you have not met any of these four requirements, your request is ineligible for an external review. Cigna will notify you of the results of the preliminary review within one business day after the review is complete:

- If you are eligible for an external review, you will have 10 business days after you receive the notice to provide any additional information.

- If you are not eligible for an external review, the notification will include the reasons why your request is not eligible, and also will provide you with contact information for the Employee Benefits Security Administration.
- If your request is not complete, Cigna's notification will describe the information or materials needed to make the request complete. You will then have the balance of the four-month filing period or, if later, 48 hours from when you received the notice, to correct your request for external review.

Referral to an Independent Review Organization (IRO)

If you are eligible for an external review, the Plan will notify you, in writing. Cigna will, by rotation, select one of at least three IROs with which the Plan has a contract to perform the external review of your claim. The IRO will be accredited by a nationally-recognized accrediting organization. Within five business days after your claim is determined acceptable, Cigna will provide the IRO with documents and information that were considered during any earlier denial. The IRO may reverse Cigna's final denial of the claim if the documents and information are not provided to the IRO within the five-day time frame.

You will receive notice from the IRO that your claim has been accepted for external review. The notice will include a statement that you have 10 business days to submit additional information. The IRO must consider this information in its review and may agree to consider additional information received after 10 business days. Within one business day after receiving additional information from you, the IRO must forward the information to the Plan. The Plan may reconsider the denial based on this additional information. If the Plan decides to reverse its denial of your claim and provide coverage or payment, it must provide written notice to you and the IRO within one business day after making the decision. The IRO will terminate the external review if it receives this notice.

The IRO will review all information and documents that are received in a timely manner. The IRO will not be bound by any decisions or conclusions that were reached by Cigna during the Plan's internal appeal process.

In addition to the documents and information provided by you and the Plan, the IRO will consider the following information or documents if they are available and the IRO considers them appropriate:

- your medical records;
- your attending health care professional's recommendation;
- reports from appropriate health care professionals and other documents submitted by the Plan, you or your treating provider;
- the terms of the Plan unless the terms are inconsistent with applicable law;
- appropriate practice guidelines, which must include applicable evidence-based standards;
- any applicable clinical review criteria developed and used by the Plan, unless the criteria are inconsistent with the terms of the Plan or with applicable law; and
- the opinion of the IRO's clinical reviewer(s) after considering the information described above to the extent the information or documents are available and the clinical reviewer(s) consider appropriate.

The assigned IRO must provide written notice of its final external review decision within 45 days after the IRO received the request for the external review. The IRO will deliver its notice of final external review decision to you and Cigna. The IRO's notice will inform you of:

- A general description of the reason for the external review and information that identifies the claim - including the date or dates of service, the health care provider, the claim amount (if applicable), the

diagnosis code and its meaning, the treatment code and its meaning, and the reason for the previous denial;
- The date it received the assignment to conduct the review and the date of its decision;
- References to the evidence or documentation, including specific coverage provisions and evidence-based standards, considered in reaching its decision;
- A discussion of the principal reason(s) for its decision, including the rationale for its decision and any evidence-based standards that were used in making its decision;
- A statement that the determination is binding except to the extent that other remedies may be available under state or federal law to either you or the Plan;
- A statement that judicial review may be available to you; and
- Current contact information, including a telephone number, for any applicable office of health insurance consumer assistance or ombudsman established under Section 2793 of the Public Health Service Act.

If the final independent decision is to approve payment or referral, the Plan will accept the decision and provide benefits for such service or procedure in accordance with the terms and conditions of the Plan. If the final independent review decision is that payment or referral will not be made, the Plan will not be obligated to provide benefits for the service or procedure. However, you may then take additional action (see *Exhaustion*, below).

Expedited External Review

Special "expedited" review procedures are also available for urgent or on-going emergency medical situations, when abiding by the standard appeals process would jeopardize your life or health. The expedited review procedures require the Plan to conduct its preliminary review immediately (rather than having five business days) and all information must be transmitted to the IRO electronically or in another prompt method (telephone, fax, etc.). The IRO must issue its final decision as soon as reasonably possible in light of your medical condition and in no case more than 72 hours after receiving the case. This expedited review is separate from your right to receive a 24-hour internal review of "urgent" care claims.

If your request is not complete, Cigna's notification will describe the information or materials needed to make the request complete. You will then have 48 hours from receipt of the notice to correct your request for external review.

