SUMMARY PLAN DESCRIPTION

for Employees and Retirees

Shell USA, Inc. Health & Wellbeing Plan

Shell US Benefits

About This Book

This book is designed to serve as a source of information about the Shell USA, Inc. Health & Wellbeing Plan available to *employees* and *retirees* of the *Company*. It also meets our legal obligation to provide you with a summary plan description (SPD) on each of the programs described in this book.

This SPD also covers:

- Information to help *employees* prepare for retirement.
- General information related to *Company* plans.
- A Glossary that defines key terms.

How to Read This Book

This SPD is intended for both active and *retired employees*. Much of the benefit plan and general information applies to both audiences. When information within a section relates only to *employees* or only to *retirees*, the text will clearly state "for *employees*" or "for *retirees*."

Throughout the SPD you will be guided where to find additional information if it exists elsewhere in the book.

Benefit descriptions are generally divided into Care benefits (medical and other care plans) and Protection benefits.

The Glossary at the end of this book defines key terms that are important for understanding your benefits. Terms included in the Glossary are italicized throughout the book.

Notice

The information in this SPD reflects terms and provisions in effect as of January 1, 2023, except as otherwise noted.

While Shell intends to continue to offer *employees* and *retirees* a competitive benefits package, the *Company* reserves the right, in its sole discretion, to modify, change, revise, amend, or terminate any of the programs or plans described in this book at any time, for any reason, and without prior notice. This SPD is not to be construed as a contract of or for employment.

If any provision contained in this SPD conflicts with, contradicts, or is unclear with regard to any provision in the official Plan document, the provision in the official Plan document will control unless otherwise specifically stated. However, with regard to any insured benefits described in this SPD, documents provided by the insurance provider describing the insured benefits will control unless any provision contained in the document is contrary to applicable law.

Important Telephone Numbers and Websites

This directory lists places you can visit online to access additional information about your benefits. Log on to NetBenefits® at **www.netbenefits.com/shell**. From the NetBenefits home page, select **Menu**, then **Health & Insurance**. Scroll down below your benefits elections for links to All Health & Insurance Forms and Reference Library.

Forms Available Under "All Health and Insurance Forms"
Be Well @ Shell Physician Results form
Affidavit of Domestic Partnership
Disabled Dependent Request form
Claim forms
Life Insurance forms

Documents Available Under "Reference Library"
Medical summaries of benefits and coverage
Dental and Vision benefits summaries
Annual Enrollment Guides
Be Well @ Shell Resources

Use the following contact information if you have questions about your benefits:

	Telephone	Website
General Benefits		
Shell Benefits Service Center	1-800-307-4355 (1-800-30-SHELL) 1-800-847-0348 (TDD)*	www.netbenefits.com/shell
Benefits information available on the Shell intranet		HR Online > Policies and Benefits > My HR Policies
Care Plans		
UnitedHealthcare Customer Care		
▪ US PPO	1-800-752-8982	www.myuhc.com
▪ US HDHP	1-800-752-8982	www.myuhc.com
▪ Kelsey-Seybold Greater Houston	1-800-752-8982	www.myuhc.com
▪ Shell Medicare Complementary	1-888-831-2645 (Senior Support)	www.myuhc.com
▪ Shell Medicare Advantage plan	1-866-413-2864, TTY 711 (Monday – Sunday; 8:00 a.m. – 8:00 p.m., local time)	retiree.uhc.com/shell
NurseLine (UHC)	1-855-677-3411	
KelseyCare Advantage Plan Greater Houston	1-866-534-0556	www.kelseycareadvantage.com/shell
US GEMS: Cigna Global Health Benefits	1-855-279-1508 (toll-free) 1-302-797-5279 (direct)	www.CignaEnvoy.com

* From overseas, dial your country's AT&T access numbers first. (Access numbers are available by calling 1-800-331-1140 or online at **www.att.com/traveler**.)

(continued)

	Telephone	Website
Care Plans *(continued)*		
CVS Caremark	1-866-221-4207	www.caremark.com
OptumRx (Shell Medicare Advantage PPO) (Shell Medicare Complementary Option)	 1-866-413-2864 1-844-600-7913	 retiree.uhc.com/shell http://retiree.uhc.com/shellmedcomprx
Be Well @ Shell	1-877-440-0367	www.bewellatshell.com
Optum Behavioral Health	1-800-752-8982 1-800-897-1795	www.liveandworkwell.com (access code: Shell) (mental health/substance abuse) www.liveandworkwell.com (access code: Shell) (Employee Assistance Program)
Cigna Dental plans	1-800-CIGNA24 1-800-244-6224	www.mycigna.com
Vision Service Plan	1-800-877-7195	www.vsp.com
Included Health	1-855-322-2098	includedhealth.com/shell
HealthEquity/WageWorks *(Flexible Spending Accounts)*	1-877-924-3967	www.wageworks.com
Protection Plans		
MetLife (Group Life Insurance) – Statement of Health Unit Customer Service – Life Claims Customer Service (Retiree Life Insurance)	 1-800-307-4355 1-800-638-6420 (prompt #1) 1-800-638-6420 (prompt #2) 1-844-510-1937	www.metlife.com/mybenefits
Farmers (Auto/Home Insurance)	1-800-438-6381	www.myautohome.farmers.com
MetLife Legal plans	1-800-821-6400 (Monday – Friday; 8:00 a.m. – 7:00 p.m., Eastern time)	www.legalplans.com
Bright Horizons Family Solutions (Back-Up Care Program)	1-877-BH-CARES (1-877-242-2737)	backup.brighthorizons.com Username: Shell Password: care4you
John Hancock (Long-Term Care)	1-800-482-0022 (Monday – Friday, 7:30 a.m. – 5:30 p.m., Central time)	www.johnhancock.com

If you are enrolled in a regional medical plan not listed here and have a question about your benefits, contact the telephone number on your ID card.

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Quick Find — For Retirees

A brief directory of topics that apply to you as a *retiree*.

Care Programs

Your family status, your stage of life, your health — all are factors in determining the type of healthcare coverage that works best for you. Shell offers a selection of Care programs with options that provide flexibility for *employees* and *retirees* to meet their changing needs.

Active Employees	Retirees
▪ Medical ▪ Dental ▪ Vision ▪ *Employee Assistance Program* ▪ Health Care and Dependent Day Care *Flexible Spending Accounts* ▪ *Health Savings Account*	▪ Medical (hired or rehired before January 1, 2017) ▪ Dental ▪ Vision

Medical Benefit Program

Table of Contents

The Shell Medical Benefit Program offers you and your *eligible dependents* access to comprehensive coverage for your medical needs — from routine preventive care and wellness to treatment of ongoing conditions, complex surgeries, and specialized treatment for serious injuries or illnesses.

Participation

Eligibility

You are eligible for coverage under the Shell Medical Benefit Program if you are:

- A *regular full-time* or *regular part-time employee* of the *Company*.
- A *retiree* who retired from the *Company* having met *retiree coverage eligibility* requirements. For an explanation of those requirements, see M-10.

Please note: if you are a *retiree* who was hired or re-hired on or after January 1, 2017, you are not eligible for *retiree* coverage under the program.

If you are eligible and enroll in the program, you can also enroll your *eligible dependents*, which include:

- Your spouse or *domestic partner*.[1]
- Your child(ren)[2] through the end of the month in which they turn 26.
- Your unmarried child(ren) age 26 or over who were physically or mentally disabled on the day before reaching their 26th birthday and were covered under the program, or under another plan sponsored through your or your spouse/domestic partner's previous employment, and who remain disabled and permanently dependent on you for financial support.
- The unmarried child(ren) of your spouse or *domestic partner* who are under age 25, whose medical expenses are eligible for deduction on your federal tax return, who live with you in a regular parent-child relationship and who are not employed full-time.
- The unmarried child(ren) of your spouse or *domestic partner* age 25 or over who were physically or mentally disabled on the day before reaching their 25th birthday and were covered under the program, or under another plan sponsored through your or your spouse/domestic partner's previous employment, and who remain disabled, live with you in a regular parent-child relationship and are permanently dependent upon you for financial support.

[1] For *retirees*, *domestic partner* coverage is only available if you retired on or after January 1, 1998.

[2] For these purposes, child or children means a biological child, stepchild, adopted child, foster child, or grandchild of whom you have legal guardianship.

Enrollment

Contact the Shell Benefits Service Center at 1-800-30SHELL (1-800-307-4355) to enroll or ask questions about your eligibility.

Employees

If you are a newly *eligible employee*, you will receive enrollment materials from the Shell Benefits Service Center. If you wish to enroll, you have 31 days to do so after your eligibility date.

- If you enroll within this 31-day period, your coverage takes effect as of your hire date or eligibility date.
- If you do not enroll within this 31-day period, you may do so at the next *group annual enrollment period* or within 31 days of a *qualified status change*. See M-8 for information on what constitutes a *qualified status change*. You are not permitted to enroll at any other time.

If you were previously enrolled in the Medical Benefit Program, canceled your coverage, and wish to re-enroll, you can only do so during a *group annual enrollment period* or within 31 days of a *qualified status change*.

Retirees

If you retired from the *Company* having met *retiree coverage eligibility* requirements*:

- You can continue coverage for yourself and your dependents by paying the required contributions, or
- If not enrolled in the Medical Benefit Program at the time of your retirement, you can enroll for coverage during a *group annual enrollment period* or within 31 days of a *qualified status change*. See M-8 for information on what constitutes a *qualified status change*.

* See M-10 for information on *retiree coverage eligibility* requirements.

Dependents

If you enroll your dependents at the same time as you enroll yourself, their coverage begins the day your coverage begins. This includes dependents enrolled along with you within 31 days of your hire or eligibility date, and dependents enrolled with you during a *group annual enrollment* or following a *qualified status change*.

If you are already enrolled and wish to add a dependent:

- Generally, newly *eligible dependents* must be added within 31 days of their eligibility. Their coverage will begin at their date of eligibility.
- For newborns and newly adopted children to be covered from their date of birth or adoption, you must enroll them within 90 days of their birth or adoption.
- If you do not enroll dependents within the allotted time, you must wait for a *group annual enrollment period* or a subsequent *qualified status change*.
- You are required to provide a Social Security number for each enrolled dependent. If requested, you will also be required to provide information verifying eligibility.

Eligible dependents of an eligible *retiree* who was not enrolled in the Medical Benefit Program at the time of his/her death, may enroll for coverage by calling the Shell Benefit Service Center within 60 days of the *retiree's* death. If these *eligible dependents* do not contact the service center within 60 days or choose not to enroll, they may not enroll at a later date.

Levels of Coverage

You select the coverage level that suits your family's needs. However, if you are a *retiree*, your selection depends on whether you and/or your dependents are eligible for *Medicare*. *Medicare* status is not a factor for active *employees*.

Retirees Please Note

Coverage levels only apply to non-*Medicare*-eligible *retirees* and non-*Medicare*-eligible dependents. *Medicare*-eligible *retirees* and dependents are enrolled as separate participants.

For Active Employees and Non-Medicare-Eligible Retirees

The Medical Benefit Program allows you to choose from these levels of coverage:

- *Participant only.*
- *Participant plus child(ren).*
- *Participant plus spouse/domestic partner.*
- *Family.*

If both you and your spouse/*domestic partner* are eligible to enroll in the Shell Medical Benefit Program as *employees* or as non-*Medicare*-eligible *retirees*, or if one of you is an *employee* and the other a non-*Medicare*-eligible *retiree*, then:

- Each of you may enroll for *Participant only coverage*, or
- One of you may enroll for *Participant plus spouse/domestic partner* or *Family coverage*.

If you are a non-*Medicare*-eligible *retiree* and you have dependents who are eligible for *Medicare*, those dependent(s) are not included in the above levels but are enrolled on a per participant basis. For example, if your spouse is eligible for *Medicare* and you have no other dependents, you would enroll in *Participant only coverage*. Your spouse would be enrolled as 1 *Medicare* participant.

For Medicare-Eligible Retirees

If you are a *Medicare*-eligible *retiree*, you and your *Medicare*-eligible dependents enroll as separate participants. However, if you are a *Medicare*-eligible *retiree* and one or more of your dependents are not eligible for *Medicare*, they can enroll for coverage under the non-*Medicare*-eligible options at these levels:

- *Spouse/domestic partner only.*
- *Child(ren) only.*
- *Spouse/domestic partner plus child(ren).*

Changing Coverage

You may only change your coverage each year during the *group annual enrollment period* or if you experience a *qualified status change*. See page M-8 for information on what constitutes a *qualified status change*.

If you have a *qualified status change*, you may change your coverage only if:

- Your change in coverage is consistent with the *qualified status change* event (except with respect to *qualified status changes* that are considered special enrollment rights), and
- You submit your request to change your coverage:
  - within 31 days after the *qualified status change*, or
  - within 90 days after the birth or adoption of a child, or
  - within 60 days from the date of determination for loss of coverage under Medicaid or State Children's Health Insurance Program (SCHIP), or eligibility for a premium assistance subsidy under Medicaid or SCHIP.

Changes in coverage are effective on the date of the *qualified status change*.

Cost

You and the *Company* share in the cost of medical coverage.

Employees

If you are a *regular full-time* or *regular part-time employee*, your election to participate in the program constitutes an election to pay your contribution by pre-tax salary reduction. However, please be aware that federal tax law does not allow pre-tax payroll deductions for *domestic partner* coverage, including coverage for children of a *domestic partner* if they are not also your tax dependents. If you enroll a *domestic partner* under the *Participant plus spouse/domestic partner* or *Family* levels, the amount of your contribution in excess of the cost of *Participant only coverage* will be deducted on an after-tax basis.

Retirees

If you are an eligible *retiree*, your contributions are made on an after-tax basis through deduction from your pension payment or, in some cases, by direct payment through invoice or Automatic Bank Withdrawal (ABW). The *Company's* share of the premium cost for your medical coverage is determined by the date you were hired by the *Company*.

- If you were hired or rehired on or after January 1, 2006, and retired having met *retiree coverage eligibility*, then you may be eligible for a Retiree Medical Supplemental Account, based on credits earned at retirement. See K-3 for information on Retiree Medical Supplemental Accounts and how credits are calculated.
- If you were hired or rehired prior to January 1, 2006, you may be eligible for a *Company* post-retirement medical premium contribution, based on years of *accredited service*. See K-5 for information on the contribution schedule.

Important Notice Related to the COVID-19 Outbreak

Pursuant to guidance issued in response to the declared national emergency as a result of the COVID-19 outbreak (the "National Emergency"), and unless future guidance by the relevant government agencies provides otherwise, the time period between March 1, 2020, and July 10, 2023, which is 60 days following the announced May 11, 2023, end of the National Emergency will be disregarded in determining the deadlines for submitting a request to change your coverage when the request is in connection with a *qualified status change* that is considered a special enrollment right, as described in the Glossary on page M-8. However, the maximum deadline extension for any such request to change coverage is one year.

Medical Coverage Overview

Employees: If you and your *eligible dependent(s)* are enrolled in the Shell Medical Benefit Program, the Shell Medical Plan is your primary coverage. Your medical coverage options are described at right in "Medical Coverage for Active Employees and Non-Medicare-Eligible Retirees," and are the same even if you or one of your *eligible dependents* is eligible for *Medicare*. However, if you have a *domestic partner* who becomes eligible for *Medicare*, you should be aware that *Medicare* may charge him/her late enrollment penalties in the future if he/she does not enroll in *Medicare* when first eligible. If this applies to you see **www.medicare.gov** for more information.

Retirees: If you and your *eligible dependent(s)* are enrolled in the Shell Medical Benefit Program, your coverage options depend on *Medicare* eligibility. You and each of your *eligible dependent(s)* must select from options available for that person's *Medicare* status.

- If you and your *eligible dependent(s)* are not yet eligible for *Medicare*, the Shell Medical Plan is your primary coverage.
- If you and your *eligible dependent(s)* are eligible for *Medicare*, *Medicare* is your primary coverage and your options under the Shell Medical Plan coordinate with *Medicare*. ***Medicare*-eligible participants can go directly to A-29 for information on their medical plan options.**
- If you and your *eligible dependent(s)* have a different *Medicare* status (one of you is *Medicare*-eligible and the other is not), your Shell Medical coverage options will differ, based on your *Medicare* status.

Medical Coverage for Active Employees and Non-Medicare-Eligible Retirees

The coverage options listed here are all part of the Shell Medical Benefit Program. Please note that, depending on your coverage option, some parts of your benefits description may be in separate documents. This SPD incorporates the information found in the US GEMS Membership Guide, and any certificates of coverage, booklet certificates, or other similar information you receive from an insurance company or regional HMO/PPO providing benefits to you under the program.

This section covers the Shell Medical Benefit Program options available to eligible:

- Active *employees* and their dependents.
- Non-*Medicare*-eligible *retirees* and their non-*Medicare*-eligible dependents.

Your Medical Coverage Options

The *Company* offers you the choice of these medical options:

- **US PPO options**, which include the US PPO and the US PPO Out-of-Area, provide coverage for medical care you receive from any licensed health care provider anywhere in the world. The US PPO options also include a designated network of doctors and other health care professionals. If you choose to use a network provider when you or your family need medical care, you'll receive a higher level of benefits. The US PPO options are administered through UnitedHealthcare (UHC).
- **US HDHP options**, which include the US HDHP and US HDHP Out-of-Area, cover the same services and utilize the same network as the US PPO option. The difference is that the US HDHP option has a *deductible* that must be met before the plan pays its share of any non-preventive services (preventive care is covered at 100%).

  The US HDHP options are qualified *high deductible health plans* that may be paired with a *Health Savings Account (HSA)** to give you additional flexibility in managing your health care. Active *employees* who enroll in a US HDHP option can contribute to an *HSA* through pre-tax payroll deduction and are eligible for a *Company* contribution to their *HSA* account (see "Health Savings Account" on page E-9). Non-*Medicare*-eligible *retirees* who enroll in the US HDHP option can open an *HSA* at a wide selection of financial institutions.
- **Kelsey-Seybold Health Greater Houston plan**, available to *employees* and non-*Medicare*-eligible *retirees* in the greater Houston and Galveston area, is a comprehensive offering of medical care delivered and coordinated by Kelsey-Seybold Clinic *physicians*. The plan is administered through UHC.
- **Regional Health Maintenance Organization (HMO) and PPO options** deliver health care through a network of doctors, other health care professionals, *hospitals*, health care centers, labs, and pharmacies. In some cases, your care must be provided exclusively through the network in order to receive benefit reimbursement. The Shell Benefits Service Center can provide you with names of regional HMOs and PPOs available to you under the Medical Benefit Program.
- **US GEMS**, the US Global Expatriate Medical Scheme, is available to *employees* on "Long-Term International Assignment" or "Local Non-National" terms pursuant to the Shell International Mobility Polices. This program is administered through CIGNA and provides worldwide health coverage for care received by enrolled *employees* and their eligible family members. You can find details of US GEMS benefit provisions in the US GEMS Membership Guide at **www.CignaEnvoy.com**, on the Shell Intranet in HR Online, and at NetBenefits.

* Note that although the HDHP options are part of the Shell USA, Inc. Health & Wellbeing Plan, Shell does not sponsor the *HSA* arrangement and it is not part of the *Plan*. Rather, an *HSA* is established and maintained by the financial institution that offers the *HSA*. The *HSA* arrangement is exempt from *ERISA* pursuant to DOL Field Assistance Bulletins 2004-1 and 2006-02. Information provided to you about the *HSA* arrangement is for purposes of your convenience only.

HMOs offer standard benefit plan designs which, in addition to different benefits and cost structures, may not have the same participation and enrollment provisions as those outlined in this book. Each HMO provides its own summary plan description, which can be obtained by contacting the HMO directly. Contact information for your HMO is on your membership ID card or can be obtained by calling the Shell Benefits Service Center.

Be Well @ Shell (BW@S) Program

The BW@S Program is a voluntary, confidential wellness component of the Medical Benefit Program, available at no cost to eligible adult participants.

The BW@S Program offers tools to help you make a personalized wellness plan and track your health progress. The BW@S Program Guide describes how to:

- Use the BW@S Health Portal to take charge of your health and earn rewards for staying engaged.
- Get a comprehensive annual wellness check and qualify for a medical premium discount.
- Manage (or prevent) a chronic condition like diabetes and hypertension.
- Take advantage of programs for weight management and smoking/tobacco cessation.
- Engage with wellness coaches and utilize online meal planning services.
- Access *Employee Assistance Program (EAP)* services: confidential mental health counseling and assistance in areas such as family life, real estate, debt management, child and elder care referrals, work-life issues and more.

You can access the BW@S Program Guide at **www.bewellatshell.com** or **www.netbenefits.com** (**menu > health insurance > reference library**). For questions regarding the Be Well @ Shell Program, you can also call the dedicated Be Well @ Shell Optum Health Support Team at 1-877-440-0367.

Network and Cost Information

The US PPO and US HDHP options provide you with coverage for care you receive from any licensed health care provider anywhere in the world. However, these plans utilize networks of designated providers. Whenever you need health care, you have a choice whether or not to use a provider who participates in the network. Using network providers generally gives you a higher level of benefits.

The Kelsey-Seybold Greater Houston option requires you to use the designated networks to receive benefits, except in the case of an emergency.

Type of Service	US PPO and US HDHP	Kelsey-Seybold Greater Houston (charter plan)
Medical, surgical, diagnostic	UnitedHealthcare ChoicePlus network	Kelsey-Seybold Clinic *physicians*, UnitedHealthcare Charter/Charter Balanced network
Prescription drug	CVS Caremark	CVS Caremark
Mental health, substance use disorder	Optum Behavioral Health	Optum Behavioral Health

Each of these networks is described more fully on the following pages. Those descriptions, along with the benefit schedules, can help you understand the value of selecting network providers.

The UHC Medical, Surgical, and Diagnostic Network

Most US PPO and US HDHP participants have access to the UHC network of designated providers (sometimes referred to as the "Choice Plus Point-of-Service network (POS)"). When you receive medical, surgical and diagnostic services through the UHC network, the plans offer a higher level of benefits because the network providers have contracted with UHC to provide care at lower agreed-upon costs.

In some rural areas of the country, the UHC network is not available. If you live outside the network area, you can enroll in the US PPO Out-of-Area or US HDHP Out-of-Area options. These options pay benefits for covered services received from any qualified doctor or health care provider, just as if you had used a network provider.

Payments are subject to a competitive fee determination, as discussed in "Program Payments for US PPO and US HDHP Covered Services" on page A-19.

When you use the UHC network, you:

- Receive a higher level of benefits. For example, in the US PPO option, you pay only a *copayment* for each covered office visit. In the HDHP option, your *coinsurance* is much less when you stay *in-network*. Once your share of covered expenses reaches the network *out-of-pocket* limit for the year, the US PPO and US HDHP options pay 100% of most covered expenses for the rest of that year.
- Receive 100% coverage for preventive care office visits and screenings.
- Do not have to file a claim form or call UHC to certify a *hospital* admission. The network provider takes care of those requirements for you.

The US PPO and US HDHP options allow you to use providers outside the network. However, except as described in "Protections Against Surprise Billing" on page A-12, when you use providers who do not participate in the UHC network, you:

- Will pay a higher share of the cost of the service.
- May be required to file your own claim for reimbursement.
- Will be required to call UHC to provide notification of your *hospital* admission if you need hospitalization.

The CVS Caremark Prescription Drug Network

The US PPO, US HDHP, and Kelsey-Seybold Greater Houston options provide prescription drug coverage through CVS Caremark. You can fill your acute care prescriptions (e.g., one-time antibiotics) at any pharmacy in the CVS Caremark network, which includes most major pharmacy chains, most independent pharmacies, and the CVS Caremark mail-order pharmacy. Maintenance medications are required to be filled through the CVS Maintenance Choice program (see page A-10), and "Specialty" medications must be filled through the CVS Specialty Pharmacy.

Prescription Drug Purchases at a Retail Pharmacy

A CVS Caremark prescription drug card is issued to you when you enroll in a US PPO, US HDHP or Kelsey-Seybold Greater Houston option. You must present the card when you fill a prescription at a network pharmacy. Your *copayment* or *coinsurance* is based on whether you purchase a generic drug, a preferred brand-name drug, a non-preferred brand-name drug, or a specialty drug (for up to a 34-day supply). If you fill a prescription at a pharmacy outside the network, you will be required to pay for your prescription in full and then file a claim with CVS Caremark for reimbursement.

CVS Maintenance Choice

The Maintenance Choice program provides flexibility to get your 90-day supply of long-term maintenance prescriptions, such as high blood pressure or cholesterol medications in multiple ways: at your local CVS pharmacy location, via mail order, and (where available) delivery directly from your local CVS pharmacy location. Your *copayment* or *coinsurance* is based on the type of drug you order (for example, a generic or brand-name prescription). If approved by you and your doctor, CVS Caremark will dispense generic drugs instead of brand-name drugs to help reduce your *copayment* or *coinsurance* expense.

Generic drugs are equivalent versions of brand-name drugs and typically are sold at a substantial discount from the branded price. Formulary brand-name drugs are carefully selected medications that can assist in maintaining quality care while helping to control costs. Non-formulary brand-name drugs generally have either a generic equivalent or a formulary brand-name alternative available.

Covered Prescription Drug Expenses

Most medications approved by the Federal Drug Administration (FDA) are covered under the US PPO, US HDHP and Kelsey-Seybold Greater Houston options, if indicated and prescribed for an illness or injury. Some medications are subject to FDA dispensing guidelines, quantity limits, or pre-authorization. Certain prescription drugs are generally excluded from coverage. The most up-to-date list of covered and preferred medications — called the "formulary"— is available by logging on to **Caremark.com** or by contacting CVS Caremark. Drugs used for cosmetic purposes or to aid in weight loss or certain items for smoking cessation, including gums, inhalers, patches, and sprays, are generally not covered under the US PPO, US HDHP and Kelsey-Seybold Greater Houston options.

Mental Health and Substance Use Disorder Network

Your benefits for mental health treatment will be the same as benefits currently available for medical/surgical care under the US PPO, US HDHP and Kelsey-Seybold Greater Houston options. *Copayments* and *coinsurance* will apply uniformly to both medical/surgical and behavioral health services. *Deductibles* and *out-of-pocket maximums* will be shared between both types of services.

Call Optum Behavorial Health at 1-800-752-8982 for mental health/ substance use disorder services or questions.

Optum Behavioral Health

The US PPO, US HDHP and Kelsey-Seybold Greater Houston options provide benefits for mental health/ substance use disorder through Optum Behavioral Health, administered by United Behavioral Health. For all mental health support, call 1-800-752-8982.

Levels of care related to mental health, substance use and addictive disorder include inpatient treatment, residential treatment, partial hospitalization day treatment, outpatient treatment and intensive outpatient treatment. Behavioral care professionals include psychiatrists, psychologists, and other qualified licensed therapists.

Other than as described in "Protections Against Surprise Billing" on page A-12, prior authorization is required for *hospital* admission and certain other services. Your doctor will seek authorization when it is required. For more details on your behavioral health benefits and services that require prior authorization, call the number on your health plan ID card.

Paying Your Share of Covered Expenses

You share in the cost of covered services through *deductibles*, *copayments*, and *coinsurance*. These cost-sharing features vary among the options and can have a big impact on your *out-of-pocket* expenses. Note that certain exceptions apply to the following descriptions of Annual Deductible, Copayments, Coinsurance, and Out-of-Pocket Maximums, as described in "Protections Against Surprise Billing" on page A-12.

Annual Deductible

The *deductible* is the amount you pay *out-of-pocket* for most covered services each year before benefits are payable. Your *deductible* is based on the medical coverage option you choose, the number of people you cover, and whether you use network providers. Combined expenses for all family members are used to satisfy the family *deductible*; however, no one person can contribute more than the individual *deductible* amount toward the family *deductible*. For example, if your plan has an individual *deductible* of $325 and family *deductible* of $650, and one family member has eligible medical expenses of $500, only $325 of those expenses count toward the family *deductible*.

Copayments

Copayments are fixed charges you pay when you receive covered services. *Copayments* represent your portion of the covered expenses. *Copays* do not count toward the *deductible*.

Coinsurance

Coinsurance is the percentage of a covered expense you are required to pay for a covered service. Your *coinsurance* depends on the health care option you select and whether you use a network provider.

Out-of-Pocket Maximum

The US PPO, US HDHP and Kelsey-Seybold Greater Houston options protect you from catastrophic medical costs by limiting the amount you pay out of your own pocket each year for the combination of *deductibles*, *copayments*, and *coinsurance*. Once your share of covered expenses reaches the *out-of-pocket* limit, the US PPO, US HDHP and Kelsey-Seybold Greater Houston options pay 100% of most covered expenses for the rest of the calendar year.

Your *out-of-pocket maximum* is based upon the number of people you cover and whether you use network providers. Expenses you pay for *in-network* services do not apply toward the *out-of-network* maximum and vice versa. Prescription drug costs (*copayments* and *coinsurance*) are included in the out-of-pocket maximum.

The following expenses do not count toward the annual *out-of-pocket maximum*:

- Charges that exceed the eligible expenses as determined by UnitedHealthcare.
- Charges that exceed program limits.
- Charges for non-covered services.

Protections Against Surprise Billing

Surprise Billing

Effective January 1, 2022, *out-of-network* providers are prohibited from balance billing you for certain "surprise" medical expenses, and the *Plan* is required to cover these services as if you received them from an *in-network* provider. Further, the *Plan* cannot apply any prior authorization requirements or other conditions to coverage for such *out-of-network* services that are more restrictive than the conditions applicable to the same service provided by an *in-network* provider. The covered services that are subject to these surprise billing protections include:

- Emergency services.
- Air ambulance services.
- Non-emergency services from an *out-of-network* provider received while you are in certain *in-network* facilities.

For the *out-of-network* services described above, this means you will pay the corresponding *in-network copay* or *coinsurance* rates and the amount you pay will count toward your *in-network deductible* and *in-network out-of-pocket maximum*, as applicable, for the year. Any applicable *coinsurance* will apply based on the "recognized amount" for the service you received, which may be lower than the amount billed by the *out-of-network* provider. The *out-of-network* providers are prohibited from billing you for any amount in excess of this level of cost sharing.

Note that for certain services (for example, post-stabilization services received after an emergency), if you are appropriately notified and consent to be balance billed by the *out-of-network* provider, these surprise billing protections may not apply. You aren't required to sign the consent form and shouldn't sign the consent form if you didn't have a choice of health care provider or facility before scheduling care. For more information about your rights and protections against surprise medical billing, visit **https://www.cms.gov/nosurprises/consumers**.

Continuity of Care

If you are currently receiving treatment for covered services from a provider whose network status changes from *in-network* to *out-of-network* during such treatment due to expiration or nonrenewal of the provider's contract, you may be eligible to request continued care from your current provider at the *in-network* benefit level for up to 90 days. The continuity of care requirement applies to a patient who is undergoing treatment for a terminal illness, a course of inpatient or institutional care, a course of treatment for pregnancy or for a serious or complex condition, or who is scheduled for nonelective surgery. This provision does not apply to provider contract terminations for failure to meet applicable quality standards or for fraud. If you would like help to find out if you are eligible for continuity of care benefits, please call the telephone number listed for your healthcare plan at the front of this book or on your ID card.

Primary Care Physicians

The US PPO and US HDHP options do not require you to designate a primary care *physician* (PCP). The Kelsey-Seybold Greater Houston option requires you to list a PCP in **myuhc.com**, but seeing a specialist within the Kelsey-Seybold *physician* network does not require a referral. You have the right to designate any primary care provider in the Kelsey-Seybold network who is available to accept you or your family members. Until you make this designation, UnitedHealthcare designates one for you. A referral is required if your designated or chosen *physician* is not a Kelsey-Seybold provider. Please check with Kelsey-Seybold to verify your *physician's* status. For children, you may designate a pediatrician as the primary care provider. You do not need prior authorization from Kelsey-Seybold Greater Houston or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in the Kelsey-Seybold network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures. For a list of participating health care professionals, including those who specialize in obstetrics or gynecology, and for information on how to select a primary care provider, contact UnitedHealthcare at 1-800-752-8982.

Your share of any covered expense is based upon the type of provider you use. Generally, you pay a lower *copayment* for care received from network doctors in PCP-designated fields, including:

- Family practice providers.
- General practice providers.
- Internists.
- Pediatricians.
- OB/GYN providers.

All other licensed, qualified providers are considered specialists under the US PPO, US HDHP and Kelsey-Seybold Greater Houston options.

Waiver/Reduction of Charges by Providers

Some providers may tell you that they will not charge you some or all of your required *copayment*, *deductible*, or *coinsurance* amounts. Please be aware that the Medical Benefit Program states that a provider's charges for medical services are not covered under the terms of the program if your required *copayment*, *deductible*, or *coinsurance* requirements are waived or reduced in this manner. For more information, see "Expenses Not Covered" on A-26.

Schedule of Benefits

Medical, Surgical and Diagnostic Benefits

Key Provisions	US PPO		US HDHP	
	In-network	*Out-of-network*	*In-network*	*Out-of-network*
Annual *deductible**	$325 per person $650 family	$1,000 per person	$1,600 per person $3,200 family (includes prescription drug costs)	$2,400 per person $4,800 family (includes prescription drug costs)
Annual *out-of-pocket maximum*	$4,000 per person* $8,000 family (includes *deductible*, prescription drug costs and other eligible expenses covered by the plan)	$7,500 per person* $15,000 family (includes *deductible*, prescription drug costs and other eligible expenses covered by the plan)	$5,000 per person* $10,000 family (includes *deductible*, prescription drug costs and other eligible expenses covered by the plan)	$10,000 per person* $20,000 family (includes *deductible*, prescription drug costs and other eligible expenses covered by the plan)
Services				
Office visits ▪ Preventive ▪ Primary care ▪ Specialists ▪ UHC virtual providers	You pay: ▪ $0 *copay* ▪ $30 *copay* ▪ $50 *copay* ▪ $10 *copay*	You pay: ▪ 30% *coinsurance* for all office visits (after *deductible*) ▪ No *out-of-network* coverage for virtual providers	You pay: ▪ $0 (no *deductible*) ▪ 10% *coinsurance* (after *deductible*)† ▪ 20% *coinsurance* (after *deductible*)† ▪ 10% *coinsurance* (after *deductible*)† † For all non-preventive office visits.	You pay: ▪ 50% *coinsurance* ▪ 50% *coinsurance*, after *deductible*, for all other doctor visits ▪ No *out-of-network* coverage for virtual providers
Hospital care (inpatient)	You pay $300 *copay* and 20% *coinsurance* (after *deductible*)	You pay 30% *coinsurance* (after *deductible*)	You pay 20% *coinsurance* (after *deductible*)	You pay 50% *coinsurance* (after *deductible*)
Outpatient care	You pay 20% *coinsurance* (after *deductible*)	You pay 30% *coinsurance* (after *deductible*)	You pay 20% *coinsurance* (after *deductible*)	You pay 50% *coinsurance* (after *deductible*)
Emergency room	You pay $200 *copay* (waived if admitted)	You pay $200 *copay* (waived if admitted)	You pay 20% *coinsurance* (after *deductible*)	You pay 20% *coinsurance*† (after *deductible*) † For non-emergent use, you pay 50%, after *deductible*.
Urgent care	You pay $30 *copay*	You pay 30% *coinsurance* (after *deductible*)	You pay 10% *coinsurance* (after *deductible*)	You pay 50% *coinsurance* (after *deductible*)
Ambulance	You pay $0 for emergency ambulance services			

(continued)

* Once the individual *out-of-pocket maximum* has been met, covered services for that individual will be paid at 100%.

Key Provisions	US PPO		US HDHP	
	In-network	*Out-of-network*	*In-network*	*Out-of-network*
Diagnostic: major imaging (MRI, CT scans, etc.)	You pay 20% *coinsurance* (after *deductible*)	You pay 30% *coinsurance* (after *deductible*)	You pay 20% *coinsurance* (after *deductible*)	You pay 50% *coinsurance* (after *deductible*)
Minor imaging/labs, X-rays, blood tests	You pay: ▪ $0 at doctor's office after office *copay* ▪ 20% *coinsurance* at *hospital*/facility (inpatient/outpatient) (after *deductible*)	You pay 30% *coinsurance* (after *deductible*)	You pay 20% *coinsurance* (after *deductible*)	You pay 50% *coinsurance* (after *deductible*)
Most other covered services	You pay 20% *coinsurance* (after *deductible*)	You pay 30% *coinsurance* (after *deductible*)	You pay 20% *coinsurance* (after *deductible*)	You pay 50% *coinsurance* (after *deductible*)
Centers of Excellence (COE)	You pay $0 with diagnosis	Not applicable	You pay $0 with diagnosis (after *deductible*)	Not applicable

Key provisions	Kelsey-Seybold Greater Houston
Annual *deductible*	$150 individual $300 family
Annual *out-of-pocket maximum* (includes deductible, prescription drug costs and other eligible expenses covered by the plan)	$2,500 individual $5,000 family
Services	
Office visits ▪ Preventive ▪ Primary care ▪ Specialists ▪ UHC virtual providers	You pay: ▪ $0 ▪ $25 *copay* ▪ $40 *copay* ▪ $10 *copay*
Hospital care (inpatient)	You pay 15%, after *deductible*
Outpatient care	You pay 15%, $40 *copay* for *physician*/surgeon fees, after *deductible*
Emergency room	You pay $200 *copay* (waived if admitted)
Urgent care	You pay $50 *copay*
Ambulance	You pay $0 for emergency ambulance services
Major imaging (MRI, CT scans, etc.)	You pay $40 *copay*/test
Minor imaging/diagnostic labs, X-rays, blood tests	You pay $0 at doctor's office after office visit *copay*
Most other covered services	You pay 15%, after *deductible*
Centers of Excellence (COE)	Eligible oncology services at Kelsey-Seybold Cancer Center covered at 100%, with diagnosis. If diagnosed and referred to MD Anderson by a Kelsey-Seybold *physician*, eligible oncology services covered at 100%.

The Kelsey-Seybold Greater Houston option is only available to *employees* and non-*Medicare*-eligible *retirees* residing in the Greater Houston and Galveston area within eligible ZIP codes.

Except as provided under "Protections Against Surprise Billing" on page A-12, *out-of-network* services are not covered.

Medical Benefits Notes

- An individual's covered expenses in excess of the individual *deductible* do not count toward the family *deductible*.
- *Copay* amounts do not count toward the *deductible*.
- Prior authorization for some services may be required.
- Once an individual's *out-of-pocket maximum* has been met, that person's eligible expenses are covered at 100%.

Prescription Drug Benefits

Prescription drug benefits for the US PPO, US HDHP and Kelsey-Seybold Greater Houston options are administered by CVS Caremark.

Key Provision	US PPO (in-network)	US HDHP (in-network)	Kelsey-Seybold Greater Houston
Annual *deductible*	No prescription drug *deductible*	$1,600 individual $3,200 family (combined with medical expenses)	No prescription drug *deductible*
Out-of-pocket maximum	$4,000 individual $8,000 family (combined with medical expenses)	$5,000 individual $10,000 family (combined with medical expenses)	$2,500 individual $5,000 family (combined with medical expenses)
Services			
Preventive drugs	No special provisions for preventive drugs	You pay: ▪ $0 for generic preventive drugs and insulin with no *deductible* ▪ 10% *coinsurance* for brand preventive drugs (no *deductible*)	No special provisions for preventive drugs
Other prescription drugs	**Retail (up to a 34-day supply)** ▪ Generic: $7 *copay* ▪ Preferred brand: $55 *copay* ▪ Non-preferred brand: $80 *copay* ▪ Specialty: $80 *copay* **Mail (up to a 90-day supply)** ▪ Generic: $15 *copay* ▪ Preferred brand: $100 *copay* ▪ Non-preferred brand: $125 *copay* ▪ Specialty: $125 *copay*	**Retail (up to a 34-day supply)** ▪ Generic: you pay 10% *coinsurance*, after *deductible* ▪ Preferred brand: you pay 20% *coinsurance*, after *deductible*, up to a maximum of $100 ▪ Non-preferred brand: you pay 35% *coinsurance*, after *deductible*, up to a maximum of $200 ▪ Specialty: you pay 25% *coinsurance*, after *deductible*, up to a maximum of $250 **Mail (up to a 90-day supply)** ▪ Generic: you pay 10% *coinsurance*, after *deductible* ▪ Preferred brand: you pay 20%, after *deductible*, up to a maximum of $200 ▪ Non-preferred brand: you pay 35% *coinsurance*, after *deductible*, up to a maximum of $400 ▪ Specialty: you pay 25% *coinsurance*, after *deductible*, up to a maximum of $500	**Retail (up to a 34-day supply)** ▪ Generic: $7 *copay* ▪ Preferred brand: $55 *copay* ▪ Non-preferred brand: $80 *copay* ▪ Specialty: $80 *copay* **Mail (up to a 90-day supply)** ▪ Generic: $15 *copay* ▪ Preferred brand: $100 *copay* ▪ Non-preferred brand: $125 *copay* ▪ Specialty: $125 *copay*

Prescriptions filled at *out-of-network* pharmacies in the U.S. are not reimbursable. If you fill a prescription at an *out-of-network* foreign/international pharmacy, you will be required to pay for your prescription in full and then file a claim with UnitedHealthcare for reimbursement. After the *deductible*, you pay 30% *coinsurance* if you are a participant in the US PPO or Kelsey-Seybold Greater Houston option and 50% *coinsurance* if you are a participant in the US HDHP option. You can find claim forms by logging into **myuhc.com** or calling UHC at 1-800-752-8982.

Mental Health and Substance Use Disorder Benefits

US PPO, US HDHP and Kelsey-Seybold Greater Houston benefits for mental health and substance use disorder care are provided through Optum Behavioral Health.

Service	US PPO		US HDHP		Kelsey-Seybold Greater Houston
	In-network	*Out-of-network*	*In-network*	*Out-of-network*	
Office visit	You pay $30 *copay*	You pay 30% *coinsurance*, after *deductible*	You pay 10% *coinsurance*, after *deductible*	You pay 50% *coinsurance* after *deductible*	You pay $25 *copay*
Inpatient care	You pay $300 *copay* and 20% *coinsurance*, after *deductible*	You pay 30% *coinsurance*, after *deductible*	You pay 20% *coinsurance*, after *deductible*	You pay 50% *coinsurance* after *deductible*	You pay 15% *coinsurance*, after *deductible*
Facility-based visits and all other coverage	You pay 20% *coinsurance*, after *deductible*	You pay 30% *coinsurance*, after *deductible*	You pay 20% *coinsurance*, after *deductible*	You pay 50% *coinsurance* after *deductible*	You pay 15% *coinsurance*, after *deductible*

Except as provided under "Protections Against Surprise Billing" on page A-12, if you are a participant in the US PPO or US HDHP options and receive mental health or substance use disorder care outside the Optum Behavioral Health network, you will be responsible for *coinsurance* and will need to file a claim to receive benefits. A claim form can be found on **myuhc.com**. For Kelsey-Seybold Greater Houston participants, *out-of-network* care for mental health or substance use disorder is not covered, except as provided under "Protections Against Surprise Billing" on page A-12.

Program Payments for US PPO and US HDHP Covered Services

The amount the US PPO and US HDHP options pay for covered expenses is first determined based on the network status of your health care providers. When you use network providers, payment for covered expenses, as outlined above, is based on negotiated fees between the provider and UnitedHealthcare (or Optum Behavorial Health in the case of mental health and substance use disorder care).

Except as provided under "Protections Against Surprise Billing" on page A-12, when not using a UHC or Optum Behavioral Health network provider, the US PPO and US HDHP options determine benefits based on the UHC Outlier Cost Management (OCM) criteria. The OCM applies geographically adjusted benchmark reimbursements using publicly available data and guidelines to determine appropriate and generally accepted payments for provider services.

Billed amounts in excess of these above-described amounts are not covered expenses and do not apply to the annual *deductible* or annual *out-of-pocket maximum*. You are responsible for any excess charges.

You are responsible for confirming your providers' network participation prior to receiving treatment. This is especially important when your provider refers you for additional specialty care, diagnostic laboratory or imaging services, or to an outpatient surgical center. For example, a network provider may refer you to a non-network surgical center, where you would be responsible for a greater share of the cost of those services. You may contact UHC Customer Service at 1-800-752-8982 or online at **www.myuhc.com** for information about the provider network. To locate network behavioral health care providers, contact Optum Behavioral Health at 1-800-752-8982 or visit **www.liveandworkwell.com** (access code: Shell).