Authority of Cigna as the Claims and Appeals Administrator

Cigna has been delegated the discretionary authority and responsibility for determining benefits described in this SPD. In processing claims and appeals, Cigna 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 Cigna decides in its sole discretion you are entitled to them. Any decision made by Cigna on appeal (or on a second voluntary appeal if you choose to file one) is final and binding, unless you file suit under ERISA.

Who Receives Payment

Generally, benefit payments will be made directly to in-network providers when they bill Cigna. If you use an out-of-network provider, after you submit the claim for payment, Cigna will pay you directly. Any benefits payable to you, if unpaid at your death, will be paid to your surviving Spouse, as beneficiary. If there is no surviving Spouse, then the benefits will be paid to your estate.

Benefit Payments to a Managing Conservator

Benefits for services provided to your minor dependent child may be paid to a third party only if the third party is named in a court order as the managing or possessory conservator of the child and Cigna has not already paid any portion of the claim. In order for benefits to be payable to a managing or possessory conservator of a child, the managing or possessory conservator must submit to Cigna, with the claim form, proof of payment of the expenses and a certified copy of the court order naming that person the managing or possessory conservator.

Anti-Assignment

Neither you nor your dependents may assign the right to benefits under the Plan to any other person, including to a health care provider. This means you and your dependents may not assign to anyone your rights to bring a claim for benefits under the Plan or to bring a legal suit under ERISA or any other federal or state law for benefits or for breach of any other duty or obligation that the Plan may owe to you (or your dependents) under the terms of the Plan or ERISA, and any attempt to assign such rights will be void and unenforceable.

This does not mean, however, that you may not authorize the Plan to pay a provider directly for its charges for medical services provided to you. In fact, you will be deemed to have authorized the Plan to pay health care providers directly for their covered charges upon your enrollment in the Plan unless you revoke this authorization by providing written notice to the Plan Administrator.

However, your authorization for the Plan to make these direct payments does not mean that you have assigned to the provider any legal right enforceable by the provider to the benefits payable under the Plan, or the right to bring a claim or lawsuit for benefits under the Plan or for breach or violation of any other duty or obligation owed to you under the Plan (or ERISA or other law). Nor does this direct payment mean that the Plan recognizes any purported assignment of benefits or claims asserted by the provider. These legal rights to benefits and claims remain yours and yours alone. In no event will the Plan, or SLB or its affiliates be liable to any third party to whom you may be liable for medical care, treatment or other services.

Authorized Representative

An authorized representative may act on your behalf (or on behalf of your covered dependent) in pursuing a benefit claim or an appeal of a denied claim. An individual or entity will only be determined to be your authorized representative for this purpose if you have provided Cigna with a written statement identifying that individual or entity as your authorized representative and describing the scope of the authority of that authorized representative; provided that, for an Urgent Care Claim or Urgent Care Appeal, a health care provider with knowledge of your medical condition will be permitted to act as your authorized representative.

In order to appoint an authorized representative, you must provide Cigna with a written statement identifying your desired authorized representative and describing the scope of the authority of your desired authorized representative. You must also comply with any other procedures that Cigna or the Plan Administrator may establish to ensure that the person or entity appointed has in fact been authorized to act on your behalf, including providing the written statement on the form specified by Cigna or the Plan Administrator.

However, no appointment of any individual or entity as an authorized representative will be valid if Cigna determines that the appointment is intended to circumvent (or in fact circumvents) the anti-assignment rules of the Plan, as described above under "*Anti-Assignment*", including where the individual or entity would be a direct or indirect beneficiary of the benefits subject to the claim. An appointment of any individual or entity

as an authorized representative will also be invalid if Cigna determines that the individual or entity has previously engaged in practices causing services not to be covered under the Plan, such as waiving deductibles or Coinsurance.

For an Urgent Care Claim only, a health care provider with knowledge of your medical condition will be permitted to act as your authorized representative without satisfying the written statement requirement.

Requirements before Filing Suit

You cannot bring any legal action against the Plan, the Plan Administrator or Cigna for any reason unless you first complete all the steps in the first appeal process described in this document. If Cigna or the Plan fails to complete a claim determination or appeal within the time limits discussed above, you may treat the claim or appeal as having been denied, and you may proceed to the next level in the review process. After completing that process, if you want to bring such a legal action, such as a civil action under ERISA Section 502(a) for judicial review of the adverse benefit determination (see *Administrative and ERISA Information*)., 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. Additional information may be available from a local U.S. Department of Labor Office.

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, Cigna may deduct the overpayment from future claims payments due to you under the Plan.