Please note that the US PPO and US HDHP options will often pay medical providers directly for covered expenses. This does not mean that the provider has any legal right to the benefits payable under the Medical Benefit Program, or the right to bring a claim or lawsuit for benefits under the program or for breach or violation of any other duty or obligation owed to you under the program (or *ERISA* or other law). In fact, you may not assign your legal rights under the Medical Benefit Program to another person or to a health care provider. Any legal rights to benefits and claims remain yours and yours alone. In no event will the program, the *Company*, or its affiliates be liable to any third party to whom you may be liable for medical care, treatment or other services. For more information, see "Non-Assignment of Benefits" at L-3.

With the Kelsey-Seybold Greater Houston option your medical care is managed by Kelsey-Seybold Clinic *physicians*. Except as provided under "Protections Against Surprise Billing" on page A-12, care received outside the network is not covered except for emergency services.

Covered Expenses

Covered expenses under the US PPO, US HDHP and Kelsey-Seybold Greater Houston options fall into these categories:

- Preventive care.
- Diagnosis and treatment.
- Inpatient *hospital* care.
- Outpatient *hospital* and ambulatory care.
- Maternity care.
- Convalescent and home health care.
- Hospice care.
- Accidental/surgical expenses for dental and vision care.
- Other expenses.

Preventive Care

The US PPO, US HDHP and Kelsey-Seybold Greater Houston options cover the following preventive care services:

- An annual physical examination.
- Pap smear — one lab fee per year for each covered female.
- An annual mammogram beginning at age 35.
- Routine infant care — medically appropriate checkups for child(ren) under two years of age.
- An immunization program covering childhood diseases for child(ren) through age 12.
- Immunization for Hepatitis B through age 18 or where medically appropriate for participants with high-risk medical conditions.
- Human papillomavirus (HPV) vaccine for females between the ages of 9 and 26.
- Zoster (shingles) vaccine for persons age 50 and older.
- Immunization for Lyme disease.
- Influenza shots for participants over age 50 or where medically appropriate for participants with high-risk medical conditions.
- Evidence-based items or services that have, in effect, a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force. Additional preventive services may be covered at 100% if received at a Be Well @ Shell Premier Prevention Partner.
- Immunizations that have, in effect, a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.
- With respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration.
- Breast pumps obtained from a durable medical equipment (DME) provider, *hospital* or *physician*. Preventive care benefits defined under the Health Resources and Services Administration (HRSA) requirement include the cost of:
  - Renting one breast pump per pregnancy in conjunction with childbirth, or
  - Purchasing one breast pump per pregnancy in conjunction with childbirth.

Diagnosis and Treatment

The US PPO, US HDHP and Kelsey-Seybold Greater Houston options cover the following diagnosis and treatment of illness or injury:

- Office visits.
- Virtual consultations.
- Diagnostic X-rays.
- Laboratory tests.
- Drugs and medicines prescribed for the treatment of an illness or injury.
- FDA-authorized over the counter ("OTC") at-home COVID-19 diagnostic tests purchased between January 15, 2022, and May 11, 2023, without a doctor's prescription.*

* Through the end of the public health emergency, as announced by the applicable government agencies, each participant and covered dependent is eligible to receive coverage for up to 8 tests per month at no cost. You must show your CVS Caremark prescription drug card to purchase an OTC at-home test at a participating location with no out-of-pocket costs, or request reimbursement through CVS Caremark for a maximum reimbursement of up to $12 per test.

Inpatient Hospital Care

The US PPO, US HDHP and Kelsey-Seybold Greater Houston options cover the following inpatient *hospital* care:

- *Hospital* charges for a semiprivate room (private room when medically necessary) and board for each day of *hospital* confinement. Room and board includes charges for a room, meals, and general duty nursing.
- Necessary services and supplies furnished by the *hospital* for use during the *hospital* stay.
- Private duty nursing care when medically necessary and recommended by a *physician*.
- Intensive care.
- Emergency transportation by ambulance, air ambulance, or regularly scheduled airline to the nearest *hospital* qualified to provide treatment.
- *Physician* visits during a *hospital* stay.
- Surgery by a qualified surgeon.

Outpatient Hospital and Ambulatory Care

The US PPO, US HDHP and Kelsey-Seybold Greater Houston options cover medically necessary outpatient services for:

- Surgery, including *physician* and surgeon charges, anesthesia, surgical supplies, and related medical care and treatment performed in a *hospital* or ambulatory surgical center.
- Emergency medical care and treatment started within 72 hours after an accident.
- Diagnostic X-rays and laboratory tests resulting from illness or injury.
- Other medically necessary services, supplies, and therapeutic treatments.

An ambulatory surgical center is a specialized facility equipped to handle surgical procedures that require *hospital* facilities but do not require an extended *hospital* stay. A UHC Specialist Management Solutions (SMS) advocate can help you determine if an ambulatory surgical center is an option for you. See page A-25.

Maternity Care

Participants and covered dependents enrolled in a US PPO, US HDHP or Kelsey-Seybold Greater Houston option are eligible for the following covered maternity benefits:

- The charges of an obstetrician and an anesthesiologist for prenatal care and *hospital* delivery.
- The charges for an approved birth center.
- The charges for *hospital*, surgical, or other medical services and supplies as described under "Inpatient Hospital Care" on this page. This includes benefits for any *hospital* stay in connection with childbirth for the mother or newborn of at least:
  - 48 hours after a vaginal delivery, or
  - 96 hours after a Cesarean section.

Notification of these *hospital* stays is not required.

There is no *deductible* or admission *copayment* for newborn infant coverage for the first continuous period of the baby's *hospital* stay, unless the stay lasts beyond the mother's discharge. Remember, if they are eligible dependents, coverage for newborns begins at birth if you contact the Shell Benefits Service Center within 90 days after the date of the birth.

Newborns' and Mothers' Health Protections Act of 1996

Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any *hospital* length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a Cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours, as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

A birth center is a specialized facility for delivering newborns following a normal, uncomplicated pregnancy. To be sure that the birth center you are considering meets the standards required for coverage by your plan, call UHC Customer Service Center at 1-800-752-8982.

Convalescent and Home Health Care

The US PPO, US HDHP and Kelsey-Seybold Greater Houston options cover convalescent care in a *Medicare*-approved skilled nursing facility, including charges for room and board, services, and supplies. For benefits to be paid, all services must be authorized by a *physician*.

Benefits for care received through such a facility are paid for a maximum of 120 days.

The US PPO, US HDHP and Kelsey-Seybold Greater Houston options also cover services for convalescent care received at home through a *Medicare*-approved home health agency. For benefits to be paid, all services must be authorized by a *physician* and:

- Provided by or supervised by a registered nurse in your home, or
- Provided by either a home health aide or licensed practical nurse and supervised by a registered nurse.

Benefits for care received at home are paid for a maximum of 30 visits in a calendar year.

Note that non-medically necessary *custodial care* that helps with the personal tasks of daily living is not covered except in conjunction with hospice care.

Hospice Care

The US PPO, US HDHP and Kelsey-Seybold Greater Houston options cover inpatient room and board charges, supplies, and services provided to a terminally ill patient at a hospice facility or in the patient's home. For a patient to qualify as terminally ill, the patient's *physician* must certify that the patient has a life expectancy of six months or less. Hospice services include:

- Nursing care by or under the supervision of a registered graduate nurse in an inpatient hospice.
- Nursing care provided at the patient's home by or under the supervision of a registered graduate nurse furnished by a home health care agency.
- Home health aide services, consisting primarily of caring for the patient, that are provided by a home health care agency.

- Counseling services for the patient and the patient's immediate family prior to the patient's death; counseling must be provided by a psychiatrist, a psychologist, or a member of a state-licensed social service organization.

To be covered under the US PPO, US HDHP or Kelsey-Seybold Greater Houston option, a hospice must meet certain requirements. To ensure that the hospice you are considering meets these requirements, call the UHC Customer Care Center at 1-800-752-8982.

Accidental/Surgical Expenses for Dental and Vision Care

The US PPO, US HDHP and Kelsey-Seybold Greater Houston options cover certain dental, vision, and hearing expenses, including:

- Oral surgery for treatment of fractures and dislocations of the jaw and administration of anesthesia (care of teeth and gums and surgical repair following removal of teeth are not covered under the medical option).
- Dental care and treatment, including orthodontic care or prosthetic devices, resulting from accidental injury to natural teeth. Treatment must be received within 72 hours and be completed within 12 months of the accidental injury.
- Eyeglasses and contact lenses, or their fittings, that are required as a result of cataract surgery or due to an accidental injury.

Travel Reimbursement Benefit

The US PPO and US HDHP options offer a travel reimbursement benefit for a broad range of covered in-network medical services that are not available within 50 miles of your home address.* This includes treatment for a diagnosed condition at a UHC Center of Excellence (COE) where one is not available in your local area. The travel reimbursement benefit includes:

- Transportation** of the patient and one companion, traveling on the same day(s), for travel that is primarily for and essential to medical care.
- Lodging at $50 per day for the patient or $100 per day if traveling with a companion.
- Annual maximum reimbursement of $2,000, inclusive of lodging.
- Lifetime maximum reimbursement of $10,000.

For reimbursement, submit your request, along with valid receipts, to UHC. All questions about the travel reimbursement benefit should be directed to UHC at 1-800-752-8982.

* All benefits under the plans, including the travel reimbursement benefit, will be administered in accordance with applicable law, including health data protection laws such as HIPAA.

** Defined as automobile mileage for the most direct route, taxi fares, economy/coach airfare, parking, train fare, boat fare, bus fare, tolls.

Other Expenses

The US PPO, US HDHP and Kelsey-Seybold Greater Houston options also cover other expenses, including various kinds of medically necessary services, supplies, and equipment provided or authorized by a *physician*, such as:

- Medical care and treatment provided on an outpatient basis.
- Services of a trained nurse when recommended by a *physician* and medically necessary under generally accepted medical standards.
- Second surgical opinions. If the second opinion disagrees with the first, the US PPO and US HDHP options cover the expense of a third surgical opinion.
- Services of a qualified physiotherapist.
- Services of a speech therapist for a child(ren) through age seven (7) and under certain specific circumstances (laryngectomy, stroke, brain damage due to accidental injury, surgery that requires rehabilitation involving speech therapy, congenital anomaly or autism diagnosis that requires rehabilitation involving speech therapy).
- Covered drugs and medicines prescribed for the treatment of a physical or mental illness or injury.
- Bandages and surgical dressings, supplies, and appliances.
- Blood and allergy serum.
- Rental of an oxygen tent, wheelchair, special *hospital* bed, or similar equipment, up to the purchase price.
- Braces, crutches, and prostheses (such as artificial limbs or eyes).
- Radiation therapy and chemotherapy.
- Bariatric surgery and complications arising therefrom, for adults 18 or older, subject to pre-authorization and approval by UnitedHealthcare.
- Panniculectomy and abdominoplasty following significant and sustained weight loss, for adults 18 and older, and subject to pre-authorization and approval by UnitedHealthcare.
- Nutritional counseling rendered by a registered dietician or medical doctor for chronic diseases in which dietary adjustment has a therapeutic effect.
- One wig per lifetime for hair loss as a result of cancer/chemotherapy.
- Replacement of durable medical equipment (DME) ordered by a *physician* for outpatient use, provided once every three calendar years.
- Treatment of gender dysphoria, in adults 18 or older, subject to pre-authorization and approval by UnitedHealthcare. The treatment plan must conform to clinical policies established by UnitedHealthcare.
- Fertility services up to lifetime maximums of $25,000 for medical services and $10,000 for fertility prescription drugs.
- Outpatient biofeedback, subject to pre-authorization and approval by Optum Behavioral Health.
- Hearing Aids — two per participant or covered dependent every five years.

Additional Covered Expenses

Centers of Excellence (COE)

Through a COE, participants in the US PPO and US HDHP options have access to world-class providers and enhanced patient care when they are diagnosed with heart, cancer, or fertility conditions, as well as for bariatric care. The program and claims administration is handled through UnitedHealthcare (UHC).

COE *physician* and/or *hospital* services are covered at 100% when you qualify for and use a UHC COE. Under the US PPO option, no *deductibles*, *copayments*, or *coinsurance* apply. Under the US HDHP option, services are covered at 100% only after the *deductible* has been satisfied, as indicated in the Schedule of Benefits on page A-14. Specific provider networks by condition include (but are not limited to):

- Adult cardiovascular care: Cleveland Clinic, Ochsner Health, St. Luke's Cardiovascular Care Providers (**www.cvcpdocs.com**).
- Adult and pediatric oncology care: M.D. Anderson Physician Network (M.D. Anderson Cancer Center); Cleveland Clinic.
- Pediatric cardiovascular care: Cleveland Clinic, Ochsner Health, Texas Children's Hospital.

- Fertility care: Contact UHC's Fertility Solutions for participating providers.
- Bariatric care: Contact UHC's Bariatric Resources Services for participating providers.

Call UHC at 1-800-752-8982 to find additional COE locations/providers.

Kelsey-Seybold Greater Houston Participants

If you are enrolled in the Kelsey-Seybold Greater Houston option, you and/or your covered dependent(s) who are diagnosed with cancer will access COE oncology care through the Kelsey-Seybold Cancer Center. Kelsey-Seybold Cancer Center *physicians* may refer patients to the MD Anderson Cancer Center in certain complex cases. *Physician* and/or *hospital* services will be covered at 100% when you are enrolled in the COE.

Participation in the COE program is completely voluntary. To receive the COE benefit, you must be enrolled in the US PPO or US HDHP option and be diagnosed with the relevant condition.

You are eligible to use a COE regardless of where you live, but travel and lodging expenses you incur while receiving care from a COE provider are covered expenses under the US PPO/US HDHP only where one is not available in your local area, as defined under "Travel Reimbursement Benefit" on page A-23.

Advocate4Me Premier

US PPO and US HDHP participants can access advocacy support through UHC's Advocacy4Me Premier program. If you have an ongoing health issue or pending inpatient *hospital* stay, a premier advocate may reach out to you. Advocates can suggest alternatives if you have received a prior authorization denial, assist you with benefit appeals, or offer you pre-admission counseling. This program provides personalized and focused support, including health education and clinical guidance, through a single point of contact. Premier team members consist of specialists, nurse experts and non-clinical advocates.

Specialist Management Solutions (SMS)

Specialist Management Solutions is an outpatient concierge service available to participants in the US PPO or US HDHP options. When you need surgery or other outpatient procedures (e.g., endoscopy or colonoscopy), and contact UHC for cost information or to find a provider, an SMS care advocate will help you identify a high-quality network surgeon, schedule appointments, and make sure you understand your options for quality care.

Included Health

If you are an *employee* or non-*Medicare*-eligible *retiree* enrolled in any plan under the Shell Medical Benefit Program, you and your covered dependents have access to Included Health. If you have a complex health issue, this benefit can help you:

- Get an expert medical opinion.
- Get answers to medical questions through Treatment Decision Support.
- Find high-quality *in-network* providers (US PPO and US HDHP participants only).
- Access specialized care teams through Communities supporting Black and LGBTQ+ health needs.

Included Health services are available without *copays*, *coinsurance* or fees. To access Included Health, you must first register by visiting **includedhealth.com/shell** or by calling 1-855-322-2098. Once registered, you can download the Included Health app and connect with your care team.

Transplant Resource Services (TRS)

US PPO and US HDHP participants who require qualified organ transplants have access to special services through UHC's United Resources Network. The TRS program provides 100% coverage for transplant services at recognized medical centers nationwide.

Qualified organ transplants include:

- Liver transplant.
- Heart transplant.
- Lung transplant.
- Heart/lung transplant.

- Kidney transplant.
- Pancreas transplant.
- Kidney/pancreas transplant.
- Liver/kidney transplant.
- Liver/intestinal transplant.
- Intestinal transplant.
- Certain bone marrow (either from you or from a compatible donor) and peripheral stem cell transplants, with or without high-dose chemotherapy.

Covered health services and supplies from a UHC-designated transplant facility for qualified procedures include:

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

If a designated transplant facility is used, the TRS program provides for reimbursement of travel and lodging expenses as follows:

- Transportation of the patient and one companion who is traveling on the same day(s) to and/or from the site of the qualified procedure for the purposes of the evaluation, the transplant procedure, and the necessary post-discharge follow-up.
- Reasonable and customary charges for lodging for the patient (while not confined) and one companion.
- If the patient is a covered dependent minor child, the transportation expenses of two companions are covered and lodging expenses are reimbursed at a $100 per diem rate.

There is a combined overall lifetime maximum of $10,000 per participant for all transportation and lodging expenses incurred by the participant and companion(s) and reimbursed under the program in connection with all qualified procedures. For more information, please call UHC at 1-800-752-8982.

The TRS program is voluntary. If you choose not to use the program for transplant services, covered expenses will be determined and payable under the US PPO and US HDHP options without regard to the TRS program.

Expenses Not Covered

The following expenses are excluded under the US PPO, US HDHP and Kelsey-Seybold Greater Houston options:

- Any confinement, care, treatment, service, or supply that is not medically necessary based upon generally accepted standards of medical practice.
- Any medical expenses incurred before coverage becomes effective.
- Any *hospital* stay, surgery, treatment, service, or supply for which benefits are payable through a government agency (except a program for civilian employees of a government, and Veterans Administration *hospital* charges for non-service-related disabilities).
- Any charges for medical services where your required *copayment*, *deductible*, or *coinsurance* requirements have been waived or reduced, any charges that you are not obligated to pay or for which you are not billed, or any charges for which you would not have been billed except that they were covered under this program. The Claims Administrator or *Plan Administrator* also has the right to require you to provide evidence that you have been charged and have paid the required *copayment*, *deductible*, or *coinsurance* amounts before the provider's charges are paid by the plan.
- Experimental or investigational treatments or procedures.
- Any confinement, care, or treatment that is not recommended and approved by a qualified *physician* acting within the scope of his or her license.
- Cosmetic surgery or any treatment or *hospital* confinement related to cosmetic surgery, except as the result of illness or bodily injury.

- Dental treatment, orthodontic care, or prosthetic dental devices, including cutting procedures in the mouth, except as the result of accidental damage to natural teeth, as described in "Accidental/Surgical Expenses for Dental and Vision Care" on page A-23.
- Eye examinations for the purpose of improving refraction.
- Eyeglasses and contact lenses, or the cost of fitting eyeglasses or contact lenses, except as the result of cataract surgery or accidental injury to the eye requiring a prescription change.
- Radial keratotomy, LASIK, or other surgical procedures for the purpose of improving refraction.
- Services of a social worker, other than Optum Behavioral Health coordinated care, or a licensed social worker who is an advanced clinical practitioner, or certain hospice care services.
- Services for educational purposes or to enhance one's personal or professional growth, development, or training.
- Injuries or diseases resulting from war or any act of war, declared or undeclared, or any international armed conflict.
- Occupational injuries or illnesses. Benefits covering these expenses normally are payable under workers' compensation or similar laws.
- Services of a speech therapist for a child(ren) who is age seven (7) or older, except under certain specific circumstances (laryngectomy, stroke, brain damage due to accidental injury, surgery that requires rehabilitation involving speech therapy, congenital anomaly or autism diagnosis that requires rehabilitation involving speech therapy).
- Education, training, and room and board expenses while confined to an institution providing schooling or training, a home for the aged, or a nursing home.
- Treatment, evaluation, or any services provided strictly for learning disabilities.
- *Custodial care*, except in conjunction with hospice care.
- Services provided by a person who is a member of your immediate family or who lives in your home.
- Any charges incurred by your dependent(s) who is also covered as an *employee* or non-*Medicare*-eligible *retiree* or as a dependent of another *employee* or non-*Medicare*-eligible *retiree* under the Medical Benefit Program.
- Services provided for the treatment of weight loss, unless certified to be medically necessary by UnitedHealthcare.
- Nutritional supplements.
- Charges more than the amount determined to be a covered expense in accordance with "Program Payments for US PPO and US HDHP Covered Expenses" at A-19.

Note that certain other expenses not specifically listed may not be covered under the US PPO, US HDHP and Kelsey-Seybold Greater Houston options. If you are not sure if your treatment is a covered expense, call UHC's Customer Service Center at 1-800-752-8982 for a benefit determination before incurring the expense.

In addition, the following hospice charges are not covered expenses:

- Services of a social worker, other than a licensed clinical social worker who is an advanced clinical practitioner, unless obtained through Optum Behavioral Health.
- Hospice care services provided by volunteers or by individuals who do not regularly charge for their services.
- Hospice care services provided by a licensed pastoral counselor for a member of his or her congregation (services performed in the course of duties for which he or she is called as a pastor or minister).
- Any legal or financial services.
- Services provided by any person living with you or who is a member of your immediate family.
- Any services or supplies not provided or billed through the hospice program and approved by the attending *physician*.

Filing Claims for the US PPO and US HDHP Options

Generally, you do not have to file a claim for benefits when using the UHC, CVS Caremark or Optum Behavioral Health networks because your participating provider files the claim for you.

If you are using a provider who is not part of the network and the provider does not agree to file a claim for you, you will need to obtain a claim form from UHC, CVS Caremark or Optum Behavioral Health. You may also need your provider's itemized service statement to submit your charges. Be sure to include the plan information located on your medical identification card and indicate whether you want payment made to you or directly to your provider.

Instructions on the claim form explain how to complete it. Any missing, inconsistent, or incorrect information can delay the processing of your claim. Mail the completed form to the address that appears on the form. You should file your claim as soon as possible after receiving treatment. Your claim must be submitted within 12 months from the date of service. Failure to comply with this important deadline will result in the forfeiture of your right to a claim for benefits. This time limit does not apply if you are legally incapacitated. If the claim relates to an inpatient stay, the date of service is the date the inpatient stay ends.

If you have any questions about how or where to file your claim, refer to the contact information located at the front of this book. For information regarding the plans' formal claims and appeals procedures, see "Claims and Appeals" on page L-4.

Coordination of Benefits

The US PPO, US HDHP, and Kelsey-Seybold Greater Houston options coordinate the benefits payable by taking into account any coverage you or your covered dependent(s) may have under any other group medical or dental plan. As a result of this coordination of benefits, it is possible for you to receive reimbursement for up to the maximum amount the plan would pay as your primary coverage.

Here is a summary of how coordination of benefits works:

- If benefits are coordinated with another group medical plan, the difference between the amount that would have been paid without coordination of benefits and the amount of benefits actually paid may be credited to the covered person.
- If benefits are coordinated with a group dental plan, any such credit applies only to the claim that was coordinated (see "Coordination of Benefits" under the Dental Plan on page B-12).
- If your spouse or *domestic partner* is covered under another group plan, that plan provides primary coverage for him or her.

Coordination of benefits for dependent child(ren) is based on the birthday rule. This means that the plan of the parent whose birthday occurs earlier in the calendar year provides primary coverage, and any other group plan provides secondary coverage.

If your covered dependent(s) is also covered under another group plan that provides primary coverage, you must file all claims with that plan first. After you receive an explanation of benefits (EOB) from that plan, you should file your claim, including the other plan's EOB, through the applicable Claims Administrator.

Medical Coverage for Medicare-Eligible Retirees and their Medicare-Eligible Dependents

This section discusses Shell's medical benefit options for *Medicare*-eligible *retirees* and *retirees'* dependents who are eligible for *Medicare*. Note that this section does not apply to non-*Medicare*-eligible *retirees* and/or their non-*Medicare*-eligible dependents or to *employees* and their dependents, even if eligible for *Medicare*.

About Medicare

Medicare is a federal program, managed by the Centers for Medicare & Medicaid Services (CMS). Once you qualify for and enroll in *Medicare* coverage, *Medicare* becomes the primary medical benefit plan for you. The same is true when your *eligible dependent* qualifies for *Medicare* (e.g., *Medicare* becomes his/her primary medical benefit plan). Because the Shell Medical Benefit Program offers coverage options that coordinate with *Medicare* and require *Medicare* enrollment, it is important that you understand how and when you and/or your *Medicare*-eligible *dependent(s)* should enroll for *Medicare* coverage.

Medicare offers health insurance to eligible participants whose eligibility is due to their age or to a disability. To qualify for *Medicare* coverage, a person must be a U.S. citizen or have been a legal resident continuously for 5 years and meet one of the following requirements:

- Age 65 or older.
- Younger than 65 with a qualifying disability.
- Any age with a diagnosis of end-stage renal disease (ESRD) or ALS.

You will receive information regarding the enrollment process directly from *Medicare*, typically within 90 days of your 65th birthday. Go to **SSA.gov/Medicare** to enroll online or call or visit your local Social Security office. Your initial *Medicare* enrollment period is 7 months long and includes the month you turn 65, the 3 months before, and the 3 months after. Your initial enrollment period begins a month earlier if your birthday is the first day of the month.

If you enroll during the 3 months prior to your birthday, *Medicare* coverage begins on the first day of your 65th birthday month (or the month before if your birthday is the first day of the month). Your *Medicare* coverage start date may be delayed if you sign up in your birthday month or during the 3-month period following your birthday month. If you enroll after the allotted 7-month enrollment period, enrollment penalties may apply.

After you enroll in *Medicare*, the Social Security Administration assigns you a Medicare Beneficiary Identifier (MBI) (formerly known as a Health Insurance Claim Number or HICN).

Understanding Medicare Components

Medicare coverage can seem complicated, as there are several components. The basic choice, however, is between 1) what is known as "original" *Medicare* or 2) a *Medicare* Advantage plan. Here are the separate parts of *Medicare* and how they fit together:

- **Part A** — *Hospital* insurance provided by the federal government. You pay no premium for Part A.
- **Part B** — Coverage for doctor visits and outpatient care, also provided by the federal government. *Medicare* Part B requires a monthly premium, adjusted based on your income.
- **Part C** — Combines Part A and Part B into a single plan (called *Medicare* Advantage) provided by a private insurance company. These plans must meet the standards of and be approved by CMS. Participants must enroll in Part A and Part B and pay the required premiums. Most *Medicare* Advantage plans include prescription drug coverage.

- **Part D** — Prescription drug coverage in a standalone plan provided by a private insurance company. These plans require a separate monthly premium and must also be approved by CMS.

Original Medicare

Original *Medicare* includes Parts A and B and covers treatment received from any qualified provider in the United States that accepts *Medicare* patients. Original *Medicare* does not include coverage for prescription drugs, so participants may opt to enroll in a separate Part D drug plan. Also, original *Medicare* participants may choose to enroll in a *Medicare* Supplement (Medigap) plan that pays a portion of covered expenses beyond what Parts A and B pay.

Medicare Advantage

Medicare Advantage plans include services covered under *Medicare* Parts A and B, and typically cover prescription drugs. They may also cover additional services that *Medicare* does not cover. *Medicare* Advantage plans may utilize networks and may or may not require you to use *in-network* providers. Premiums vary by plan. The Shell Medicare Advantage PPO and the KelseyCare Advantage Plan Greater Houston are *Medicare* Advantage plans.

For more about *Medicare*, call 1-800-MEDICARE (1-800-633-4227) or go online at **www.Medicare.gov**.

Shell Medical Benefits for Medicare-Eligible Participants

The medical benefits Shell offers you (a *Medicare*-eligible *retiree*) and all eligible *retirees' Medicare*-eligible dependents, coordinate with each participant's *Medicare* enrollment.

Before enrolling in a Shell coverage option, you and/or your dependent must:

- Enroll in *Medicare* Part A and Part B.
- Provide your Medicare Beneficiary Identifier (MBI), formerly known as a Health Insurance Claim Number (HICN), to the Shell Benefits Service Center.
- Maintain a physical U.S. street address on file with the Shell Benefits Service Center.

The Shell Benefits Service Center will send enrollment instructions and benefit information about your Shell medical coverage options to you or your *eligible dependent* approximately 60 days prior to your or your *eligible dependent's* 65th birthday. If you or your *eligible dependent* qualify for *Medicare* earlier than age 65, you must contact the Shell Benefits Service Center to advise of your *Medicare* eligibility and to receive information about your Shell coverage options.

The government requires standard communications to be provided to *Medicare* plan participants, explaining their rights under *Medicare*. The Shell Medical Benefit Program must provide these documents annually to every *Medicare*-eligible individual. If you and/or your *eligible dependent(s)* are *Medicare*-eligible, you will each receive your own set of information in the mail. These standard communications generally do not require you to take any action.

Coverage Options for Medicare-Eligible Participants

The following medical options coordinate with *Medicare* to provide coverage for *Medicare*-eligible *retirees* and *retirees' Medicare*-eligible dependents:

- **Shell Medicare Advantage PPO** — A *Medicare* Advantage plan as described in "Understanding Medicare Components," Part C on page A-29. The Shell Medicare Advantage PPO includes prescription drug coverage and provides the same benefits whether or not you use a network provider, as long as the provider accepts *Medicare*. For details see "Shell Medicare Advantage PPO Option" on page A-32.
- **KelseyCare Advantage Plan** — A *Medicare* Advantage plan for participants in the greater Houston and Galveston area. KelseyCare includes prescription drug coverage and provides access to Kelsey-Seybold providers and affiliates. For details, see "KelseyCare Advantage Plan Greater Houston" on page A-34.
- **Other regional *Medicare* Advantage and *Medicare* Supplement options** — In some areas, regional *Medicare* Advantage plans and *Medicare* Supplement plans are offered through the Shell Medical Benefit Program. Details and benefit information on each of these options can be obtained by contacting the insurer directly. Call the Shell Benefits Service Center for customer service phone numbers and websites of options available to you.

The Shell Medicare Complementary Option is no longer available to new enrollees. Current participants may continue with the plan. However, if you disenroll, you will not be allowed to re-enroll at a later date. The plan coordinates with traditional *Medicare* Part A and Part B to reimburse a portion of eligible medical expenses, including prescription drugs. For details, see "Shell Medicare Complementary Option" on page A-35.

Bundled Plans

If you and your dependents include both *Medicare*-eligible and non-*Medicare*-eligible participants, and wish to enroll in medical coverage under the Shell Medical Benefit Program, you may be required to enroll in corresponding plans, based on the administrators of the medical plans. For example, if you are *Medicare*-eligible and your spouse/*domestic partner* is non-*Medicare*-eligible and you enroll yourself in the Shell Medicare Advantage PPO administered by UnitedHealthcare (UHC), you must enroll your spouse/*domestic partner* in one of the UHC-administered non-*Medicare*-eligible plans (US PPO plan, US HDHP plan, or Kelsey-Seybold Greater Houston plan).

Shell Medicare Advantage PPO Option

The Shell Medicare Advantage PPO option is a UnitedHealthcare Group Medicare Advantage PPO plan that has been designed exclusively for the Shell Medical Benefit Program. Unlike traditional PPO plans, you pay the same *copay* or *coinsurance* whether you seek care from an *in-network* or *out-of-network* medical provider, as long as the provider accepts the plan and has not opted out of *Medicare*. The Shell Medicare Advantage PPO option is primarily *copay*-based, which means you are only responsible for paying a fixed-dollar *copay* for most covered services.

Plan Highlights

The following is a summary of benefits under the Shell Medicare Advantage PPO option. For complete plan details, please refer to the Summary of Benefits and detailed Plan Guide available at **retiree.uhc.com/shell** or call UnitedHealthcare at 1-866-413-2864, TTY 711, 8 a.m. – 8 p.m. local time, Monday through Friday.

Annual *deductible*	$0
Annual *out-of-pocket maximum*	$3,000
Preventive care (e.g., annual wellness visit, annual physical, cancer screenings)	You pay $0
Office visits ▪ Primary care ▪ Specialty	 ▪ You pay $15 *copay* ▪ You pay $25 *copay*
Hospital services ▪ Inpatient ▪ Outpatient	 ▪ You pay $250 per stay ▪ You pay 20% *coinsurance*
Emergency care	You pay $120 *copay* (waived if admitted)
Urgent care	You pay $35 *copay* (waived if admitted)
Ambulance	You pay $150 *copay*
Skilled nursing facility	$0 *copay* per day: days 1 – 20; $80 *copay* per additional day up to 100 days
Private duty nursing	$5,000 limit per year
Mental health care ▪ Inpatient ▪ Outpatient (group therapy) ▪ Outpatient (individual therapy) ▪ Virtual behavioral health	 ▪ $250 *copay* per stay (up to 190 days) ▪ $15 *copay* ▪ $25 *copay* ▪ $25 *copay*
Benefits not covered by original *Medicare* ▪ Acupuncture ▪ Routine foot care (6 visits per year) ▪ Routine eye exam ▪ Hearing aid allowance	 ▪ You pay $25 *copay* ▪ You pay $25 *copay* ▪ You pay $25 *copay* ▪ $500 every 3 years

Prescription drug coverage under the Shell Medicare Advantage PPO option is administered by OptumRx, a *Medicare* Part D prescription drug plan. See pages A-37 – A-38 for information on prescription drug benefits under the Shell Medicare Advantage PPO option.

The Shell Medicare Advantage PPO provides additional features at no cost, including:

- Renew Active® by UHC, which includes a gym membership at a fitness location you can select from a nationwide network.
- UnitedHealthcare Healthy at Home post-discharge program, which provides up to 30 days of benefits when referred by a UHC advocate following an inpatient stay at a *hospital* or skilled nursing facility. Benefits include home-delivered meals, non-emergency transportation, and in-home personal care, with no *copay*.
- HouseCalls, a program that offers an annual clinical visit in the comfort of your home.
- NurseLine, a service that provides 24-hour access to registered nurses.
- Virtual doctor visits that allow you to use your computer or mobile device to ask a doctor questions or to seek advice.
- Hearing aid discounts.
- Chronic condition management programs specifically designed for seniors.
- A Personal Emergency Response System (PERS) free of charge. The PERS device will provide emergency assistance through Lifeline with the push of a button, connecting participants with help.

Filing Claims for the Shell Medicare Advantage PPO

When using a UHC network doctor or other health care provider who participates in *Medicare* and accepts the UHC plan, you only need to present your Shell Medicare Advantage PPO ID card and pay your required *copay* or *coinsurance*. The healthcare provider will bill UHC for the rest of the cost of your covered services, up to the limit set by *Medicare*.

Complete Documents

This book, along with the certificates of coverage and benefit summaries provided to you by UnitedHealthcare and OptumRx, constitute the Summary Plan Description for the Shell Medicare Advantage PPO option. Other communications pertaining to *Medicare* are provided to you at the time of enrollment as required by law.

Medicare Enrollment Notice

Medicare does not allow enrollment in more than one *Medicare* Advantage or *Medicare* Part D prescription drug plan. Because the Shell Medicare Advantage PPO and the KelseyCare Advantage Plans are packaged programs that include *Medicare* Part D prescription drug coverage through OptumRx, *Medicare* will not approve your enrollment in the Shell Medicare Advantage PPO option or KelseyCare Advantage Plan if you are enrolled in a separate, privately purchased *Medicare* Advantage or *Medicare* Part D plan.

KelseyCare Advantage Plan Greater Houston

KelseyCare Advantage Plan Greater Houston is offered to *Medicare*-eligible *retirees* and *retirees' Medicare*-eligible dependents who reside in eligible ZIP codes in the greater Houston and Galveston area. This option provides access to all Kelsey-Seybold primary care and specialist *physicians*, as well as over 4,000 Kelsey-Seybold "affiliate specialists."

Plan Highlights

The following is a summary of benefits under the KelseyCare Advantage Plan Greater Houston. For complete plan details, please refer to **www.kelseycareadvantage.com/shell**, or call 713-442-7555 or toll free 1-866-534-0665.

Annual *deductible*	$0
Annual *out-of-pocket maximum*	$3,400
Office visits ▪ Preventive ▪ Primary care ▪ Specialty	 ▪ Paid at 100%, no *copay* ▪ No *copay* ▪ You pay $20 *copay*
Virtual healthcare ▪ Primary care ▪ Specialty	 ▪ No *copay* ▪ You pay $15 *copay*
Hospital services ▪ Inpatient ▪ Outpatient (ambulatory surgical center) ▪ Outpatient (*hospital* facility)	You pay: ▪ $250 per stay ▪ $250 per visit ▪ $225 per visit
Emergency care	You pay $75 *copay*
Urgent care	You pay $35 *copay*
Ambulance	You pay $100 *copay*
Skilled nursing facility	▪ $0 *copay*, days 1 – 20 ▪ You pay $125 *copay* per additional day up to 100 days
Private duty nursing	$5,000 limit per year
Mental health care ▪ Inpatient ▪ Outpatient (group therapy) ▪ Outpatient (individual therapy)	You pay: ▪ $250 *copay* per stay ▪ $0 *copay* ▪ $0 *copay*
Benefits not covered by original *Medicare* ▪ Annual physical (preventive exam) ▪ Acupuncture ▪ Routine foot care ▪ Routine eye exam	 ▪ You pay $0 *copay* ▪ You pay $20 *copay* ▪ You pay $20 *copay* ▪ You pay $0 *copay*

Prescription drug coverage under the KelseyCare Advantage Plan Greater Houston is administered by KelseyCare Advantage with CVS Caremark as the Pharmacy Benefits Manager. This coverage qualifies as a *Medicare* Part D prescription drug plan. See pages A-37 – A-38 for information on prescription drug benefits under the plan.

The KelseyCare Advantage Plan Greater Houston offers additional features at no extra cost, such as transportation and allowances for hearing aids, as well as a basic gym membership at a participating location through SilverSneakers®. For more information on additional features for KelseyCare Advantage Plan participants, visit **www.kelseycareadvantage.com/shell** or call 713-442-7555 (or toll free 1-866-534-0665).

Shell Medicare Complementary Option

The Shell Medicare Complementary option, administered by UnitedHealthcare, coordinates with *Medicare* Part A and Part B to reimburse participants for 80% of their covered medical expenses. Prescription drug benefits under the plan are provided by OptumRX, a *Medicare* Part D prescription drug plan. See pages A-37 – A-38 for information on prescription drug benefits under the plan.

The Shell Medicare Complementary Option is closed to new participants. If you are currently enrolled in the plan, you may continue to participate. If you disenroll from the plan, you will not be able to re-enroll at a later date.

Plan Features

Plan benefits are determined as if you were being reimbursed under *Medicare* Parts A and B, whether or not you are actually enrolled in *Medicare*. As a result, any amounts that would have been paid by *Medicare* (Parts A and B) are deducted from the Shell Medicare Complementary benefit, subject to billing limitations.

Covered expenses under the Shell Medicare Complementary option are generally the same as those listed for the US PPO and US HDHP options for non-*Medicare*-eligible *retirees* (see pages A-20 – A-26). Expenses not covered under the plan are also generally the same as those described on pages A-26 – A-27. The Shell Medicare Complementary option does not include the Centers of Excellence or Be Well @ Shell programs.

Plan Highlights

The following is a summary of benefits under the Shell Medicare Complementary option. For complete plan details, please refer to the Summary of Benefits available on NetBenefits.

Annual *deductible*	$350 per person
Annual *out-of-pocket maximum**	$3,000 per person $6,000 family
Your expenses	You pay 20% after the *deductible*
Maximum lifetime benefit	Unlimited
Office visits — preventive care	You pay $0
Office visits — primary and specialty	You pay 20% after the *deductible* for all of these services
Diagnostic services, labs, X-rays	
Hospital services (inpatient and outpatient)	
Emergency care	
Urgent care	
Ambulance	
Mental health care	
Other covered services	
Hospice care	You pay $0

* Prescription drug *copayments* do not count toward the annual *out-of-pocket maximum*.

Private Duty Nursing Care

Medicare and the Shell Medicare Complementary option cover private duty nursing care if it involves skilled nursing or rehabilitation services that can be provided only by licensed medical professionals.

The Shell Medicare Complementary option does not cover *custodial care*, except in conjunction with hospice care. Such care is not considered a covered expense under the Shell Medicare Complementary option, even if it is ordered by a doctor and performed by a licensed medical professional.

Pretreatment Review

The best way to understand which private duty nursing expenses are covered is to call UnitedHealthcare in advance. This will help you determine whether the proposed care is covered before expenses are incurred. A final determination as to whether services are considered a covered expense is made when a claim is submitted to UnitedHealthcare.

How Shell Medicare Complementary Benefits Are Paid

The following example shows how Shell Medicare Complementary benefits are paid for Ken, a *retiree* who:

- Has already satisfied the *Medicare* Part B *deductible*,
- Is hospitalized for 10 days for a surgical procedure, then receives outpatient follow-up care, and
- Incurs covered charges totaling $12,850 (itemized expenses and amounts payable are as shown).

	Charges[1]	Medicare pays [Part A + Part B]		Ken pays his annual deductible	Shell Medicare Complementary pays	Ken pays the balance
Hospital expenses	$8,500	$7,212[2]	$0	$350[3]	$750.40	$187.60
Surgeon's charges	$3,000	$0	$2,400	$0	$0	$600.00
Anesthesiologist	$750	$0	$600	$0	$0	$150.00
Total inpatient charges	$12,250	$10,212		$350	$750.40	$937.60
Physician office visits	$600	$0	$480	$0	$0	$120.00
Total charges for all care	$12,850	$10,692		$350	$750.40	$1,057.60

[1] Assumes providers accept *Medicare* assignment. Charges shown are the amounts approved by *Medicare*.

[2] Amount shown reflects the 2018 Part A *deductible* amount — $1,340.

[3] The $350 annual *deductible* under the Shell Medicare Complementary option is deducted from the *Medicare* Part A *deductible*, then the Shell Medicare Complementary option pays 80% of remaining *hospital* expenses.

Filing Claims for the Shell Medicare Complementary Option

Most bills and receipts need to be submitted to *Medicare* first. Typically, providers will do that for you and many of these claims will then be forwarded to UnitedHealthcare (UHC) so that Shell Medicare Complementary benefits can be processed. If *Medicare* doesn't forward the claim to UHC, you have to apply for Shell Medicare Complementary benefits yourself.

To do so, obtain a claim form from UHC by calling UHC's Customer Service Center at 1-800-752-8982. Instructions on the claim form explain how to complete it, as well as how each type of medical expense should be submitted. For expenses that are covered by *Medicare*, you must send UHC the Explanation of Medicare Benefits you received from *Medicare*, together with your completed claim form.

UHC requires a diagnosis, the provider's name and the procedure code for each item processed. If the provider's name and procedure code aren't shown on the Explanation of Medicare Benefits, you must obtain a detailed billing from the provider to attach to your claim form. Mail the completed claim form to the address listed on the form. You should file your claim as soon as possible after receiving treatment. All claims must be filed within 12 months from the date of service. Failure to comply with this important deadline will result in the forfeiture of your right to a claim for benefits.

Prescription Drug Coverage for Shell Medicare Advantage PPO, KelseyCare Advantage Greater Houston and Shell Medicare Complementary Option

The Shell Medical Benefit Program offers a *Medicare* Part D prescription drug plan as part of a packaged benefit plan for eligible *retirees* and covered *eligible dependent(s)* who are enrolled in the Shell Medicare Advantage PPO, the KelseyCare Advantage Plan or the Shell Medicare Complementary option. You are automatically enrolled in *Medicare* Part D if you enroll in Shell's Medicare Advantage PPO, KelseyCare Advantage plan or the Shell Medicare Complementary option. (If you enroll in a regional Shell Medicare Advantage HMO, prescription drug coverage is provided through the HMO.)

Plan Features

Shell pays *Medicare* prescription drug plan Part D premiums for individuals enrolled in the Shell Medicare Advantage PPO, KelseyCare Advantage Greater Houston or Shell Medicare Complementary option. If your income exceeds a certain level, the government requires you to pay an additional premium for Part D coverage. This additional premium is called the Income-Related Monthly Adjustment Amount or IRMAA. If this applies to you, you pay IRMAA in the same manner as you pay your Part B premium, deducted from your Social Security payment or directly. Please call *Medicare* toll-free at 1-800-MEDICARE (1-800-633-4227) if you have questions about IRMAA.

Shell Medicare Advantage PPO Participants

- Your prescription drug benefits are provided by OptumRx, a Medicare Part D plan affiliated with UnitedHealthcare.
- Shell Medicare Advantage participants receive a combined medical and prescription drug card.
- For questions about your drug benefits, including questions about the OptumRx formulary, contact UHC at 1-866-413-2864 or visit **retiree.uhc.com/shell**.
- Out-of-pocket copays are lower when you purchase prescriptions at OptumRx network pharmacies or via mail order.

Shell Medicare Complimentary Option Participants

- Your prescription drug benefits are provided by OptumRx, a Medicare Part D plan affiliated with UnitedHealthcare. The plan is also known as UnitedHealthcare Group Medicare Rx.
- Shell Medicare Complementary participants receive a prescription drug card to use at the pharmacy.
- For questions about your drug benefits, including questions about the OptumRx formulary, call 1-844-600-7913 or visit **retiree.uhc.com/shellmedcomprx**.
- Out-of-pocket copays are lower when you purchase prescriptions at OptumRx network pharmacies or via mail order.

KelseyCare Advantage Plan Greater Houston Participants

- Your prescription drug benefits are provided by KelseyCare Advantage, with CVS Caremark as the Pharmacy Benefit Manager.
- KelseyCare Advantage Greater Houston participants receive one ID card representing both medical and prescription drug coverage.
- For questions about your drug benefits or the KelseyCare Advantage formulary, call 1-888-970-0914 or visit **www.kelseycareadvantage.com/shell**.
- Out-of-pocket copays are lower when you purchase prescriptions at Kelsey pharmacy, CVS pharmacy or H-E-B pharmacy locations or via mail order.

Plan Highlights

The following is a summary of your prescription drug benefits under the Shell Medicare Advantage PPO and Shell Medicare Complementary Option. For a complete description of benefits, limitations, exclusions and restrictions, see the Evidence of Coverage available on UHC's website.

Shell Medicare Advantage PPO Shell Medicare Complementary Option	
At OptumRx participating pharmacies or mail order	
Annual *out-of-pocket maximum* for prescription drugs	$2,950
Short-term (up to a 34-day supply)	
▪ Preferred generic	$7 *copay*
▪ Preferred brand	$47 *copay*
▪ Non-preferred drug	$80 *copay*
▪ Specialty tier	$80 *copay*
Maintenance medication (up to a 90-day supply)/mail order	
▪ Preferred generic	$15 *copay*
▪ Preferred brand	$90 *copay*
▪ Non-preferred drug	$125 *copay*
▪ Specialty tier	$125 *copay*

The following is a summary of your prescription drug benefits under the KelseyCare Advantage Greater Houston option. For a complete description of benefits, limitations, exclusions and restrictions, see the Evidence of Coverage available on the KelseyCare Advantage website.

KelseyCare Advantage Greater Houston	
At Kelsey pharmacy, CVS pharmacy, H-E-B pharmacy or mail order*	
Annual *out-of-pocket maximum* for prescription drugs	$7,400
Short-term (up to a 34-day supply)	
▪ Generic	$0 *copay*
▪ Preferred brand	$40 *copay*
▪ Non-preferred brand	$80 *copay*
▪ Specialty	31% *coinsurance*
Maintenance medication (up to a 90-day supply)/mail order	
▪ Generic	$0 *copay*
▪ Preferred brand	$100 *copay*
▪ Non-preferred brand	$200 *copay*
▪ Specialty	31% *coinsurance*

* *Copays* are higher for prescriptions filled at other retail pharmacy locations.

Important information about your prescription drug coverage

The government requires that you have an annual opportunity to opt out of the OptumRx or KelseyCare Advantage prescription drug coverage. Please be aware that your Shell *retiree* coverage under the Shell Medicare Advantage PPO, KelseyCare Advantage Greater Houston, and Shell Medicare Complementary option includes both medical and prescription drug coverage. If you opt out of the OptumRx or KelseyCare Advantage prescription drug plan, you will lose both medical and prescription drug coverage.

Medicare does not allow enrollment in more than one *Medicare* Advantage or *Medicare* Part D prescription drug plan. Because the Shell *Medicare* coverage options include *Medicare* Part D prescription drug coverage through OptumRx or KelseyCare Advantage, *Medicare* will not approve your enrollment in the Shell plans if you are enrolled in a separate, privately purchased *Medicare* Advantage or *Medicare* Part D plan.

If your enrollment in the Shell *Medicare* coverage options is denied by *Medicare*, you will receive notifications from the Shell Benefits Service Center and UnitedHealthcare. If you do not take action, you will not be enrolled in the Shell *Medicare* coverage option. Instead, you may be enrolled into the US PPO (or if you have non-*Medicare* eligible dependents already enrolled in Shell coverage, the same plan as your dependents), and you will not have an opportunity to change your enrollment until the next group annual enrollment period or following a qualified status change. If you opt out of Shell *Medicare* coverage for a privately purchased *Medicare* Advantage or *Medicare* Part D plan and you have dependent(s), their Shell medical coverage will also end. However, they may be able to continue coverage. (See "Continuation of Coverage" on page F-1).

Other Medical Coverage Options

Medicare Supplement Options

In certain locations, you may choose to enroll in a *Medicare* Supplement option offered through the Shell Medical Benefit Program. These plans supplement *Medicare's* reimbursement for covered medical expenses and pay a higher benefit if you use a network provider.

If a *Medicare* Supplement option is available in your area, you will receive benefit and cost information directly from the Shell Benefits Service Center during the *group annual enrollment period*.

Regional Medicare Advantage Options

In addition to the Shell Medicare Advantage PPO and the KelseyCare Advantage Greater Houston, the Shell Medical Benefit Program offers *Medicare*-eligible *retirees* and *retirees' Medicare*-eligible dependents access to local *Medicare* Advantage options in certain areas across the country. In order to participate in one of these regional programs, you must live within a specified ZIP code area determined by the *Medicare* Advantage insurance provider.

Generally, these programs provide HMO-like benefits through a network of doctors, *hospitals* and other health care providers. *Medicare* Advantage programs replace traditional *Medicare* Part A and B and provide all of your medical benefits, including prescription drug coverage. Except in the case of emergency health care, you are required to use the exclusive provider network in order to receive benefits.

The *Medicare* Advantage options available in your area are listed in the material you receive from the Shell Benefits Service Center during the *group annual enrollment period*.

Important Information About Your Medical Benefits — For All Participants

The following sections provide information pertaining to all participants in the Shell Medical Benefit Program — *employees*, *retirees* (non-*Medicare*-eligible and *Medicare*-eligible), and all covered dependents.

Events Affecting Coverage

The following are events that have an impact on your coverage under the Medical Benefit Program:

Loss of Eligibility

Coverage for you and/or your *eligible dependent(s)* ends on the last day of the month in which you or the dependent(s) no longer meets the eligibility requirements. However, you may be able to continue coverage. (For details, see "Continuation of Coverage" on page F-1).

If a surviving spouse or *domestic partner* elects to cancel his or her coverage, or coverage is cancelled due to nonpayment of premium contributions, he or she will not be eligible to enroll again at a later date.

Death

Employees — Hired or Rehired on or After January 1, 2017

If you die while you are an *employee*, and you had dependent coverage at the time of your death, your dependents are covered for three months following the month in which you die. The *Company* pays all contributions during this three-month period. Thereafter, your dependent(s) may continue coverage up to an additional thirty-three (33) months by paying the full cost of continuation coverage.

If you die while you are an *employee* as the result of an occupational accident, and you had dependent coverage at the time of your death, your dependent(s) may continue coverage by paying the required premium contributions until they no longer meet the definition of *eligible dependent(s)*. For your surviving spouse, this means coverage may continue until the end of his or her life. Your dependents who continue coverage under this provision do not have the right to add new dependents to their coverage under the Plan. The *Company* continues to subsidize coverage until your dependent(s) no longer qualify for coverage.

Employees — Hired or Rehired Prior to January 1, 2017

If you die while you are an *employee*, before you meet the *retiree coverage eligibility* requirements (see the Glossary for *retiree coverage eligibility* requirements), and you had dependent coverage at the time of your death, your dependent(s) are covered for three months following the month in which you die. The *Company* pays all contributions during this three-month period. Thereafter, your dependent(s) may continue coverage by paying the full cost. Your dependent(s) may continue coverage until they no longer meet the definition of *eligible dependent(s)*.

If you die while you are an *employee*, after you meet the *retiree coverage eligibility* requirements or as the result of an occupational accident, and you had dependent coverage at the time of your death, your dependent(s) may continue coverage by paying the required premium contributions until they no longer meet the definition of *eligible dependent(s)*. For your surviving spouse, this means coverage may continue until the end of his or her life. Your dependents who continue coverage under this provision do not have the right to add new dependents to their coverage under the Plan. The *Company* continues to subsidize coverage until your dependent(s) no longer qualify for coverage.

Retirees

If you had dependent coverage at the time of your death, your dependent(s) may continue coverage by paying the required premium contributions. Your dependent(s) may continue coverage until they no longer meet the definition of *eligible dependent(s)*. For your surviving spouse, this means coverage may continue until the end of his or her life. Your dependents who continue coverage under this provision do not have the right to add new dependents to their coverage under the Plan.

If your *eligible dependent(s)* were not enrolled at the time of your death, they may enroll for coverage by contacting the Shell Benefits Service Center within 60 days of the date of your death.

As noted under "Loss of Eligibility" on page A-40, if your surviving spouse or *domestic partner* cancels his/her coverage, or coverage is canceled due to lack of premium payment, he or she will not be able to re-enroll.

Employment Events (Employees Only)

- **Leaves of Absence (Disability, Personal and Military):** If you are on a leave of absence, your benefits may be impacted. See "Leaves of Absence" on page J-15.
- **Change in Number of Hours Worked:** If your employment status changes to *part-time employee* status (less than 20 hours per week), your coverage ends. However, you may be able to continue coverage (see "Continuation of Coverage" on page F-1). Conversely, if your employment status changes from *part-time employee* to *regular part-time employee* or *regular full-time employee*, you become eligible to participate in the Medical Benefit Program, effective on the date of your change in status.
- **Layoff or Termination:** If you are laid off due to lack of work or if your employment is terminated, your coverage ends on the last day of the month. However, you may be able to continue coverage (see "Continuation of Coverage" on page F-1).
- **Retirement:** If you were hired or rehired on or after January 1, 2017, you are not eligible for *retiree* coverage under the Shell Medical Benefit Program. Coverage for you and your dependents ends at your retirement. If you were hired or rehired prior to January 1, 2017, and retire having attained *retiree coverage eligibility*, you may continue your coverage by paying the required premium. See "Shell Benefits Under Retirement" on page K-1 for additional information.

Medical Benefit Program Amendment or Termination

Your coverage changes or ends on the date this program is amended or terminated, respectively. However, if you or your dependent(s) incur covered expenses before the program is amended or terminated, benefits are paid according to the program provisions in effect before the change.

Right of Recovery

The Shell Medical Benefit Program has the right to recover benefits paid on behalf of participants that were:

- Made in error, or
- Due to a mistake in fact or misrepresentation of facts.

If the Shell Medical Benefit Program provides a benefit for you or your *eligible dependent(s)* that exceeds the amount that should have been paid, the program will:

- Require that the overpayment be returned when requested, or
- Reduce a future benefit payment for you or your *eligible dependent(s)* by the amount of the overpayment.

Subrogation

The Medical Benefit Program has the right to recover benefits paid on your behalf for expenses for which a third party is liable. For further information, see "Right to Subrogation" on page G-1.

Qualified Medical Child Support Orders (QMCSOs)

Section 609(a) of *ERISA* provides that a group health plan will provide benefits in accordance with the applicable requirements of any qualified medical child support order (QMCSO). A QMCSO is a medical child support order issued under state law that creates or recognizes the existence of an alternate recipient's rights to receive benefits for which a participant or *beneficiary(ies)* is eligible under a group health plan, and that satisfies certain additional requirements in Section 609(a) of *ERISA*.

If a QMCSO has been issued with respect to your child, the original certified copy of a medical child support order should be forwarded for processing and a determination of whether it constitutes a QMCSO to:

Shell Benefits Service Center
QMCSO Processing
P.O. Box 770003
Cincinnati, OH 45277-0071

A summary of the Shell Medical Benefit Program's procedures (Processing Guidelines for Shell Oil Medical Benefit Program Qualified Medical Child Support Orders) is available, free of charge, from the Shell Benefits Service Center upon written request to the address listed at left or by calling 1-800-30-SHELL (1-800-307-4355).

Similarly, a "National Medical Support Notice," which is a notice issued by a state agency to enforce a medical child support order (and is deemed to constitute a QMCSO), also should be sent to the address listed at left in this section for processing.

Conversion Privilege

The US PPO, US HDHP, Kelsey-Seybold Greater Houston and US GEMS options do not allow you to convert your coverage to an individual policy. If you are enrolled in a regional HMO/PPO option, you should contact the insurer directly for information regarding the availability of a conversion privilege.

Supplemental Information

Please note that, depending on your medical coverage option, some parts of your benefits description may be in separate documents. As such, the SPD supplements the information found in the separate documents: certificates of coverage, booklet certificates or other similar documents you receive from an insurance company providing benefits to you under the Shell Medical Benefit Program.

Dental Benefit Program

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Good dental hygiene, regular checkups and timely dental care are important to your overall health. The Dental Benefit Program supports preventive dental care and also provides benefits for essential dental services, such as fillings and dentures.

Overview

The *Company* offers you the choice of these dental options, both administered by Cigna:

- **Cigna Dental PPO option** offers coverage for dental care from any qualified provider. The monthly premium for the Cigna Dental PPO is higher than that of the Cigna Dental HMO option. The option pays or reimburses a specified percentage of the charges for covered services, up to an annual maximum benefit and separate orthodontic lifetime maximum benefit. Some services may also require the patient to meet a *deductible* before Shell shares in the cost of covered expenses.
- **Cigna Dental HMO** offers coverage for dental care through the Cigna HMO network of dental providers. Each enrolled family member must designate a primary care dentist (PCD) to coordinate his or her individual dental care needs. This option features relatively low monthly premiums and patient *copayments* for most covered services, and no annual maximum benefit or orthodontic lifetime maximum benefit; however, you must use designated dental providers to receive benefits.

Participation

Eligibility

You are eligible for coverage under the Dental Benefit Program if you are:

- A *regular full-time* or *regular part-time employee* of the *Company*.
- A *retiree* who retired from the *Company* having met *retiree coverage eligibility* requirements. For an explanation of those requirements, see M-10.

If you are eligible and enroll in the program, you can also enroll your *eligible dependents*, which include:

- Your spouse or *domestic partner*.[1]
- Your child(ren)[2] through the end of the month in which they turn 26.
- Your unmarried child(ren) age 26 or over who were physically or mentally disabled on the day before reaching their 26th birthday and were covered under the program, or under another plan sponsored through your or your spouse/domestic partner's previous employment, and who remain disabled and permanently dependent on you for financial support.
- The unmarried child(ren) of your spouse or *domestic partner* who are under age 25, whose medical expenses are eligible for deduction on your federal tax return, who live with you in a regular parent-child relationship and who are not employed full-time.
- The unmarried child(ren) of your spouse or *domestic partner* age 25 or over who were physically or mentally disabled on the day before reaching their 25th birthday and were covered under the program, or under another plan sponsored through your or your spouse/domestic partner's previous employment, and who remain disabled, live with you in a regular parent-child relationship and are permanently dependent upon you for financial support.

[1] For *retirees*, *domestic partner* coverage is only available if you retired on or after January 1, 1998.

[2] For these purposes, child or children means a biological child, stepchild, adopted child, foster child, or grandchild of whom you have legal guardianship.

Enrollment

Contact the Shell Benefits Service Center at 1-800-30SHELL (1-800-307-4355) to enroll or ask questions about your eligibility.

Employees

If you are a newly eligible *employee*, you will receive enrollment materials from the Shell Benefits Service Center. If you wish to enroll, you have 31 days to do so after your eligibility date.

- If you enroll within this 31-day period, your coverage takes effect as of your hire date or eligibility date.
- If you do not enroll within this 31-day period, you may do so at the next *group annual enrollment period* or within 31 days of a *qualified status change*. See M-8 for information on what constitutes a *qualified status change*. You are not permitted to enroll at any other time.

If you were previously enrolled in the Dental Benefit Program, canceled your coverage, and wish to re-enroll, you can only do so during a *group annual enrollment period* or within 31 days of a *qualified status change*.

Retirees

If you retired from the *Company* having met *retiree coverage eligibility* requirements* on or after May 1, 1988:

- You can continue coverage for yourself and your dependents by paying the required contributions, or
- If not enrolled in the Dental Benefit Program at the time of your retirement, you can enroll for coverage during a *group annual enrollment period* or within 31 days of a *qualified status change*. See M-8 for information on what constitutes a *qualified status change*.

* See M-10 for information on *retiree coverage eligibility* requirements.

Dependents

If you enroll your dependents at the same time as you enroll yourself, their coverage begins the day your coverage begins. This includes dependents enrolled along with you within 31 days of your hire or eligibility date, and dependents enrolled with you during a *group annual enrollment* or following a *qualified status change*.

If you are already enrolled and wish to add a dependent:

- Generally, newly *eligible dependents* must be added within 31 days of their eligibility. Their coverage will begin at their date of eligibility.
- For newborns and newly adopted children to be covered from their date of birth or adoption, you must enroll them within 90 days of their birth or adoption.
- If you do not enroll dependents within the allotted time, you must wait for a *group annual enrollment period* or a subsequent *qualified status change*.

Eligible dependents of an eligible *retiree* who was not enrolled in the Dental Benefit Program at the time of his/her death, may enroll for coverage by calling the Shell Benefits Service Center within 60 days of the *retiree's* death. If these *eligible dependents* do not contact the service center within 60 days or choose not to enroll, they may not enroll at a later date.

Important Notice Related to the COVID-19 Outbreak

Pursuant to guidance issued in response to the declared national emergency as a result of the COVID-19 outbreak (the "National Emergency"), and unless future guidance by the relevant government agencies provides otherwise, the time period between March 1, 2020, and July 10, 2023, which is 60 days following the announced May 11, 2023, end of the National Emergency will be disregarded in determining the deadlines for submitting a request to change your coverage when the request is in connection with a *qualified status change* that is considered a special enrollment right, as described in the Glossary on page M-8. However, the maximum deadline extension for any such request to change coverage is one year.

Levels of Coverage

You select the coverage level that suits your family's needs.

For Active Employees and Retirees

The Dental Benefit Program allows you to choose from these levels of coverage:

- *Participant only.*
- *Participant plus child(ren).*
- *Participant plus spouse/domestic partner.*
- *Family.*

Changing Coverage

You may only change your coverage each year during the *group annual enrollment period* or if you experience a *qualified status change*. See page M-8 for information on what constitutes a *qualified status change*.

If you have a *qualified status change*, you may change your coverage only if:

- Your change in coverage is consistent with the *qualified status change* event, except with respect to *qualified status changes* that are considered special enrollment rights.
- You submit your request to change your coverage:
  - Within 31 days after the *qualified status change*, or
  - Within 90 days after the birth or adoption of a child, or
  - Within 60 days from the date of determination for loss of coverage under Medicaid or State Children's Health Insurance Program (SCHIP) or eligibility for a premium assistance subsidy under Medicaid or SCHIP.

Changes in coverage are effective on the date of the *qualified status change*.

Cost

You and the *Company* share in the cost of dental coverage.

Employees

If you are a *regular full-time* or *regular part-time employee*, your election to participate in the program constitutes an election to pay your contribution by pre-tax salary reduction. However, please be aware that federal tax law does not allow pre-tax payroll deductions for *domestic partner* coverage, including coverage for children of a *domestic partner* if they are not also your tax dependents. If you enroll a *domestic partner* under the *Participant plus spouse/domestic partner* or *Family* levels, the amount of your contribution in excess of the cost of *Participant only* coverage will be deducted on an after-tax basis.

Retirees

If you are an eligible *retiree*, your contributions are made on an after-tax basis through a deduction from your pension payment, or in some cases, by direct payment through invoice or Automatic Bank Withdrawal (ABW).

How the Dental Benefit Program Options Work

Cigna Dental PPO

When you enroll in the Cigna Dental PPO option, you may seek care from any qualified, licensed dental care provider. However, the Cigna Dental PPO option includes preferred providers in many areas who discount the cost of their services. Under a *dental PPO* option, you pay a percentage of covered expenses or *coinsurance*, subject to a *deductible* and benefit maximums.

With the Cigna Dental PPO option, in order to be considered a covered expense, the treatment, procedure, or service must be:

- Essential for the necessary care and treatment of the teeth and gums,
- Performed by or under the direction of a dentist, endodontist, periodontist, orthodontist, or oral surgeon, and
- Within reasonable and customary limits.

If you are enrolled in the Cigna Dental PPO option and your dentist proposes services that are estimated to cost more than $200, it is recommended that you or your dentist contact Cigna for a Pretreatment Review. Cigna will evaluate the proposed treatment plan and will advise if the proposed procedures are covered and the amount of benefits payable.

In most cases, your dentist's recommendations are approved. At times, however, payments are based upon an alternative plan of treatment rather than the one your dentist proposed. If this occurs, you may proceed with the original treatment plan, but the benefit payment will be based upon the reasonable and customary charge for the alternative procedure. (For more information, see "Alternative Procedures" on page B-12.)

To obtain a Pretreatment Review, call Cigna's Dental Claims Office at 1-800-244-6224 for assistance.

Reasonable and Customary Charges

The Cigna Dental PPO option limits covered expenses to reasonable and customary charges. "Reasonable and customary charges" are amounts normally charged by a dentist, endodontist, periodontist, or orthodontist and are in line with charges usually made for similar services performed in the same locality for persons having similar conditions.

Cigna, the Claims Administrator, determines whether your dental expenses are reasonable and customary by considering the severity of the condition being treated and any complications or unusual circumstances requiring additional time, skill, or experience on the part of your dental provider.

Cigna Dental HMO

When you enroll in the Cigna Dental HMO option, you must designate a primary care dentist to coordinate all of your dental care needs. Services not provided by or referred through your primary care dentist are not covered expenses under a *dental HMO* option.

The Cigna Dental HMO option uses the Cigna HMO network of dental providers, which includes dentists and dental specialists who agree to offer their services to enrolled patients for a specified *copayment* per covered service, as detailed in the Patient Dental Charge Schedule or the Schedule of Benefits that summarizes common services.

Pretreatment Review

A Pretreatment Review is not necessary under the Cigna Dental HMO option because your *copayments* are established under the Patient Dental Charge Schedule.

How the Dental Benefit Program Options Compare

Paying Your Share of Covered Expenses

You share in the cost of covered services through *deductibles*, *copayments*, and *coinsurance*. These cost-sharing features vary between the options and can have a big impact on your out-of-pocket expenses.

Annual Deductible

The *deductible* is the amount you pay for covered services before the Cigna Dental PPO option begins to pay basic and major dental services. The *deductible* does not apply to diagnostic and preventive services.

The Cigna Dental HMO option does not include a *deductible* for any covered dental services.

Benefit Maximums

The Cigna Dental PPO option limits the amount of benefits paid by the program in any calendar year. The annual benefit maximum is the total of all benefits paid by the program for diagnostic and preventive, basic, and major services from January 1 through December 31 of each year. Payment for services and treatments that are started in one year and completed in the next calendar year are based upon the year in which the service was delivered.

The Cigna Dental HMO option does not include maximum benefit limits.

Coinsurance

When you incur a covered dental expense under the Cigna Dental PPO option, you are responsible for a percentage of covered charges for that service. Your *coinsurance* depends on the type of dental service you receive and your provider's reasonable and customary charge for that service.

The Cigna Dental HMO option does not require *coinsurance* for any covered dental services.

Copayments

The Cigna Dental PPO option does not require *copayments* for any covered dental services.

Under the Cigna Dental HMO option, you are responsible for a fixed charge or *copayment* for each covered dental service. The *copayment* is determined by the Patient Dental Charge Schedule that is updated each year.

Schedule of Benefits

The following chart summarizes the benefits under both the Cigna Dental PPO and Cigna Dental HMO options. The *copayments* listed under the Cigna Dental HMO option are estimated based upon the current Patient Dental Charge Schedule, which is available through the Shell Benefits Service Center at **www.netbenefits.com** or by calling Cigna Dental Health directly at 1-800-244-6224.

Key Provisions	Cigna Dental PPO		Cigna Dental HMO	
	Coverage	***Services Included in Treatment***	***Coverage***	***Services Included in Treatment***
Annual *deductible*	Individual: $50 Family: $100	N/A	N/A	N/A
Annual benefit maximum	$2,000 per person	N/A	N/A	N/A
Preventive treatment	100%, no *deductible*	▪ Oral evaluations ▪ Prophylaxis: routine cleanings ▪ X-rays: routine ▪ X-rays: non-routine ▪ Fluoride application ▪ Space maintainers: non-orthodontic ▪ Emergency care to relieve pain	100%, no *deductible* for most diagnostic and preventive procedures*	▪ Oral evaluations ▪ Prophylaxis: routine cleanings ▪ X-rays: routine ▪ X-rays: non-routine ▪ Fluoride application ▪ Space maintainers: non-orthodontic ▪ Emergency care to relieve pain
Basic treatment	80% after *deductible*	▪ Restorative: fillings ▪ Endodontics: minor and major ▪ Periodontics: minor and major ▪ Oral surgery: minor ▪ Anesthesia: general and IV sedation ▪ Repairs: bridges, crowns, and inlays ▪ Repairs: dentures ▪ Denture relines, rebases, and adjustments ▪ Sealants: per tooth	100%, no *deductible* for fillings; *copays* required for most other basic treatments*	▪ Restorative: fillings ▪ Endodontics: minor and major ▪ Periodontics: minor and major ▪ Oral surgery: minor ▪ Anesthesia: general and IV sedation ▪ Repairs: bridges, crowns, and inlays ▪ Repairs: dentures ▪ Denture relines, rebases, and adjustments ▪ Sealants: per tooth

(continued)

Key Provisions	Cigna Dental PPO		Cigna Dental HMO	
	Coverage	***Services Included in Treatment***	**Coverage**	***Services Included in Treatment***
Major restorative	50% after *deductible*	▪ Inlays and onlays ▪ Prosthesis over implant ▪ Crowns: prefabricated stainless steel/resin ▪ Crowns: permanent cast and porcelain ▪ Bridges and dentures ▪ Surgical implant	See Benefit Summary which includes charge schedule, available on NetBenefits	▪ Inlays and onlays ▪ Prosthesis over implant ▪ Crowns: prefabricated stainless steel/resin ▪ Crowns: permanent cast and porcelain ▪ Bridges and dentures ▪ Surgical implant*
Orthodontic treatment	You pay 50% *coinsurance* (after *deductible*)	▪ Coverage for *employee/retiree* and all dependents ▪ Lifetime benefits maximum: $2,000 per person	See Benefit Summary which includes charge schedule, available on NetBenefits	Coverage for *employee/retiree* and all dependents*
Cutting procedures	100% after $50 *deductible* (not included in the Annual Benefit Maximum)	Oral surgery: major	See Benefit Summary which includes charge schedule, available on NetBenefits	Oral surgery: major*

* Please refer to the Benefits Summary, available in the Reference Library on NetBenefits, for a complete listing of covered procedures and charges.

Covered Expenses

Covered expenses under the Dental Benefit Program fall into the following categories:

- Diagnostic and preventive services.
- Basic services.
- Major services.
- Orthodontic services.

Diagnostic and Preventive Services

The Cigna Dental PPO option and the Cigna Dental HMO option provide coverage for the following preventive services:

- Teeth cleaning (dental prophylaxis) twice a year for each covered person. Individuals diagnosed with periodontal disease are eligible for two additional cleanings per year upon dentist's recommendation.
- Fluoride treatments twice a year for each covered dependent(s) under age 19.
- Space maintainers (fixed bands) to replace teeth extracted or lost prematurely.

Diagnostic services include:

- Consultations.
- Oral examinations, two each year for each covered person.
- Bite-wing X-rays, two each year for each covered person.
- Complete series X-rays, one series every three years for each covered person.
- Emergency care to temporarily relieve dental pain when no other dental service, except X-rays, is performed. Please note that if you are enrolled in the Cigna Dental HMO option, emergencies are covered as follows:
  - If you are in acute pain during office hours, contact your network dentist, who will provide care.
  - If you are unable to reach your network dentist, call Cigna Dental Health 24 hours a day, seven days a week for the name and location of a network dentist near you.
  - If an emergency occurs after business hours or a network dentist is not available, you may go to any dentist and be reimbursed up to $50 for immediate relief (a $54 *copayment* is required after regularly scheduled hours). To be reimbursed for emergency care, send a copy of your bill to Cigna Dental Health, Specialty Referrals, P.O. Box 188045, Chattanooga, TN 37422.

Basic Services

The Cigna Dental PPO option and the Cigna Dental HMO option provide coverage for the following basic services:

- Most fillings, including amalgam and composite (composite fillings are limited to anterior teeth).
- Re-cementing of inlays or crowns.
- Sealants (up to age 14) for one treatment per tooth every three years.
- Most oral surgery (includes most extractions to the extent not covered by a group medical plan. and is limited to surgical removal of diseased teeth).
- Endodontic treatment, including root canal therapy, except molars and bicuspids.

Major Services

The Cigna Dental PPO option and the Cigna Dental HMO option provide coverage for the following major services:

- Crowns — a dental restoration covering the exposed portion of a tooth.
- Bridges, including repair.
- Inlay — a filling that is cemented into a tooth cavity.
- Onlay — an inlay increased to cover the entire chewing surface of the tooth.
- Dentures, including repair and relining after six months.

If you need a bridge or denture to replace an existing appliance, the service is covered if:

- The existing bridge or denture cannot be made serviceable, and
- Five years have elapsed since the existing bridge or denture was installed. (The five-year requirement does not apply if your denture or bridgework is being replaced because of injury or additional extractions.)

In addition, the Cigna Dental PPO option provides coverage for the following major services:

- Gold and porcelain fillings.
- Implants — a dental restoration replacing a missing tooth.
- Oral surgery and other cutting procedures.

Orthodontic Services

Cigna Dental PPO Option

The Cigna Dental PPO option covers the following orthodontic services for adults and child(ren).

- Orthodontic evaluation and development of an orthodontic treatment plan.
- Appliances for tooth guidance and retention needed to correct the alignment of teeth.
- Follow-up care.

Benefit payments are made after a specific orthodontic procedure is completed; however, benefit payments for maintenance visits are made quarterly.

If you or your covered dependent is undergoing active orthodontic treatment at the time of enrollment, the Cigna Dental PPO option pays benefits beginning with the first monthly treatment charge incurred after coverage begins. Charges for previously installed bands or orthodontic appliances are not covered.

Call Cigna's Dental Health Claims Office at 1-800-244-6224 for more information.

Cigna Dental HMO Option

With the Cigna Dental HMO option, orthodontic services are covered for both child(ren) and adults and are subject to *copayments* as outlined in the Patient Dental Charge Schedule, available through the Shell Benefits Service Center or by calling Cigna Dental Health at 1-800-244-6224. Covered services include an orthodontic consultation, evaluation, treatment plan, and interceptive care, as well as a normal 24-month banded case, including follow-up care.

If you or your covered dependent(s) is undergoing active orthodontic treatment when you enroll in the Cigna Dental HMO option, the benefit is prorated for the period that continued care is required, based upon a 24-month treatment plan.

Treatment in Progress

The Cigna Dental PPO option and the Cigna Dental HMO option cover certain treatments that are in progress when your coverage terminates. In this situation, you or your covered dependent(s) may be covered if either of the following conditions is met:

- If a dental procedure (other than orthodontic treatment) that requires at least two visits on separate days to a dental office began before coverage ended, coverage for that procedure is extended for 90 days after the date coverage ended, unless coverage was terminated for non-payment of contributions, or
- In the case of orthodontic treatment: If the orthodontist agreed to or is receiving monthly payments, coverage for that treatment is extended for 60 days after the date coverage ended. If the orthodontist agreed to or is receiving quarterly payments, coverage is extended to the end of the calendar quarter or 60 days, whichever is later.

Expenses Not Covered

The following expenses are not covered by the Cigna Dental PPO option or the Cigna Dental HMO option:

- Services that are not necessary or are in excess of specified coverage.
- Charges that you are not legally required to pay or charges that would not have been made if you were not covered under the Dental Benefit Program.
- Services covered under a group medical plan to the extent that benefits are provided by such plan.
- Cosmetic dental services.
- A separate charge for sterilization of instruments or materials used in providing dental services.
- Cost of hospitalization and *hospital*-provided costs.
- Experimental procedures.
- Appliances or restorations whose main purpose is to change the vertical dimension of the teeth.
- Treatment of temporomandibular joint (TMJ) dysfunction, except for oral examinations or dental X-rays that may be necessary to make a diagnosis.
- Extra sets of dentures or other dental appliances.
- Charges for lost or stolen bridges, dentures, or orthodontic appliances.
- Replacement of fixed prosthodontic and removable prosthodontic appliances that are rendered non-functional due to patient abuse, misuse, or neglect.
- Services required as a result of a self-inflicted injury.
- Services required as a result of injury received in a declared or undeclared war or during service in the armed forces of any country.
- Charges for missed appointments or failure to complete claim forms.
- Charges for services covered under workers' compensation laws.

Additional expenses not covered by the Cigna Dental PPO option include:

- Education or training in personal hygiene, plaque control, or dietary instruction.
- Prescription drugs and additional charges for anesthesia, except when general anesthesia is medically necessary for oral surgery.
- Temporary wiring or permanent bonding of teeth together (periodontal splinting).
- Precision or semi-precision attachments or appliances.
- Procedures or appliances that would increase or decrease the bite of the upper or lower teeth.
- Porcelain or acrylic veneers of crowns or pontics on, or replacing, the upper or lower first, second, and third molars.
- Fees in excess of reasonable and customary charge limits.

Additional expenses not covered under the Cigna Dental HMO option include:

- Fixed prosthodontic, removable prosthodontic, and root canal treatment in progress before Cigna Dental HMO option coverage begins.
- Prescription drugs or administration of sedation or a general anesthetic (Maryland residents are covered when the medication or general anesthetic is medically necessary).
- Any other service listed as not covered or not specified as covered under the Patient Dental Charge Schedule.
- Except for emergency care, services not performed or authorized by your designated network dentist.
- Hospitalization, including any associated incremental charges for dental services performed in a *hospital*.
- Implants or attachments repairs.

If dental work is recommended or considered necessary but is not performed until a later date, the work is considered to begin on the date the work actually took place rather than the date it was recommended or deemed necessary.

Important Information about Your Dental Benefits — for All Participants

The following sections provide information pertaining to all participants in the Dental Benefit Program — *employees*, *retirees*, and all covered dependents.

Applying for Benefits

Cigna Dental PPO Option

To apply for benefits you must obtain a claim form by calling Cigna or from the Shell Benefits Service Center at **www.netbenefits.com**. Fill out your portion of the claim form and sign it to indicate whether the payment should be made:

- To you, if you paid the dentist directly, or
- To the dentist, if payment was not made in full.

Then give the form to your dentist. He or she has to:

- Complete the rest of the form, or
- Attach another form that includes all the requested information.

Please review the form to ensure all required fields are completed properly. Any missing, inconsistent, or incorrect information delays the processing of your claim.

The completed form should be mailed to Cigna's Dental Claims Office at the address on the form. If the claim is for a dental procedure covered by your group medical plan, file the claim with the medical carrier first.

You should file your claim as soon as possible after receiving treatment. Claims must be submitted within 12 months from the date of service. Failure to comply with this important deadline will result in the forfeiture of your right to a claim for benefits.

If a claim for benefits is denied, you may file an appeal. (For details, see page L-5, "Health Care Benefits Claims Procedure.")

Call Cigna at 1-800-244-6224 for a claim form.

Alternative Procedures

Often, there is more than one accepted method of repairing or treating a particular condition. After all claim information is received and evaluated, the benefit payment is based upon the method that Cigna's dental consultants consider to be appropriate and in accordance with current dental practice standards.

Cigna Dental HMO Option

The Cigna Dental HMO option does not require claim forms. You pay your dentist the *copayment* outlined in the Patient Dental Charge Schedule and any additional costs are handled directly by Cigna Dental Health and your dentist.

Coordination of Benefits

The Cigna Dental PPO and Cigna Dental HMO options coordinate the benefits payable by taking into account any coverage you or your covered dependent(s) may have under any other group medical or dental plan. As a result of this coordination of benefits, it is possible for you to receive reimbursement for up to the maximum amount the plan would pay as your primary coverage.

Here is a summary of how coordination of benefits works:

- If benefits are coordinated with another group medical plan, the difference between the amount that would have been paid without coordination of benefits and the amount of benefits actually paid may be credited to the covered person.

- If benefits are coordinated with a group dental plan, any such credit applies only to the claim that was coordinated (see "Coordination of Benefits" on page B-12).
- If your spouse or *domestic partner* is covered under another group plan, that plan provides primary coverage for him or her.

Coordination of benefits for dependent child(ren) is based upon the birthday rule. This means that the plan of the parent whose birthday occurs earlier in the calendar year provides primary coverage, and any other group plan provides secondary coverage.

If your covered dependent(s) is also covered under another group plan that provides primary coverage, you must file all claims with that plan first. After you receive an explanation of benefits (EOB) from that plan, you should file your claim, including the other plan's EOB, through the applicable Claims Administrator.

Events Affecting Coverage

The following are events that have an impact on your coverage under the Dental Benefit Program:

Loss of Eligibility

Coverage for you and/or your *eligible dependent(s)* ends on the last day of the month in which you or the dependent(s) no longer meets the eligibility requirements. However, you may be able to continue coverage. (For details, see "Continuation of Coverage" on page F-1).

If a surviving spouse or *domestic partner* elects to cancel his or her coverage, or coverage is cancelled due to nonpayment of premium contributions, he or she will not be eligible to enroll again at a later date.

Death

Employees

If you die while you are an *employee*, and you had dependent coverage at the time of your death, your dependents are covered for three months following the month in which you die. The *Company* pays all contributions during this three-month period. Thereafter, your dependent(s) may continue coverage up to an additional thirty-three (33) months by paying the full cost of continuation coverage.

If you die while you are an *employee* as the result of an occupational accident, and you had dependent coverage at the time of your death, your dependent(s) may continue coverage by paying the required premium contributions until they no longer meet the definition of *eligible dependent(s)*. For your surviving spouse, this means coverage may continue until the end of his or her life. Your dependents who continue coverage under this provision do not have the right to add new dependents to their coverage under the Plan. The *Company* continues to subsidize coverage until your dependent(s) no longer qualify for coverage.

Retirees

If you had dependent coverage at the time of your death, your dependent(s) may continue coverage by paying the required premium contributions. Your dependent(s) may continue coverage until they no longer meet the definition of *eligible dependent(s)*. For your surviving spouse, this means coverage may continue until the end of his or her life. Your dependents who continue coverage under this provision do not have the right to add new dependents to their coverage under the Plan.

If your *eligible dependent(s)* were not enrolled at the time of your death, they may enroll for coverage by contacting the Shell Benefits Service Center within 60 days of the date of your death.

As noted under "Loss of Eligibility" at left in this section, if your surviving spouse or *domestic partner* cancels his/her coverage, or coverage is canceled due to lack of premium payment, he or she will not be able to re-enroll.

Employment Events (Employees Only)

- **Leaves of Absence (Disability, Personal and Military)** — If you are on a leave of absence, your benefits may be impacted. See "Leaves of Absence" on page J-15.
- **Change in Number of Hours Worked** — If your employment status changes to *part-time employee* status (less than 20 hours per week), your coverage ends. However, you may be able to continue coverage (see "Continuation of Coverage" on page F-1). Conversely, if your employment status changes from *part-time employee* to *regular part-time employee* or *regular full-time employee*, you become eligible to participate in the Dental Benefit Program, effective on the date of your change in status.
- **Layoff or Termination** — If you are laid off due to lack of work or if your employment is terminated, your coverage ends on the last day of the month. However, you may be able to continue coverage (see "Continuation of Coverage" on page F-1).
- **Retirement** — You may continue your coverage by paying the required premium. See "Shell Benefits Under Retirement" on page K-1 for additional information.

Dental Benefit Program Amendment or Termination

Your coverage changes or ends on the date this program is amended or terminated, respectively. However, if you or your dependent(s) incur covered expenses before the program is amended or terminated, benefits are paid according to the program provisions in effect before the change.

Conversion Privilege

Cigna Dental PPO Option

The Cigna Dental PPO option does not include an option to convert your coverage to an individual policy.

Cigna Dental HMO Option

The Cigna Dental HMO option is portable. This means that, if your coverage ends, you can convert it to an individual policy. Keep in mind that the benefits under an individual policy are different from those you currently have, and you will be required to pay the full cost of coverage. For more information, contact Cigna Dental Health at 1-800-244-6224.

Vision Benefit Program

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Healthy eyes are an important part of your overall health. The Vision Benefit Program, offered through VSP, can reduce your costs for eye exams and prescription eyewear. When you receive services from a VSP provider, the plan will pay a larger share of expenses than when you use a non-VSP provider.

Participation

Eligibility

You are eligible for coverage under the Vision Benefit Program if you are:

- A *regular full-time* or *regular part-time employee* of the *Company*.
- A *retiree* who retired from the *Company* having met *retiree coverage eligibility* requirements. For an explanation of those requirements, see M-10.

If you are eligible and enroll in the program, you can also enroll your *eligible dependents*, which include:

- Your spouse or *domestic partner*.[1]
- Your child(ren)[2] through the end of the month in which they turn 26.
- Your unmarried child(ren) age 26 or over who were physically or mentally disabled on the day before reaching their 26th birthday and were covered under the program, or under another plan sponsored through your or your spouse/domestic partner's previous employment, and who remain disabled and permanently dependent on you for financial support.
- The unmarried child(ren) of your spouse or *domestic partner* who are under age 25, whose medical expenses are eligible for deduction on your federal tax return, who live with you in a regular parent-child relationship and who are not employed full-time.
- The unmarried child(ren) of your spouse or *domestic partner* age 25 or over who were physically or mentally disabled on the day before reaching their 25th birthday and were covered under the program, or under another plan sponsored through your or your spouse/domestic partner's previous employment, and who remain disabled, live with you in a regular parent-child relationship and are permanently dependent upon you for financial support.

[1] For *retirees*, *domestic partner* coverage is only available if you retired on or after January 1, 1998.

[2] For these purposes, child or children means a biological child, stepchild, adopted child, foster child, or grandchild of whom you have legal guardianship.

Enrollment

Contact the Shell Benefits Service Center at 1-800-30SHELL (1-800-307-4355) to enroll or ask questions about your eligibility.

Employees

If you are a newly eligible *employee*, you will receive enrollment materials from the Shell Benefits Service Center. If you wish to enroll, you have 31 days to do so after your eligibility date.

- If you enroll within this 31-day period, your coverage takes effect as of your hire date or eligibility date.
- If you do not enroll within this 31-day period, you may do so at the next *group annual enrollment period* or within 31 days of a *qualified status change*. See M-8 for information on what constitutes a *qualified status change*. You are not permitted to enroll at any other time.

If you were previously enrolled in the Vision Benefit Program, canceled your coverage, and wish to re-enroll, you can only do so during a *group annual enrollment period* or within 31 days of a *qualified status change*.

Retirees

If you retired from the *Company* having met *retiree coverage eligibility* requirements* on or after May 1, 1988:

- You can continue coverage for yourself and your dependents by paying the required contributions, or
- If not enrolled in the Vision Benefit Program at the time of your retirement, you can enroll for coverage during a *group annual enrollment period* or within 31 days of a *qualified status change*. See page M-8 for information on what constitutes a *qualified status change*.

* See M-10 for information on *retiree coverage eligibility* requirements.

Dependents

If you enroll your dependents at the same time as you enroll yourself, their coverage begins the day your coverage begins. This includes dependents enrolled along with you within 31 days of your hire or eligibility date, and dependents enrolled with you during a *group annual enrollment* or following a *qualified status change*.

If you are already enrolled and wish to add a dependent:

- Generally, newly *eligible dependents* must be added within 31 days of their eligibility. Their coverage will begin at their date of eligibility.
- For newborns and newly adopted children to be covered from their date of birth or adoption, you must enroll them within 90 days of their birth or adoption.
- If you do not enroll dependents within the allotted time, you must wait for a *group annual enrollment period* or a subsequent *qualified status change*.

Eligible dependents of an eligible *retiree* who was not enrolled in the Vision Benefit Program at the time of his/her death, may enroll for coverage by calling the Shell Benefits Service Center within 60 days of the retiree's death. If these *eligible dependents* do not contact the service center within 60 days or choose not to enroll, they may not enroll at a later date.