Information and Consents Required from You

As a condition of receiving benefits under the Plan, you and your covered dependents consent to the release of any information Cigna determines is necessary to send to parties who need the information for claims purposes, as well as the release of medical information for use in Plan administration; however, medical information released to either the Plan Sponsor or the Plan Administrator will not be used to affect your continued employment, pay, promotion or other incidents of employment. In considering a claim or an appeal, the Plan has the right to require a medical examination when and as often as may be required. The Plan also has the right to review your or your covered dependents' medical records, and any additional evidence deemed necessary as evidence on which a claim or an appeal under the Plan may be based.

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 medical benefits is commonly known as the SLB Medical Plan.

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 medical benefits.

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 Cigna as the Claims Administrator to process, investigate and decide claims and manage the daily administration of the Plan. The Plan

Administrator also has delegated discretionary authority to Cigna to process, investigate and decide appeals under the Plan for the applicable benefits. Contact information for Cigna is as follows:

Medical, Prescription and Dental	Vision
Cigna P.O. Box 182223 Chattanooga, TN 37422-7223 Phone: 800-668-1506	Cigna Vision P.O. Box 385018 Birmingham, AL 35238-5018 Phone: 800-668-1506

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 Medical Plan, but reserves the right to change or end all or part of the Group Plan including the Medical 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 Medical 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 Medical 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

Some terms that are used frequently in this SPD are capitalized because they have specific meanings. Those terms are defined below.

Active Employee(s)

You are an "Active Employee" if you are on an SLB U.S. payroll and are receiving compensation from the *Company*. If you are absent from work on an unpaid leave of absence you are not an Active Employee for purposes of the Plan.

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's 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.

Admissible Compensation

"Admissible Compensation" includes your *Base Pay*, bonuses such as merit and PIP bonuses (if any), shift differential, overtime pay and commissions.

Admissible Compensation does not include special compensation such as moving allowances, severance pay, tuition reimbursements, hiring bonuses, one-time special recognition awards or cash-in-lieu of vacation.

Annual Deductible

The "Annual Deductible" is the amount you must pay out-of-pocket each year for covered expenses before the Medical Plan starts to reimburse expenses, with certain exceptions.

Annual Enrollment

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

Annual Out-of-Pocket Maximum

The "Annual Out-of-pocket Maximum" is the most you pay for covered medical expenses during a given calendar year as described in *Cost-Sharing*.

Base Pay

"Base Pay" is your base rate of pay excluding overtime, shift differential, bonuses, incentive compensation and other amounts paid in addition to your base rate of pay. Your Base Pay includes 401(k) contributions and any before-tax medical or dependent care contributions.

Claims Administrator

The Claims Administrator is Cigna. 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 Solutions.

Coinsurance

"Coinsurance" is the percentage of a covered expense you must pay after you meet your *Annual Deductible* and before you meet your *Annual Out-of-Pocket Maximum*.

Company (also referred to as SLB)

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

Copay

A "Copay" is the flat dollar amount you may pay when you receive certain services or supplies. Copays apply to the prescription drug and vision plans.

Eligible Dependent

An "Eligible Dependent" is a *Spouse* or child who meets the requirements of the *Eligible Dependents* section.

Eligible Employee

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

Group Plan

The "Group Plan" is the Schlumberger Group Welfare Benefits Plan.

HSA-qualified Dependents

Your "HSA-qualified Dependents" are individuals you claim as dependents for federal income tax purposes. Examples of HSA-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.

iThrive

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

Maximum Charge

The "Maximum Charge" is the maximum amount the Plan will consider for a particular out-of-network service or supply in determining benefits payable under the Plan.

- For (a) services furnished by an out-of-network provider in an in-network facility while you are receiving in-network services at that in-network facility, or (b) emergency services rendered in an out-of-network hospital, or by an out-of-network provider in an in-network hospital, the Maximum Charge is the amount agreed to by the out-of-network providers and Cigna or such amount as may be required by applicable state or Federal Law.

- For out-of-network emergency services that result in an inpatient admission, the Maximum Charge is the median amount negotiated with in-network facilities.

- For out-of-network services other than those described above, the Maximum Charge is the lesser of (a) the provider's normal charge for a similar service or supply, (b) the amount agreed to by the out-of-network provider and Cigna, or (c) a policyholder-selected percentile of charges made by providers of such service or supply in the geographic area where it is received as compiled in a database selected by Cigna. If sufficient charge data is unavailable in the database for that geographic area to determine the Maximum Charge, then state, regional or national charge data may be used. If sufficient charge data is unavailable in the database for that geographic area to determine the Maximum Charge, then data in the database for similar services may be used.