Important Notice Related to the COVID-19 Outbreak

Pursuant to guidance issued in response to the declared national emergency as a result of the COVID-19 outbreak (the "National Emergency"), and unless future guidance by the relevant government agencies provides otherwise, the time period between March 1, 2020, and July 10, 2023, which is 60 days following the announced May 11, 2023, end of the National Emergency will be disregarded in determining the deadlines for submitting a request to change your coverage when the request is in connection with a *qualified status change* that is considered a special enrollment right, as described in the Glossary on page M-8. However, the maximum deadline extension for any such request to change coverage is one year.

Levels of Coverage

You select the coverage level that suits your family's needs.

For Active Employees and Retirees

The Vision Benefit Program allows you to choose from these levels of coverage:

- *Participant only.*
- *Participant plus child(ren).*
- *Participant plus spouse/domestic partner.*
- *Family.*

Changing Coverage

You may only change your coverage each year during the *group annual enrollment period* or if you experience a *qualified status change*. See page M-8 for information on what constitutes a *qualified status change*.

If you have a *qualified status change*, you may change your coverage only if:

- Your change in coverage is consistent with the *qualified status change* event, except with respect to *qualified status changes* that are considered special enrollment rights.
- You submit your request to change your coverage:
  - Within 31 days after the *qualified status change*, or
  - Within 90 days after the birth or adoption of a child, or
  - Within 60 days from the date of determination for loss of coverage under Medicaid or State Children's Health Insurance Program (SCHIP) or eligibility for a premium assistance subsidy under Medicaid or SCHIP.

Changes in coverage are effective on the date of the *qualified status change*.

Cost

Employees

Whether you are a *regular full-time employee* or *regular part-time employee*, you pay the full cost of vision coverage. Your election to participate in the program constitutes an election to pay your contribution by pre-tax salary reduction. However, please be aware that federal tax law does not allow pre-tax payroll deductions for *domestic partner* coverage, including coverage for children of a *domestic partner* if they are not also your tax dependent. If you enroll a *domestic partner* under the *Participant plus spouse/domestic partner* or *Family* levels, the amount of your contribution in excess of the cost of *Participant only coverage* will be deducted on an after-tax basis.

Retirees

You pay the full cost of vision coverage. Your contributions are made on an after-tax basis through deduction from your pension payment or, in some case, by direct payment through invoice or Automatic Bank Withdrawal (ABW).

How the Vision Benefit Program Works

You may choose to use a VSP doctor or affiliate provider or receive care from any licensed eye care professional. However, the level of benefits you receive under the Vision Benefit Program depends on your provider choice.

Using VSP Preferred and Affiliate Providers for a Higher Level of Benefits

Each time you need vision care, you can:

- Use VSP doctors or affiliate providers who discount the cost of their services. VSP manages a network of more than 37,000 eye care professionals nationwide. When you receive care from one of these providers, the program pays a higher level of benefit and your share of the covered expense is reduced, or
- Choose any licensed ophthalmologist, optometrist, or optician who is not a VSP doctor or affiliate provider, and you will have to pay for the services and supplies on the day of service. Then you must file a claim for reimbursement from VSP. (For details, see "Applying for Benefits" on page C-8.)

When You Use a VSP Doctor or Affiliate Provider...	When You Use Other Providers...
▪ You receive the highest level of coverage for your vision care. ▪ You have no claim forms to file.	▪ You receive limited coverage. ▪ You have to file claim forms.

To access network benefits, simply select a VSP doctor or affiliate provider and call to make an appointment. Be sure to identify yourself as a Shell/VSP member. You will also need your ID number (last four digits of your Social Security number) when you call.

Paying Your Share of Covered Expenses

You share in the cost of covered services through *copayments*. When you incur a covered vision expense from a VSP doctor or affiliate provider, part of the expense is paid by VSP and part is your responsibility. *Copayments* are your portion of covered vision expenses.

Once you pay a $10 *copayment* for a vision exam and a $25 *copayment* for materials (lenses and frames), if applicable, VSP pays:

- 100% of the cost of one comprehensive eye exam every calendar year,
- 100% of the cost of one set of prescription lenses every calendar year, and
- 100% of the specified wholesale price of one set of frames every calendar year, up to $200 retail. (For more expensive frames, you pay the difference in cost at a 20% discount.) You may purchase a second pair of glasses at 20% off the retail cost within 12 months of your last eye exam.

You must pay any additional charges for materials not covered under the program or for the following cosmetic options:

- Blended, laminated, oversized, progressive multifocal, or ultraviolet-protected lenses.
- Lens coatings.
- A more expensive frame than the program allowance (at the wholesale price).
- Contact lenses, except as noted at right in this section.
- Optional cosmetic processes.

VSP Discounts

When you use a VSP doctor or affiliate provider, you can receive discounts for eyewear and vision services.

Contact Lenses

Each calendar year, you may exchange your lens and frame benefits for a contact lens benefit of up to $150, with a 15% discount off professional fees for elective contact lens evaluations and fittings. Discounts are applied to the VSP provider's reasonable and customary charges and are available within 12 months of the covered eye examination.

Additional Prescription Glasses

You are entitled to receive a discount of 20% toward the purchase of additional complete pairs of prescription glasses (lenses, lens options, and frames) from a VSP doctor within 12 months of your last eye exam. Additional pair means any complete pair of prescription glasses purchased beyond the benefit frequency allowed. These discounts do not apply to vision care benefits obtained from other providers not affiliated with VSP.

Laser Surgery

You can also receive discounts on photorefractive keratectomy (PRK), laser-assisted in-situ keratomileusis (LASIK), and Custom LASIK for qualified candidates. Discounts vary by location, but on average amount to 15% off the contracted laser center's reasonable and customary charge. Additionally, if the participating laser center is offering a temporary price reduction, you will receive an additional 5% off the promotional price.

The maximum you will pay is:

- $1,500 per eye for PRK.
- $1,800 per eye for LASIK.
- $2,300 per eye for Custom LASIK.

Your VSP doctor can determine if you are a qualified candidate and refer you to a contracted laser surgery center.

Schedule of Benefits

The following chart summarizes the benefits under the Vision Benefit Program.

Key Provisions	Description	Copay	Frequency
WellVision exam	Focuses on your eyes and overall wellness.	$10	Every calendar year
Prescription glasses		$25	See frames and lenses
▪ Frame	▪ $200 allowance for a wide selection of frames. ▪ $220 allowance for featured frame brands. ▪ 20% savings on the amount over your allowance. ▪ $110 Costco® frame allowance.	Included in prescription glasses	Every calendar year
▪ Lenses	▪ Single vision, lined bifocal, and lined trifocal lenses. ▪ Impact-resistant lenses for dependent children.	Included in prescription glasses	Every calendar year
▪ Lens enhancements	▪ Progressive lenses. ▪ Tints/Light-reactive lenses. ▪ Average savings of 30% on other lens enhancements.	$0 $0	Every calendar year
Contacts (instead of eyeglasses)	▪ $150 allowance for contacts and contact lens exam (fitting and evaluation). ▪ 15% savings on a contact lens exam (fitting and evaluation).	$0	Every calendar year
Essential medical eye care	▪ Retinal screening for members with diabetes. ▪ Additional exams and services for members with diabetes, glaucoma, or age-related macular degeneration. ▪ Treatment and diagnoses of eye conditions, including pink eye, vision loss, and cataracts available for all members. ▪ Limitations and coordination with your medical coverage may apply. Ask your VSP doctor for details.	$0 $20 per exam	As needed
Extra savings			
Glasses and sunglasses	▪ Extra $20 to spend on featured frame brands. Go to **vsp.com/offers** for details. ▪ 20% savings on additional glasses and sunglasses, including lens enhancements, from any VSP provider within 12 months of your last WellVision Exam.		
Routine retinal screening	No more than a $39 copay on routine retinal screening as an enhancement to a WellVision Exam.		
Laser vision correction	Average 15% off the regular price or 5% off the promotional price; discounts only available from contracted facilities.		

Expenses Not Covered

The following expenses are not covered by the Vision Benefit Program:

- Non-prescription plano lenses.
- Two pairs of glasses instead of bifocals.
- Orthopedics or vision training, or any associated supplemental testing.
- Medical or surgical treatment of the eyes.
- Corrective vision treatment of an experimental nature such as, but not limited to, LASIK and PRK surgery.
- Any eye exam or corrective eyewear required by an employer as a condition of employment.
- Lost or broken lenses or frames, except at normal intervals when services are otherwise available.
- Services or supplies not specifically listed above.

Important Information About Your Vision Benefits — for All Participants

The following sections provide information pertaining to all participants in the Vision Benefit Program — *employees*, *retirees*, and all covered dependents.

Applying for Benefits

You do not have to file a claim if you go to a VSP doctor or affiliate provider.

If you go to other providers not affiliated with VSP, you have to pay for services and then submit an itemized statement of treatment, together with your ID (last four digits of your Social Security number), your name, the patient's name (if different), and the patient's birth date, to VSP. You are reimbursed for costs up to the benefit limits outlined in "Schedule of Benefits" on page C-7. Contact VSP at 1-800-877-7195 or visit the Shell Benefits Service Center at **www.netbenefits.com** to obtain a claim form.

Coordination of Benefits

The Vision Benefit Program coordinates the benefits payable by taking into account any coverage you or your covered dependent(s) may have under any other group medical or vision plan. As a result of this coordination of benefits, it is possible for you to receive reimbursement for up to the maximum amount the plan would pay as your primary coverage.

Here is a summary of how coordination of benefits works:

- If benefits are coordinated with another group medical plan, the difference between the amount that would have been paid without coordination of benefits and the amount of benefits actually paid may be credited to the covered person.
- If benefits are coordinated with another group vision plan, the Vision Benefit Program pays the difference between the full amount of the expense, up to the amount the program would have paid without the coordination of benefits, and the amount of benefits actually paid.
- If your spouse or *domestic partner* is covered under another group plan, that plan provides primary coverage for him or her.

Coordination of benefits for dependent child(ren) is based upon the birthday rule. This means that the plan of the parent whose birthday occurs earlier in the calendar year provides primary coverage, and any other group plan provides secondary coverage.

If your covered dependent(s) is also covered under another group plan that provides primary coverage, you must file all claims with that plan first. After you receive an explanation of benefits (EOB) from that plan, you should file your claim, including the other plan's EOB, through the applicable Claims Administrator.

Events Affecting Coverage

The following are events that have an impact on your coverage under the Vision Benefit Program:

Loss of Eligibility

Coverage for you and/or your *eligible dependent(s)* ends on the last day of the month in which you or the dependent(s) no longer meets the eligibility requirements. However, you may be able to continue coverage. (For details, see "Continuation of Coverage" on page F-1.)

If a surviving spouse or *domestic partner* elects to cancel his or her coverage, or coverage is cancelled due to nonpayment of premium contributions, he or she will not be eligible to enroll again at a later date.

Death

Employees

If you die while you are an *employee*, and you had dependent coverage at the time of your death, your dependents are covered for three months following the month in which you die. The *Company* pays all contributions during this three-month period. Thereafter, your dependent(s) may continue coverage up to an additional thirty-three (33) months by paying the full cost of continuation coverage.

If you die while you are an *employee* as the result of an occupational accident, and you had dependent coverage at the time of your death, your dependent(s) may continue coverage by paying the required premium contributions until they no longer meet the definition of *eligible dependent(s)*. For your surviving spouse, this means coverage may continue until the end of his or her life. Your dependents who continue coverage under this provision do not have the right to add new dependents to their coverage under the Plan. The *Company* continues to subsidize coverage until your dependent(s) no longer qualify for coverage.

Retirees

If you had dependent coverage at the time of your death, your dependent(s) may continue coverage by paying the required premium contributions. Your dependent(s) may continue coverage until they no longer meet the definition of *eligible dependent(s)*. For your surviving spouse, this means coverage may continue until the end of his or her life. Your dependents who continue coverage under this provision do not have the right to add new dependents to their coverage under the Plan.

If your *eligible dependent(s)* were not enrolled at the time of your death, they may enroll for coverage by contacting the Shell Benefits Service Center within 60 days of the date of your death.

As noted under "Loss of Eligibility" at left in this section, if your surviving spouse or *domestic partner* cancels his/her coverage, or coverage is canceled due to lack of premium payment, he or she will not be able to re-enroll.

Employment Events (Employees Only)

- **Leaves of Absence (Disability, Personal and Military)** — If you are on a leave of absence, your benefits may be impacted. See "Leaves of Absence" on page J-15.
- **Change in Number of Hours Worked** — If your employment status changes to *part-time employee* (less than 20 hours per week), your coverage ends. However, you may be able to continue coverage (see "Continuation of Coverage" on page F-1). Conversely, if your employment status changes from *part-time employee* to *regular part-time employee* or *regular full-time employee*, you become eligible to participate in the Vision Benefit Program, effective on the date of your change in status.
- **Layoff or Termination** — If you are laid off due to lack of work or if your employment is terminated, your coverage ends on the last day of the month. However, you may be able to continue coverage (see "Continuation of Coverage" on page F-1).
- **Retirement** — You may continue your coverage by paying the required premium. See "Shell Benefits Under Retirement" on page K-1 for additional information.

Vision Benefit Program Amendment or Termination

Your coverage changes or ends on the date this program is amended or terminated, respectively. However, if you or your dependent(s) incur covered expenses before the program is amended or terminated, benefits are paid according to the program provisions in effect before the change.

Conversion Privilege

The Vision Benefit Program does not include an option to convert your coverage to an individual policy.

Employee Assistance Program (EAP)

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Employees and their families are automatically enrolled in the *Employee Assistance Program (EAP)*, which is administered by Optum Behavioral Health. This important benefit is available to you and your household family members at no cost.

Employees Only

This program is available to Shell *employees* and their families only. *Retirees* are not eligible for the EAP.

Overview

Through the EAP, you and your family members are eligible for ten free counseling sessions per person, per issue, per year. Your sessions with a professional counselor can be conducted by phone, by video, or face-to-face, and cover a range of issues, including:

- Confidential counseling on personal situations such as relationships, grief and loss, stress, anxiety, or depression.
- Legal information and resources on topics like real estate transactions, civil lawsuits, and landlord/tenant issues.
- Financial information related to retirement planning, saving for college, or tax questions.
- Access to counseling professionals in a variety of fields.

24-Hour Access

The EAP is available 24 hours a day, seven days a week by calling 1-800-897-1795 or visiting **www.liveandworkwell.com** (access code: Shell). The website also includes educational materials and a national database of child and elder care resources.

How the EAP Can Help

The EAP can help with things like:

- Balancing work and family.
- Managing your time.
- Finding childcare.
- Elder care issues.
- Alcohol or drug dependencies.
- Anger management.
- And much more.

Continuation of Coverage

You and your household family members do not need to elect continuation coverage for EAP benefits, as those benefits will be fully paid for by the *Company* for the maximum applicable COBRA period of coverage if you lose coverage as a result of a *qualifying event*. (For more information, see "COBRA Coverage Period" on page F-3.)

Tax Savings Programs for Active Employees

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Employees Only

This section contains information that applies to Shell *employees* only. If you are a *retiree*, you are not eligible for these programs.

Health Care and Dependent Care Account Programs

The *Company* offers *eligible employees* the opportunity for tax savings through *Flexible Spending Accounts (FSAs)*. These programs allow you to set aside money for health care and dependent day care expenses on a pre-tax basis. Although *FSAs* require some planning on your part, you may find that the financial rewards are worth the effort.

Flexible Spending Accounts — An Overview

When you participate in Shell's Health Care Account and/or Dependent Day Care Account programs, you make contributions via payroll deduction before taxes are taken out, which lowers your taxable income. The pre-tax dollars in your account(s) can be used to reimburse you for eligible health care and/or dependent day care expenses. Participation in each program is separate, and you cannot use money from one of the programs to reimburse expenses covered by another program.

- The Health Care Account (HCA) may be used to help pay for eligible health care expenses that are not covered by your Shell medical, dental, or vision plans. The HCA is available to *eligible employees* who are not enrolled in the HDHP option.
- The Dependent Day Care Account (DDCA) may be used to reimburse expenses you incur for day care for your child(ren) or other dependent(s) so that you and your spouse can work. The DDCA is available to all *eligible employees*.

Expenses reimbursed through the Health Care Account and Dependent Day Care Account cannot be taken as a deduction or federal tax credit, respectively, when you file your income taxes.

Participation

Eligibility

You are eligible to enroll in an *FSA* if you are a *regular full-time* or *regular part-time employee* of a *participating company*.

However, you are **not** eligible to enroll in the HCA if you participate in the US HDHP option. The HDHP option is a qualified *high-deductible health plan* that is eligible for a *Health Savings Account (HSA)*. Because the IRS allows tax advantages in both HCAs and *HSAs*, individuals are not allowed to participate in both types of plans.* *HDHP* participants can enroll in the Dependent Day Care Account.

* Enrolling in the Health Care Account would also disqualify you from contributing to a *Health Savings Account* in connection with any *high-deductible health plan* you may have through another plan or insurance provider.

Enrollment

You may enroll in an *FSA*:

- During the *group annual enrollment period*, or
- Within 31 days after your eligibility date, or
- Within 31 days after a *qualified status change*. (For information on what constitutes a *qualified status change*, see page M-8.)

To enroll at any time outside the *group annual enrollment period*, contact the Shell Benefits Service Center at 1-800-30-SHELL (1-800-307-4355) or visit **www.netbenefits.com**. You will need to specify the pre-tax amount you wish to contribute during the year to the Health Care Account, the Dependent Day Care Account, or both. This amount is deducted from your pay and credited to your Health Care and/or Dependent Day Care Accounts in equal installments throughout the year.

Note

Please read through this entire section to understand the features and requirements related to *FSAs*. Because *FSAs* offer special tax advantages, the IRS applies strict rules and limitations regarding their use. Before enrolling in an *FSA*, take time to carefully estimate your expected expenses. There are no refunds of unused *FSA* contributions. You forfeit any unused funds remaining in either Account Program.

Contributions

Contributions are deducted from your pre-tax pay in the amount you specify at enrollment, subject to IRS limitations.

- **Health Care Account:** You may contribute up to $2,850 annually, subject to a $120 minimum annual contribution.
- **Dependent Day Care Account:** You may contribute up to the lesser of the following amounts on an annual basis, subject to a $120 minimum annual contribution: $5,000 ($2,500 if you are married and filing separate federal income tax returns), or your earned income (or your spouse's earned income), if lower.

Changing Your Contributions

Federal tax law prohibits changes to your *FSA* participation or contribution amount during the year unless you have a *qualified status change*.* Therefore, unless you have a *qualified status change*, you must continue making your elected monthly contributions for the full program year.

If you do experience a *qualified status change*, you may change or discontinue your *FSA* contributions **only if**:

- The change is consistent with the *qualified status change* event, and
- You submit your request to change your contributions within 31 days after the *qualified status change*, and
- Your requested change is submitted prior to the close of the final payroll cycle for the current calendar year.

The change becomes effective on the date of your *qualified status change*. If you change your contributions to an *FSA* because of a *qualified status change*, the new amount should be the monthly amount you want deducted over the remainder of the year. However, your total contribution amount cannot exceed the program limits.

* For information on what constitutes a *qualified status change*, see page M-8.

How FSAs Work

Some Basic Rules

In exchange for the tax advantages offered by *FSAs*, the IRS applies strict rules and limitations regarding their use. In addition to the rules and limitations previously described, please take note of the following:

- There are no refunds of unused *FSA* contributions. You forfeit any unused funds remaining in either program account, so it is important to carefully estimate your expenses when determining your contribution amount.
- The deadline to incur *FSA*-eligible expenses is December 31 of the plan year that contributions are made.
- *FSAs* are subject to non-discrimination testing requirements, intended to ensure that programs do not favor highly compensated employees. This could make it necessary to reduce or terminate contributions for certain participants. You will be notified if such reductions are required.
- Because *FSA* contributions are not subject to Social Security tax, your Social Security benefits may be affected (reduced) if you are earning less than the Social Security wage base.

Health Care Account — Eligible Expenses

Expenses reimbursed through the HCA must be eligible expenses — that is, health care expenses that qualify as allowable tax deductions for services provided during the period you participated in the program. These typically include health care expenses you and your family incur that are not reimbursed by your Medical, Dental, and/or Vision benefit programs.

Eligible health care expenses are reimbursable when incurred by:

- You and your spouse.
- Your child who is under age 27 at the end of the tax year.
- All dependents you claim on your tax return.
- Any person you could have claimed as a dependent except that:
  - the person filed a joint tax return,
  - the person had gross income of $4,300 or more, or
  - you (or your spouse if filing jointly) could be claimed as a dependent on someone else's tax return.

The following are examples of eligible and ineligible expenses:

FSA — Health Care Account	
Eligible Expenses	***Ineligible Expenses***
Medical expenses incurred by you or your family, such as annual *deductibles*, *copayments*, or *coinsurance*. Mental health and substance abuse care expenses incurred by you or your family. Dental expenses incurred by you or your family such as: ▪ Adult orthodontics. ▪ Dental educational programs (e.g., plaque control and dental hygiene instruction). ▪ Treatment for temporomandibular joint (TMJ) dysfunction or other services excluded under your dental plan. Vision expenses incurred by you or your family, such as: ▪ Routine eye examinations. ▪ Eyeglasses. ▪ Contact lenses, including all necessary supplies and equipment. ▪ LASIK or PRK surgery. Hearing expenses incurred by you or your family such as: ▪ Routine hearing examinations, and/or ▪ Hearing aids and their repair.	Over-the-counter medicine or drugs (other than insulin) or items used for general health, such as vitamins or toothpaste. Cosmetic surgery. Expenses for *custodial care* in a nursing home. Dues for athletic clubs, health clubs, or spas. Eligible health care expenses deducted on your personal income tax returns. Payroll deductions for contributions to *Company*-sponsored medical, dental, and/or vision plans. Contributions to health plans that are not *Company*-sponsored.

For a full list of eligible expenses, go to **www.wageworks.com**.

Before you decide to contribute, remember that health care expenses claimed under the HCA are not eligible to be claimed as a deduction on your federal income tax return. While it may be uncommon for your health care expenses to be high enough to qualify for this deduction, you may want to speak with your tax advisor to determine whether the HCA is more advantageous than claiming a deduction for health care expenses on your federal tax return. Additional information can be found in IRS Publications 502 and 969 (available at **www.irs.gov**).

Dependent Day Care Account — Eligible Expenses

Expenses reimbursed through the DDCA must be incurred during the period in which you participate in the program and for the purpose of providing care for your qualified dependent(s) that enables you and your spouse to be gainfully employed. You also may participate if your spouse is disabled or is a full-time student for at least five months during the year. You may not use the funds in your DDCA to reimburse yourself for care or services provided by:

- Your spouse.
- Your child(ren) under age 19.
- Anyone whom you could claim legally as a dependent on your federal income tax return and whose principal residence is in your home.

For the purposes of the Dependent Day Care Account, the IRS considers a qualified dependent to be:

- Your child(ren) under age 13, or
- A spouse or other dependent who is physically or mentally incapable of self-care, depends upon you for more than half of his or her financial support, and lives with you for more than half the year.

To be reimbursed for dependent day care expenses related to individuals other than children under age 13, the dependent cannot have personal income above the amount of the federal income tax personal exemption allowance for that calendar year.

The following are examples of eligible and ineligible Dependent Day Care Account expenses:

FSA — Dependent Day Care Account	
Eligible Expenses	***Ineligible Expenses***
Charges for a babysitter, whether in or out of the home, when the care enables you and your spouse to work.	Charges by a neighbor or individual babysitter/day care provider when the care is not related to enabling you and your spouse to work.
Dependent care centers that provide day care (not residential care) for dependent adults.	Expenses for overnight camps.
The cost of nursery schools, day care centers, and summer camps (summer camps are limited to day programs).	Overnight care in a convalescent nursing home for a dependent spouse or relative.
Services provided by housekeepers if their primary responsibility is the wellbeing and protection of an *eligible dependent*.	Transportation to and from the care location when provided by someone other than the caregiver.
Transportation to and from the care location, when provided by the caregiver.	Expenses related to education at private schools.

Before you decide to contribute, remember that dependent day care expenses that are claimed under the DDCA are not eligible to be claimed as a federal income tax credit (or, in some states, a state tax credit). Depending on your income and tax bracket, you may save more in taxes by using the federal income tax credit (or state tax credit, if applicable) rather than participating in the Dependent Day Care Account Program. Again, dependent day care expenses cannot be reimbursed under the Dependent Day Care Account Program and claimed as a tax credit. You should consult with your tax advisor before making your decision to contribute to the Dependent Day Care Account Program. Additional information can be found in IRS Publication 503 (which is available at **www.irs.gov**).

FSA Reimbursement Process

The *FSA* programs are administered by HealthEquity, formerly known as WageWorks. HealthEquity/WageWorks processes requests for reimbursement under the *FSAs*. If you have questions about an *FSA* claim, call HealthEquity/WageWorks at 1-877-924-3967 or the Shell Benefits Service Center at 1-800-30-SHELL (1-800-307-4355).

FSAs have specific dates set by the IRS around the time period when you can incur eligible expenses and the deadlines for filing your claims.

Health Care Account	Dependent Day Care Account
Timing for incurring expenses In order for expenses to be eligible for reimbursement under your Health Care Account the expenses must be incurred by December 31 of the year in which your contributions are made and while actively participating in the program.	**Timing for incurring expenses** In order for expenses to be eligible for reimbursement under your Dependent Day Care Account the expenses must be incurred by December 31of the year in which your contributions are made and while actively participating in the program.
Deadline for filing claims Claims for reimbursement can be filed at any time during the year, up to the full amount of your annual contribution. Your claims must be filed no later than March 31 of the calendar year following the program year (January 1 – December 31) in which the contributions are made. For example, if you enroll at annual enrollment and remain active all year, you will be able to use your 2023 Health Care Account election amount to reimburse eligible expenses you incur from January 1, 2023, through December 31, 2023, and the filing deadline for 2023 Health Care Account reimbursement is March 31, 2024.	**Deadline for filing claims** Claims for reimbursement must be filed no later than March 31 of the calendar year following the program year (January 1st – December 31) in which the contributions are made. Reimbursement can only be made after the services have been provided, and in an amount not exceeding the balance in your Dependent Day Care Account. For example, if you enroll at annual enrollment and remain active all year, you will be reimbursed from your 2023 Dependent Day Care Account for eligible expenses you incur from January 1, 2023, through December 31, 2023, as long as you file your claims by March 31, 2024.

Applying for FSA Reimbursement

When you submit your application for reimbursement from your Health Care Account or Dependent Day Care Account, you are required to also submit appropriate proof of your eligible health care or dependent day care expenses. Appropriate proof of expenses includes:

- **Health Care Account Program:** A bill, itemized receipt, or explanation of benefits from any medical, dental and/or vision plan, or program under which you or your qualified dependent(s) is covered.
- **Dependent Day Care Account Program:** A bill, invoice, or receipt that includes the day care provider's name, tax identification number or Social Security number, dates of service, and cost of service.

There are several ways you can submit your claims for reimbursement from your Health Care Account or Dependent Day Care Account:

- On the HealthEquity/WageWorks website at **www.wageworks.com**: You can apply for reimbursement, or you can elect to make an online payment directly to a provider.
- Using the HealthEquity/WageWorks EZ Receipts® free mobile app on your smartphone.
- By fax or mail. You can download the reimbursement claim form at **www.wageworks.com**.

For your **Health Care Account only**, there are two additional options for reimbursement. You can also:

- **Use your HealthEquity/WageWorks debit card:** When you enroll in the Health Care Account Program, you receive a HealthEquity/WageWorks health care card ("debit card"). You can use your debit card to pay health care providers and pharmacies directly for eligible services, goods, and prescriptions. Additionally, you can use the debit card at general merchants and drugstores that have an industry standard checkout system capable of automatically verifying whether a purchased item is eligible for reimbursement under this program.
- **Use automatic reimbursement, linked to your US PPO or Kelsey-Seybold Greater Houston option Medical Benefit Program expenses:** Out-of-pocket expenses that you incur for medical, prescription drugs, mental health and substance abuse care under the US PPO or Kelsey-Seybold Greater Houston options will be reimbursed automatically from your Health Care Account without having to file a claim.* If you do not wish to have this automatic reimbursement service, you can contact HealthEquity/WageWorks and request to file your claims directly for reimbursement.

* Remember that only those expenses not reimbursed by any insurance or benefit plan are eligible to be paid from your Health Care Account. Therefore, you must notify HealthEquity/WageWorks if any expenses included in an US PPO or Kelsey-Seybold Greater Houston option claim are covered under another benefit program and, as a result, are not eligible for reimbursement.

Note

If you use the HealthEquity/WageWorks debit card, you are not eligible for the automatic reimbursement option.

Events Affecting Participation

FSA contributions are deducted from your pay. As a result, if your pay stops, so do your contributions. However, you may be eligible to have your HCA contributions continue on an after-tax basis. (See "Continuation of Coverage" on page F-1.) Your participation in the Dependent Day Care Account ceases when you stop working.

Leaves of Absence — Disability, Personal, and Military

If you are on a leave of absence, your benefits may be impacted. For further information, see "Leaves of Absence" on page J-15.)

Change in Number of Hours Worked

If your employment status changes to *part-time employee* (less than 20 hours per week), your coverage ends. However, you may be able to continue your HCA contributions on an after-tax basis (see "Continuation of Coverage" on page F-1). Conversely, if your employment status changes from *part-time employee* to *regular part-time employee* or *regular full-time employee*, you become eligible to participate in the *FSAs*, effective on the date of your status change. You can enroll within 31 days of your eligibility date. If you do not enroll within 31 days of your eligibility date, you may enroll during any *group annual enrollment period*.

Layoff, Termination of Employment, Retirement, or Death

Your participation in an *FSA* ends when your employment ends, when you retire from the *Company*, or when you die. However, you or your *eligible dependent(s)* may be able to have your HCA contributions continue on an after-tax basis. (See "Continuation of Coverage" on page F-1.)

Program Amendment or Termination

Your coverage changes or ends on the date the *FSAs* are amended or terminated. However, if you or your dependent(s) incurred covered expenses before the *FSA* was amended or terminated, benefits are paid according to the *FSA* provisions in effect before the change.

Health Savings Account

Participants in the US HDHP, who meet eligibility requirements, can open an affiliated *Health Savings Account (HSA)** with recordkeeping by Fidelity. If you are eligible and establish an affiliated *HSA* through Fidelity, you can contribute via payroll deduction and the *Company* will also contribute to your account.

* Note that although the HDHP options are part of the Shell USA, Inc. Health & Wellbeing Plan, Shell does not sponsor the *HSA* arrangement and it is not a part of the Welfare Plan. Rather, an *HSA* is established and maintained by the financial institution that offers the *HSA*. The *HSA* arrangement is exempt from the Employee Retirement Income Security Act of 1974, as amended ("*ERISA*") pursuant to DOL Field Assistance Bulletins 2004-1 and 2006-02. The general information on *HSAs* provided here is for your convenience only.

Health Savings Account — An Overview

The purpose of an *HSA* is to help you accumulate funds to pay for current or future out-of-pocket medical expenses such as your *deductibles* and *coinsurance*. There are a number of advantages to establishing an *HSA*. For example:

- You decide how much you want to contribute, up to annual IRS limits, and you can change the amount of your contributions at any time during the year. Your change will generally take effect in one or two pay periods.
- Your *HSA* balance rolls over from year to year and belongs entirely to you, even if you change medical plan options, leave the *Company*, or retire.
- You may be able to invest your *HSA* balance in a variety of investment options offered through your *HSA* provider.
- *HSAs* provide multiple federal tax advantages:
  - Your *HSA* contributions via payroll deduction are pre-tax.
  - Any investment growth in your *HSA* is tax-free.
  - Distributions from your *HSA* are not taxable if used for qualified medical expenses.
  - The *Company* contribution to your *HSA* does not add to your taxable income.
- While Shell's contribution to your *HSA* and your *HSA* contributions via payroll deduction are only funded to the affiliated *HSA* with recordkeeping by Fidelity, you have the flexibility to move your *HSA* assets from Fidelity to an *HSA* at another financial institution at any time.

Participation

Eligibility

To be eligible to open a Shell-affiliated *HSA* with recordkeeping by Fidelity, you and your covered dependents must be enrolled in the US HDHP.

You are **not** eligible for an *HSA* if you are enrolled in *Medicare* or in any other medical plan that is not an IRS-qualified *high-deductible plan*. If you are contributing to an *HSA* and enroll in *Medicare* during the year, you cannot make further contributions to your *HSA*. If you are not eligible for Medicare but one or more of your dependents becomes Medicare-eligible, you may continue to contribute to your HSA. However, if your coverage level changes as a result of your dependent's Medicare eligibility, your contribution limits will be affected.

Establishing an HSA

After you have enrolled in the US HDHP option, you can open an *HSA* with Fidelity through NetBenefits. In order to receive the *Company* contribution to your *HSA*, you must first set up the *HSA* and designate a *beneficiary*. This is a separate *beneficiary* designation from the one that applies to your Shell protection plans.

Contributions

The *Company* contribution is based on your coverage level under the US HDHP option:

US HDHP coverage level	Shell contribution for 2023
Participant only	$500
Other coverage levels	$1,000

The IRS establishes a maximum contribution level for the year, which includes contributions from all sources. This means that you cannot contribute more than the maximum amount reduced by the amount of the contribution you receive from Shell.

US HDHP coverage level	Maximum combined contribution for 2023
Participant only	$3,850 (after subtracting the *Company* contribution, you can contribute up to $3,350)
Other coverage levels	$7,750 (after subtracting the *Company* contribution, you can contribute up to $6,750)

If you are at least age 55 (and meet the *HSA* eligibility requirements), you may elect to make a catch-up contribution of up to an additional $1,000 to your *HSA*.

If you are eligible and elect to open a Shell-affiliated *HSA* during the year, up through October 31, you will be eligible for the full *Company* contribution, based on your US HDHP coverage level. If you open an *HSA* on November 1 or later, you will not be eligible for the *Company* contribution until the following year.

How HSAs Work

Qualified Medical Expenses

Qualified medical expenses are generally those health care expenses that the IRS would allow as an income tax deduction (the same types of expenses that qualify under a Health Care *FSA*). These are out-of-pocket health care expenses that are incurred during the time you are contributing to the *HSA*, and that are not paid or reimbursed by your health insurance. If you question whether an expense is qualified, go to **www.netbenefits.com** or call 1-800-SHELL (1-800-307-4355) and speak with a Fidelity *HSA* Service specialist.

You can use your *HSA* funds to pay for qualified medical expenses incurred by:

- You and your spouse (regardless of whether you file taxes jointly or separately).
- All dependents you claim on your tax return.
- Any person you could have claimed as a dependent except that:
  - The person filed a joint tax return,
  - The person had gross income of $4,300 or more, or
  - You (or your spouse if filing jointly) could be claimed as a dependent on someone else's tax return.

Using Your HSA

Your Shell-affiliated *HSA* is established with Fidelity, and you access your account through Fidelity. For information on how to use an *HSA*, visit **Fidelity.com/UseHSAvideo**. For questions or more information, call 1-800-SHELL (1-800-307-4355) and speak with a Fidelity HSA Service specialist.

Events Affecting Participation

An *HSA* is not tied to employment. However, your *HSA* contributions are deducted from your pay. As a result, if your pay stops, so do your contributions, along with your eligibility for the *Company HSA* contribution. If you continue participation in the US HDHP through COBRA (see "Continuation of Coverage" on page F-1) or enroll in another high-deductible plan, you can still contribute to your *HSA* on an after-tax basis. You can then deduct those contributions from your adjusted gross income when you file your tax return. Even if you cease making contributions to your *HSA*, you can continue to take distributions for qualified expenses.

Remember ...

The assets in your *HSA* belong to you. You do not have to make further contributions or be enrolled in a *high-deductible plan* in order to invest *HSA* assets or take qualified distributions. However, you do have to be enrolled in a *high-deductible plan* if you wish to make contributions to an *HSA*.

Leaves of Absence — Disability, Personal, and Military

If you are on a leave of absence, your contributions may be impacted. For further information, see "Leaves of Absence" on page J-15.)

Change in Number of Hours Worked

If your employment status changes to *part-time employee* (under 20 hours per week) and your coverage under the US HDHP ends, you may be able to continue your *HSA* contributions on an after-tax basis if you are continuing your US HDHP participation through COBRA (see "Continuation of Coverage" on page F-1) or if you are enrolled in another *high-deductible medical plan*. Conversely, if your employment status changes from *part-time employee* to *regular part-time employee* or *regular full-time employee*, and you elect to enroll in the US HDHP option, you will be able to establish a Shell-affiliated *HSA* through Fidelity.

Layoff, Termination of Employment, Retirement, or Death

As noted, an *HSA* is not tied to employment. Layoff, termination, and retirement only impact your ability to make pre-tax contributions via payroll deduction. You can continue to contribute to an *HSA* as long as you remain eligible (e.g., enrolled in a qualified *high-deductible medical plan* and not enrolled in *Medicare*). You can also cease contributing and continue to use your *HSA* for qualified distributions, including COBRA premiums. If you die, the assets in your *HSA* become the property of your designated *beneficiary*.

Continuation of Coverage (COBRA) — All Participants

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The Consolidated Omnibus Budget Reconciliation Act of 1985, known as COBRA, gives *employees*, *retirees*, and their covered *eligible dependent(s)* the opportunity to elect a temporary extension of their group health coverage when their coverage is lost due to a *qualifying event*.

Note

This section applies to all participants (*employees*, *retirees*, covered *eligible dependents*) in the Shell Medical Benefit Program, Dental Benefit Program, and/or Vision Benefit Program.

Participation

Eligibility

If you or your covered *eligible dependent(s)* are enrolled in the *Company's* Medical Benefit Program, Dental Benefit Program, and/or Vision Benefit Program and your coverage ends due to a *qualifying event*, you may elect to purchase COBRA continuation coverage.

In order to be eligible for COBRA coverage, you and/or your covered *eligible dependent(s)* must experience a *qualifying event* that causes a loss of coverage. This chart shows the events that constitute a COBRA *qualifying event* and which participants are affected.

COBRA Qualifying Event	Employee		Retiree	
	Constitutes a Qualifying Event for ...			
	You	Dependents	You	Dependents
Your death		X		X
Divorce or legal separation*		X		X
Termination of employment (other than for gross misconduct)	X	X		
Your entitlement to *Medicare*		X		X
Loss of dependent eligibility*		X		X
Reduction in work hours	X	X		
Reorganization of the *Company* under Chapter XI**	X	X	X	X
Termination of partner relationship between you and your *domestic partner**		X		X

* See "Notice Requirements" on page F-3.

** See "Special Rule for Bankruptcy" on page F-3.

Notice Requirements

You or your covered *eligible dependent(s)* must notify the Shell Benefits Service Center at 1-800-30-SHELL (1-800-307-4355) within 60 days after the *qualifying event* for COBRA continuation coverage to be available. Additionally, you must notify the Shell Benefits Service Center if you become covered under another group medical, dental, and/or vision plan.

Special Rule for Bankruptcy

If the *Company* files a proceeding under Chapter XI of the Bankruptcy Code, a *qualifying event* may occur. If the bankruptcy results in a loss of coverage, a covered person, including certain *retirees* and their family members who have post-retirement health coverage, will have access to continuation of coverage under COBRA.

Important Notice Related to the COVID-19 Outbreak

Pursuant to recent guidance issued in response to the declared national emergency as a result of the COVID-19 outbreak (the "National Emergency"), and unless future guidance by the relevant government agencies provides otherwise, the time period between March 1, 2020, and July 10, 2023, which is 60 days following the announced May 11, 2023, end of the National Emergency will be disregarded in determining the deadlines, provided, however, that the maximum extension for any notification, election or premium payment deadline is one year.

Note for Active Employees

Upon experiencing a *qualifying event*, you do not need to elect continuation coverage for *Employee Assistance Program* benefits, as those benefits will be fully paid for by the *Company* for the maximum applicable COBRA period of coverage.

Enrollment

Once the COBRA Administrator becomes aware that a *qualifying event* has occurred, the person who lost coverage due to the event will receive a notice of his or her right to elect continuation coverage and information about how to make a COBRA coverage election. A COBRA coverage election must be made within 60 days of the date of that notice.

Cost of COBRA Participation

Generally, COBRA participants are required to pay the full cost of their coverage (both the *employee/retiree* portion and the *Company* portion) plus a 2% COBRA administration fee.

Disabled persons are charged 150% rather than 102% of the full cost of coverage for the additional 11 months of coverage when an 18-month period is extended to 29 months because of their disability (see "Coverage Period — Employees and Dependents" on the next page).

Coverage Period

The COBRA coverage period begins on the first day of your or your *eligible dependent's* loss of coverage due to a *qualifying event*. However, you will not have coverage until you or your *eligible dependent(s)* make a COBRA election. Once the election is made, coverage will continue retroactively from the date of the *qualifying event* that caused the loss of coverage.

The maximum period of coverage available under COBRA varies depending on the *qualifying event* that resulted in the coverage loss.

Employees and Dependents

The maximum period is 18 months if you are an *employee* and you and your covered *eligible dependent(s)* lose coverage as a result of your:

- Termination of employment, or
- Reduction in the number of work hours.

The 18-month period may be extended to 29 months from the date of the *qualifying event* if the COBRA participant is determined to be disabled (for Social Security disability purposes) at any time during the first 60 days of COBRA coverage. You must provide the COBRA administrator with notice of that determination within 60 days and before the end of the initial 18-month period. You also must notify the COBRA administrator within 30 days of any final determination that the person is no longer disabled.

If more than one *qualifying event* occurs during an initial 18-month or 29-month COBRA period, the *eligible dependent(s)* may elect COBRA continuation coverage for a maximum period of 36 months from the date of the first COBRA *qualifying event*. You or your *eligible dependent(s)* must provide notice of the second *qualifying event* within 60 days of the event in order to receive the additional coverage.

Dependents of Employees and Retirees

The maximum period of coverage is 36 months if you are an *employee* or *retiree* and your covered *eligible dependent(s)* lose coverage as the result of one of the following *qualifying events*:

- Your death.
- Divorce or legal separation.
- Termination of your domestic partnership.
- Your entitlement to *Medicare*.
- They no longer qualify as *eligible dependent(s)*.

When Continuation Coverage Ends

Continuation coverage ends when:

- The covered person becomes enrolled in another group medical, dental, and/or vision plan (see "Notice Requirements" on page F-3).
- The COBRA coverage period has been exhausted.
- The cost of the continued coverage is not paid in a timely manner.
- The number of hours a *part-time employee* is scheduled to work increases to at least 20 hours a week, making him or her once again eligible to enroll in the Medical Benefit Program, Dental Benefit Program, and/or Vision Benefit Program.
- The *Company* terminates all group health plans for all *employees* and *retirees*.

Continuing Participation Under the Health Care FSA Program

If you are an *employee* participating in the Health Care Account (HCA) and become ineligible due to loss of status as a *regular full-time* or *regular part-time employee*, your contributions and coverage under the HCA ends on the date of your status change. However, you can continue to apply for reimbursement from the account, up to the amount you elected to contribute for the year, to cover eligible health care expenses that you incurred before your coverage termination date. Reimbursement requests must be submitted by March 31 of the calendar year following the current calendar year.

For the Current Year

If your employment terminates for any reason (other than gross misconduct), you may continue your participation in the HCA by paying your contributions (plus the 2% COBRA administration fee) for the remainder of the year (i.e., through December 31) on an after-tax basis. If you choose this option, you may apply for reimbursement from your HCA, up to the amount you elected to contribute for the year, for eligible health care expenses you incur through December 31 or your COBRA paid-through date if you opt not to continue coverage through December 31. Your claims must be filed no later than March 31 of the calendar year following the program year (January – December 31).

COBRA continuation coverage is not available under the Dependent Day Care Account Program. Your contributions to the Dependent Day Care Account end on the date you are no longer eligible to participate in the program, but you can be reimbursed for prior expenses incurred while still enrolled. Filing time limits apply for reimbursement.

Right to Subrogation

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Subrogation is the substitution of one person in the place of another with respect to a lawful claim, demand, or right against a third party. The Medical Benefit Program includes the "right to subrogation" provisions that protect the plan against claims for which someone else may be liable.

Note

This section applies to all participants (*employees*, *retirees*, covered dependents) in the Shell Medical Benefit Program.

Right of Recovery

If the medical options under the Medical Benefit Program* pay expenses for which a third party (other than the covered person or the *Company*) is liable, the plan is subrogated to your recovery rights. This means that the plan has the right to full reimbursement of plan benefits paid as a result of the third party's actions from any amounts that you recover from the third party. The plan's right to reimbursement is not limited for any reason, including by any costs or fees incurred in pursuit of a recovery from the third party.

* For the *Medicare* Advantage plans available to *Medicare*-eligible *retirees* and their *Medicare*-eligible dependents, this section applies only to the prescription drug portions of the plans.

Obligation to Comply

If you incur expenses for which a third party may be liable and for which you seek reimbursement under the Medical Benefit Program, you are obligated to comply with the plan's subrogation requirements. These requirements include that you:

- Provide the program with information necessary to enforce its recovery rights, and
- Not take any action that would prejudice the program's ability to recover, including entering into a settlement agreement with the third party without the program's consent.

Filing a Suit or Claim

You may also be required to execute a reimbursement or assignment agreement. You also must inform the program of any suit or claim against a third party or insurance carrier within 60 days of bringing the action. Failure to comply with these obligations can result in denial of benefits or termination of coverage. In order to enforce the program's recovery rights, the *Plan Administrator* may:

- Bring or join in an action against the third party or any insurance carrier that makes or could make payment on a claim.
- Offset future benefits against amounts you have recovered from the third party or an insurance carrier.
- Bring an action to set aside any settlement agreement entered into without the consent of the *Plan Administrator*.
- Bring an action against you for an equitable lien or constructive trust against amounts you received from the third party or insurance carrier.
- Release or obtain information necessary to enforce its subrogation rights.
- Take other action as it deems appropriate.

Failure to cooperate is considered a breach of contract. As such, the plan has the right to terminate, offset or deny future benefits, and/or take legal action.

Contact the Claims Administrator

If you incur injuries for which a third party may be liable and for which you file a claim under the Medical Benefit Program, please call the appropriate claims administrator at the toll-free number on your ID card.

Subrogation Example

If you are injured in a car accident that is not your fault, and you receive benefits under the US PPO option to treat your injuries, the program has the right to take legal action in your name against the driver who caused the accident and that driver's insurance carrier to recover the cost of those benefits.

Protection Programs

Retirees Please Note

With one exception, the programs in this section are available to Shell *employees* only. If you are a *retiree*, you are not eligible for these benefits. You are eligible to participate in the Group Automobile and Home Insurance Plan described on page J-12. Note also that Shell no longer offers enrollment in Long-Term Care Insurance or Retiree Life Insurance. If you are already enrolled in those programs, you can continue your participation directly with their respective providers (see chart below).

Shell offers a variety of programs to protect you and your family financially from life's unexpected events. We provide several *Company*-paid coverages, plus the flexibility to choose optional *employee*-paid coverages to meet your family's needs.

Shell offers the following protection programs:

Active Employees	Retirees
▪ Disability Income Programs ▪ Survivor Benefit ▪ Occupational Accidental Death Benefit ▪ Group Life Insurance ▪ Voluntary Personal Accidental Insurance ▪ Business Travel Accident Insurance ▪ Back-up Care Program ▪ Group Legal Program ▪ Automobile & Home Insurance	▪ Automobile & Home Insurance

Closed to New Enrollees

- **Long-Term Care Insurance (current participants only):** For information, see page N-2 in the Appendix of this book or contact John Hancock at 1-800-482-0022 or www.johnhancock.com.
- **Retiree Life Insurance (current enrollees and participants only):** For information, see page N-7 in the Appendix of this book or contact MetLife at 1-844-510-1937.

Disability Income Programs

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The *Company's* Disability Income Programs provide you with short-term and long-term income protection if you are unable to work because of illness or injury.

Short-Term Income Protection Is Provided by...	Long-Term Income Protection Is Provided by...
▪ **The *Company*-paid Disability Benefit Plan**, which continues your pay in the event of an *occupational* or *non-occupational disability*, and ▪ **The *employee*-paid Income Protection Insurance Plan**, which provides income in the event your pay is reduced or ceases due to a *non-occupational disability*.	▪ **The *employee*-paid Long-Term Disability Program**, an optional program that provides income if you become totally disabled for an extended period of time, and ▪ **The *Company*-paid Shell Pension Plan**, a retirement plan that provides a disability pension if you become totally and permanently disabled and qualify for benefits. (For details, see the Shell Pension Plan in the "Wealth" summary plan description.)

Disability Benefit Plan

Under the Disability Benefit Plan, your pay continues if you are unable to work because of illness or injury.

Participation

Eligibility

The *Company* offers benefits for *occupational* and *non-occupational disabilities*:

- ***Occupational disability*:** You are eligible for benefits if you:
  - Are a *regular full-time* or *regular part-time employee* of a *participating company*, and
  - Have an *occupational disability* and are unable to work.
- ***Non-occupational disability*:** You are eligible for benefits once you complete one year* of *accredited service* with a *participating company* and then have a *non-occupational disability* and become unable to work. You must be a *regular full-time employee* or a *regular part-time employee* at the time your *non-occupational disability* begins to be eligible for benefits.

* During the first year of service, staff and non-represented, onshore, hourly employees may be allowed up to one (1) week of disability leave of absence with pay.

Enrollment

You are automatically enrolled for Disability Benefit Plan coverage:

- As of your hire date, if you are hired as a *regular full-time employee* or *regular part-time employee*, or
- As of the date your employment status changes to *regular full-time employee* or *regular part-time employee*.

Cost

The *Company* pays benefits under the Disability Benefit Plan from its general assets. There is no cost to you.

Benefit Amount

Your disability benefit amount is 100% or 50% of your straight-time pay, as applicable, depending upon the length of your absence and, in the case of *non-occupational disability*, your years of *accredited service*. (For details, see "Schedule of Benefits" at right and on page H-4.)

Straight-time pay includes any night-shift bonus, but excludes overtime, premium pay, bonuses, and other extra compensation:

- **For *regular full-time employees,*** straight-time pay is established by your local management and based upon one of two rates:
  - The normal straight-time rate for your regular classification at the time your disability begins. This rate is used even though you may have been working temporarily in a classification having a higher or lower rate of pay than your regular classification, or
  - The normal straight-time rate based upon your forward weekly schedule at the time your disability begins.
- **For *regular part-time employees,*** straight-time pay is based upon your *standard hours election* and your part-time hourly rate.

No benefits are paid for an unscheduled workday.

Schedule of Benefits

There are two schedules of benefits under the Disability Benefit Plan.

Occupational Disabilities — Maximum Benefit Period

If you suffer an *occupational disability*, you may receive a maximum of 26 weeks of full pay followed by a maximum of 26 weeks of half pay, regardless of the length of your *accredited service*.

When an *occupational disability* prevents you from performing your required duties, your disability benefits are offset by certain workers' compensation payments and are adjusted as follows:

- During the 26 weeks you are eligible to receive full pay, your disability benefits are reduced by the amount of any workers' compensation payments you receive; and
- During the subsequent 26 weeks that you are eligible to receive half pay, your disability benefits are reduced so that half pay plus any workers' compensation payments does not exceed your full pay.

Non-Occupational Disabilities — Maximum Benefit Period

If you suffer a *non-occupational disability*, you may be eligible to receive a combination of full pay and half pay for the specified maximum period below.

The maximum benefit period for *non-occupational disabilities* is based upon your completed years of *accredited service* at the time your disability begins.

Completed Years of Accredited Service	Maximum Weeks of Full Pay*	Maximum Weeks of Half Pay	Combined Weeks of Benefits
1	2	4	6
2	3	8	11
3	4	12	16
4	5	16	21
5	6	20	26
6	7	24	31
7	8	28	36
8	9	32	41
9	10	36	46
10	11	41	52
11	12	40	52
12 and over	13	39	52

* For *regular part-time employees*, a week of pay is based upon your *standard hours election* and part-time hourly rate.

US Family Leave Policy

Under the *Company's* US Family Leave Policy, there are two types of leaves that do not impact your available *non-occupational disability* benefits but do run concurrent to FMLA:

- **Maternity Leave (for the birthing mother):** Provides up to eight weeks of fully-paid maternity disability leave, immediately after birth, regardless of service. Maternity disability leave benefits prior to birth, or beyond eight weeks after birth, fall under the Disability Income Program. Once certified medically to return to work or at the end of the Maternity Leave period, whichever is later, the birthing mother may then commence Parental Leave.
- **Parental Leave (for all employees):** Provides up to eight weeks of fully-paid leave for *eligible employees* experiencing the addition of a child through childbirth, surrogacy, or legal adoption.

Policy information is located on **HR Online Home Page > Life Events — What to do when I > Have a Baby or Adopt**.

Maternity Leave and Parental Leave are classified as Personal Leave with Pay for pay and benefits purposes. See "Leaves of Absence" on page J-15 for information about the status of your benefits while you are on leave.

Determining the Duration of Benefits

With either type of disability (single or several different disabilities), if you become disabled, benefits will be paid to you for so long as you remain disabled up to the maximum benefit period, subject to the following exclusions and limitations:

- Full-pay benefits are paid first. Once full-pay benefits are exhausted, half-pay benefits begin.
- You can use partial weeks of disability benefits. In such a case, your benefit amount is based upon the number of workdays in your regularly scheduled workweek. A daily benefit rate is calculated and applied to the number of scheduled workdays you are absent due to a disability.
- You may not receive benefits for longer than your period of disability, and in no event, longer than the maximum benefit period.
- You may not carry over unused benefits from year to year.
- When you receive disability benefits, your remaining disability benefits are reduced accordingly and do not refresh until you have a refresh event (as explained below).
- Your maximum benefit period "refreshes" on January 1 of each year if you are *actively at work*. Disability benefits paid to you may or may not cross over the calendar year:
  - Where you are receiving disability benefits that cross over a calendar year (meaning, you are out on disability on January 1), your maximum benefit period will refresh when you have returned to *actively at work* status (meaning, not on disability, vacation, or some other leave) for more than six calendar days following the end of your disability. If you become disabled from the same injury or illness within six calendar days from the date you returned to work, your maximum benefit period does not refresh. In such a case, your subsequent absence is considered a continuation of the original disability and is subject to the benefits remaining from the previous maximum benefit period.
- For purposes of determining your *non-occupational disability* maximum benefit period, you receive a step-up in *accredited service* on your service anniversary (the anniversary of your date of hire) if you are *actively at work* on that date. If you are not *actively at work* on your service anniversary, you receive this step-up on the first day you return to *actively at work* status. The step-up in benefits on account of your service anniversary does not constitute a refresh of your maximum benefit period. This means the step-up will only increase the benefits available to you for the remainder of the year by the amount of the step-up.
- The maximum benefit periods for *occupational disabilities* and *non-occupational disabilities* run separately. Receipt of *occupational disability* benefits will not reduce the maximum *non-occupational disability* benefits available to you and vice versa.

See below for examples of how the rules are applied:

Example 1	John suffers a *non-occupational disability* on January 5th. As of this date, John has 17 years of *accredited service*, which means he has 13 weeks of full-pay benefits and 39 weeks of half-pay benefits available to him. John's disability continues for 15 weeks, so John receives 13 weeks of full pay followed by 2 weeks of half pay. When John returns to work in April, he has 37 weeks of half-pay benefits remaining for any additional *non-occupational disability* absences until a refresh event occurs on January 1 (assuming he is *actively at work* on that date).
Example 2	Based on the facts stated in Example 1: In December of the same year, John suffers another *non-occupational disability*. A refresh event has not yet occurred. This means that John still has 37 weeks of half-pay benefits remaining for a *non-occupational disability*. John's disability continues for 5 weeks, and John receives 5 weeks of half pay. John returns to work in January of the next calendar year. His *non-occupational disability* bank refreshes to 13 weeks of full pay and 39 weeks of half pay when he has returned to *actively at work* status for more than six calendar days.

(continued)

Example 3	Christina suffers a *non-occupational disability* on April 3rd. As of this date, Christina has 3 years of *accredited service*, which means she has 4 weeks of full-pay benefits and 12 weeks of half-pay benefits available to her. Christina's disability continues for 5 weeks, so Christina receives 4 weeks of full pay followed by 1 week of half pay. When Christina returns to work in May, she has 11 weeks of half pay benefits remaining for any additional *non-occupational disability* absences. On June 1 Christina has a service anniversary. Because she is *actively at work* on that date, she receives a step-up in *accredited service*. As a result, her *non-occupational disability* maximum benefit period is increased and is now 1 week of full-pay benefits and 15 weeks of half-pay benefits.
Example 4	David suffers a *non-occupational disability* and utilizes 4 weeks of full-pay benefits. He returns to work for 5 days and then suffers an *occupational disability*. Because the maximum benefit periods for *occupational disabilities* and *non-occupational disabilities* run separately, David's receipt of 4 weeks of *non-occupational disability* full-pay benefits has not reduced the *occupational disability* benefits available to him. He has the maximum 26 weeks of full pay followed by 26 weeks of half-pay *occupational disability* benefits available to him.

Applying for Benefits

Elimination Period

In certain cases, benefits payable for a *non-occupational disability* may not begin until after you have completed your elimination period, which means you are absent for one complete scheduled workday or eight scheduled working hours, whichever is less.

There is no elimination period for an *occupational disability*.

The Application Process

To receive benefits under the Disability Benefit Plan, you must follow these steps:

- If you become ill or injured while at work, ask your manager to be excused.
- If you become ill or injured while off duty and you are unable to work, notify your manager promptly in accordance with local procedures.
- Follow local procedures for reporting your disability if you are unable to contact your manager or if someone else must report your disability for you.
- Comply with local procedures, including coding your time in the appropriate timekeeping system and completing and submitting a "Non-Occupational Accident and Illness Notice" ("Medical Certification Form (MedCert)" or location equivalent), to establish required proof of disability. (California employees must complete and file a "MedCert Form" or location equivalent.) In addition, as needed or requested (at 30-day intervals), provide additional written statements from your doctor using the Non-Occupational Accident and Illness Notice ("MedCert Form" or location equivalent). These forms are available as specified in your local procedures or via **www.netbenefits.com**.
- Obtain appropriate medical attention during your disability.
- If requested, permit a doctor, designated by the *Company*, to examine you to determine your condition during your disability.
- Follow the care and treatment recommendations made by your doctor or the doctor designated by the *Company*.

- When requested, provide notices and reports as required under workers' compensation or similar laws.
- As soon as your doctor establishes a recommended return-to-work date, contact your manager and, if requested, report for an examination by a doctor designated by the *Company*.

Exclusions and Limitations

Benefits are not paid for a disability sustained while you are:

- Absent from work and fail to comply with the procedures and requirements for the payment of benefits.
- Working for another employer.
- Engaged in your own misconduct.
- Under suspension.
- On a personal leave or on military annual weekly/weekend reserve duty. However, if your disability lasts beyond the time you were scheduled to return to work, you are eligible for benefits on the date of your scheduled return.
- On active military leave if the injury or illness was incurred in the performance of military duties.

If you have excessive absences due to accident or illness, the *Company* may appoint a *physician* to investigate and determine the probable future frequency or duration of such absences. The *Company* also has sole discretion to freeze disability benefits available to you (in other words, it may withhold benefits) where it suspects there is abuse of the Disability Benefit Plan. The *Company* deals with each case individually and may approve or deny benefits.

Events Affecting Coverage

Death

Coverage ends as of the date of your death.

Employment Events

- **Personal leave:** You are not eligible to receive disability benefits for periods while you are out on a personal leave (including vacation). If you become disabled while on a personal leave and your disability lasts beyond the time you are scheduled to return to work, you are eligible for benefits on the date of your scheduled return.
- **Military leave:** You are not eligible to receive disability benefits for disabilities beginning while you are out on reserve military duty. If you become disabled while on annual weekly/weekend reserve duty, benefits for any illness or injury apply as of the date you are scheduled to return to work if you are still disabled at that time. If you go into active military service, your coverage ends on the date your leave begins. This means you are not eligible to receive disability benefits for disabilities beginning while you are out on military leave. If you become disabled while in active service and your disability lasts beyond the date you were scheduled to return to work, you will be eligible for benefits on the date of your scheduled return, provided that your disability is not related to your performance of military duties.
- **Change in number of hours worked:** If your employment status changes to *part-time employee*, your coverage ends. Conversely, if your employment status changes from *part-time employee* to *regular part-time employee* or *regular full-time employee*, you become eligible to participate in the Disability Benefit Plan, effective on the date of your change in status.
- **Layoff, termination or retirement:** Your coverage and any disability benefits end when your employment terminates.

Plan Amendment or Termination

Your coverage changes or ends on the date the Disability Benefit Plan is modified or terminated.

ERISA

The Disability Benefit Plan is not covered by *ERISA*, and there are no formal plan documents.

Income Protection Insurance Plan

The Income Protection Insurance (IPI) plan, underwritten by Metropolitan Life Insurance Company (MetLife), allows you to purchase additional insurance to supplement any pay received under the Disability Benefit Plan when you are unable to work because of a *non-occupational disability*.

Participation

Eligibility

You are eligible for coverage under the IPI Program if you are a *regular full-time* or *regular part-time employee* of a *participating company*.

You are **not** eligible for coverage under the IPI Program if you work in California, Rhode Island, or Puerto Rico, because you are covered by the applicable state disability law listed below:

- California Unemployment Compensation Disability Benefits Law.
- Rhode Island Temporary Disability Insurance Law.
- Puerto Rico Temporary Disability Insurance Law.

Enrollment

Contact the Shell Benefits Service Center at 1-800-30SHELL to enroll or ask questions about your eligibility.

If you are eligible to participate in the IPI Program and you are *actively at work*, you may enroll anytime within 31 days after your hire date by contacting the Shell Benefits Service Center.

If you are an *employee* newly eligible to enroll in the IPI Program, due to an increase in the number of hours worked (20 or more hours per week), you will receive enrollment materials from the Shell Benefits Service Center. If you wish to enroll, you have 31 days to do so after your eligibility date:

- If you enroll within this 31-day period, you are not required to provide evidence of insurability acceptable to MetLife, and your coverage takes effect as of your hire date or eligibility date.
- If you do not enroll within this 31-day period, or you wish to raise your benefit level, you may do so by contacting the Shell Benefits Service Center. You must provide *Evidence of Insurability* (EOI) acceptable to MetLife and submit a "Statement of Health" form (available on NetBenefits) before your application can be approved. If MetLife needs additional medical information to approve your application, you may be required to undergo a physical examination by a doctor acceptable to the insurance company. The examination, if required, is at your expense.

Your coverage takes effect as follows:

- If your application for late enrollment or request to raise your benefit level is accepted, and you are *actively at work*, you are covered from the date of acceptance.
- If you are not *actively at work* on the acceptance date, your coverage or increase in coverage begins when you return to work.

If you discontinue coverage and later wish to reapply, you will be subject to the late enrollment procedure and will be required to provide Evidence of Insurability (EOI) acceptable to MetLife and submit a "Statement of Health" form (available on NetBenefits) before your application can be approved.

Cost

You pay the entire cost of coverage under the IPI Program through monthly after-tax payroll deductions.

You may purchase coverage at one of two benefit levels:

- Half (50%) pay.
- Quarter (25%) pay.

The premium you pay for these benefit levels depends on your annual base pay. You will receive information regarding the cost of coverage for both benefit levels in the enrollment materials you receive from the Shell Benefits Service Center.

Benefit Amount

Benefits are payable under the IPI Program only when your benefits under the Disability Benefit Plan drop below full-pay status. Depending upon the level of coverage you choose, your benefit amount is either 50% or 25% of your straight-time pay:

If You Choose ...	The Maximum Weekly Benefit Is...
50% of pay	$2,500
25% of pay	$1,250

No benefits are paid for an unscheduled workday.

For information about straight-time pay for both *regular full-time* and *regular part-time employees*, see "Benefit Amount" under "Disability Benefit Plan," page H-3.

Below are some examples of what your weekly benefit would be at certain annual base pay increments, based on whether you choose the half-pay or quarter-pay benefit level.

Annual Base Pay	Half-Pay Weekly Benefit	Quarter-Pay Weekly Benefit
$25,000	$240.38	$120.19
$50,000	$480.77	$240.38
$75,000	$721.15	$360.58
$100,000	$961.54	$480.77
$125,000	$1,201.92	$600.96
$150,000	$1,442.31	$721.15
$175,000	$1,682.69	$841.35
$200,000	$1,923.08	$961.54
$225,000	$2,163.08	$1,081.73
$250,000	$2,403.85	$1,201.92
$260,000 and above	$2,500.00	$1,250.00

Maximum Benefit Period

Your maximum benefit period is based upon your completed years of *accredited service* at the time your disability begins and is provided on a per-incident basis. No weekly benefits will be paid for more than the maximum benefit period.

Years of Accredited Service	Maximum Weeks of IPI Benefits
Under 1	52
1	50
2	49
3	48
4	47
5	46
6	45
7	44
8	43
9	42
10	41
11	40
12 and above	39

Determining the Duration of Benefits

Your maximum benefit period is described above and is based on your length of *accredited service* at the time your *non-occupational disability* begins. Benefits will be paid to you, when your Disability Benefit Plan benefits drop below full-pay status, and will continue for so long as you remain disabled up to the maximum benefit period, subject to the same exclusions and limitations described in "Determining the Duration of Benefits" under "Disability Benefit Plan," page H-5.

Here is an example of how IPI Program benefits can supplement the Disability Benefit Plan for a *non-occupational disability*.

Jack is a *regular full-time employee*. He has five years of *accredited service* and his annual base pay is $33,800 ($650 per week). Jack is disabled in an accident at home, and it is so serious that he is away from work for one year, starting on July 1. Jack had previously enrolled in the IPI Program and chosen half-pay benefits.

Weeks of Disability	Disability Benefit Plan		IPI Program	Totally Weekly Disability Income
	Full Pay	*Half Pay*	*Half Pay*	
First 6	$650/week	–	–	$650/week
Next 20	–	$325/week	$325/week	$650/week
Next 26	–	–	$325/week	$325/week
Total 52 Weeks of Disability				

For *regular part-time employees*, a week of pay is based upon your *standard hours election* and part-time hourly rate.

Applying for Benefits

To Qualify for Benefits

You can apply for benefits under the IPI Program if you are:

- Disabled due to a non-occupational cause,
- Under the care of a doctor who is treating your disability, and
- Receiving no more than half-pay disability benefits from the *Company*.

Medical Examination

For pending claims, the *Company* or MetLife may ask you to be examined by a doctor of its choice, at its expense, to investigate your disability status and your claim.

Elimination Period

You must be absent for one complete scheduled workday or eight scheduled working hours, whichever is less, before benefits can be paid.

The Application Process

To receive benefits under the IPI Program, you must follow these steps:

- Complete a "Non-Occupational Accident and Illness Notice" ("Medical Certification Form" ("MedCert") or location equivalent) properly to provide proof of your disability and to claim benefits. Additional forms should be completed when your disability continues for an extended period of time, generally at 30-day intervals. A "MedCert Form" is available as specified in your local procedures or via **www.netbenefits.com**, and
- File your claim within at least 90 days of the date your absence from work began.

Exclusions and Limitations

Benefits are not paid for a disability sustained if:

- You are covered by a state disability law in California, Rhode Island, or Puerto Rico.
- You are not treated for your disability by a qualified *physician*.
- Your disability is considered a work-related injury or sickness and benefits are payable under any workers' compensation or similar law.
- You are receiving full pay under the Disability Benefit Plan.
- You are receiving 100% of your regular pay, vacation pay, or holiday pay, or you are on a personal leave or dependent care leave.
- Your disability starts during a personal leave or military leave for annual weekly/weekend reserve duty. However, if your disability extends beyond the time you were scheduled to return to work, you are eligible for benefits on the date you were scheduled to return.
- You are on a military leave for active duty.
- You commit a felony.

Events Affecting Coverage

Death

Coverage ends as of the date of your death.

Employment Events

- **Leaves of absence:** If you are on a leave of absence, your benefits may be impacted. (For further information (see "Leaves of Absence" on page J-15).
- **Change in number of hours worked:** If your employment status changes to *part-time employee* status (less than 20 hours per week), your coverage ends. Conversely, if your employment status changes from *part-time employee* to *regular part-time employee* or *regular full-time employee*, you become eligible to participate in the Income Protection Insurance Program effective on the date of your change in status. You are only able to enroll without providing evidence of insurability to MetLife if you enroll within 31 days after your eligibility date.

- **Layoff, termination or retirement:** Your coverage and any disability benefits end when your employment terminates, and you have scheduled benefits remaining. In that case, benefits are paid until you recover or until you use up all of your benefits, whichever occurs first.

Cancellation of Premium Deductions

If you cancel the authorization for payroll deductions of your premium, your coverage ends on the last day of the month for which premiums were deducted from your pay.

IPI Program Amendment or Termination

Your coverage changes or ends on the date this program is amended or terminated. However, if you are totally disabled when the program terminates, benefits are paid until you recover or until your benefits are exhausted, whichever occurs first.

Claim Information

Initial Determination

Important Notice Related to the COVID-19 Outbreak

Pursuant to recent guidance issued in response to the declared national emergency as a result of the COVID-19 outbreak (the "National Emergency"), and unless future guidance by the relevant government agencies provides otherwise, the time period between March 1, 2020, and July 10, 2023, which is 60 days following the announced May 11, 2023, end of the National Emergency will be disregarded in determining the deadlines for filing initial claims and appeals described in this section, provided, however, that the maximum extension for any claim, appeal, or external review request filing deadline is one year.

You must submit a written claim for IPI Program disability benefits for MetLife's review, using the appropriate claim form. If your claim is approved, you will receive a payment directly from MetLife.

If your claim is denied, MetLife will notify you in writing of its decision to deny your claim. Such notification will be provided to you within a reasonable period, not to exceed 45 days from the date you submitted your claim, except for situations requiring an extension of time because of matters beyond the control of the program.

In such cases, MetLife may have up to two additional extensions of 30 days each to provide you such notification. If MetLife needs an extension, it will notify you in writing prior to the expiration of the initial 45-day period (or prior to the expiration of the first 30-day extension period if a second 30-day extension period is needed), state the reason why the extension is needed, and state when it will make its determination.

If an extension is needed because you did not provide sufficient information or filed an incomplete claim, the time from the date of MetLife's notice requesting further information and an extension until MetLife receives the requested information does not count toward the time period MetLife is allowed to notify you as to its claim decision. You will have 45 days to provide the requested information from the date you receive the extension notice from MetLife.

If MetLife denies your claim, in whole or in part, the written notification of the claims decision will state the reason(s) why your claim was denied and reference the specific plan provision(s) on which the denial is based. If the claim is denied because MetLife did not receive sufficient information, the claims decision will describe the additional information needed and explain why such information is needed. Further, if an internal rule, protocol, guideline, or other criteria was relied upon in making the denial, the claims decision will state the rule, protocol, guideline, or other criteria or indicate that such rule, protocol, guideline, or other criterion was relied upon and that you may request a copy free of charge.

The written notification will also include a description of the procedure for requesting an appeal of the initial benefit determination and a statement of your right to bring a civil action under Section 502(a) of *ERISA* following an adverse benefit determination upon appeal. You have the right to file a civil lawsuit only if you file an appeal from the initial determination and your appeal is denied. You may not file a lawsuit until any appeal is denied.

Appealing the Initial Determination

If MetLife denies your claim, you may submit a written request to appeal their decision. Upon receiving your request, MetLife will provide you, free of charge, copies of documents, records, and other information relevant to your claim. You must submit your written appeal to MetLife at the address indicated in the "General Plan Information" section of this summary plan description within 180 days of receiving MetLife's decision.

Your appeal must include, at minimum, the following information:

- Your name,
- Name of the program,
- Reference to the initial decision, and
- An explanation of why you are appealing the initial determination.

In addition, you may submit along with your appeal any written comments, documents, records, or other information relating to your claim.

After MetLife receives your written request appealing the initial determination, MetLife will conduct a full and fair review of your claim. Deference will not be given to the initial denial, and MetLife's review will look at the claim anew. The review on appeal will take into account all comments, documents, records, and other information that you submit relating to your claim without regard to whether such information was submitted or considered in the initial determination. The person who will review your appeal will not be the same person as the person who made the initial decision to deny your claim. In addition, the person who is reviewing the appeal will not be a subordinate of the person who made the initial decision to deny your claim.

If the initial denial is based, in whole or in part, on a medical judgment, MetLife will consult with a health care professional with appropriate training and experience in the field of medicine involved in the medical judgment. This health care professional will not have consulted on the initial determination, and will not be a subordinate of any person who was consulted on the initial determination.

MetLife will notify you in writing of its final decision within a reasonable period of time, but no later than 45 days after MetLife's receipt of your written request for review, except that under special circumstances, MetLife may have up to an additional 45 days to provide written notification of the final decision. If such an extension is required, MetLife will notify you prior to the expiration of the initial 45-day period, state the reason(s) why such an extension is needed, and state when it will make its determination. If an extension is needed because you did not provide sufficient information, the time period from MetLife's notice to you of the need for an extension to when MetLife receives the requested information does not count toward the time MetLife is allowed to notify you of its final decision. You will have 45 days to provide the requested information from the date you receive the notice from MetLife.

If MetLife denies the claim on appeal, MetLife will send you a final written decision that states the reason(s) why the claim you appealed is being denied and reference any specific plan provision(s) on which the denial is based. If an internal rule, protocol, guideline, or other criteria was relied upon in denying the claim on appeal, the final written decision will state the rule, protocol, guideline, or other criteria or indicate that such rule, protocol, guideline, or other criteria was relied upon and that you may request a copy free of charge. Upon written request, MetLife will provide you, free of charge, with copies of documents, records, and other information relevant to your claim. If your appeal is denied, you have the right to file a lawsuit under Section 502(a) of *ERISA*.

Long-Term Disability Program

The Long-Term Disability (LTD) Program, underwritten by Metropolitan Life Insurance Company (MetLife), provides you with financial protection if you are unable to work for an extended period of time because of illness or injury.

Participation

Eligibility

You are eligible to participate in the LTD Program if you are a *regular full-time* or *regular part-time employee* of a *participating company*.

Enrollment

Contact the Shell Benefits Service Center at 1-800-30SHELL to enroll or ask questions about your eligibility.

If you are eligible to participate in the LTD Program and you are *actively at work*, you may enroll anytime within 31 days after your hire date by contacting the Shell Benefits Service Center.

If you are an *employee* who is newly eligible to enroll in the LTD Program due to an increase in your number of hours worked (20 or more hours per week), you may do so within 31 days after your eligibility date:

- If you enroll within this 31-day period, your coverage takes effect as of your hire date or eligibility date. If you are not *actively at work* on the date you apply, your coverage begins when you return to work.
- If you do not enroll within this 31-day period, you may do so by contacting the Shell Benefits Service Center. You must provide Evidence of Insurability (EOI) acceptable to MetLife and submit a "Statement of Health" form (available on NetBenefits) before your application can be approved. If MetLife needs additional medical information to approve your application, you may be required to undergo a physical examination by a doctor acceptable to the insurance company. The examination, if required, is at your expense.

Your coverage takes effect as follows:

- If your application for late enrollment is accepted, and you are *actively at work*, you are covered from the date of acceptance.
- If you are not *actively at work* on the acceptance date, your coverage begins when you return to work.

If you discontinue coverage and later wish to reapply, you will be subject to the late enrollment procedure and will be required to provide Evidence of Insurability (EOI) acceptable to MetLife and submit a "Statement of Health" form (available on NetBenefits) before your application can be approved.

Cost

You pay the entire cost of coverage under the LTD Program through monthly after-tax payroll deductions. Your contributions are used to pay the premium for this fully-insured benefit.

To determine your cost and benefit level, your annual base pay is calculated using scheduled straight-time hours, up to 40 hours each week. Scheduled straight-time hours in excess of 40, overtime hours, shift differentials, special allowances or bonuses, and other pay are excluded. For *regular part-time employees*, base pay is based upon your *standard hours election* and your part-time hourly rate.

You will receive information regarding the monthly cost of coverage and the annual salary maximum in the enrollment materials you receive from the Shell Benefits Service Center.

Benefit Amount

After you are disabled and unable to work for 52 weeks (the elimination period), the LTD Program pays a monthly benefit equal to 60% of your monthly base pay at the time the disability began. For *regular part-time employees*, base pay is based on your *standard hours election* and your part-time hourly rate.

The maximum monthly LTD benefit is $10,250; the minimum monthly LTD benefit is not less than 5% of basic monthly earnings, which is your monthly rate of pay from the *participating company*, excluding overtime and other extra pay.

All benefit payments under the LTD Program are subject to "Overpayment Recovery" rules described at right. Basic monthly earnings in effect as of the date of your disability will be used to compute your monthly LTD benefit.

Offsetting Benefits

Your monthly LTD benefit is reduced by the amount of income you receive from other sources, including:

- Benefits payable under any workers' compensation law, occupational disease law, and/or insurance or other arrangement that was established to conform to a disability benefits law.
- Benefits received from the Shell Pension Plan.
- *Company*-sponsored or government-provided disability benefits.
- Social Security benefits. You must apply for Social Security benefits within your ninth month of disability, which is before you begin collecting LTD benefits. If you are receiving LTD benefits, it is assumed that you are also collecting Social Security benefits. Your LTD payment will be reduced automatically, unless you provide MetLife with proof that you have applied for Social Security benefits and have signed the LTD Acknowledgement Form. This form confirms that you will repay all overpayments and authorizes MetLife to obtain the information on awards directly from the Social Security Administration. If benefits are denied, you must pursue appeals to the Social Security Administration as required by the program.
- 50% of rehabilitative employment earnings, for up to two years. After two years, your LTD benefit is reduced by 100% of such earnings (see "Rehabilitation," on page H-18).

While your monthly LTD benefit is reduced by the amount of income you receive from any of the sources listed previously, your Social Security benefit is determined based upon the law in effect on the first day for which you are entitled to receive LTD benefits for that disability period.

If you receive a lump-sum settlement from any of the sources listed previously, the settlement is converted to a monthly equivalent and taken into account in the computation of your LTD benefit over the period for which it applies or a reasonable future period, as appropriate. LTD benefits are not subject to inflation adjustments.

Overpayment Recovery

If at any time the total amount paid on a claim is more than the total amount due, including any overpayment resulting from retroactive awards received from other sources as listed in "Offsetting Benefits," MetLife will recover the excess amount from you. MetLife may also recover the excess amount by reducing any future benefits payable to you.

Below is an example of how LTD benefits are computed for three *employees* who become totally disabled:

- Jane is 47 years old and has 20 years of service; she qualifies for a disability pension.
- Tom is 37 years old and has 10 years of service; he does not qualify for a disability pension.
- Sally is 30 years old and has three years of service; she does not qualify for a disability pension.

	Jane	Tom	Sally
Monthly base bay	$3,500	$3,000	$2,500
60% benefit objective	$2,100	$1,800	$1,500
Other sources of income:			
▪ Social Security*	$1,012	$1,003	$930
▪ Shell Pension Plan	$834	**	**
▪ Monthly LTD benefit	$254	$797	$570

* These examples assume that these *employees* qualify for Social Security disability benefits. Although most *employees* qualify for such benefits, some do not. If Jane, Tom, and Sally had not qualified for Social Security benefits, their monthly LTD benefit would have been: Jane – $1,266; Tom – $1,800; and Sally – $1,500.

** Tom and Sally are eligible to receive a Deferred Vested Pension at age 65. At that time, their LTD benefits will be reduced by amounts received from the Shell Pension Plan.

For information about disability pensions, see the Shell Pension Plan in the "Wealth" summary plan description.

Applying for Benefits

To Qualify for Benefits

To qualify for LTD benefits, you must be disabled — that is, you must:

- Be under the regular care of a doctor,
- Be unable, by reason of your illness or injury, to perform the duties of your own job, or another job available within a *participating company* for which you are reasonably qualified, during the elimination period and the 24 months following the elimination period,
- Apply for benefits, including submitting medical evidence of disability acceptable to MetLife, and
- Obtain MetLife's approval of your claim.

You may also qualify for LTD benefits if you are approved for disability benefits under the federal Social Security Act for the same injury or sickness for which you are claiming LTD benefits. In addition, you must meet all of the following requirements:

- You submit written notice of a claim for LTD benefits under the program during the 52-week elimination period.
- Your initial claim for Social Security disability benefits is made on or before the expiration of the 52-week elimination period.
- You are awarded Social Security disability benefits on or before the expiration of a period of 24 consecutive months from the date you completed the 52-week elimination period, and you provide MetLife with a copy of the Notice of Award of Social Security disability benefits within such period.
- The date of disability indicated in the Notice of Award of Social Security disability benefits is either:
  - Your date last worked prior to becoming disabled, or
  - A date during the 52-week elimination period, provided you subsequently received LTD benefits approval from MetLife by reason of your inability to perform the duties of your own job, or another job within the *Company*, as described previously.

For proof of claim to establish your disability on the basis of the award of Social Security disability benefits, you must also submit documentation satisfactory to MetLife of the following items:

- The date you applied for Social Security disability benefits, and
- The complete Notice of Award of Social Security disability benefits, including the date of such award and the date of disability indicated in such award.

Depending upon the level at which you are awarded Social Security disability benefits, you must also submit documentation satisfactory to MetLife of one of the following:

- If awarded Social Security disability benefits at either the initial or reconsideration level, a letter or some written confirmation from the Social Security Administration containing a text description of the diagnosis for the condition for which you were approved for Social Security disability benefits, or
- If awarded Social Security disability benefits at the Administrative Law Judge level: The Administrative Law Judge Favorable Decision.

When You Must Give Proof of a Claim

You must give MetLife written proof of a claim no later than 90 days following the end of the 52-week elimination period. However, you must give written proof of a claim to establish your disability on the basis of the Notice of Award of Social Security disability benefits within 30 days after you receive such award, but in no event beyond 24 months from the end of the 52-week elimination period.

In addition, to verify that you continue to receive Social Security disability benefits after MetLife initially approves your claim for LTD benefits under this program, MetLife may periodically request that you send proof that you continue to receive such benefits. MetLife may require that you sign and provide a Social Security Authorization on an annual basis.

The Application Process

Approximately 90 days before the 52-week elimination period ends, you will receive the following forms:

- "Statement of Claim for Long-Term Disability Benefits."
- "Reimbursement Agreement for Delayed or Denied Workers' Compensation Claims."
- "Authorization to Secure Award or Disallowance Information."
- "Authorization Form for Electronic Funds Transfer of Disability Payments (Electronic Direct Deposit)."

Once you receive these forms:

- Complete the claimant or *employee* portion of the application forms. Carefully follow the instructions on the forms. Be sure to answer all questions fully;
- Have the doctor who is treating you for your disability complete the medical portion of the "Statement of Claim for Long-Term Disability Benefits" form; and
- Mail or fax all completed forms and any required statements to MetLife.

MetLife will require written statements from your doctor as official proof of disability and may further ask that you be examined by a MetLife-appointed doctor. You may also be asked to submit periodic proof of your continuing disability.

When the claim is processed, you are notified of the benefits to be paid. If any benefits are denied, you will receive a written explanation.

Because it is assumed that you are receiving Social Security disability benefits and that your LTD benefits will be reduced accordingly, you should apply for Social Security benefits 90 to 120 days before the 52-week elimination period ends.

Duration of Benefits

Monthly LTD benefits may continue for up to 24 months. After 24 months, you may continue to receive LTD benefits for as long as you are disabled if:

- You remain under a doctor's care, and
- You are unable to perform the duties of any job for which you are reasonably qualified taking into consideration your education, training, experience, and past earnings.

Benefits may be payable for life if you provide proper proof of your continued disability.

Successive Periods of Disability

Before Qualifying for LTD Benefits

Assume that you become disabled, are out of work for one month, and return to work for up to 15 workdays. If you then suffer a disability related to the original disability and are once again unable to work, you are not required to complete a new elimination period before LTD benefits can begin. Instead, the number of days you worked are added to the original 52-week elimination period.

After Qualifying for LTD Benefits

Assume that you were disabled and received LTD benefit payments. Then, within three months after returning to work, you suffer a disability related to the original disability. In this case, the two disabilities are considered one continuing disability for LTD purposes, and you are not required to complete a new elimination period before LTD benefits can begin again. However, LTD benefits are not paid if you are receiving benefits from the Disability Benefit Plan.

Your illness or injury is considered a separate disability and you are required to satisfy another 52-week elimination period before LTD benefit payments can begin again if:

- You were disabled, you returned to work and were back at work for more than three months, and you suffer a disability related to the original disability, or
- You were disabled, you returned to work and, after at least one day of active work, you become disabled due to an unrelated illness or injury.

Rehabilitation

The LTD Program is designed to encourage and help qualified disabled *employees* to participate in rehabilitative employment. Rehabilitative employment is any employment, approved by MetLife, in which you engage for wage or profit while you are unable, due to injury or illness, to fully perform the duties of your gainful occupation. Selection for participation in rehabilitation programs is based upon the degree of your disability and your individual experience, training, and education.

While participating in an approved rehabilitation program, your monthly benefit, before reduction for other income benefits, is increased by 10%.

For up to two years, 50% of rehabilitative employment earnings are included in the computation for your LTD benefit. After two years, 100% of such earnings are taken into account. Social Security also provides rehabilitation programs and may reduce your Social Security benefits if you elect to participate (see "Offsetting Benefits" on page H-15).

A rehabilitation program is one that has been approved by MetLife to help you return to work. It may include, but is not limited to, your participation in one or more of the following activities:

- Return to work on a modified basis with a goal of resuming employment for which you are reasonably qualified by training, education, experience, and past earnings.
- On-site job analysis.
- Training to improve job-seeking skills.
- Vocational assessment.
- Short-term skills enhancement.
- Vocational training.
- Restorative therapies to improve functional capacity to return to work.

In addition, if you are disabled and participate in an approved rehabilitation program, you will be reimbursed for eligible family care expenses, as described on the next page, for each eligible family member, which are incurred during the first 24 months of monthly benefit payments.

An eligible family member is a person who is both:

- Living with you, as part of your household, and
- Chiefly dependent upon you for support.

Eligible family care expenses are monthly expenses incurred by you so that you can participate in rehabilitative employment, up to $250 for each eligible family member. These are expenses incurred either:

- To provide child care with respect to an eligible family member under age 13. Child care must be provided by a licensed child care facility or other qualified child care provider. The child care provider may not be a member of your immediate family or living in your residence, or
- To provide care to an eligible family member who, as a result of a mental or physical impairment, is incapable of caring for himself or herself. Family care expenses for services provided by a member of your immediate family or anyone living in your residence will not be reimbursed.

Eligible family care expenses do not include expenses for which you are eligible for reimbursement under any other group plan or program or from any other source.

You must provide satisfactory proof to MetLife that:

- You incurred such charges, and
- The eligible family member is incapable of caring for himself or herself and is chiefly dependent upon you for support.

Exclusions and Limitations

LTD benefits are not paid for any disability:

- For which you are not under the continuous care of a licensed doctor.
- For which you fail to follow medical instructions.
- For which you fail to furnish proof of your continued disability.
- During which you are engaged in any gainful occupation (excluding rehabilitative employment).
- That you sustained while on disciplinary leave or absence without leave.
- That you sustained as the result of committing, or trying to commit, a felony or other serious crime or assault.
- That is the result of intentionally self-inflicted injury or attempted suicide.
- That was due to an act of war, insurrection, or rebellion.
- That was due to active participation in a riot.
- That you incurred while serving in the armed forces of any nation.

The following rehabilitation limitations also apply:

- LTD benefits are payable for up to 24 months after they begin for any disability caused by alcohol abuse, drug abuse, or a mental or nervous disorder only if you are undergoing rehabilitation under a doctor-supervised rehabilitation program. After that time, you must be confined to an approved institution to continue receiving LTD benefits.
- LTD benefits plus rehabilitative employment earnings may not exceed your pre-disability base pay.
- If you refuse to participate in a Social Security Rehabilitation Program and, as a result, your Social Security benefit is reduced, the LTD Program does not make up the amount of the Social Security benefit reduction.

Events Affecting Coverage

Death

Coverage ends as of the date of your death. However, if you die while receiving a monthly LTD benefit, the program will pay your eligible survivor(s) a lump-sum amount equal to 3 times your last gross monthly benefit. Eligible survivor(s) include your spouse or *domestic partner* and your dependent child(ren) who are under age 25.

The full benefit will be paid to the surviving spouse. Only if there is no surviving spouse will benefits be made to dependent children under the age of 26. If there are no dependent children under the age of 26, no benefit will be paid.