- For covered services for Open Access Plus, the Maximum Charge is the lesser of (a) the provider's normal charge for a similar service or supply, or (b) the amount agreed to by the out-of-network provider and Cigna or a percentage of a fee schedule Cigna has developed that is based upon a methodology similar to a methodology utilized by Medicare to determine the allowable fee reimbursement for the same or similar service within the geographic market.

Negotiated Fees (Negotiated Rates)

"Negotiated Fees" (or Negotiated Rates) are the rates a network provider agrees to charge for covered services.

Non-preferred Drug (Non-preferred Brand Name Drug)

A "Non-preferred Drug" is any brand name prescription medication that CVS/Caremark does not classify as a Preferred Drug.

Plan (also referred to as the Medical Plan)

The "Plan" is the medical 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.

Preferred Drug (Preferred Brand Name Drug)

A "Preferred Drug" is any brand name prescription medication that CVS/Caremark has evaluated for its therapeutic and economic value and has classified as "Preferred." Preferred Drugs may sometimes be referred to as Performance Drugs.

SLB (also referred to as the Company)

"SLB" 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 - HEALTH SAVINGS ACCOUNTS

A Health Savings Account (HSA) is automatically provided if you elect the Saver HSA or the Choice HSA medical option. The HSA lets you save money on a tax-free basis to pay for eligible out-of-pocket health care expenses for you and your covered *HSA-qualified Dependents* any time you need it. The HSA is basically a personal bank account that you own and control—you manage transactions, investments and withdrawals related to your account.

Note: Neither SLB's arrangement for making contributions to the HSAs of eligible employees nor the HSAs themselves are plans subject to ERISA or COBRA. HSAs are not a part of the Plan or the Group Plan, and HSAs are not sponsored by SLB.

Setting Up Your Account

Contributions cannot be deposited to your HSA until you establish your account at the bank selected by the Plan to manage these accounts. To establish your account, you must sign any forms and supply any other information the bank requires. Once your account is established, it may take up to two payroll periods before the first contributions are deposited. Once established, your account will grow with company contributions and, if you choose to make them, your own contributions, along with interest and investment earnings.

Company Contributions

SLB makes a contribution to your HSA each year, based on the medical plan option and level of coverage you elect.

The Company HSA contribution is automatically deposited into your HSA account by January 31 each year or within two pay periods after you open your account, whichever is later. Company contributions to your HSA account will be pro-rated if you enroll in coverage after December 31 of the preceding year.

In some years, the Company may make an additional discretionary contribution for participating in certain activities or events. Discretionary contributions will be paid to your HSA account according to the special programs as announced.

Your Contributions

You may also make pre-tax contributions to your HSA based on the level of coverage you elect. Federal regulations limit how much you and the *Company* can contribute to your account each year.

If you are age 55 or older, you may contribute an additional amount per year as "catch-up" contributions as per Federal regulations.

Your contributions will begin with the first pay period in January or within two pay periods after you open your account, whichever is later. The amount deducted from your pay will be the annual amount you elect to contribute divided by the payroll periods left in the calendar year when contributions begin.

Using Your Health Savings Account

You can make tax-free withdrawals from your Health Savings Account at any time as long as you use the money to pay for qualified healthcare expenses that are not reimbursed by any healthcare plan. These include costs such as your *Annual Deductible*, Coinsurance and most other out-of-pocket healthcare expenses for you and your *HSA-qualified Dependents*, including prescription drugs, vision and dental care services.

Your HSA-qualified Dependents include any individuals that you claim as a dependent on your federal income tax return.

Examples of Eligible and Ineligible HSA-related Expenses

Eligible expenses for reimbursement through your HSA are any payments that the IRS considers to be eligible healthcare expenses not reimbursed by any health insurance plan, such as:

- deductibles, coinsurance and copays under any healthcare plan, including the SLB Medical and Dental Plans;
- out-of-pocket payments for healthcare that exceed Maximum Charges;
- out-of-pocket expenses for prescription drugs and mental health services;
- the cost of orthodontia (braces) not covered by any 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; and
- premiums, contributions, or other payments for any healthcare plan or insurance policy if you become unemployed or retire.

Ineligible expenses include:

- services, treatments, equipment or supplies reimbursed by Medicare or any healthcare plan;
- expenses you deduct on your income tax returns;

- premiums, contributions or other payments for any healthcare plan or insurance policy while you are actively working;
- 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;
- weight loss programs, even if recommended by your doctor; and
- herbal remedies.