Payment made to your dependent child(ren) will be divided equally among the child(ren). Such payment will be made directly to the child(ren) or to a person named by MetLife to receive payments on behalf of the child(ren). This designation will be valid and effective against all claims by others who represent or claim to represent the child(ren). If no eligible survivor(s) exist, no benefits will be paid.

Employment Events

- **Leaves of absence:** If you are on a leave of absence, your benefits may be impacted. (For further information (see "Leaves of Absence" on page J-15).
- **Change in number of hours worked:** If your employment status changes to *part-time employee* (less than 20 hours per week), your coverage ends. Conversely, if your employment status changes from *part-time employee* to *regular part-time employee* or *regular full-time employee*, you become eligible to participate in the LTD Program, effective on the date of your change in status. You are only able to enroll without providing evidence of insurability to MetLife if you enroll within 31 days after your initial eligibility date.
- **Layoff, termination or retirement:** Your coverage ends when your employment terminates, unless you are totally disabled (as defined in "To Qualify for Benefits" on page H-16). If you are totally disabled at the time of your termination, LTD benefits begin after you complete the 52-week elimination period. If you are receiving LTD benefits at the time of your termination, they continue for as long as you continue to meet the eligibility requirements.

Cancellation of Premium Deductions

If you cancel the authorization for payroll deductions of your premium, your coverage ends on the last day of the month for which premiums were deducted from your pay.

LTD Program Amendment or Termination

Your coverage changes or ends on the date this program is amended or terminated. However, if you are totally disabled (as defined in "To Qualify for Benefits" on page H-16) when the program terminates, benefits are paid until you recover or your benefits are exhausted.

Claim Information

Initial Determination

A claim for LTD Program disability benefits must be submitted to MetLife, in writing, using the appropriate claim form. MetLife will review your claim. Approved claims will result in a payment directly from MetLife. If your claim is denied, MetLife will notify you in writing of its decision to deny your claim. Such notification will be provided to you within a reasonable period, not to exceed 45 days from the date you submitted your claim, except for situations requiring an extension of time because of matters beyond the control of the LTD Program.

In such cases, MetLife may have up to two additional extensions of 30 days each to provide you such notification. If MetLife needs an extension, it will notify you in writing prior to the expiration of the initial 45-day period (or prior to the expiration of the first 30-day extension period if a second 30-day extension period is needed), state the reason(s) why the extension is needed, and state when it will make its determination. If an extension is needed because you did not provide sufficient information or filed an incomplete claim, the time from the date of MetLife's notice requesting further information and an extension until MetLife receives the requested information does not count toward the time period MetLife is allowed to notify you as to its claim decision. You will have 45 days to provide the requested information from the date you receive the extension notice requesting further information from MetLife.

If MetLife denies your claim, in whole or in part, the written notification of the claims decision will state the reason(s) why your claim was denied and reference the specific plan provision(s) on which the denial is based. If the claim is denied because MetLife did not receive sufficient information, the claims decision will describe the additional information needed and explain why such information is needed. Further, if an internal rule, protocol, guideline, or other criteria was relied upon in making the denial, the claims decision will state the rule, protocol, guideline, or other criteria or indicate that such rule, protocol, guideline, or other criteria was relied upon and that you may request a copy free of charge. The written notification will also include a description of the procedure for requesting an appeal of the initial benefit determination and a statement of your right to bring a civil action under Section 502(a) of *ERISA* following an adverse benefit determination upon appeal.

You have the right to file a civil lawsuit only if you file an appeal from the initial determination and your appeal is denied. You may not file a lawsuit until any appeal is denied.

Appealing the Initial Determination

If MetLife denies your claim, you may appeal the decision to MetLife. Upon your written request, MetLife will provide you, free of charge, with copies of documents, records, and other information relevant to your claim. You must submit your appeal to MetLife at the address indicated on the claim form within 180 days of receiving MetLife's decision.

Appeals must be in writing and must include at least the following information:

- Your name,
- Name of the program,
- Reference to the initial decision, and
- An explanation of why you are appealing the initial determination.

As part of your appeal, you may submit any written comments, documents, records, or other information relating to your claim.

After MetLife receives your written request appealing the initial determination, MetLife will conduct a full and fair review of your claim. Deference will not be given to the initial denial, and MetLife's review will look at the claim anew. The review on appeal will take into account all comments, documents, records, and other information that you submit relating to your claim without regard to whether such information was submitted or considered in the initial determination. The person who will review your appeal will not be the same person as the person who made the initial decision to deny your claim. In addition, the person who is reviewing the appeal will not be a subordinate of the person who made the initial decision to deny your claim. If the initial denial is based, in whole or in part, on a medical judgment, MetLife will consult with a health care professional with appropriate training and experience in the field of medicine involved in the medical judgment. This health care professional will not have consulted on the initial determination, and will not be a subordinate of any person who was consulted on the initial determination.

MetLife will notify you in writing of its final decision within a reasonable period of time, but no later than 45 days after MetLife's receipt of your written request for review, except that under special circumstances, MetLife may have up to an additional 45 days to provide written notification of the final decision. If such an extension is required, MetLife will notify you prior to the expiration of the initial 45-day period, state the reason(s) why such an extension is needed, and state when it will make its determination. If an extension is needed because you did not provide sufficient information, the time period from MetLife's notice to you of the need for an extension to when MetLife receives the requested information does not count toward the time MetLife is allowed to notify you of its final decision. You will have 45 days to provide the requested information from the date you receive the notice from MetLife.

If MetLife denies the claim on appeal, MetLife will send you a final written decision that states the reason(s) why the claim you appealed is being denied and reference any specific plan provision(s) on which the denial is based. If an internal rule, protocol, guideline, or other criteria was relied upon in denying the claim on appeal, the final written decision will state the rule, protocol, guideline, or other criteria or indicate that such rule, protocol, guideline, or other criteria was relied upon and that you may request a copy free of charge.

Upon written request, MetLife will provide you, free of charge, with copies of documents, records, and other information relevant to your claim. If your appeal is denied, you may have the right to file a lawsuit under Section 502(a) of *ERISA*.

However, if on the date MetLife upholds the denial of your claim for LTD benefits you have not yet received notice of a final determination of your claim for Social Security disability benefits, a lawsuit may not be started with respect to your claim for LTD benefits under the program until a reasonable period of time expires following the earlier of:

- The date MetLife receives a copy of the final denial of your request for Social Security disability benefits by an Administrative Law Judge, or
- The expiration of a period of 24 consecutive months from the date you completed the elimination period under the program.

No lawsuit may be started more than three years after the time proof must be given.

Survivor Income Programs

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The Survivor Income Programs provide financial protection for your survivors to help them meet their financial obligations in the event of your death. The programs also give you the opportunity to purchase additional coverage for yourself, as well as insurance that will provide you with benefits in the event of a family member's death.

With these goals in mind, the Survivor Income Programs offer:

- A base of protection through the *Company*-paid Survivor Benefit Program.
- An additional *Company*-paid death benefit if you die as a direct result of an accident while at work, through the Occupational Accidental Death Benefit Program (OADBP).
- The option to purchase additional insurance for yourself through the Group Life Insurance Program and/or the Voluntary Personal Accident Insurance Program.
- The opportunity to purchase life and accident insurance for your spouse or *domestic partner* and/or eligible *child(ren)* through the Group Life Insurance Program* and/or the Voluntary Personal Accident Insurance Program*.
- Additional *Company*-paid protection for you while traveling on *Company* business through the Business Travel Accident Insurance Program.

* Dependent coverage is available only if you purchase Group Life Insurance and/or Voluntary Personal Accident Insurance coverage for yourself.

Survivor Benefit Program and Occupational Accidental Death Benefit Program

The Survivor Benefit Program provides *Company*-paid life insurance coverage. The OADBP provides a work-related accidental death benefit. Both programs are underwritten by Metropolitan Life Insurance Company (MetLife).

Participation

Eligibility

You are eligible to participate in the Survivor Benefit Program and the OADBP if you are a *regular full-time* or *regular part-time employee* of a *participating company*.

Enrollment

If you are eligible to participate in the Survivor Benefit Program and the OADBP, you are enrolled automatically for coverage as of your hire date. If you are a *regular part-time employee* who is newly eligible to participate in the Survivor Benefit Program and the OADBP, you are enrolled automatically for coverage as of your eligibility date.

If you are not at work on the day coverage is scheduled to begin, your coverage starts when you report to work.

Cost

The *Company* pays the entire cost of coverage under the Survivor Benefit Program and the OADBP.

Benefit Amount

- **Survivor Benefit Program:** Provides *employees* term life insurance coverage with a benefit equal to two years' pay. For benefit purposes, your pay is determined on the same basis used to calculate your vacation pay. For *regular part-time employees*, base pay is based upon your *standard hours election* and your part-time hourly rate.
- **OADBP:** Provides a benefit of $500,000 if you die as the direct result of an accident while at work.

Applying for Benefits

Payment of Benefits

If you die, benefits under the Survivor Benefit Program and the OADBP are payable to your *beneficiary(ies)*. Proof-of-death documents will be requested from your *beneficiary(ies)*, and the claims will be processed by MetLife.

If there is no *beneficiary(ies)* designated or no surviving *beneficiary(ies)* at your death, MetLife may determine the *beneficiary(ies)* to be one or more of the following who survive you:

- Your spouse or *domestic partner*,
- Your *child(ren)*,
- Your parent(s),
- Your sibling(s),or
- Your estate.

If a *beneficiary(ies)* or a payee is a minor or incompetent to receive payment, MetLife will pay that person's guardian.

Naming a Beneficiary

It's important that you name a *beneficiary(ies)* to receive your Survivor Benefit Program and the OADBP benefit in the event of your death. Your *beneficiary(ies)* may be your estate, a trust, or any person(s) you designate. You may change your *beneficiary(ies)* at any time by contacting the Shell Benefits Service Center and requesting a "Beneficiary Designation" form, or you may designate your *beneficiary(ies)* online via NetBenefits.

Please note that the *beneficiary(ies)* designation must be on record with the Shell Benefits Service Center to be valid.

Filing a Claim

To file a claim under the Survivor Benefit Program and/or the OADBP, your *beneficiary(ies)* must contact the Shell Benefits Service Center at 1-800-30-SHELL.

Settlement Options

Your *beneficiary(ies)* can receive all or part of the benefits as a lump-sum payment or choose among other settlement options, including insured investment accounts and guaranteed income payments. Additional information on these options will be provided to your *beneficiary(ies)*.

Accelerated Benefit Option

Under the Survivor Benefit Program, an Accelerated Benefit Option (ABO) allows *employees* who are terminally ill and meet certain requirements to apply to receive a portion of their Survivor Benefit in advance of their death.

Under the Accelerated Benefit Option (ABO), a portion of your benefit amount may be paid prior to your death if medical certification shows that your life expectancy is reduced to 24 months or less. Accelerated benefits are payable up to 50% of the coverage amount in effect to a maximum of $250,000.

Accelerated benefits are not paid if:

- Your benefits are assigned.
- The *Company* or MetLife was notified that all or a portion of the benefits are to be paid to a former spouse as part of a divorce agreement.
- Your life expectancy is reduced as the result of your attempted suicide or intentionally self-inflicted injury.
- Your Accelerated Benefit Option (ABO) Eligible Survivor Benefit Life Insurance is scheduled to end within six months after the date you request an accelerated benefit.

The ABO will end on the earliest of:

- The date the ABO-Eligible Life Insurance ends,
- The date you or your legal representative assign all ABO-Eligible Life Insurance benefits, or
- The date you or your legal representative exhaust all ABO-Eligible Life Insurance benefits.

OADBP Exclusions and Limitations

Exclusions

Benefits are not paid from the OADBP if a loss results from:

- Suicide.
- Physical or mental illness, diagnosis of or treatment for the illness.
- Any infection, unless it is pus-producing and occurs through or at the time of an accidental cut or wound.
- Service in any military, naval, or air force of any country.
- War or any act of war, declared or undeclared, including resistance to armed aggression.
- Participation in a felony.
- Commuting to or from your normal place of employment.
- Personal activities or objectives that are not necessarily or predominantly related to your work. A personal activity or objective, such as travel to and from and/or participation in sporting, dining, social, and cultural activities, is not considered predominantly related to your work unless it is required and authorized by the *Company*.

Limitations

Not all losses resulting from a work-related accident are covered under the OADBP. Benefits are payable only if all of the following conditions are met:

- You are accidentally injured while you are covered under the program,
- The injury occurs at your normal place of work or during business travel while you are performing your normal work duties. Business travel is travel that is:
  - Required and authorized by the *Company*,
  - Paid for by the *Company*, and
  - Intended primarily to further the *Company's* interests,
- The loss you suffer is the direct result of the accidental injury only, and
- Your death occurs within one year after the accident. This condition is waived if, after that date, you are in a coma or on a life support system as the result of either the accident or the injuries you suffered as the result of the accident. In either case, death must occur before you regain consciousness or you are able to function without life support.

Survivor Benefit Program Tax Considerations

The law provides that, with certain exceptions, your gross income must include the cost of any group term life insurance policy over $50,000 that the *Company* carries on your behalf, to the extent that the cost exceeds any amount you pay toward the purchase of that insurance. This income is taxable for purposes of federal income tax and Social Security tax. The Survivor Benefit Program is subject to this provision.

As a result, if you have taxable income from group term life insurance coverage over $50,000 under the Survivor Benefit Program, you may request an explanation of how that income is calculated near the time you receive your W-2 form. The amount is shown on your W-2 form and is included in Box 1 "Wages, tips, other compensation" and in Box 3 "Social Security wages." When required, this amount also is reported for purposes of state and municipal taxes.

Funeral Discount Program

A funeral discount program through Dignity Memorial is available to eligible participants of the Survivor Benefit Program. The Dignity Memorial network consists of licensed funeral, cremation and cemetery providers that are affiliates of Service Corporation International "SCI." SCI was founded in 1962 and is North America's largest provider of death care products and services.

Services include:

- Discounts of up to 10% off funeral, cremation and cemetery services and/or 5% off already discounted funeral package plans provided through a Dignity Memorial funeral home.

- Unlimited access to Dignity's comprehensive end-of-life planning tool and resource library.
- Expert Assistance to help make final wishes easier to manage.
- Bereavement Travel Services to assist with time-sensitive travel arrangements to be with loved ones (when services are provided through a Dignity Memorial location).

Services are available for the *employee* (insured) and extended family, which includes the:

- Insured's spouse.
- Insured's *children*.
- Parents of the insured.
- Parents of the insured's spouse.
- Grandparents of the insured.
- Grandparents of the insured's spouse.
- Great-grandparents of the insured.
- Great-grandparents of the insured's spouse.

At the Dignity Memorial funeral home location, the *employee* and/or their family member will have to identify themselves as being eligible for the discount by way of the MetLife/Dignity program.

If you have questions about the discount and planning services, call Final Wishes Planning at 1.866.853.0954 or log onto **www.finalwishesplanning.com**.

Events Affecting Coverage

Employment Events

- **Leaves of absence:** If you are on a leave of absence, your benefits may be impacted (see "Leaves of Absence" on page J-15).
- **Change in number of hours worked:** If your employment status changes to *part-time employee* (less than 20 hours per week), your coverage ends. Conversely, if your employment status changes from *part-time employee* to *regular part-time employee* or *regular full-time employee*, you become eligible to participate in the Survivor Benefit Program and the OADBP, effective on the date of your change in status.
- **Layoff, termination or retirement:** Your coverage ends when your employment terminates, unless you are totally disabled. If you are totally disabled at the time of your termination and you die within one year, death benefits may be payable.

Survivor Benefit Program and OADBP Amendment or Termination

Your coverage changes or ends on the date this program is amended or terminated.

Survivor Benefit Program Conversion Privilege

You may convert all or part of your life insurance coverage under the Survivor Benefit Program to an individual policy offered by MetLife:

- When your employment ends, or
- When the number of hours you are working is reduced to less than 20 hours a week.

This privilege extends only to life insurance benefits and does not include work-related accidental death benefits. If you convert your coverage within 31 days after your employment ends, you are not required to provide evidence of insurability.

You can obtain a conversion notice form from the Shell Benefits Service Center, which will provide you with the information you need to contact MetLife. You must complete the conversion application with MetLife within 31 days after your employment ends.

Death Benefit During the Conversion Period

If you die during the 31-day conversion period, a death benefit equal to the amount of group coverage previously in force is payable whether or not you applied for an individual policy.

Group Life Insurance

You may purchase additional active group life insurance, when eligible, to provide more protection for your family in the event of your death. You may also purchase dependent life insurance coverage for your spouse or *domestic partner* and your eligible *child(ren)*. These coverage options are available under the Group Life Insurance Program, which is also underwritten by MetLife.

Participation

Eligibility

You are eligible to purchase life insurance coverage under the Group Life Insurance Program if you are a *regular full-time* or *regular part-time employee* of a *participating company*.

If you purchase coverage for yourself, you may also elect coverage for your spouse or *domestic partner* and/or your eligible *child(ren)*. If both you and your spouse or *domestic partner* are eligible to enroll in the Group Life Insurance Program as *employees*, each of you must enroll separately. *Child(ren)* may be covered by only one *employee*.

An *eligible employee* cannot be covered as a dependent under this program.

Enrollment

If you are not *actively at work* on the day your coverage increase under the Group Life Insurance Program normally would begin, coverage for you and your dependent(s) is delayed until you return to work as a regular *employee*.

Active Group Life Insurance

To purchase active group life insurance for yourself and coverage for your spouse or *domestic partner* and/or your eligible *child(ren)*, call the Shell Benefits Service Center within 31 days after your hire date. If you are an *employee* who is newly eligible to enroll in the active Group Life Insurance Program due to an increase in your number of hours worked (20 or more hours per week), and you are *actively at work*, you may do so within 31 days after your eligibility date. Your coverage up to 5 times your annual base pay takes effect as of your hire date, eligibility date or the date you return to work as a regular *employee* (whichever occurs later).

If you do not enroll yourself and/or your spouse or *domestic partner* within 31 days after your hire date or initial eligibility date, you have to provide evidence of insurability by completing a MetLife "Statement of Health" form and submitting it with your application. Any dependent(s) not enrolled within 31 days of eligibility must complete a "Statement of Health" form as well. MetLife may also require you and/or your dependent(s) to have a physical examination if additional medical evidence is necessary or if the amount of life insurance coverage you requested exceeds certain coverage limits. (For more information on when you must provide evidence of insurability, see "Changing Your Coverage" on page I-7.)

If evidence of insurability is required, and you are *actively at work*, coverage begins on the date MetLife approves your application. If you are not *actively at work* on the date your coverage is approved, your coverage begins when you return to work.

Coverage for your dependent(s) will begin on the later of the date MetLife approves your dependent(s)' application or the date MetLife approves your application.

A "Statement of Health" form must be completed fully if your spouse or *domestic partner* or your eligible *child(ren)* is:

Hospitalized within the three-month period prior to your enrollment date.

- Confined at home under a doctor's care because of illness or injury when coverage is scheduled to begin.
- Receiving or entitled to receive any disability income benefits from any source due to any illness or injury.

A "Statement of Health" form must also be completed fully if your spouse or *domestic partner* requests coverage greater than $50,000. "Statement of Health" forms are available from the Shell Benefits Service Center or online at NetBenefits.

Active Group Life Insurance Benefit Amount

Coverage for Yourself

You may purchase active group life insurance coverage for yourself equal to 1, 1½, 2, 2½, 3, 3½, 4, 4½, 5, 5½, 6, 6½, or 7 times your annual base pay, up to a maximum benefit of $4 million. Amounts in excess of 5 times annual base pay will require evidence of insurability approved by MetLife and you must be *actively at work* prior to coverage going into effect.

For *regular part-time employees*, base pay is based upon your *standard hours election* and your part-time hourly rate.

If the coverage amount you elect is not an even multiple of $500, your benefit amount is rounded to the next higher multiple of $500.

Example: If your annual base pay is $35,100 and you choose coverage equal to 3 times your annual base pay, your life insurance benefit amount is $105,500.

3 x $35,100 = $105,300,
rounded to the next higher $500 = $105,500

Coverage for Your Dependent(s)

If you purchase active group life insurance coverage for yourself, you may also purchase coverage for your spouse or *domestic partner* in increments of $50,000, up to a maximum of $500,000 as long as the amount does not exceed the *employee's* current group life insurance benefit.

If you purchase coverage for yourself, you also may purchase coverage for your eligible *child(ren)*. You have two coverage options: $5,000 per child or $10,000 per child.

Cost

You pay for coverage under the Group Life Insurance Program through monthly after-tax payroll deductions. The rate you pay depends on the coverage level(s) you elect and the age of the people you cover.

You will receive information regarding the cost of active coverage for yourself and your *eligible dependent(s)* in the enrollment materials you receive from the Shell Benefits Service Center.

Changing Your Coverage

You may decrease or cancel your group life insurance coverage at any time by calling the Shell Benefits Service Center at 1-800-30-SHELL.

You may increase your active coverage during the *group annual enrollment period* by one half or 1 times your base pay (for example, from 3 to 3½ or 4 times your annual base pay) without providing evidence of insurability to MetLife. You must be *actively at work* before this increase will take effect.

However, you have to supply evidence of insurability if:

- You request an increase for an amount that is greater than 1 times your base pay (for example, from 3 to 4½ times your base pay),
- You request an increase in coverage amount that is greater than 5 times your base pay, or
- You wish to increase your spouse's or *domestic partner's* coverage by greater than $50,000.

For any of the events mentioned previously, you must submit a MetLife "Statement of Health" form with your request to increase coverage. You may be required to take a physical examination, depending upon your medical history and the level of coverage increase you request.

Increases in coverage requiring evidence of insurability take effect only if, and after, MetLife approves your request and you are *actively at work*. If you are not *actively at work* on the date your coverage is approved, your coverage begins when you return to work.

Applying for Benefits

Payment of Benefits

When you die, benefits are paid to the *beneficiary(ies)* you named. If there is no *beneficiary(ies)* designated or no surviving *beneficiary(ies)* at your death, MetLife may determine the *beneficiary(ies)* to be one or more of the following who survive you:

- Your spouse or *domestic partner*,
- Your *child(ren)*,
- Your parent(s),
- Your sibling(s), or
- Your estate.

If a *beneficiary(ies)* or a payee is a minor or incompetent to receive payment, MetLife will pay that person's guardian.

Naming a Beneficiary

It's important that you name a *beneficiary(ies)* to receive your group life insurance benefit in the event of your death. Your *beneficiary(ies)* may be your estate, a trust, or any person(s) you designate. You may change your *beneficiary(ies)* at any time by contacting the Shell Benefits Service Center and requesting a "Beneficiary Designation" form, or you may designate your *beneficiary(ies)* online via NetBenefits.

Please note that the *beneficiary(ies)* designation must be on record with the Shell Benefits Service Center to be valid.

Filing a Claim

To file a claim under the Group Life Insurance Program, you or your *beneficiary(ies)* must contact the Shell Benefits Service Center at 1-800-30-SHELL.

Settlement Options

Payment can be made in a lump sum or in installments. MetLife pays benefits to the *beneficiary(ies)* as soon as possible after it receives the required proof of death and the *beneficiary(ies)'s* claim for benefits.

Exclusion and Limitations

There are no exclusions or limitations other than the maximum coverage limits previously discussed.

Tax Considerations

The law provides that, with certain exceptions, your gross income must include the cost of any group term life insurance policy more than $50,000 that you purchase, to the extent that the cost exceeds any amount you pay toward the purchase of insurance. This income is taxable for purposes of federal income tax and Social Security tax. Based upon current group life insurance rates and IRS Table I rates, the Group Life Insurance Program is not currently subject to this provision. You will be advised of any change impacting the tax consideration of your group life insurance coverage.

Events Affecting Coverage

Employment Events

- **Leaves of absence (disability, personal and military):** If you are on a leave of absence, your benefits may be impacted (see "Leaves of Absence" on page J-15).
- **Change in number of hours worked:** If your employment status changes to *part-time employee* (less than 20 hours per week), your coverage ends. Conversely, if your employment status changes from *part-time employee* to *regular part-time employee* or *regular full-time employee*, you become eligible to participate in the Group Life Insurance Program, effective on the date of your change in status. You can enroll at any time once you are eligible. You only can enroll without providing evidence of insurability to MetLife if you enroll within 31 days after your eligibility date.
- **Layoff or termination:** If your employment is terminated, your coverage ends on the last day of the month in which your employment ends. However, you may convert your group life insurance coverage to an individual policy (see "Active Group Life Insurance Portability" below and "Active Group Life Insurance Conversion Privilege" on page I-10). If you are totally disabled on the date your employment ends and you die within one year, a death benefit may be payable.
- **Retirement:** Active group life insurance for you and your spouse or *domestic partner* and *child(ren)* ends on the last day of the month in which you retire. You may convert your group life insurance to an individual policy (see "Active Group Life Insurance Portability" below and "Active Group Life Insurance Conversion Privilege" on page I-10).

  Note: If you are enrolled in *retiree* group life insurance and want information about continuing your coverage in retirement, contact MetLife at 1-844-510-1937.

Plan Amendment or Termination

Your coverage changes or ends on the date this program is amended or terminated.

Active Group Life Insurance Portability

Portability enables participants to continue coverage lost after termination of employment. Portability conditions are generally more favorable than what is typically available through the conversion of coverage provisions. Portability is available for *employee*, spouse or *domestic partner*, and *child(ren)* coverage. (Portability is not available for *retiree* group life insurance or through the Survivor Benefit Program.)

You must complete and send a Group Life Insurance portability form to MetLife within 31 days from the date that benefits were terminated. You can obtain a portability form from the Shell Benefits Service Center at 1-800-30-SHELL.

The same or lesser amounts of coverage in force and lost at termination may continue under portability up to a maximum of $1,000,000.

Coverage for...	Minimum portable coverage amount is...	Maximum duration of portable coverage is
Employee	$20,000	January 1st of the year you reach age 80. You may convert the reduced or terminated portable amounts to an individual life insurance policy.
Spouse or *domestic partner*	$10,000	The date that your spouse or *domestic partner* reaches age 70. You can convert the terminated amounts to an individual life insurance policy.
Eligible *Child(ren)*	$1,000	To age 23, subject to state requirements.

Portable coverage for handicapped dependent *child(ren)* may be extended beyond the limiting age (age 23) provided the *child(ren)* is physically or mentally incapable of self-sustaining employment. A "Statement of Dependent Eligibility Beyond Limiting Age" form must be completed and submitted to MetLife within 31 days after the eligible *child(ren)* attains the limiting age.

Active Group Life Insurance Conversion Privilege

If your employment terminates, you can convert your existing active Group Life Insurance Program coverage and any coverage for your spouse or *domestic partner* to another form of life insurance, other than term life insurance, which is available through MetLife. Rates for such individual policies depend on the type of insurance selected and the age and risk factors of the insured individual. You can obtain a conversion form from the Shell Benefits Service Center which will provide you with the information you need to contact MetLife. You must complete your conversion application with MetLife within 31 days from the date your Group Term Life coverage ends.

Voluntary Personal Accident Insurance

The Voluntary Personal Accident Insurance (VPAI) Program, which is also underwritten by MetLife, allows you to purchase insurance for yourself and your family to provide a benefit in the event of accidental death, dismemberment, or paralysis.

Participation

Eligibility

You are eligible to participate in the VPAI Program if you are a *regular full-time* or *regular part-time employee* of a *participating company*. You may also purchase insurance under this program for your spouse or *domestic partner*, or your eligible *child(ren)*.

Enrollment

You may enroll in the VPAI Program:

- Within 31 days after your hire date, or
- During the *group annual enrollment period*.

Contact the Shell Benefits Service Center at 1-800-30SHELL to enroll or ask questions about your eligibility.

If you are an *employee* who is newly eligible to enroll in the VPAI Program due to an increase in your number of hours worked (20 or more hours per week), you may do so within 31 days after your eligibility date. Your coverage takes effect as of your hire date or eligibility date.

If both you and your spouse/*domestic partner* are eligible to participate in the VPAI Program as *employees* of a *participating company*, then:

- Each of you may enroll in Program Level I Employee-Only coverage, or
- One of you may enroll in Program Level II Employee and *Family coverage*.

If you do not enroll within 31 days of your hire date or eligibility date, you cannot enroll until the next *group annual enrollment period*; however, if you elected Program Level I Employee-Only coverage, you could change to Program Level II coverage if you marry or add *child(ren)* during the year. Requests to make this change must be made within 31 days after the *qualified status change* (see the Glossary on page M-8). Coverage takes effect as of the date of the election.

Changing Coverage

You may only change your coverage each year during the *group annual enrollment period* or if you experience a *qualified status change*. See page M-8 for information on what constitutes a *qualified status change*.

If you have a *qualified status change*, you may change your coverage only if:

- Your change in coverage is consistent with the *qualified status change* event (except with respect to *qualified status changes* that are considered special enrollment rights), and
- You submit your request to change your coverage:
  - Within 31 days after the *qualified status change*, or
  - Within 90 days after the birth or adoption of a child, or
  - Within 60 days from the date of determination for loss of coverage under Medicaid or State Children's Health Insurance Program (SCHIP), or eligibility for a premium assistance subsidy under Medicaid or SCHIP.

Changes in coverage are effective on the date of the *qualified status change*.

Types of Coverage

The VPAI Program provides you with coverage for accidental death, dismemberment, or paralysis 24 hours a day, 365 days a year, on and off the job.

Cost

When purchasing VPAI Program coverage, you can take advantage of group insurance rates, which are typically lower than individual policy rates. The amount you pay depends on the program and level of coverage you choose. You have two program options:

- Program Level I Employee-Only coverage, and
- Program Level II Employee and *Family coverage*.

You pay the entire cost of coverage under the VPAI Program through monthly payroll deductions. Your election to participate in the program is also your election to pay your premiums by pre-tax payroll deductions.

Contributions for Program Level II coverage applicable to your *domestic partner* are made on an after-tax basis on account of federal tax law.

Benefit Amount

The benefit amount you receive under the VPAI Program depends on the program and level of coverage you choose.

If you select Program Level I Employee-Only coverage, you may select a benefit amount of up to 10 times your annual base pay, to a maximum benefit of $1,000,000. For *regular part-time employees*, base pay is based upon your *standard hours election* and your part-time hourly rate.

If you elect Program Level II Employee and *Family coverage*, you may select a benefit amount of up to 10 times your annual base pay, to a maximum benefit of $1,000,000. The benefit amount for your dependent(s) is a percentage of your own coverage and depends on your family's composition at the time of the loss, as follows:

If you elect employee and family coverage and have...	Your spouse's or domestic partner's eligible benefit is...	Each child's eligible benefit is...
A spouse or *domestic partner* only	70% of your benefit amount	Not applicable
Child(ren) only	Not applicable	25% of your benefit amount
A spouse or *domestic partner* and *child(ren)*	60% of your benefit amount	15% of your benefit amount

Schedule of Benefits

If, as the result of a covered accident, you or your covered dependent(s) die or suffer a loss (as described below) within 365 days after the date of that accident, you or your *beneficiary(ies)* receive the benefit described in the chart below. The benefit is based upon the benefit amount for which the person who suffered the loss was insured on the date of the injury.

Covered dependent(s) receive a percentage of the benefit shown, as listed below. If your covered *child(ren)* suffers a loss of a hand, foot, arm, or leg, the percentage used to calculate the benefit amount will be twice the percentage used to calculate your benefit amount for that same loss.

If you or your covered dependent(s) suffer more than one loss described below in a single accident, MetLife will pay for each loss, but not to exceed the full benefit amount.

Loss Suffered	For You: Percent of Your Benefit Amount	For Your Spouse or Domestic Partner: Percent of Their Benefit Amount	For Your Child(ren): Percent of Their Benefit Amount
Loss of Life	100%	100%	100%
Loss of Hand	50%	50%	100%
Loss of Foot	50%	50%	100%
Loss of Arm	50%	50%	100%
Loss of Leg	50%	50%	100%
Loss of Sight of One Eye	50%	50%	50%
Loss of Any Combination of Hand, Foot or Sight of One Eye	100%	100%	100%
Loss of Thumb and Index Finger of Same Hand	25%	25%	25%
Loss of Speech and Hearing	100%	100%	100%
Loss of Speech or Hearing	50%	50%	50%
Loss of Hearing in One Ear	25%	25%	25%
Paralysis of Both Arms and Both Legs	100%	100%	100%
Paralysis of Both Legs	100%	100%	100%
Paralysis of the Arm and Leg on Either Side of the Body	100%	100%	100%
Paralysis of One Arm or Leg	50%	50%	50%
Brain Damage	100%	100%	100%
Coma	2% Monthly up to 50 Months	2% Monthly up to 50 Months	2% Monthly up to 50 Months

Loss means:

- **For a hand or foot** — a hand or foot severed at or above the wrist or ankle joint, but below the elbow or knee.
- **For sight** — permanent and uncorrectable loss of sight in an eye (visual acuity must be 20/200 or worse in the eye or the field of vision must be less than 20 degrees).
- **For speech or hearing** — entire and irrecoverable loss of the function that continues for six consecutive months following the accidental injury.
- **For thumb and index finger** — severance through or above the metacarpophalangeal joints.
- **For quadriplegia** — complete, irreversible paralysis of both arms and both legs.
- **For paraplegia** — total paralysis of both legs.
- **For hemiplegia** — total paralysis of both an arm and a leg on one side of the body.

Paralysis means loss of use, without severance, of an arm or a leg and the hand and foot attached to it that is determined by competent medical authority to be permanent, complete, and irreversible (paralysis of a limb refers to paralysis of an arm or leg that is not the result of quadriplegia, paraplegia, or hemiplegia).

Brain damage means permanent and irreversible physical damage to the brain causing the complete inability to perform all of the substantial and material functions and activities normal to everyday life. Such damage must manifest itself within 120 days of the accidental injury, require a hospitalization of at least seven days and persist for 12 consecutive months after the date of the accidental injury.

Exposure and Disappearance Coverage

Benefits are paid for covered losses that occur due to exposure to the elements. In addition, death benefits may be paid if the covered person's body is not found within one year after the conveyance in which he or she was traveling disappeared, sank, wrecked, or made a forced landing and was stranded; or within one year of the date the person was reported missing to the authorities.

Coma

If you or your covered dependent(s) lapses into a coma within 365 days after a covered accidental injury and are continuously comatose for at least 31 consecutive days, the monthly benefit is 2% of the benefit amount minus any additional amount paid or payable as the result of another loss sustained from the same accident. Benefits end after benefit payments are made for a maximum of 50 months or the date the coma ended, whether by death, recovery, or any other change of condition, whichever occurs first.

Common Disaster Benefit (Program Level II Coverage Only)

If both you and your spouse or *domestic partner* die, either in the same covered accident or in different covered accidents that occur within 24 hours of each other, your spouse's or *domestic partner's* benefit amount is increased to 100% of the benefit amount for which you were insured on the date of the accident.

Special Benefits

Seat Belt Benefit

If you or your covered dependent(s) dies as the result of a covered accidental injury that occurs while driving or riding in a private passenger car, the VPAI Program pays a seat belt benefit equal to 10% of the benefit amount, up to $50,000, with a minimum benefit of $1,000, for which the person was insured. This benefit is paid only if the official accident report verifies that the covered person's seat belt was properly fastened. This benefit is in addition to all other benefits that may be paid.

Air Bag Benefit

If you or your covered dependent(s) dies as the result of a covered accidental injury that occurs while driving or riding in a private passenger car, the VPAI Program pays an air bag benefit equal to 10% of the benefit amount, up to $50,000, with a minimum benefit of $1,000, for which the person was insured. This benefit is paid only if the official accident report verifies that the covered person's seat belt was properly fastened at the time of the accident and the vehicle in which the deceased was traveling was equipped with functioning air bags. This benefit is in addition to all other benefits that may be paid.

Hospital Confinement Benefit

If you or your covered dependent(s) is involved in a covered accident that results in hospitalization, the VPAI Program pays a monthly *hospital* confinement benefit of 1% of the benefit amount up to $2,500 a month, for a maximum of 12 months, during the period of hospitalization. This benefit is payable following a four-day elimination period.

Rehabilitation Benefit

If you or a covered dependent(s) suffers dismemberment or paralysis as the result of a covered accidental injury, the VPAI Program pays the lesser of:

- The actual charge for the rehabilitation,
- 50% of the full amount of the VPAI Program benefit, or
- $10,000.

This benefit is payable on a quarterly basis when proof is provided showing therapy charges have been paid.

Child Care Benefit (Program Level II Coverage Only)

If you or your spouse or *domestic partner* dies as the result of a covered accidental injury, the VPAI Program pays a child care benefit equal to 5% of your benefit amount, up to $7,500 per year, on behalf of any eligible *child(ren)* who is under age 13. This benefit is in addition to all other benefits that may be paid.

To receive this benefit, your *child(ren)* must be enrolled in a state-licensed day care center on the date of your, your spouse's or *domestic partner's* death, or they must enroll within 365 days after your, your spouse's or *domestic partner's* death.

This benefit is payable quarterly upon receipt of proof that child care center charges have been paid, for a maximum of four consecutive years, as long as your *child(ren)* continues to be enrolled in a state-licensed day care center or until his or her 13th birthday, whichever occurs first.

If you have no dependent *child(ren)* who qualifies for this benefit on the date of your accident, an additional benefit of $2,500 is paid to your designated *beneficiary(ies)*.

Child Education Benefit (Program Level II Coverage Only)

If you or your spouse or *domestic partner* dies as the result of a covered accidental injury, the VPAI Program pays a child education benefit equal to 10% of your benefit amount, up to $20,000 per year, to any eligible *child(ren)* who:

- Was enrolled as a full-time student in an institution of higher learning at the time of your, your spouse's or *domestic partner's* death, or
- Was in 12th grade and enrolls in an institution of higher learning within 365 days of your, your spouse's or *domestic partner's* death.

This benefit is payable semiannually upon receipt of proof that tuition charges have been paid, for a maximum of four consecutive years, as long as your *child(ren)* is a full-time student. It is in addition to all other benefits that may be paid.

If you have no dependent *child(ren)* who qualifies for this benefit on the date of your accident, an additional benefit of $2,500 is paid to your designated *beneficiary(ies)*.

Spouse/Domestic Partner Retraining Benefit (Program Level II Coverage Only)

If you die as the result of a covered accidental injury, your spouse or *domestic partner* is reimbursed for the cost, up to $25,000, of any licensed professional or trade school training programs he or she enrolls in, as long as:

- Enrollment takes place within one year after your death and expenses are incurred within two years after the date of the loss,
- Expenses are incurred for tuition and training materials, and
- He or she completes the program for which he or she enrolled successfully.

This benefit is paid semiannually upon receipt of proof that incurred tuition charges have been paid, for up to two academic years.

If you do not have a spouse or *domestic partner* who qualifies for this benefit on the date of your accident, an additional benefit of $2,500 is paid to your designated *beneficiary(ies)*. This benefit is in addition to all other benefits that may be paid.

Extended Dependent Coverage for Surviving Dependent(s) (Program Level II Coverage Only)

If you die as the result of a covered accidental injury, the VPAI Program pays your spouse or *domestic partner* a monthly survivor benefit equal to 1% of your benefit amount for six consecutive months after your death, up to $25,000.

Total Disability Premium Waiver

Under the VPAI Program, your premiums are waived and coverage may continue if you are considered totally disabled and meet the following conditions:

- The total disability resulted from a covered accidental injury,
- The total disability began while you were covered under the program,
- You are totally disabled for 180 continuous days,
- You are unable to perform the substantial and material duties of your regular occupation, and
- You are under the care and supervision of a licensed *physician* or surgeon.

If you meet all of the described conditions, your premiums will continue to be waived and coverage may continue until one of the following occurs:

- You fail to submit the required proof of continuous disability,
- You recover,
- You reach age 65 if you became disabled before age 60,
- Five years elapsed since the beginning of the disability, if you became disabled at or following age 60, or
- The master contract is terminated.

Medical Premium Assistance

If you are involved in a covered accident and suffer bodily injury that results in the termination of your employment and you are not entitled to any *Company* subsidy toward medical coverage, you are paid a total benefit equal to 5% of your full benefit amount, up to $1,000 a month (annual maximum of $12,000).

This benefit is paid for a maximum of 18 months, as long as you:

- Continue to make payments for the *Company's* medical coverage (under COBRA) beyond the time coverage would otherwise end, and
- Are not covered under another medical plan.

If you are injured or die in a covered accident and your dependent(s) continue participating in a *Company*-sponsored medical plan without any *Company* subsidy toward medical coverage under COBRA, a benefit equal to 5% of the full benefit amount, up to $1,000 a month (annual maximum of $12,000), is payable to your spouse or *domestic partner*, or your child's legal guardian if your spouse or *domestic partner* is not living at the time of your death, for a maximum of 18 months.

Your dependents will be required to provide proof that:

- They have elected to continue their coverage under COBRA, and
- Premiums have been paid.

Applying for Benefits

Payment of Benefits

If you or your covered dependent(s) suffers accidental death, dismemberment, or paralysis, benefits are paid to the *beneficiary(ies)* you named. If there is no *beneficiary(ies)* designated or no surviving *beneficiary(ies)* at your death, MetLife may determine the *beneficiary(ies)* to be one or more of the following who survive you:

- Your spouse or *domestic partner*,
- Your *child(ren)*,
- Your parent(s),
- Your sibling(s), or
- Your estate.

If a *beneficiary(ies)* or a payee is a minor or incompetent to receive payment, MetLife will pay that person's guardian.

In the event of loss of life, benefits are paid to your named *beneficiary(ies)*. Any other loss for you or your dependent(s), including dismemberment and paralysis, is paid to you.

Naming a Beneficiary

It's important that you name a *beneficiary(ies)* to receive your VPAI benefit in the event of your death. Your *beneficiary(ies)* may be your estate, a trust, or any person(s) you designate. You may change your *beneficiary(ies)* at any time by contacting the Shell Benefits Service Center and requesting a "Beneficiary Designation" form, or you may designate your *beneficiary(ies)* online via NetBenefits.

Please note that the *beneficiary(ies)* designation must be on record with the Shell Benefits Service Center to be valid.

Filing a Claim

To file a claim under the VPAI Program, contact the Shell Benefits Service Center to obtain a claim form and assistance with submitting the form to MetLife.

Exclusions and Limitations

VPAI Program benefits are not paid for any loss caused by, contributed to, as a consequence of, or that results from any of the following risks, even though the proximate and precipitating cause of the loss may be accidental bodily injury:

- Physical or mental illness or infirmity, or the diagnosis or treatment of such illness or infirmity.
- Infection, other than infection occurring in an external accidental wound.
- Suicide or attempted suicide, while sane or insane; intentionally self-inflicted injuries; or any attempt to inflict such injuries.
- Service in the armed forces of any country or international authority, except the United States National Guard.
- Travel in an aircraft for the purpose of parachuting or otherwise exiting from such aircraft while it is in flight.
- Parachuting or otherwise exiting from an aircraft while such aircraft is in flight, except for self preservation.
- Losses incurred while committing or attempting to commit a felony.
- Losses incurred while under the influence of unprescribed drugs or alcohol.
- Losses incurred during the voluntary intake of poison, gas, or fumes.

Events Affecting Coverage

Employment Events

- **Leaves of absence (disability, personal and military):** If you are on a leave of absence, your benefits may be impacted (see "Leaves of Absence" on page J-15).
- **Change in number of hours worked:** If your employment status changes to *part-time employee* (less than 20 hours per week), your coverage ends. Conversely, if your employment status changes from *part-time employee* to *regular part-time employee* or *regular full-time employee*, you become eligible to participate in the VPAI, effective on the date of your change in status.
- **Layoff, termination or retirement:** If you are laid off due to lack of work or if your employment is terminated, your coverage ends immediately. However, you may be able to continue coverage (see "Total Disability Premium Waiver" on page I-16).

Loss of Dependent(s) Eligibility

Coverage for your covered dependent(s) ends when your insurance ends or on the date your dependent(s) no longer qualifies as a dependent, whichever occurs first.

VPAI Program Plan Amendment or Termination

Your coverage changes or ends on the date this program is amended or terminated.

Business Travel Accident Insurance

This *Company*-paid insurance, which is underwritten by MetLife, provides financial protection if you, your *eligible dependent(s)*, or guests are dismembered or die while traveling on *Company* business.

Participation

Eligibility

You are eligible for coverage under the Business Travel Accident Insurance (BTAI) Program if you are a *regular full-time* or *regular part-time employee* of a *participating company*.

Coverage is also available for eligible guests and your spouse, *domestic partner*, or eligible *child(ren)*. Coverage for you will begin when you leave your regular place of employment, your residence or other location, whichever occurs last, for the purpose of traveling to the destination that is the object of your business travel. Your BTAI coverage ends when you return to or arrive at your residence or your regular place of employment (whichever occurs first).

Coverage for your dependent(s) or guests will begin when your dependent(s) or guest leaves his or her residence or other location, whichever occurs last, for the purpose of traveling to the destination that is the object of your business travel. Your dependent(s)' (or guest's) coverage ends when he or she returns to or arrives at his or her residence or when you arrive at your regular place of employment (whichever occurs first).

Enrollment

If you are eligible to participate in the BTAI Program, you are automatically enrolled for coverage as of your hire date. If you are a *regular part-time employee* who is newly eligible to participate in the BTAI Program, you are automatically enrolled for coverage as of your eligibility date.

Cost

The *Company* pays the entire cost of coverage under the BTAI Program.

Types of Coverage

The BTAI Program provides you with coverage 24 hours a day, 365 days a year, during business travel. This includes travel by train, airplane, automobile, or other private or public means of transportation, as well as coverage while you are on business travel assignment, including travel to, from and in the airport, and being struck by aircraft, military transport, and during war, whether declared or undeclared, or acts of war, insurrection, rebellion, riot, or terrorist acts.

During airplane business travel, you are covered if you are traveling in an aircraft (whether in commercial service or *Company*-owned, leased, controlled, or chartered) as a passenger, crew member, co-pilot, or pilot. However, coverage when you are traveling as a crew member, co-pilot, or pilot must be approved by the *Company*.

Commuting to and from your normal work location is not covered under the program, although *Company*-provided transportation to offshore facilities by boat, seaplane, or helicopter is covered.

Business Travel

Depending upon the covered accident, traveling on business does not include:

- Travel between your residence and regular place of employment.
- Regular driving assignments for truck drivers, delivery persons, chauffeurs, and other commercial drivers employed by the *Company*.
- Leaves of absence.
- Vacations.
- Personal deviations.
- Travel to, from and within Afghanistan and Iraq.
- War or acts of war occurring in Afghanistan, Iraq, the U.S., its territories and possessions, and the covered person's domicile.

Personal Trip Coverage

While on business travel, the BTAI Program also covers you on personal trips of no more than 14 days that take place more than 100 miles from your primary place of residence or regular place of employment and not done during chargeable vacation time or leaves of absence. For example, vacation time added to a business trip would not be covered under the BTAI Program.

Change in Location/Regular Place of Employment

MetLife considers your regular place of employment to have changed and your business travel to have ended if you are expected to remain in the location to which you have traveled for more than 30 days or if MetLife deems the new location to be your regular place of employment.

If you remain in one location for more than 30 days, as of the 31st day, your new location will be considered your regular place of employment. BTAI coverage would no longer apply to an accidental injury sustained in that new regular place of employment. However, if you travel on business from that new regular place of employment, BTAI coverage would apply to the new trip

Exposure and Disappearance Coverage

You and your *eligible dependent(s)* are also covered for losses that occur as the result of unavoidable exposure to the elements, where the exposure is a direct result of a covered accident independent of other causes.

In addition, death benefits may be paid if your or your *eligible dependent(s)'s* body is not found within one year of the date when:

- The aircraft or other vehicle in which you were traveling on business for which coverage is provided under a covered accident was scheduled to have arrived at its destination, and the conveyance is operated by a common carrier.
- The aircraft or other vehicle in which you were traveling disappears, sinks, is stranded, or wrecked.
- You or your *eligible dependent(s)* is reported missing to the authorities if traveling in any other aircraft or vehicle.

Benefit Amount

Employees

Your BTAI Program benefit equals 1 times your annual base pay, but not less than $50,000. For *regular part-time employees*, pay is based upon your *standard hours election* and your part-time hourly rate. The maximum benefit amount is $300,000.

Dependent Spouse, Domestic Partner and Child(ren)

Your dependent spouse or *domestic partner* is covered for $50,000 and your covered *child(ren)* is covered for $10,000. Your dependent(s) is covered only while traveling for the purpose of accompanying or joining you when you are traveling on *Company* business.

Company Guests

Guests traveling at the invitation of the *Company* and whose expenses are paid by the *Company* are covered for $50,000 if they are dismembered or die in an accident during that trip.

Aggregate Maximum

MetLife will not pay more than $3,000,000 for all covered losses and injuries sustained by all insured persons under the BTAI Program as a result of any one covered accident or series or combination of covered accidents directly arising out of the one or more associated events. Events are associated if they have a common cause or are a chain of events forming part of a larger or broader event, even if the individual events themselves are separate in time and place.

If the total amount claimed by all insured persons is greater than this amount, the amount MetLife will pay to each insured person will be reduced in the same proportion, so the total amount does not exceed the $3,000,000 maximum. All accidents are reviewed separately and will stand on their own merit.

Schedule of Benefits

If you, your *eligible dependent(s)*, or guest(s) dies as the result of a covered accident while traveling on *Company* business, the BTAI program pays 100% of each covered person's applicable program benefit or principal sum to your *beneficiary(ies)*.

If, however, any injury due to a covered accident occurs, the BTAI Program pays a benefit for the following losses:

Loss Suffered	Benefit Paid
Both hands or both feet	100% of principal sum
Sight in both eyes	100% of principal sum
One hand and one foot	100% of principal sum
Speech and hearing in both ears	100% of principal sum
Total and permanent disability	100% of principal sum
Either arm or leg	75% of principal sum
Either hand or foot	75% of principal sum
Sight in one eye	50% of principal sum
Speech or hearing in both ears	50% of principal sum
Thumb and index finger of the same hand	25% of principal sum

Loss means:

- **For sight:** Permanent and uncorrectable loss of sight in the eye. Visual acuity must be 20/200 or worse in the eye or the field of vision must be less than 20 degrees.
- **For speech/hearing:** A loss of speech/hearing continuing for six consecutive months after which a *physician* must determine the loss to be entire and irrevocable.
- **For thumb and index finger of the same hand:** The thumb and index finger are severed permanently through or above the third joint from the tip of the index finger and the second joint from the tip of the thumb.

The benefit for total and permanent disability is paid in monthly installments of 1%, beginning after 12 consecutive months of disability, up to a maximum of 60 months, with the balance of the full amount, if any, paid in a lump sum. This benefit does not apply to your covered dependents(s) or guests.

Paralysis

If you become paralyzed within 365 days of a covered accident, a BTAI Program benefit is paid as follows:

Extent of Paralysis	Benefit Paid
Quadriplegia (no movement in both upper and lower limbs)	100% of principal sum
Paraplegia (no movement of both lower limbs)	100% of principal sum
Hemiplegia (no movement of both upper and lower limbs of one side of the body)	100% of principal sum

Coma

If you, your *eligible dependent(s)*, or guest(s) lapses into a coma as the result of a covered accident, the BTAI program benefit is 1% of the principal sum. This amount is paid monthly, beginning on the seventh day of your coma. Benefits end after 100 months or upon your death, whichever is earlier.

Coma means a state of deep and total unconsciousness from which the comatose person cannot be aroused. Such state must begin within 30 days of the accidental injury and continue for seven consecutive days.

Special Benefits

Seat Belt Benefit

If you, your *eligible dependent(s)*, or guest(s) dies or is injured during business travel, the BTAI Program pays a seat belt benefit equal to 10% of the benefit amount, up to $25,000, with a minimum benefit of $1,000. This benefit is paid only if the official accident report verifies that the covered person's seat belt was properly fastened. This benefit is in addition to all other benefits that may be paid.

Air Bag Benefit

If you, your *eligible dependent(s)*, or guest dies as a result of an accidental injury sustained in a covered accident, the BTAI Program also pays an air bag benefit equal to 5% of the benefit amount, up to $10,000, with a minimum benefit of $1,000. This benefit is paid only if the official accident report verifies that the covered person's seat belt was properly fastened and the vehicle in which the deceased was traveling was equipped with functioning air bags. This benefit is in addition to all other benefits that may be paid.

Child Care Benefit

If you or your spouse or *domestic partner* dies as the result of a covered accident, the BTAI Program pays a child care benefit equal to the child care center charges incurred for a period of up to four consecutive years, not to exceed an annual maximum of $5,000 and an overall maximum of 20% of your benefit amount per child, on behalf of any eligible *child(ren)* who is under age 13. This benefit is in addition to all other benefits that may be paid.

To receive this benefit, your eligible *child(ren)* must be enrolled in a state-licensed day care center on the date of your death or must enroll within 365 days after your death. MetLife may require proof of your *child(ren)'s* continued enrollment in a child care center during the period for which a benefit is being claimed.

MetLife will pay this benefit quarterly once proof the child care center charges have been paid is received. Payment will be made to the person paying the charges on behalf of your *child(ren)*. If you have no eligible *child(ren)* who qualifies for this benefit on the date of your or your spouse or *domestic partner's* death, MetLife will pay $1,000 to your designated *beneficiary(ies)*. If your eligible *child(ren)* later qualifies for this benefit, MetLife will deduct the amount paid from any future payment.

Hospital Confinement Benefit

The BTAI program will pay an additional benefit of $2,000 if:

- A covered guest is confined in a *hospital* as a result of an accidental injury sustained in a covered accident,
- MetLife has paid a benefit for a covered loss resulting from that injury,
- This benefit is in effect on the date of the injury, and
- The confinement occurs within 12 months of the covered accident.

MetLife will only pay benefits for one period of continuous confinement for any accidental injury. That period will be the first period of confinement that qualifies for payment.

Applying for Benefits

Payment of Benefits

In the event of loss of life, BTAI program benefits are paid to the named *beneficiary(ies)*.

If a *beneficiary(ies)* or a payee is a minor or incompetent to receive payment, MetLife will pay that person's guardian. If there is no *beneficiary(ies)* designated or no surviving *beneficiary(ies)* at your death, MetLife may determine the *beneficiary(ies)* to be one or more of the following who survive you:

- Your spouse or *domestic partner*,
- Your *child(ren)*,
- Your parent(s),
- Your sibling(s), or
- Your estate.

For any other loss for you or your dependent(s), including dismemberment or paralysis, benefits are paid to you.

Naming a Beneficiary

It's important that you name a *beneficiary(ies)* to receive your BTAI benefit in the event of your death. Your *beneficiary(ies)* may be your estate, a trust, or any person(s) you designate. You may change your *beneficiary(ies)* at any time by contacting the Shell Benefits Service Center and requesting a "Beneficiary Designation" form, or you may designate your *beneficiary(ies)* online via NetBenefits.

Please note that the *beneficiary(ies)* designation must be on record with the Shell Benefits Service Center to be valid.

Filing a Claim

To file a claim under the BTAI program, you or your *beneficiary(ies)* must contact the Shell Benefits Service Center at 1-800-30-SHELL (1-800-307-4355). The Shell Benefits Service Center will provide you with a claim form and assistance in filing your claim.

Exclusions and Limitations

The BTAI Program does not cover losses resulting from any of the following:

- Physical or mental illness or infirmity, or the diagnosis or treatment of such illness or infirmity.
- Suicide or attempted suicide.
- Intentionally self-inflicted injury.
- Infection, other than infection occurring in an external accidental wound or from accidental food poisoning.
- Participation in hazardous activities such as scuba diving, bungee jumping, skydiving, hang gliding, ballooning, drag racing, driving a car fitted for competitive racing, aerial hunting, aerial skiing, or travel in an aircraft for the purpose of parachuting or otherwise exiting an aircraft while the aircraft is in flight except for the purpose of self-preservation.
- Service in the armed forces of any country or international authority, except the United States National Guard.
- Any nuclear reaction or release of nuclear energy. This includes the radioactive, toxic, explosive or other hazardous or contaminating properties of radioactive matter.
- The emission, discharge, dispersal, release, or escape of any solid, liquid, or gaseous chemical or biological agent.
- Any incident related to travel in an aircraft (as a pilot, crew member, flight student or while acting in any capacity other than as passenger and parachuting or otherwise exiting from such aircraft while the aircraft is in flight except for the purpose of self-preservation) that:
  - Does not have a valid Certification or Airworthiness,
  - Is not flown by a pilot with a valid license to operate that aircraft,
  - Is a device used for: testing or experimental purposes, by or for any military authority, for travel or designed for travel beyond the earth's atmosphere, for crop dusting, spraying or seeding, for fire fighting, for skydiving, for hang gliding, for pipeline or power inspection, for sky writing, for aerial photography or exploration, for racing, endurance tests, stunt or acrobatic flying, or for any use that requires a special permit from the Federal Aviation Administration.
- Travel to, from, and within the following countries: Afghanistan and Iraq.
- War, whether declared or undeclared; or act of war, insurrection, rebellion, riot or Terrorist Act.
- For any loss if the injured party is intoxicated at the time of the incident and is the operator of a vehicle or other device involved in the incident.
- For any loss caused or contributed to by the injured party committing or attempting to commit a felony.
- For any loss caused by or contributed to by a covered person's voluntary intake or use by any means of:
  - Any drug, medication, or sedative, unless it is taken or used as prescribed by a *physician*, or an over-the-counter drug, medication, or sedative taken as directed,
  - Alcohol in combination with any drug, medication, or sedative, or
  - Poison, gas, or fumes.

Events Affecting Coverage

Employment Events

- **Change in number of hours worked:** If your employment status changes to *part-time employee* (less than 20 hours per week), your coverage ends. Conversely, if your employment status changes from *part-time employee* to *regular part-time* or *regular full-time employee*, you automatically begin participation in the BTAI, effective on the date of your change in status.
- **Layoff, termination or retirement:** If you are laid off due to lack of work, if your employment is terminated or if you retire, your coverage ends when your employment terminates.

BTAI Program Amendment or Termination

Your coverage changes or ends on the date this program is amended or terminated.

Other Protection Programs

Table of Contents

We recognize that you have important responsibilities and commitments outside of work. To help support you with life's everyday challenges, the *Company* offers programs that provide additional resources and protection for you and your family.

Back-Up Care Program

To support working families, we offer the Back-Up Care Advantage Program®, which provides temporary solutions when normal care arrangements for your child or adult/elder dependent are unavailable. This benefit is offered through Bright Horizons.

Participation

Eligibility

The Back-Up Care Advantage Program is available across the United States for active *employees* who are *regular full-time* or *regular part-time employees* of a *participating company*. Back-Up Care Advantage Program dependents are defined as:

- **Child:** Your natural or legally adopted child, your stepchild who resides with you and is wholly dependent upon you for support and maintenance, or children of *domestic partners*, and
- **Adult/Elder:** Your spouse/*domestic partner*, your parent and your spouse's/*domestic partner's* parent or your grandparent and your spouse's/*domestic partner's* grandparent.

How the Program Works

The Back-Up Care Advantage Program is a voluntary benefit that gives you 24-hour access to a team of Back-Up Care Consultants. Consultants will find and schedule center-based or in-home care on your behalf.

Back-up care offers valuable support for a range of needs, including:

- Your regular caregiver, or spouse or *domestic partner* is unavailable.
- Your child's regular care center or school is closed.
- You need assistance when recovering from illness or surgery.
- You have to travel on business or relocate to another city.
- Your loved one is mildly ill or recovering from surgery.

The program defines "mildly ill care" as care for an illness that is temporary and non- progressive in nature, where the dependent feels too ill to engage in normal activities and may need short rest periods until feeling better — but does not feel so ill that they need to stay in bed. Symptoms such as low-grade fever, diarrhea, a rash with fever, and ear infections are typical examples.

Please note that caregivers may not dispense prescription or over-the-counter medication directly to any care recipient. Medication administration requires an in-home health care professional, which will result in an additional fee being applied to the service. The *employee* will be responsible for the additional fee.

As an *eligible employee*, you receive a maximum of 15 days of back-up care per calendar year to use for your dependent(s) or self. The program allows for a combination of care arrangements (in-home and center-based), regardless of the type of care arrangement or the dependent(s) (including self-care) for whom they are used. The 15 days are cumulative over the contract year for each *employee*.

Excluded Activities

To ensure the safety of the dependent(s) and caregivers while care is being provided, certain activities are generally prohibited unless prior authorizations have been made. For example — during care, there can be no transportation in a private vehicle, no accompaniment to a body of water, and no leaving the authorized care premises or allowing visitors unless prior authorization of the *employee* and notification of Bright Horizons Family Solutions® (no authorized visitors may be under 18 years of age).

Cost

The *Company* subsidizes the cost of the program, and you only pay for care if you utilize the services. Bright Horizons Family Solutions® will bill you directly for the *copayment* amount and any additional fees. The subsidized *copayments* are as follows:

- $0 per hour per child for center-based care, and
- $4 per hour for up to three dependents for in-home care.

Additional fees could include:

- Evening, weekend and medical care.
- Medication administration by a Registered Nurse (RN) or Licensed Practical Nurse (LPN).

Note that benefits received under this program are subject to applicable taxes. Accordingly, the value of the *Company* subsidy you receive under this program is reported and treated as taxable income by the *Company* in accordance with applicable tax laws.

Out-of-Network Care

Out-of-Network Care is back-up care provided to a dependent by a caregiver identified and selected by an *eligible employee* outside the network. An *eligible employee* may use Out-of-Network Care only when authorized and where no other option for services in network is reasonably available.

Crisis Care

When activated, Crisis Care is back-up care provided to a dependent by a caregiver identified and selected by an *eligible employee* outside the network. Crisis Care is available only when activated, in its sole discretion, during national or local health emergencies (e.g., COVID-19 pandemic), natural disasters (e.g., hurricanes, floods, and wildfires), labor strikes (e.g., interruptions in public transportation) or other crisis events. The *Company's* liaison will be notified when Crisis Care is activated and deactivated.

The *employee* reimbursement rate shall be $100 for each date of care for Out-of-Network Care or Crisis Care. No other costs shall be paid or reimbursed in connection with use of Out-of-Network Care or Crisis Care.

Registering for Service

To begin using the Back-Up Care Advantage Program, register online at **backup.brighthorizons.com**. You can also register by phone at 1-877-BH-CARES (1-877-242-2737). See **HR Online > Policies and Benefits > My HR Policies > Policies and Benefits > My Balance > Backup Care for Children and Elders** for the initial user name and password.

Events Affecting Coverage

Employment Events

- **Leaves of absence (disability, personal and military):** If you are on a leave of absence, your benefits may be impacted (see "Leaves of Absence" on page J-15).
- **Change in number of hours worked:** If your employment status changes to *part-time employee* status, your coverage ends. Conversely, if your employment status changes from *part-time employee* to *regular part-time employee* or *regular full-time employee*, you become eligible to participate in the Back-Up Care Program, effective on the date of your change in status.
- **Layoff, termination or retirement:** If you are laid off due to lack of work or if your employment is terminated, your coverage ends immediately.

Back-Up Care Program Amendment or Termination

Your coverage changes or ends on the date this program is amended or terminated.

Group Legal Program

You may purchase coverage for certain personal legal services at a low monthly rate through MetLife Legal Plans, Inc.

Participation

Eligibility

You are eligible to purchase coverage under the Group Legal Program if you are a *regular full-time* or *regular part-time employee* of a *participating company*.

You may purchase:

- *Employee* coverage (regardless of your marital status) for yourself and your eligible child(ren), or
- *Family coverage* for yourself, your spouse or *domestic partner*, and your eligible child(ren).

Contact the Shell Benefits Service Center at 1-800-30SHELL to enroll or ask questions about your eligibility.

Enrollment

You may enroll in the Group Legal Program within 31 days after your hire date. Coverage remains in effect for the rest of the plan year. After the first 31-day period, you may not start or change coverage levels except during the *group annual enrollment period*.

If you enroll in the Group Legal Program during a *group annual enrollment period*, your coverage is effective for the entire plan year.

Cost

If you choose coverage under the Group Legal Program, you pay a monthly premium, which is deducted automatically from your pay on an after-tax basis. The enrollment materials you receive from the Shell Benefits Service Center will include the cost of coverage for you and your family.

Obtaining Legal Services

MetLife Legal Plans makes all determinations regarding attorneys' fees and what constitutes covered services. MetLife Legal Plans maintains a nationwide network of participating law firms. Lawyers in this network are called "plan attorneys."

To use the Group Legal Program, visit **www.legalplans.com** or call MetLife Legal Plans' Client Service Center at 1-800-821-6400. If you are a spouse, *domestic partner*, or an *eligible dependent(s)*, you will need the last four digits of the *employee's* Social Security number.

If you use the MetLife Legal Plans website at **www.legalplans.com**, click "Employee/Members Click Here," and provide the last four digits of the *employee's* Social Security number when prompted. If you use the Client Service Center, the client service representative will give you a case number, provide you with the telephone number of plan attorneys most convenient to you, and answer any questions you may have about the program.

Contact the plan attorney to discuss a legal matter over the phone or to schedule an appointment (evening and Saturday appointments are available). After you establish a relationship with your plan attorney, you may call him or her directly; however, either you or your plan attorney must obtain a case number for any new legal matter.

You can tell the client service representative that you want to use your own attorney. Also, in areas where there are no participating law firms, you will be asked to select your own attorney. In both of these circumstances, MetLife Legal Plans reimburses you for the actual fees incurred, up to the non-plan attorney's fees, in accordance with a fee schedule. (For a copy of the current fee schedule, contact MetLife Legal Plans.)

To obtain legal services, contact MetLife Legal Plans' Client Service Center at 1-800-821-6400, between 7:00 A.M. and 6:00 P.M. Central time, Monday through Friday. The Client Service Center is closed on holidays.

Covered Services

The Group Legal Program offers you prepaid legal assistance on a variety of personal matters, as described in this section:

- **If you purchase *employee* coverage:** "You" means you and your eligible child(ren), unless the description of the benefit excludes coverage of your eligible child(ren).
- **If you purchase *family coverage*:** "You" means you, your spouse or *domestic partner*, and your eligible child(ren), unless the description of the benefit excludes coverage for your spouse or *domestic partner*, or eligible child(ren).

Defense of Civil Lawsuits

Administrative Hearing Representation

This service covers you in defense of civil proceedings before a municipal, county, state, or federal administrative board, agency, or commission. Administrative hearing representation:

- Includes the hearing before an administrative board or agency over an adverse governmental action.
- Does not apply where services are available or are being provided by virtue of any form of insurance policy.
- Does not include family-law matters, post-judgment matters, or litigation of a job-related incident.

Civil Litigation Defense

This service covers you for arbitration proceedings or civil proceeding before a municipal, county, state, or federal administrative board, agency, or commission, or in a trial court of general jurisdiction. Civil litigation defense:

- Does not apply where services are available or are being provided by virtue of any form of insurance policy.
- Does not include family-law matters, post-judgment matters, matters with criminal penalties, or litigation of a job-related incident.
- Does not include bringing counterclaims, third party claims, or cross claims.

Incompetency Defense

This service covers you in the defense of any incompetency action, including court hearings when there is a proceeding to find you incompetent.

Identify Theft Defense

This service provides you with consultations with an attorney regarding potential creditor actions resulting from identity theft and attorney services as needed to contact creditors, credit bureaus, and financial institutions. It also provides defense services for specific creditor actions over disputed accounts. Identity theft defense services:

- Include limiting creditor harassment and representation in defense of any action that arises out of the identity theft such as foreclosure, repossession, or garnishment, up to and including trial, if necessary.
- Provide you with online help and information about identity theft and prevention.
- Do not include counter, cross, or third-party claims; bankruptcy; any action arising out of family-law matters, including support and post-decree issues; or any matter where the creditor is affiliated with the sponsor or employer.

Access to LifeStages Identity Management Services

The Group Legal Plan also includes LifeStages Identity Management, provided through Cyberscout, LLC. This service gives you access to both proactive services when you believe your personal data has been compromised, and resolution services to assist you in recovering from account takeover or identity theft. Lifestages resources include:

- Unlimited assistance to fix issues and handle notifications.
- Credit and fraud monitoring.
- Recovery and replacement assistance.

Tax Audits

This service covers reviewing tax returns and answering questions the IRS or state or local taxing authority has concerning your tax return; negotiating with the agency; advising you on necessary documentation; and attending an IRS or state or local taxing authority audit. The service does not include prosecuting a claim for the return of overpaid taxes or the preparation of any tax returns.

Immigration Assistance

This service covers advice and consultation, preparation of affidavits and powers of attorney, review of any immigration documents, and helping you prepare for hearings.

Criminal and Traffic Matters

Juvenile Court Defense

This service covers the defense of you and your dependent child(ren) in any juvenile court matter, provided there is no conflict of interest between you and your child(ren). In that event, this service provides an attorney for you only, including services for parental responsibility.

Traffic Ticket Defense

This service covers your representation in defense of any traffic ticket except driving-under-the-influence or vehicular homicide, including court hearings, negotiation with the prosecutor, and trial. Traffic ticket defense does not include representation for driving-under-the-influence or vehicular homicide.

Restoration of Driving Privileges

This service covers you with representation in proceedings to restore your driver's license.

Family Law

Name Change

This service covers you for all necessary pleadings and court hearings for a legal name change.

Premarital Agreement

This service covers the preparation of an agreement by you and your fiancé/partner prior to your marriage or legal union (where allowed by law), outlining how property is to be divided in the event of separation, divorce, or death of a spouse or *domestic partner*. Representation is provided only to you. Your fiancé/partner must have separate counsel or must waive representation.

Protection from Domestic Violence

This service covers you (the Plan member) only, not your spouse, domestic partner or dependents, as the victim of domestic violence. It provides you with representation to obtain a protective order, including all required paperwork and attendance at all court appearances. The service does not include representation in suits for damages, defense of any action, or representation for the offender.

Adoption (Contested and Uncontested)

This service covers all legal services and court work in a state or federal court for an adoption for you and your spouse or *domestic partner* if you are enrolled for *family coverage*.

Guardianship or Conservatorship (Contested and Uncontested)

This service covers the establishment of your guardianship or conservatorship over a person and his or her estate when you are appointed guardian or conservator or your spouse or *domestic partner* is appointed guardian or conservator and you are enrolled for *family coverage*. It includes obtaining a permanent and/or temporary guardianship or conservatorship, gathering any necessary medical evidence, preparing the paperwork, attending the hearing, and preparing the initial accounting. This service does not include representation of the person over whom guardianship or conservatorship is sought, or any annual accountings after the initial accounting.

Personal Injury

Subject to applicable law and court rules, plan attorneys handle personal injury matters (where you are the plaintiff) at a maximum fee of 25% of the gross award. It is your responsibility to pay this fee and all other fees and costs.

Debt Matters

Debt Collection Defense

This service provides you with an attorney's services for negotiation with creditors for a repayment schedule and to limit creditor harassment, and representation in defense of any action for personal debt collection, foreclosure, repossession, or garnishment, up to and including trial, if necessary. Debt collection defense does not include:

- Vacating a judgment.
- Counter, cross, or third-party claims.
- Bankruptcy.
- Any action arising out of family-law matters, including support and post-decree issues.
- Any matter where the creditor is affiliated with the sponsor or employer.

Personal Bankruptcy

This benefit covers you and your spouse or *domestic partner* if you are enrolled for *family coverage* in bankruptcy planning, the preparation and filing of a personal bankruptcy or wage-earner petition, and representation at all court hearings and trials. This benefit does not include bankruptcy or wage-earner petitions for any business in which you, your spouse, or your *domestic partner* may have an interest, and it is not available if the *Company* is the creditor, even if you choose to reaffirm that specific debt.

Real Estate Matters

Eviction and Tenant Problems (Tenant only)

This service helps you, as a tenant, with matters involving leases, security deposits, or other disputes with a residential landlord. This benefit also covers eviction defense, up to and including trial, if necessary. This service does not include:

- Disputes with other tenants.
- Actions to recover security deposits.
- Representation as a plaintiff in a lawsuit against the landlord.

Security Deposit Assistance (Primary Residence — Tenant Only)

This service covers counseling you, as a tenant, may receive to help recover a security deposit from your residential landlord for your primary residence. Services include:

- Reviewing the lease and other relevant documents.
- Preparing a demand letter to the landlord for the return of the deposit.
- Assisting you in prosecuting a small claims action.
- Helping prepare documents.
- Advising on evidence, documentation, and witnesses.
- Preparing you for the small claims trial.

This service does not include the plan attorney's attendance or representation at the small claims trial, collection activities after a judgment, or any services relating to post-judgment actions.

Refinancing of Home

This service covers the review or preparation, by an attorney representing you, of all relevant documents (including the mortgage and deed, and documents pertaining to title, insurance, recordation, and taxation), which are involved in the refinancing of or in obtaining a home equity loan on your primary residence. This service includes obtaining a permanent mortgage on a newly constructed home. It does not include services provided by any attorney representing a lending institution or title company nor does it include the refinancing of a second home, vacation property, rental property, or property held for business or investment.

Sale or Purchase of Home

This service covers the review or preparation, by an attorney representing you, of all relevant documents (including the construction documents for a new home, the purchase agreement, mortgage and deed, and documents pertaining to title, insurance, recordation, and taxation), which are involved in the sale or purchase of your primary residence or of a vacant property to be used for building a primary residence. The service also includes attendance of an attorney at closing. It does not include services provided by any attorney representing a lending institution or title company nor does it include the sale or purchase of a second home, vacation property, rental property, property held for business, or investment or leases with an option to buy.

Home Equity Loans (Primary Residence)

This service covers the review or preparation of a home equity loan for your primary residence.

Property Tax Assessment

This service covers review and advice on a property tax assessment on your residence. It also includes filing the paperwork; gathering the evidence; negotiating a settlement; and attending the hearing necessary to seek a reduction of the assessment.

Boundary or Title Disputes

This service covers negotiations and litigation arising from boundary or real property title disputes involving a your residence, where coverage is not available under the yours homeowner or title insurance policies. The service includes filing to remove a mechanic's lien.

Zoning Applications

This service provides the services of a lawyer to help you get a zoning change or variance for the your residence. Services include reviewing the law, reviewing the surveys, providing advice, preparing applications, and preparing for and attending the hearing to change zoning.

Consumer Protection

Consumer Protection Matters

This service covers you as a plaintiff, for representation, including trial, in disputes over consumer goods and services where the amount being contested exceeds the small claims court limit in that jurisdiction and is documented in writing. This service does not include disputes over real estate, construction, insurance, or collection activities on a judgment.

Small Claims Assistance

This service includes counseling on prosecuting a small claims action, helping you prepare documents, advising you on evidence, documentation, and witnesses, and preparing you for trial. The service does not include the plan attorney's attendance or representation at the small claims trial, or services or collection activities related to post-judgment actions.

Wills and Estate Planning

Trusts

This service covers the preparation of revocable and irrevocable trusts for you. It does not include tax planning or services associated with funding the trust after it is created.

Living Wills

This service covers the preparation of a living will for you.

Power of Attorney

This service covers the preparation of power of attorney when you are granting the power.

Probate

Subject to applicable law and court rules, plan attorneys handle probate matters at a fee 10% lower than their normal fee. It is your responsibility to pay this reduced fee and all costs.

Wills and Codicils

This service covers the preparation of a will or testamentary trust for you. The service includes the preparation of will amendments or codicils, but does not include financial or tax planning, and the documentation required for estates larger than the federal estate tax exemptions.

Document Preparation

Affidavit

This service covers preparation of an affidavit where you are the person making the statement.

Deeds

This service includes the preparation of a deed for which you are either the grantor or grantee.

Demand Letters

This service covers preparing letters that demand money, property, or some other property interest of yours (except an interest that is an excluded service), mailing them to the addressee, and forwarding and explaining any response to you.

Negotiations and representation in litigation are not included.

Document Review

This service includes the review of any personal legal document of yours by a plan attorney.

Mortgages

This service covers the preparation of any mortgage or deed of trust for which you are the mortgagor. This service does not include documents pertaining to business, commercial, or rental property.

Notes

This service includes preparation of a promissory note for which you are the payor or payee.

Office Consultations and Telephone Advice

This service provides you the opportunity to discuss with an attorney any personal legal matters that are not excluded specifically or prohibited. The plan attorney explains your rights, points out your options, and, if needed, recommends a course of action. The plan attorney identifies any further coverage available under the program and represents you if you request it. If representation is covered, you will not be charged for the plan attorney's services.

If representation is recommended but is not covered, the plan attorney provides a written fee statement in advance. You may choose to retain the plan attorney at your own expense, seek outside counsel, or do nothing. There is no limit to the number of times you can consult or call a plan attorney during the year. However, for a matter that is not covered, this service is not intended to provide you with continuing access to a plan attorney so that you can undertake your own representation.

Exclusions and Limitations

Certain matters are excluded from coverage under the Group Legal Program. No services, not even a consultation, can be provided in connection with the following matters:

- Employment-related matters, including *Company* or statutory benefits.
- Matters involving the *Company*, MetLife and affiliates, and plan attorneys.
- Matters in which there is a conflict of interest between the *employee* and spouse or dependent(s) in which case services are excluded for the spouse and dependent(s).
- Appeals and class actions.
- Farm and business matters, including rental issues, when the participant is the landlord.
- Patent, trademark, and copyright matters.
- Costs or fines.
- Frivolous or unethical matters.
- Matters for which an attorney-client relationship exists prior to your eligibility for program benefits.

If a claim for legal services is denied, in whole or in part, MetLife Legal Plans will furnish you in writing the reason(s) for the denial and information as to the steps that need to be taken if you wish to appeal that denial.

Events Affecting Coverage

Employment Events

- **Disability, leaves of absence (disability, personal and military) or reduction in hours worked:**
  - If your pay is reduced for any reason (if, for example, you are disabled, you take a leave of absence, or your work hours are decreased), coverage continues and premiums are deducted from your reduced pay. If the reduced pay does not cover the total premium cost, you are required to pay the premium directly to the Shell Benefits Service Center for the balance of the plan year, to continue your coverage.
  - If your pay stops completely as a result of a leave of absence, you are required to pay the premium directly to the Shell Benefits Service Center for the balance of the plan year, to continue your coverage (see "Leaves of Absence" on page J-15).
- **Loss of eligibility, termination or retirement:** If you cease to be eligible to participate in the program or if your employment with the *Company* ends, the program covers the legal fees for those covered services that were opened and pending during the period you were enrolled in the program. No new matters may be started after you become ineligible.

Continuing Group Legal Coverage

You may continue group legal coverage for you and your covered *eligible dependent(s)* for up to 12 months at full cost after your eligibility for the program ends by making payments directly to MetLife. For more information on how to continue coverage, contact MetLife Legal Plans directly at 1-800-821-6400.

Group Legal Program Plan Amendment or Termination

Your coverage changes or ends on the date this program is amended or terminated.

What Else You Should Know

Program Confidentiality, Ethics, and Independent Judgment

Your use of the program and its legal services is confidential. The plan attorney will maintain strict confidentiality with respect to the traditional lawyer-client relationship. The *Company* will know nothing about your legal problems or the services you use under the program. The *Company* will have access only to limited statistical information needed for orderly plan administration. No one will interfere with your plan attorney's independent exercise of professional judgment when representing you. All attorney services provided under the program are subject to ethical rules established by the courts for lawyers.

The plan attorney will adhere to the rules of the program, and he or she will not receive any further instructions, direction, or interference from anyone else connected with the program. The plan attorney's obligations and relationship are exclusively to and with you. MetLife Legal Plans or the law firm providing services under the program is responsible for all services provided by its attorneys.

You should understand that the program has no liability for the conduct of any plan attorney. You have the right to file a complaint with the state bar concerning attorney conduct pursuant to the program.

Plan attorneys will refuse to provide services if the matter is clearly without merit, frivolous, or for the purpose of harassing another person. If you have a complaint about the legal services you received or the conduct of an attorney, call MetLife Legal Plans. Your complaint will be reviewed and you will receive a response within two business days of your call.

Other Special Rules

In addition to the covered services and exclusions listed earlier, certain rules apply in special situations.

What if other coverage is available to you?

If you are entitled to receive legal representation provided by any other organization, such as a government agency, or if you are entitled to legal services under any other legal plan, coverage is not provided under this program.

However, if you are eligible for legal aid or public defender services, you are still eligible for benefits under this program, as long as you meet the program's eligibility requirements.

What if you are involved in a legal dispute with your dependent(s)?

You may need legal help with a problem involving your spouse or *domestic partner*, or your child(ren). In some cases, both you and your dependent(s) may need an attorney. If it would be improper for one attorney to represent both you and your dependent(s), only you are entitled to representation by the plan attorney; your dependent(s) is not covered under the program.

What if you are involved in a legal dispute with another employee?

If you or your dependent(s) is involved in a dispute with another *eligible employee* or that *employee's* dependent(s), MetLife Legal Plans will arrange for legal representation with independent and separate counsel for both parties.

What if the court awards attorneys' fees as part of a settlement?

If you are awarded attorneys' fees as a part of a court settlement, the program must be repaid from this award to the extent that it paid the fee for your attorney.

Group Automobile and Home Insurance Plan

You may purchase voluntary insurance for your car, home or apartment, and other personal property through Farmers Group.

For Employees and Retirees

This plan is available to both *employees* and retirees of the *Company* who meet eligibility requirements.

Participation

Eligibility

You are eligible to participate in the Group Automobile and Home Insurance Plan if you are:

- A *regular full-time* or *regular part-time employee* of the *Company*.
- A *retiree* who retired from the *Company* having met *retiree coverage eligibility* requirements.*

* For information on the requirements for *retiree coverage eligibility*, see page M-10 and "Other Benefits Available After You Retire" on page K-5.

Enrollment

You can enroll in the Group Automobile and Home Insurance Plan at any time during the year. The best time to look into this option is before the expiration of any similar policy you have with another carrier. That will enable you to compare your current insurance benefits and costs with those available through the Group Automobile and Home Insurance Plan.

You can apply for group automobile and home insurance by calling Farmers directly at 1-800-438-6381. Questions about group automobile and home insurance should also be directed to Farmers. The Group Automobile and Home Insurance Plan is not administered by the Shell Benefits Service Center.

Cost

If you choose coverage under the Group Automobile and Home Insurance Plan, your premium can be paid:

- By payroll deduction on an after-tax basis (if you are an *employee*),
- By automatic deduction from your bank account,
- By being billed to you directly by Farmers, or
- By monthly recurring credit card charge.

Types of Coverage

The Group Automobile and Home Insurance Plan offers the following types of insurance:

- Homeowners.
- Condominium.
- Renters.
- Mobile home.
- Automobile.
- Recreational vehicle.
- Boat owners.
- Excess liability.

Exclusions and Limitations

The Group Automobile and Home Insurance Plan is for personal insurance only. This means it insures only individuals and their property. Businesses and commercial risks cannot be insured under the Group Automobile and Home Insurance Plan.

For Employees Only

If you pay your premiums through payroll deduction and your pay is reduced for any reason (if, for example, you are disabled, your work hours are reduced, or you take a leave of absence), your coverage under the Group Automobile and Home Insurance Plan continues and your premiums are deducted from your reduced pay. If your reduced pay does not cover the total premium cost, or if your pay stops completely as a result of disability, leave of absence, layoff, termination, retirement, or death, you (or your *eligible dependent(s)* in the event of your death) must contact Farmers and change your premium payment method to automatic deduction from your bank account, monthly credit card charge or direct billing in order for your coverage to continue. See "Leaves of Absence" on page J-15.

When You Retire or Leave the Company

If you are covered under the Group Automobile and Home Insurance Plan when you retire, your coverage continues as long as you pay your monthly premium through automatic deduction from your bank account, monthly credit card charge or direct billing from Farmers.

If you terminate from the *Company* for any other reason, your policy continues through the end of its term and will continue renewing semi-annually as long as you continue to pay the premiums through automatic deduction from your bank account, monthly credit card charge or direct billing from Farmers.

Severance Pay Plan

If your job is eliminated, you may be eligible to receive payment and/or benefits from the *Company*.

Participation

Eligibility

You are eligible to receive a severance payment under the Severance Pay Plan if your job is eliminated due to a business need to reduce or consolidate workforce levels, reorganize or restructure, to make staffing changes, or improve the efficiency of the organization and:

- You are a *regular full-time employee* of the *Company*, and you complete at least one year of continuous, full-time service immediately before your termination date, or
- You are a *regular part-time employee* and you complete at least one year of *accredited service* before your termination date,
- You have not voluntarily terminated your employment, died, or been terminated due to Discharge prior to the date of termination scheduled by the *Company*, and
- You are not participating in any other severance program offered by the *Company* (no duplication of benefits).

For purposes of the Severance Pay Plan, the term "Company" does not include Shell US Hosting Company. Also, for purposes of the Severance Pay Plan, "Discharge" shall mean termination of employment by the *Company* for any of the following reasons as determined in its sole discretion: absenteeism or substandard productivity or performance; dishonesty; insubordination; violation of *Company* work rules or policies; or for any other reason the *Company* determines to be grounds for involuntary termination of employment.

Cost

The *Company* pays the entire cost of benefits under the Severance Pay Plan from the *Company's* general assets.

How the Plan Works

Benefit Amount

If you qualify, a lump-sum severance payment is paid to you at the time you terminate employment. Your severance payment is one week's pay for each year of continuous, regular full-time or regular part-time service completed as of your last day of work. A week's pay is calculated on the same basis as vacation pay. The maximum benefit is 10 weeks of pay.

Applicable taxes are withheld from your severance payment, which is paid in a lump sum. Should the *Company* be required by law, contract, or otherwise to make any other payments on your behalf (e.g., garnishments), these payments will be deducted, or may be offset, from your severance payment provided under the Severance Pay Plan. In addition, any amount owed to the *Company* (e.g., loans, tax advances, overpayments, etc.) will be deducted from the payment.

Upon termination, you will receive pay in lieu of any earned vacation, including any deferred vacation, less any vacation taken prior to termination. Deductions for unused vacation purchased through the Shell Vacation Purchase Plan will be refunded to you upon termination on an after-tax basis.

Severance pay normally is not paid where comparable work and pay are offered to you in connection with the sale of any part of the business

Filing a Claim

Normally, benefits are paid to you automatically if your employing *Company* determines that you are eligible for benefits under the Severance Pay Plan. However, if you believe that you are eligible for benefits, you may file a claim with the *Plan Administrator* at the address listed in the "General Plan Information" section of this summary plan description. Your claim must be submitted within 12 months of the date your employment is terminated. Failure to comply with this important deadline will result in the forfeiture of your right to a claim for benefits.

When Coverage Ends

Coverage under the Severance Pay Plan changes or ends on the date that it is amended or terminated and upon your termination of employment.

Leaves of Absence

The following charts summarize how various events and leaves of absences affect your *Company* benefits. More information is available at the end of each benefit section.

Care				
Event or Leave of Absence	***Medical Benefit Program***	***Dental Benefit Program***	***Vision Benefit Program***	***Health Care and/or Dependent Day Care Account Program (FSA)***
Disability leave **with pay**	Coverage continues with monthly premiums deducted from your pay.	Coverage continues with monthly premiums deducted from your pay.	Coverage continues with monthly premiums deducted from your pay.	Coverage continues with contributions deducted from your pay.
Disability leave **without pay**	Coverage continues at the *Company's* expense.	Coverage continues at the *Company's* expense.	You can arrange to continue coverage via direct payment.	Health Care Account contributions can continue on an after-tax basis. Dependent Care Account contributions stop.
Personal leave **with pay**	Coverage continues with monthly premiums deducted from your pay.	Coverage continues with monthly premiums deducted from your pay.	Coverage continues with monthly premiums deducted from your pay.	Coverage continues with contributions deducted from your pay.
Personal leave **without pay**	You can arrange to continue coverage via direct payment. *Company* contributions continue.	You can arrange to continue coverage via direct payment. *Company* contributions continue.	You can arrange to continue coverage via direct payment.	Health Care Account contributions can continue on an after-tax basis. Dependent Care Account contributions stop.
Personal leave **without pay** for advanced education	You can arrange to continue coverage via direct payment. *Company* contributions continue.	You can arrange to continue coverage via direct payment. *Company* contributions continue.	You can arrange to continue coverage via direct payment.	Health Care Account contributions can continue on an after-tax basis. Dependent Care Account contributions stop.
Dependent care leave **without pay**	You can arrange to continue coverage via direct payment. *Company* contributions continue.	You can arrange to continue coverage via direct payment. *Company* contributions continue.	You can arrange to continue coverage via direct payment.	Health Care Account contributions can continue on an after-tax basis. Dependent Care Account contributions stop.
FMLA leave **without pay**	You can arrange to continue coverage via direct payment. *Company* contributions continue.	You can arrange to continue coverage via direct payment. *Company* contributions continue.	You can arrange to continue coverage via direct payment.	Health Care Account contributions can continue on an after-tax basis. Dependent Care Account contributions stop.