Your Health Savings Account Debit Card

Your Health Savings Account comes with a debit card to give you convenience and flexibility in how you pay your out-of-pocket healthcare costs. When you have an eligible expense, you can either pay for it yourself and leave the money in your Health Savings Account to grow over time; or, you can use your debit card to pay for it with the money in your account.

If you don't need to use your HSA savings in the current year, the money will remain in your account until you do need it at any time in the future. No vesting rules or service requirements apply to your account. You always own all the money in your HSA as of the date it is deposited - even *Company* contributions. If you retire or leave the Company, the full value of your account goes with you.

Investing Your Health Savings Account

Contributions to your HSA are initially invested in a long-term savings account. Interest on your account is compounded daily and credited to your account on a monthly basis. Once your account balance reaches $1,000, you may invest the funds in your HSA among any of the available investment fund options. The options include fixed income, asset allocation and equity funds.

You may access your HSA account information, view your contribution and transaction history and manage your account investments online from the Reimbursement Accounts tab on *iThrive.*

Tax Advantages of your HSA

Your Health Savings Account lets you benefit from a triple tax advantage:

- your voluntary contributions – and all Company contributions – go into your Health Savings Account before taxes are withheld;
- withdrawals – today, tomorrow or in the future – are not subject to taxes as long they are used to pay for eligible healthcare expenses for you and your HSA-qualified Dependents; and
- earnings on your Health Savings Account, if any, are tax-free.

A Closer Look at Certain State Taxes

Contributions and/or earnings are taxable in the following states: AL, CA, NH, NJ, TN, and WI. You are responsible for IRS reporting of any taxable distributions you receive from your Health Savings Account.

Keeping your HSA Account

You are always 100% vested in your Health Savings Account, including Company contributions, as of the date the funds are deposited to your account. You keep any money left over at the end of the year and into the future. Even if you switch medical coverage, retire or leave the Company, the balance in your account is always yours to keep.

APPENDIX B - 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 an SLB employee and are enrolled in the SLB US Medical or Dental Plan (and in certain cases, the Health Care Spending Account) which are referred to jointly in this Appendix as the "SLB 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 an SLB employee and you are covered by an SLB 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 SLB;
- divorce or legal separation from your spouse; or
- your spouse becomes entitled to Medicare.

Dependent children of an SLB employee who are covered by an SLB 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 SLB;
- 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 SLB Plan.

Similar rights may apply to certain retirees, spouses, and dependent children if SLB 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 SLB 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.

SLB 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 SLB Medical Plan, Dental Plan and in some cases the Health Care Spending Account at the time the qualifying event occurred.

If SLB changes or ends group health coverage under the SLB 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

COBRA coverage may continue for up to 36 months unless coverage was lost because of a termination of employment or reduction in work hours. In these cases, COBRA coverage for you and your dependents may be continued for up to 18 months.

Extension for Disability

The 18-month period may be extended to 29 months if the Social Security Administration determines you (or a family member who is a qualified beneficiary based on your termination of employment or reduction in hours) became disabled for purposes of Social Security within 60 days following the date COBRA coverage began. To receive this extension, you must notify the Plan Administrator of the Social Security disability determination within 60 days following the date of the determination and before the end of the original COBRA period. You must also notify the Plan Administrator within 30 days of any final determination that you (or the dependent) are no longer Social Security disabled.

You may notify the Plan Administrator by calling the US Benefits Center at 1-800-474-4015. Notice provided in any other manner will not be considered sufficient notice.

Extension for Second Qualifying Event

The 18-month period may be extended for up to 36 months for a dependent if a second qualifying event occurs during the initial 18-month period (or 29-month period if a disability) that gives rise to a 36-month COBRA period, such as death or divorce.

Maximum Period of COBRA Coverage

COBRA coverage cannot extend beyond 36 months from the date of the qualifying event that originally made you eligible for coverage. In addition, COBRA coverage will end before the expiration of your COBRA coverage period for any of the following reasons:

- SLB no longer provides group health plan coverage to any of its employees;
- you fail to pay the premium for continuation coverage on time;
- you become covered under another group health plan;
- you become entitled to Medicare; or
- your coverage is extended for up to 29 months due to disability and a final determination is made that you are no longer disabled.

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 SLB 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
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 C - 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 ("SLB") 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 SLB 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 SLB US Benefits Team at ***https://esm.slb.com/hr*** or contact the SLB HIPAA Privacy Officer at:

Attention: HIPAA Privacy Officer
SLB 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 SLB 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.

<u>Your Rights</u>

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.