(continued)

Care				
Event or Leave of Absence	***Medical Benefit Program***	***Dental Benefit Program***	***Vision Benefit Program***	***Health Care and/or Dependent Day Care Account Program (FSA)***
Military leave (annual weekend/weekly reserve duty)*	Coverage continues with monthly premiums deducted from your pay.	Coverage continues with monthly premiums deducted from your pay.	Coverage continues with monthly premiums deducted from your pay.	Coverage continues with contributions deducted from your pay.
Military leave (active service) **with pay**	Coverage continues with monthly premiums deducted from your pay.	Coverage continues with monthly premiums deducted from your pay.	Coverage continues with monthly premiums deducted from your pay.	Coverage continues with contributions deducted from your pay.
Military leave (active service) **without pay**	You can arrange to continue coverage via direct payment. *Company* contributions continue.	You can arrange to continue coverage via direct payment. *Company* contributions continue.	You can arrange to continue coverage via direct payment.	Health Care Account contributions can continue on an after-tax basis. Dependent Care Account contributions stop.

* Special rules apply to military leaves for initial training on entering a reserve unit. Contact your local Human Resources Department for additional information if this situation applies to you.

Protection					
Event or Leave of Absence	***Disability Benefit Plan***	***Income Protection Insurance Program***	***Long-Term Disability Program***	***Survivor Benefit Program and OADB Program***	***Group Life Insurance Program***
Disability leave **with pay**	You receive applicable benefits based upon your years of *accredited service*.	Coverage continues until your benefits are exhausted. Monthly premiums will be deducted from your pay.	Coverage continues with monthly premiums deducted from your pay.	Coverage continues at the *Company's* expense.	Coverage continues with monthly premiums deducted from your pay.
Disability leave **without pay**	Benefits are exhausted.	Coverage continues until your benefits are exhausted. Monthly premiums are waived.	Coverage continues at no cost to you.	Coverage continues at the *Company's* expense.	Coverage continues. Monthly premiums are waived.
Personal leave **with pay**	Benefits are available based upon your years of *accredited service*.	Coverage continues with monthly premiums deducted from your pay.	Coverage continues with monthly premiums deducted from your pay.	Coverage continues at the *Company's* expense.	Coverage continues with monthly premiums deducted from your pay.

(continued)

Protection					
Event or Leave of Absence	***Disability Benefit Plan***	***Income Protection Insurance Program***	***Long-Term Disability Program***	***Survivor Benefit Program and OADB Program***	***Group Life Insurance Program***
Personal leave **without pay**	You are not eligible for benefits. Benefits apply as of the date you are scheduled to return to work if you are still disabled at that time.	Coverage stops at the end of the month in which the last premium is deducted from your pay.	Coverage stops at the end of the month in which the last premium is deducted from your pay.	Coverage continues at the *Company's* expense.	You can arrange to continue coverage via direct payment.
Personal leave **without pay** for advanced education	You are not eligible for benefits. Benefits apply as of the date you are scheduled to return to work if you are still disabled at that time.	Coverage stops at the end of the month in which the last premium is deducted from your pay. *Employees* who work in California or Rhode Island do not lose coverage.	Coverage stops at the end of the month in which the last premium is deducted from your pay.	Coverage continues at the *Company's* expense.	You can arrange to continue coverage via direct payment.
Dependent care leave **without pay**	You are not eligible for benefits. Benefits apply as of the date you are scheduled to return to work if you are still disabled at that time.	Coverage stops at the end of the month in which the last premium is deducted from your pay.	Coverage stops at the end of the month in which the last premium is deducted from your pay.	Coverage continues at the *Company's* expense.	You can arrange to continue coverage via direct payment.
FMLA leave **without pay**	You are not eligible for benefits. Benefits apply as of the date you are scheduled to return to work if you are still disabled at that time.	Coverage stops at the end of the month in which the last premium is deducted from your pay.	Coverage stops at the end of the month in which the last premium is deducted from your pay.	Coverage continues at the *Company's* expense.	You can arrange to continue coverage via direct payment.
Military leave (annual weekend/ weekly reserve duty)*	You are not eligible for benefits. Benefits apply as of the date you are scheduled to return to work if you are still disabled at that time.	Coverage continues with monthly premiums deducted from your pay. Benefits apply as of the date you are scheduled to return to work if you are still disabled at that time.	Coverage stops while you are in the uniformed services.	Coverage continues at the *Company's* expense.	Coverage continues with monthly premiums deducted from your pay.

(continued)

Protection					
Event or Leave of Absence	***Disability Benefit Plan***	***Income Protection Insurance Program***	***Long-Term Disability Program***	***Survivor Benefit Program and OADB Program***	***Group Life Insurance Program***
Military leave (active service) **with pay**	Your coverage stops as of the date the leave begins.	Your coverage stops as of the date the leave begins.	Coverage stops while you are in the uniformed services.	Coverage continues at the *Company's* expense.	Coverage continues with monthly premiums deducted from your pay.
Military leave (active service) **without pay**	Your coverage stops as of the date the leave begins.	Your coverage stops as of the date the leave begins.	Coverage stops while you are in the uniformed services.	Coverage continues at the *Company's* expense.	You can arrange to continue coverage via direct payment.

* Special rules apply to military leaves for initial training on entering a reserve unit. Contact your local Human Resources Department for additional information if this situation applies to you.

Protection *(continued)*						
Event or Leave of Absence	***Voluntary Personal Accident Insurance Program***	***Business Travel Accident Insurance Program***	***Group Automobile and Home Insurance Plan***	***Group Legal Program***	***Long-Term Care Insurance Plan***	***Back-Up Care Program***
Disability leave **with pay**	Coverage continues with monthly premiums deducted from your pay.	Not applicable.	Coverage continues with monthly premiums deducted from your pay.	Coverage continues with monthly premiums deducted from your pay.	Coverage continues with monthly premiums deducted from your pay. If you are receiving plan benefits, premiums are waived.	You are not eligible to participate.
Disability leave **without pay**	You can arrange to continue coverage via direct payment.	Not applicable.	You can arrange to continue coverage via direct payment.	You can arrange to continue coverage via direct payment.	You can arrange to continue coverage via direct payment. If you are receiving plan benefits, premiums are waived.	You are not eligible to participate.
Personal leave **with pay**	Coverage continues with monthly premiums deducted from your pay.	Not applicable.	Coverage continues with monthly premiums deducted from your pay.	Coverage continues with monthly premiums deducted from your pay.	Coverage continues with monthly premiums deducted from your pay.	You are not eligible to participate.

(continued)

Protection *(continued)*						
Event or Leave of Absence	***Voluntary Personal Accident Insurance Program***	***Business Travel Accident Insurance Program***	***Group Automobile and Home Insurance Plan***	***Group Legal Program***	***Long-Term Care Insurance Plan***	***Back-Up Care Program***
Personal leave without pay	You can arrange to continue coverage via direct payment.	Not applicable.	You can arrange to continue coverage via direct payment.	You can arrange to continue coverage via direct payment.	You can arrange to continue coverage via direct payment.	You are not eligible to participate.
Personal leave without pay for advanced education	You can arrange to continue coverage via direct payment.	Not applicable.	You can arrange to continue coverage via direct payment.	You can arrange to continue coverage via direct payment.	You can arrange to continue coverage via direct payment.	You are not eligible to participate.
Dependent care leave without pay	You can arrange to continue coverage via direct payment.	Not applicable.	You can arrange to continue coverage via direct payment.	You can arrange to continue coverage via direct payment.	You can arrange to continue coverage via direct payment.	You are not eligible to participate.
FMLA leave without pay	You can arrange to continue coverage via direct payment.	Not applicable.	You can arrange to continue coverage via direct payment.	You can arrange to continue coverage via direct payment.	You can arrange to continue coverage via direct payment.	You are not eligible to participate.
Military leave (annual weekend/ weekly reserve duty)*	Coverage continues with monthly premiums deducted from your pay.	Not applicable.	Coverage continues with monthly premiums deducted from your pay.	Coverage continues with monthly premiums deducted from your pay.	Coverage continues with monthly premiums deducted from your pay.	You are not eligible to participate.
Military leave (active service) with pay	Coverage continues with monthly premiums deducted from your pay. Your coverage stops if the leave extends beyond 30 days.	Not applicable.	Coverage continues with monthly premiums deducted from your pay.	Coverage continues with monthly premiums deducted from your pay.	Coverage continues with monthly premiums deducted from your pay.	You are not eligible to participate.
Military leave (active service) without pay	You can arrange to continue coverage via direct payment. Coverage stops if the leave extends beyond 30 days.	Not applicable.	You can arrange to continue coverage via direct payment.	You can arrange to continue coverage via direct payment.	You can arrange to continue coverage via direct payment.	You are not eligible to participate.

* Special rules apply to military leaves for initial training on entering a reserve unit. Contact your local Human Resources Department for additional information if this situation applies to you.

Other Policies (For more information, go to the United States Policies & Guidelines section of HROnline.)				
Event or Leave of Absence	***Vacation***	***Adoption Assistance Policy***	***Learning Account***	***Educational Reimbursement***
Disability leave with pay*	You earn vacation credit for up to 183 days.	You are eligible to participate.	You are eligible to participate.	You are not eligible to participate.
Disability leave without pay*	You earn vacation credit for up to 183 days (includes disability leave with pay).	You are eligible to participate.	You are eligible to participate.	You are not eligible to participate.
Personal leave with pay	You earn vacation credit for up to 30 days.	You are eligible to participate.	You are eligible to participate.	You are not eligible to participate.
Personal leave without pay	You earn vacation credit for up to 30 days.	You are eligible to participate.	You are eligible to participate.	You are not eligible to participate.
Personal leave without pay for advanced education	You earn vacation credit for up to 30 days.	You are eligible to participate.	You are eligible to participate.	You are not eligible to participate.
Dependent care leave without pay	You earn vacation credit for the duration of the leave.	You are eligible to participate.	You are eligible to participate.	You are not eligible to participate.
FMLA leave without pay	You earn vacation credit for the duration of the leave.	You are eligible to participate.	You are eligible to participate.	You are not eligible to participate.
Military leave (annual weekend/weekly reserve duty)*	You earn vacation credit for the duration of the leave.	You are eligible to participate.	You are eligible to participate.	You are not eligible to participate.
Military leave (active service) with and without pay**	You earn vacation credit for the duration of the leave.	You are eligible to participate.	You are eligible to participate.	You are not eligible to participate.

* For these leaves, you earn this vacation credit only if you return to work at the end of the leave. If you do not return to work, then vacation credit is earned through the last day worked prior to the beginning of the leave.

** Special rules apply to military leaves for initial training on entering a reserve unit. Contact your local Human Resources Department for additional information if this situation applies to you.

Preparing for Retirement

This section is specifically intended for *employees* who are nearing retirement, to prepare you with information you will need to make decisions about your benefits.

Shell Benefits Under Retirement

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When you retire, you may be able to continue medical, dental and vision coverage for yourself and your *eligible dependents* if you meet certain requirements. You also may be able to continue certain protection plans. In addition, Shell offers a Learning Account you can use during your first year of retirement.

Hired or Rehired on or After January 1, 2017

Important: If you were hired or re-hired on or after January 1, 2017, you will not be eligible for Shell *retiree* medical insurance.

Medical, Dental, and Vision Programs

Eligibility

To be eligible for Shell medical, dental and vision benefits during your retirement, you must retire having met *retiree coverage eligibility* requirements, which generally means you must either:

- Be at least age 50 and have your age plus your *eligibility service* equal at least 80, or
- Terminate employment at age 65 or older with eligibility for a regular pension under the Shell Pension plan, or
- Satisfy the 70-point eligibility rules (be at least age 50 with 20 or more years of *eligibility service* and you terminate employment under special circumstances, such as a qualifying severance/reduction in force).

Eligibility service is your *accredited service* — the length of time you have been employed by the *Company* or time credited to you for other reasons — plus certain other service recognized under the Shell Pension Plan. For a more detailed description of *retiree coverage eligibility*, *eligibility service* and *accredited service*, see the Glossary, page M-1.

Participation

If eligible, you can continue your participation in Shell's Medical, Dental and/or Vision programs by paying your *retiree* contributions. If you are not enrolled when you retire, you can enroll yourself and *eligible dependents* during any *group annual enrollment period* or within 31 days after a *qualified status event*. If you are enrolled and decide to terminate your coverage at retirement, you will be allowed to re-enroll at any *group annual enrollment* or within 31 days after a *qualified status change*. Also, If you should die prior to your re-enrollment into the program(s), your surviving *eligible dependent(s)* may elect coverage by contacting the Shell Benefits Service Center within 60 days of the date of your death

In the Medical Benefit Program, levels of coverage and coverage options are essentially the same for *retirees* as for active *employees*, as long as you are not eligible for *Medicare*. *Medicare* eligibility changes the coverage levels and medical options available to you or to a *Medicare*-eligible dependent. Information about your medical coverage as a non-*Medicare*-eligible retiree and as a *Medicare*-eligible retiree is included in the Medical Benefit Program section of this SPD, pages A-1 – A-42.

In the Dental and Vision programs, coverage levels and options for *retirees* are the same as they are for active *employees*. Information about these programs is covered in their respective sections, starting on pages B-1 and C-1.

Your Cost for Medical, Dental and/or Vision Coverage in Retirement

Your contributions for post-retirement coverage under the Medical, Dental, and Vision Benefit programs are made on an after-tax basis by deduction from your pension payment or, in some cases, by direct payment via invoice or Automatic Bank Withdrawal (ABW).

While you pay the full cost of the premiums for dental and vision coverage, you and the *Company* share in the cost of your medical benefit coverage. The *Company's* share of your premium for medical coverage is based on when you were hired by the *Company* and your years of *accredited service* at retirement.

Cost of Medical Benefit Coverage for Employees Hired on or After January 1, 2006

If you were hired or rehired by the *Company* on or after January 1, 2006, you may be eligible for the Retiree Medical Supplemental Account upon your retirement. In order to receive the Retiree Medical Supplemental Account at retirement, you must:

- Be hired by the *Company* on or after January 1, 2006, or be rehired by the *Company* on or after January 1, 2006,
- Not be eligible for any *Company*-sponsored *retiree* medical coverage based upon any previous service with the *Company* prior to January 1, 2006, and
- Qualify for *retiree coverage eligibility* at the time of your retirement.

Calculation of Retiree Medical Supplemental Account Credits

The Retiree Medical Supplemental Account will be established upon your retirement, and the number of credits available in your account will be determined at that time.

The credit balance will be calculated by multiplying the following factors:

- Your completed years and months of *accredited service* between the ages of 40 and 60, divided by 20,
- The annual premium for the *retiree participant plus spouse/domestic partner* level of coverage for the US PPO option at the time of your retirement,
- The historical five-year average rate of premium increase to the US PPO option, based upon the year of your retirement plus the four previous years, expressed as a percentage,
- The numeric value of five, and
- 80% (.80).

Note: If you retire on a qualified disability pension, as defined under the Shell Pension Plan, you will receive the maximum *Company* subsidy available for active *employees* toward *retiree* medical premiums for yourself and your enrolled dependent(s) until you reach age 60. At age 60, the *Company* will establish your Retiree Medical Supplemental Account and credits will be calculated as if you worked for the *Company* until age 60.

Using Retiree Medical Supplemental Account Credits

The credits can be used to cover *retiree* medical premiums for *Company*-sponsored coverage up to an amount equal to 80% of the total US PPO option premium. Credits can only be used toward *retiree* medical coverage available under the Shell Medical Benefit Program.

The Retiree Medical Supplemental Account is a non-interest-bearing account and cannot be passed to an estate or to *beneficiary(ies)*. However, your surviving spouse and any *eligible dependent(s)* may continue to access the account to pay for Shell-sponsored medical coverage. If your *eligible dependent(s)* are not enrolled at the time of your death, they must elect coverage under the Shell Medical Benefit Program within 60 days of your death in order to access the account.

Once you have used all of the credits in your Retiree Medical Supplemental Account, you will be responsible for paying the entire cost of your *retiree* medical coverage.

Factors such as the premium rate for the medical option in which you are enrolled, the number of credits you have in your Retiree Medical Supplemental Account, and the size of the credit withdrawals you elect, will determine how long the credits in your account will last. Each year during the *group annual enrollment period*, you can select how many credits you want to use, in 10% increments from 0% to 80%, toward your *Company*-sponsored *retiree* medical coverage in the coming year.

Examples:

1. The total premium for your *retiree* medical coverage is $500 per month and you elect to use credits from your Retiree Medical Supplemental Account to pay 80% of the premium. Credits worth $400 will be withdrawn from your account on a monthly basis to cover 80% of the monthly cost. You will be responsible for paying the remaining $100 each month.
2. Instead of using your credits to pay 80% of the cost of your *retiree* medical coverage, you choose to use fewer credits per year and pay only 50% of your premiums from your Retiree Medical Supplemental Account. If the total cost of your medical premium is $500 per month, $250 worth of credits (50% of the total premium) will be withdrawn from your account on a monthly basis, and you will be responsible for paying the remaining $250 each month.

Cost of Medical Benefit Coverage for Employees Hired Before January 1, 2006

If you were hired or rehired by the *Company* before January 1, 2006, you may be eligible for a *Company* post-retirement medical premium contribution based on your full years of *accredited service*. In order to receive a *Company* premium subsidy, you must:

- Qualify for *retiree coverage eligibility* at the time of your retirement, and
- Be enrolled in a *Company*-sponsored medical option under the Shell Medical Benefit Program.

The maximum dollar value of the *Company* subsidy for non-*Medicare*-eligible *retirees* is based on 80% of the premiums established for the US PPO option. For *Medicare*-eligible *retirees* enrolled in a *Medicare* option sponsored by the *Company*, the dollar value of the maximum *Company* subsidy is based upon 80% of the premiums established for the Medicare Complementary option.

The following contribution schedule describes the percentage of the maximum *Company* contribution available to you based on your full years of *accredited service* at the time you retire. This schedule applies across all medical options under the Shell Medical Benefit Program.

Full years of accredited service with retiree coverage eligibility	Company premium contribution (% of Company subsidy)
30 and over	100%
29	95%
28	90%
27	85%
26	80%
25	75%
24 – 10	70%
Less than 10	No *Company* contribution

For details on Shell's Medical, Dental and Vision benefits for *retirees* and active *employees*, see pages A-1, B-1, and C-1 in this SPD.

Retiree Life Insurance

In order for you to have *retiree* life insurance coverage after you retire, you must **already** be enrolled in Retiree Group Life Insurance. This program is no longer available to new enrollees as of January 1, 2022. If you are enrolled and want Information on your Retiree Life Insurance, see page N-7 in the Appendix of this book or contact MetLife at 1-844-510-1937.

Other Benefit Programs Available After You Retire

For your planning purposes, you will have access to the following benefit programs after your retirement:

Group Automobile and Home Insurance Plan

As an eligible *retiree*, you may continue your coverage for your car, home or apartment, or other personal property, or enroll at any time by contacting Farmers Group, Inc. at 1-800-438-6381. You will be responsible for paying your premiums on a direct billing basis.

If you are enrolled in the program at the time of your retirement, and pay your premiums through after-tax payroll deductions, you will need to contact Farmers to set up a direct billing arrangement. For details on the program, see page J-12.

Group Legal Program

Once you retire, your participation in the Group Legal Program ends. However, your benefits will continue for any eligible legal fees associated with covered services that were initiated and pending at the time of your retirement. No new matters may be started after your employment ends.

If you were enrolled in the Group Legal Program at the time of your retirement, you have the option of purchasing up to 12 months of legal service benefits on a direct billing basis. For more information on the available coverage and cost, contact MetLife Legal at 1-800-821-6400.

Retiree Learning Account

When you retire, you will be eligible for a $1,000 Learning Account in the first year following your retirement date. This benefit can be used to cover the cost of courses you take to help you adjust to retirement. There is no per-course limit.

The *retiree* Learning Account is designed to cover the costs you incur for courses, seminars, conferences, and/or workshops you take that are of interest to you and are related to your retirement, including:

- Classes on the use of leisure time (e.g., sports and hobbies).
- Personal financial planning courses.
- Classes on the psychology of retirement.
- Computer courses.

The *retiree* Learning Account does not provide reimbursement for such items as books, equipment, and tools.

Learning Account reimbursements are subject to all applicable taxes. However, you may wish to consult with your personal tax advisor to determine if your reimbursement can be treated as a deduction on your personal income tax return.

Post-Retirement Education Reimbursement

Requests for post-retirement educational reimbursement, along with proof of completion and proof of payment, should be scanned and sent to **HR-Operations@shell.com**.

General Plan Information

This section provides general information about the plans and policies described in this book. It supplements the descriptions of individual plan and program provisions in the preceding sections and presents information that is required to be given to you under the Employee Retirement Income Security Act of 1974 *(ERISA)*. Unless otherwise specified, the provisions of this section apply to all plans or programs described in this book.

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Plan Information

Plan Administrator

The US Benefits Manager serves as the *Plan Administrator*. The *Plan Administrator* has the authority to control and manage the operation and administration of the plans, and discretion to interpret their provisions, as outlined in the plan documents. (For information on the *Plan Administrator* for the programs described in this book, refer to the ERISA Plan information charts beginning on page L-20.)

Funding

Medical Benefit Program

The Medical Benefit Program is funded through contributions made by the *Company* and the participants. The Shell US PPO and US HDHP options, the US GEMS option, the Kelsey-Seybold Greater Houston option, and the Medicare Complementary option (for *retirees*) are self-insured. The regional HMOs/*PPOs* and *Medicare* Supplemental or *Medicare* Advantage options are fully insured. All participant contributions are held in a tax-exempt trust under a Trust Agreement with Principal Trust Company as Trustee and are to be used solely for payment of claims by participants and beneficiaries, regional HMO/*PPO* and *Medicare* option premiums, and administrative expenses. The Trustee is responsible for:

- Investing contributions to the Trust to increase earnings, and
- Making funds available for payment of claims, regional HMO/*PPO* and *Medicare* option premiums, and administrative expenses.

The *Plan Administrator* has an arrangement with certain service providers, including Cigna, CVS Caremark, Optum and UnitedHealthcare (UHC), under which they serve as Claims Administrators to:

- Process claims for covered expenses under the Shell Medical Benefit Program, and
- Make benefit payments out of funds made available by the Trust.

The *Company* reserves the right to amend or terminate the Trust Agreement and to change the Trustee at any time. The *Company* also reserves the right to amend or terminate the Medical Benefit Program or any of the medical options and to change the contribution rates at any time.

Dental Benefit Program

The Cigna Dental PPO Option under the Dental Benefit Program is funded through *Company* and participant contributions to a tax-exempt trust under a Trust Agreement with Principal Trust Company as Trustee. The Trustee is responsible for:

- Investing the contributions of the Trust to increase the earnings, and
- Making funds available to pay claims and administrative expenses.

The *Plan Administrator* has an arrangement with Cigna under which they serve as Claims Administrator to:

- Process claims for covered expenses for the Cigna Dental PPO option, and
- Make benefit payments out of funds made available by the Trust.

The Cigna Dental Care (DHMO) option is provided through an insurance contract with Cigna Dental Health, Inc. Cigna Dental Health provides access to its network of providers.

The *Company* reserves the right to amend or terminate the Trust Agreement or change the Trustee at any time. The *Company* also reserves the right to amend or terminate the Dental Benefit Program or any of the dental options and to change the contribution rates at any time.

Other Care and Protection Plans

The Health Care Account Program is funded by employee-directed contributions.

The following Care and Protection plans and programs are fully insured and *employees* who participate in them pay the full cost of coverage:

- Vision Benefit Program.
- Income Protection Insurance Program (open states).
- Long-Term Disability Program.
- Group Life Insurance Program (including Retiree Life Insurance, which is only available to eligible participants who enrolled prior to January 1, 2022).
- Voluntary Personal Accident Insurance Program.
- Group Legal Program.
- Long-Term Care Insurance Program, which is only available to eligible participants who enrolled prior to January 1, 2012.

The following Protection programs are fully insured and the *participating companies* pay the entire cost of coverage:

- Survivor Benefit Program.
- Occupational Accidental Death Benefit Program.
- Business Travel Accident Insurance Program.
- Employee Assistance Program.

The Back-Up Care Program and the Severance Pay Plan are funded by general assets of the *Company*.

Inspection of Documents

This book contains summary plan descriptions (SPDs) for the *Company's* health and welfare benefit plans and reflects the plan provisions in effect as of January 1, 2022, except where otherwise noted. Terms of the plans are contained in the plan documents on file with the *Company*. You may obtain copies of these documents from the *Plan Administrator* by addressing your written request to the *Plan Administrator* at the address listed in "ERISA Plan Information" charts beginning on page L-20.

The information presented in the summary plan descriptions does not replace the official plan documents that legally govern each plan's operation. Unless otherwise provided, if there is a conflict between the SPD and the plan document, the plan document controls. If you would like to review the documents or to receive copies of them, contact the Shell Benefits Service Center or the *Plan Administrator*.

No Right to Employment

Your eligibility or your right to the benefits described in this book should not be interpreted as an employment contract. You may leave the *Company* at any time for any reason. Likewise, the *Company* is not committed to any fixed term of employment.

Non-Assignment of Benefits

The plan generally prohibits any interest in or benefit payable under the plan from anticipation, alienation, sale, transfer, assignment, pledge, encumbrance, or charge, including, without limitation, to any health care provider or other provider of services. Any attempt by a participant or *beneficiary* to do so will be void and of no effect. This prohibition includes any interest in or benefit payable under the plan from being subject to any legal or equitable process including garnishment, attachment, levy, seizure, or lien.

This means that you may not assign to a health care provider (or to anyone) your rights to receive benefits under the plan, or to bring a claim or lawsuit for benefits or for breach or violation of any other duty or obligation owed to you under the plan. These rights are yours alone and may not be transferred to another party. No medical provider, or any other person or entity, is permitted to bring a claim against the plan under *ERISA* or any other law through a purported assignment, and any attempt to assign such rights will be void and unenforceable. In no event will the plan, the *Company*, or its affiliates be liable to any third party to whom you may be liable for care, treatment or other services.

For information on provider direct payments, see "Program Payments for US PPO and US HDHP Covered Expenses" on page A-19.

Forum and Venue

The exclusive forum and venue for any legal or equitable action relating to or arising under the plan shall be in the United States District Court for the Southern District of Texas, Houston Division, so long as the federal courts may assert subject matter jurisdiction over the action (unless the parties to the action have agreed otherwise). In the event the action is not subject to the subject matter jurisdiction of the federal courts, the exclusive forum and venue for such action shall be the district courts of Harris County, Texas (unless the parties to the action have agreed otherwise). Per the terms of the plan, you consent to the personal jurisdiction of these courts, as applicable, and waive any objections to personal jurisdiction or inconvenience of the forum and venue specified in this paragraph.

The Future of the Plan

The *Company* reserves the right to amend the plan or any *component program* from time to time or to terminate them entirely. You will be informed of any material amendments. In the event a plan or program is terminated, you will be notified as well.

Claims and Appeals

Important Notice Related to the COVID-19 Outbreak

Pursuant to recent guidance issued in response to the declared National Emergency as a result of the COVID-19 outbreak (the "National Emergency"), and unless future guidance by the relevant government agencies provides otherwise, the time period between March 1, 2020, and July 10, 2023, which is 60 days following the announced May 11, 2023, end of the National Emergency will be disregarded in determining the deadlines for filing initial claims, appeals, and requests for external review described in this section, provided, however, that the maximum extension for any claim, appeal, or external review request filing deadline is one year.

A claim is a request for a plan or program benefit by a participant or authorized representative. The law requires each plan that is subject to *ERISA* to set up reasonable rules for filing benefit claims. The law also allows a reasonable amount of time for the Claims Administrator to evaluate a claim and decide whether to pay benefits based on the information contained in the claim. The use of the claims procedure is mandatory in pursuing claims for benefits.

All claims for Care and Protection plans and programs must be submitted in writing (except in those cases where the claim is submitted electronically or telephonically by the service provider) to the applicable Claims Administrator (see "ERISA Plan Information" charts beginning on page L-20, for a listing of the Claims Administrators for each of the plans and programs).

Claim forms are available from the appropriate Claims Administrator. The procedures for initially applying for plan benefits are found in the sections describing those benefits, on the following pages:

Benefit Plan or Program	Page
Medical Benefit Program	A-28
Dental Benefit Program	B-12
Vision Benefit Program	C-8
Health Care Account Program	E-7
Dependent Day Care Account Program	E-7
Disability Benefit Plan	H-6
Income Protection Insurance Program	H-11
Long-Term Disability Program	H-16
Survivor Benefit Program	I-3
Occupational Accidental Death Benefit Program	I-3
Group Life Insurance Program*	I-8
Voluntary Personal Accident Insurance Program	I-17
Business Travel Accident Insurance Program	I-22
Backup Care Program	J-3
Group Legal Program	J-5
Severance Pay Plan	J-14
Long-Term Care Insurance Program	N-4

* The Group Life Insurance Program includes Retiree Life Insurance.

The Claims Administrator reviews the claims and reaches a decision as to whether to accept or deny the claims. Even though it does not happen often, disagreements about benefits may arise and are usually resolved quickly. However, if you are unable to resolve the disagreement, formal appeals processes are in place to help you appeal a denied claim.

Claims and appeals of claim denials are reviewed as soon as reasonable under the circumstances. There are different time frames for consideration of claims and appeals depending on the type of plan or program. The time frames for these plans and programs are separated accordingly and discussed on the following pages. Once you exhaust all applicable levels of appeal for a denied claim, you have two years from the date of final denial to file suit in court to further pursue a claim for the part of the benefit denied you.

Health Care Benefits Claims Procedure

Medical, Dental and Health Care Account Claims

The following claims procedures apply only to claims under the following health care programs:

Medical Benefit Program	US PPO options US HDHP options US GEMS Kelsey-Seybold Greater Houston plan Medicare Complementary option (medical benefits only)
Dental Benefit Program	Cigna Dental PPO
Health Care Account Program	

The rules described herein are generally applicable to all health care programs. However, if you participate in an HMO or an insured option under the Medical Benefit Program, the Cigna Dental Care (DHMO) option under the Dental Benefit Program, or another insured option, the Vision Benefit Program, or the Long-Term Care Insurance Program, specific information concerning the applicable claim and appeal procedures is provided in your certificate of participation or other information provided by the applicable HMO or insurance company. Claims and appeals for denied claims under such programs should be filed with the applicable HMO or insurance company in accordance with its procedures.

Note, however, that claims regarding eligibility or enrollment under all of the Medical Benefit Program, Dental Benefit Program, Vision Benefit Program or Health Care Account Program benefit options are subject to these claims procedures as indicated below (see "Claims Regarding Eligibility or Enrollment" on page L-14).

Types of Claims

Health claims for benefits under the Medical, Dental, and Health Care Account programs should be filed with the appropriate Claims Administrator for each benefit program (or benefit program option) in accordance with the procedures and time periods described for each of these benefit programs. Your claim for benefits under one of these programs will be characterized as one of the following types of claims:

Urgent Care Claims

An urgent care claim is any claim where any delay in treatment could jeopardize your health, life, or ability to regain maximum function or, in the opinion of a *physician* with knowledge of your medical condition, subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. Your claim will be treated as an urgent care claim if the *physician* treating you advises the Claims Administrator that the claim meets the criteria for an urgent care claim as defined above. Urgent care claims may be filed in writing or by telephone. Whether a claim meets the urgent care criteria is determined at the time the claim is being considered. For example, if your condition has improved, a claim that initially met the urgent care criteria may be considered a pre-service or post-service claim on appeal. In this instance, the appeal will be provided under the appropriate guidelines for a pre-service or post-service claim.

Pre-Service Claims

Pre-service claims are claims that are conditioned on obtaining approval prior to obtaining care in order to get the maximum benefit.

Post-Service Claims

Post-service claims are any claims that are not pre-service claims or urgent care claims and do not require pre-approval in order to get the maximum benefit.

Most claims will be post-service claims.

Concurrent Claims

Concurrent claims are any claims that involve an ongoing course of treatment. Typically, concurrent claims will be handled as either a pre-service claim or urgent care claim, depending on the circumstances.

It is important to know what type of claim you have because the appeal procedures and deadlines vary depending on the type of claim involved. These deadlines are summarized below and described in detail following the chart.

Applicable Time Limits	Urgent Care Claims	Pre-Service Claims	Post-Service Claims
Plan provides notice of initial benefits decision	**72 hours** after receiving the initial claim, if it was proper and complete. **24 hours** in the case of a concurrent claim, if you request to extend the authorized treatment at least **24 hours** before the existing authorization ends.	**15 days** after receiving the initial claim. **30 days**, if special circumstances require an extension and you are notified in advance. In the case of a concurrent claim, you will be notified in advance of any reduction or termination of treatment so you may appeal the decision.	**15 days** after receiving the initial claim. **30 days**, if special circumstances require an extension and you are notified in advance. In the case of a concurrent claim, you will be notified in advance of any reduction or termination of treatment so you may appeal the decision.
Deadline for requesting first-level appeal	**180 days** after receiving notice of initial decision from the plan.	**180 days** after receiving notice of initial decision from the plan.	**180 days** after receiving notice of initial decision from the plan.
Plan notice of decision on first-level appeal	**72 hours** after receiving your request.	**15 days** after receiving your request.	**30 days** after receiving your request.
Request for second-level appeal	**N/A.** There is no second-level appeal for urgent care claims.	**180 days** after receiving decision on first-level appeal.	**180 days** after receiving decision on first-level appeal.
Plan notice of decision on second-level appeal	**N/A.** There is no second-level appeal for urgent care claims.	**15 days** after receiving your request.	**30 days** after receiving your request.
Deadline for requesting external review	**Four months** after receiving decision on first-level appeal.	**Four months** after receiving decision on second-level appeal.	**Four months** after receiving decision on second-level appeal.
Notice of preliminary external review eligibility	**Six business days** after receiving the request for external review.	**Six business days** after receiving the request for external review.	**Six business days** after receiving the request for external review.
Notice of preliminary expedited external review eligibility	**Immediately** upon perfection of the external review claim, and in no event later than **72 hours** of receipt of a qualifying request for expedited external review.	**N/A**	**N/A**
Notice of external review decision	**45 days** after reviewer's receipt of a qualifying request for external review.	**45 days** after reviewer's receipt of a qualifying request for external review.	**45 days** after reviewer's receipt of a qualifying request for external review.
Notice of expedited external review decision	**72 hours** after reviewer's receipt of a qualifying request for expedited external review.	**N/A**	**N/A**

Detailed Description of the Claims Process

The Initial Benefits Decision

If you file a claim, an initial benefits decision on your claim will be provided to you within the following time periods, based on the type of claim.

Urgent Care Claim — No Later Than 72 Hours After the Claim Is Filed

Your urgent care claim will be reviewed by the Claims Administrator. The Claims Administrator will provide you with its initial benefits decision on your urgent care claim as soon as possible, taking into account your medical condition, but not longer than 72 hours after the claim is received. If the urgent care claim is a concurrent claim (i.e., involves approval to extend a currently authorized course of treatment), the decision will be provided not later than 24 hours after receipt of the claim, as long as your request is made at least 24 hours before your currently authorized treatment would otherwise end. If you do not make your claim at least 24 hours before coverage would otherwise end, the 72-hour rule will apply. Notice may be by telephone or in person followed by written or electronic notification.

If additional information is required to process your urgent care claim, you will be notified of the information necessary as soon as possible, but not later than 24 hours after your claim is filed, and you will be given at least 48 hours to provide the information. The Claims Administrator will provide you with its initial benefits decision within 48 hours after the end of the additional time period (or after receipt of the information, if earlier).

If your claim names a specific claimant, medical condition and service, or supply for which approval is requested, and is submitted to a plan representative responsible for handling benefit matters, but otherwise fails to follow the plan's procedures for filing pre-service urgent care claims, you will be notified of the failure within 24 hours and of the proper procedures to be followed. The notice may be oral unless you request written notification.

Pre-Service Claim — No Later Than 15 Days After the Claim Is Filed

Your pre-service claim will be reviewed by the Claims Administrator. The Claims Administrator will provide you with its initial benefits decision on your pre-service claim within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after the claim is received. The 15-day period may be extended up to an additional 15 days due to circumstances outside the plan's control. In that case, you will be notified of the need for the extension before the end of the initial 15-day period. If additional information is necessary to process your claim, you will be advised of the specific information necessary and given 45 days to provide such information, and the Claims Administrator's deadline for providing you with its initial benefits decision will be suspended from the date the Claims Administrator sent you the notice requesting additional information until the earlier of (1) the date the Claims Administrator receives the requested information, or (2) the expiration of the 45-day period given to you to provide the requested information. If you fail to provide the additional information within the 45-day period, the initial benefits decision will be made without regard to this information.

If your claim names a specific claimant, medical condition and service, or supply for which approval is requested, and is submitted to the Claims Administrator responsible for handling benefit matters, but otherwise fails to follow the plan's procedures for filing pre-service claims, you will be notified of the failure within five days and of the proper procedures to be followed. The notice may be oral unless you request written notification. If the claim is a concurrent claim (i.e., seeks approval for an ongoing course of treatment), the decision will be provided in sufficient time to permit you to appeal the decision and obtain a decision on appeal before plan coverage would otherwise end.

Post-Service Claim — No Later Than 30 Days After the Claim Is Filed

Your post-service claim will be reviewed by the Claims Administrator. The Claims Administrator will provide you with its initial benefits decision on your post-service claim within a reasonable period of time, but not later than 30 days after the claim is received. The 30-day period may be extended up to an additional 15 days due to circumstances outside the plan's control. In that case, you will be notified of the need for the extension before the end of the initial 30-day period. If additional information is necessary to process your claim, you will be advised of the specific information necessary and given 45 days to provide that information, and the Claims Administrator's deadline for providing you with notice of its initial benefits decision will be suspended from the date the Claims Administrator sends the notice of extension until the earlier of (1) the date the Claims Administrator receives the additional information, or (2) the expiration of the 45-day period given to you to provide the requested information. If you fail to provide the additional information within the 45- day period, the initial benefits decision will be made without regard to this information.

Notice of a Denial of Initial Benefit Claim

A denial of your benefit claim includes: (1) a denial, reduction, or termination of your benefit, (2) the benefit program's failure to provide or make a payment (in whole or in part) for a benefit, or (3) a cancellation or discontinuance of a benefit that has a retroactive effect.

If your claim for a benefit is denied in whole or in part, the Claims Administrator will notify you of the denial within the time limits described above. The notice will either be in the form of an Explanation of Benefits (EOB) statement or a letter and will include the following information: (1) information sufficient to identify the claim involved, including the date or dates of service, the health care provider, and the claim amount (if applicable), (2) the specific reasons for the denial, including the denial code and its meaning and a description of any standard relied upon to deny the claim, (3) references to the specific plan provisions on which the denial is based, (4) a description of any additional material or information necessary for you to perfect your claim and an explanation of why such material or information is necessary, and (5) a description of the review procedures and the time limits applicable to such procedures, including a statement of your right to bring a civil action under section 502 of *ERISA* following an adverse benefit determination on review. For urgent care claims, the notice will include a description of the expedited review process applicable to your claim, and such notice may be provided by telephone, provided that a written or electronic notification is given to you no later than three days after the oral notification. A notice of a denial of your benefit claim will also, to the extent applicable, contain the information described in "Special rules regarding claims" further in this section.

First-Level Appeal

If your initial claim for benefits is denied, you have the right to request a review of this denial (i.e., a "first-level appeal"). The first-level appeal of your benefit claim will be conducted by the Claims Administrator. You have up to 180 days after you receive notice of a denial of your claim to request a first-level appeal. Requests for first-level appeal must be made in writing (or orally, but only if your claim is an urgent care claim), and you should provide your name, the patient's name, the date of service, the amount of the charge, the name of the plan or program, a reference to the initial decision, and an explanation of the basis for your appeal request. See "Special rules regarding claims" further in this section.

Time Limits for First-Level Appeal of Claims and Notice Requirements

The Claims Administrator will provide you with notice of its decision through an Explanation of Benefits (EOB) statement or letter within the following time periods:

- 72 hours after receiving such request, in the case of an urgent care claim.
- 15 days after receiving such request, in the case of a pre-service claim.
- 30 days after receiving such request, in the case of a post-service claim.

If your claim is denied in whole or in part, the notice of denial of your claim upon first-level appeal will include (1) the information described in "Notice of a denial of initial benefit claim," (2) a statement that, upon request and free of charge, you will be provided reasonable access to and copies of all documents, records and other information relevant to your claim for benefits, and (3) a statement describing the plan's final appeal procedures (and a statement of your right to obtain information about that procedure). The notice will also, to the extent applicable, contain the information described in "Special rules regarding claims" further in this section.

Second-Level Appeal

For claims other than urgent care claims, you may file a second-level appeal if your claim is denied on first-level appeal. Second level of appeal claims are made to the Claims Administrator. Your request for final review should be made as soon as possible depending on the medical circumstances involved, but no later than 180 days after you receive the notice of denial on first-level appeal. See "Special rules regarding claims."

Requests for second-level appeal must be made in writing and you should provide your name, the patient's name, the date of service, the amount of the charge, the name of the plan or program, a reference to the initial decision, and an explanation of the basis for your appeal. See "Special rules regarding claims."

Time Limits for Second-Level Appeal and Notice of Decision

The Claims Administrator will provide you with a notice of its decision on second-level appeal within:

- 15 days after receiving your request in the case of a pre-service claim, or
- 30 days after receiving your request in the case of a post-service claim.

If your claim is denied in whole or in part, the notice of denial upon second-level appeal will include the following information: (1) all information required to be included in a notice of denial of a claim upon first-level appeal, as set forth in "Time limits for first-level appeal of claims and notice requirements" on page L-9, (2) a discussion of the decision to deny the claim on second-level appeal, (3) a statement of your right to bring a civil action under section 502(a) of *ERISA* or to file a request for an external review if your claim is denied on final review, including information on how to file a request for an external review and the time limits that apply, and (4) 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 contract information. The notice will also, to the extent applicable, contain the information described in "Special rules regarding claims."

Special Rules Regarding Claims

At each level of the claim review process, you have the right to review your claim file, and you may submit written comments, documents, records, and other information with respect to your claim, regardless of whether such information was considered during the initial or a prior level of review. You will be provided, free of charge, with any new or additional evidence that was considered by the Claims Administrator or *Plan Administrator*, as applicable, 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, your appeal cannot be denied 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 for a concurrent claim (to the extent such continued coverage is required by Department of Labor regulation 29 C.F.R. 2560.503-1(f)(2)(ii)) until your appeal has been decided.

You will be notified of your right to request the diagnostic and treatment codes (and their meanings) in all notices of benefit claim denials, and such information will be provided to you upon request. A request for a diagnostic and/or treatment code will not be considered, in itself, to be a request for an internal appeal or external review.

Also, at each stage of review, the reviewer will be a different individual (and will not be a subordinate of the prior reviewer). The reviewer will fully and fairly review your claim, taking into account any additional information you submit, and will not give deference to any prior benefits decision. No decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to the reviewer will be based on the likelihood that the reviewer will support a denial of benefits.

If your request for review is based in whole or in part on medical judgment, the reviewer will consult with a health care professional who has the appropriate training and experience in the field of medicine involved in the medical judgment, and who is not the same person consulted in any prior level of review. If an internal rule, guideline, protocol, or other similar criterion was relied upon in deciding your claim, any notice of denial will include a statement that a description of such rule will be provided to you free of charge upon written request. If any denial is based on medical necessity, experimental treatment, or similar exclusion, the notice will include a statement that an explanation of the scientific or clinical judgment that formed the basis for the decision, applying the terms of the plan to your medical condition, will be provided to you free of charge upon written request. Finally, if an expert was consulted in connection with your benefits determination, you will be given the identity of such individual upon written request.

External Review

Request for External Review — Medical Benefit Program

(US PPO and US HDHP options, US GEMS option, Kelsey-Seybold Greater Houston plan, and Shell Medicare Complementary option. Also, claims for prescription drug benefits only in the Shell Medicare Advantage PPO and KelseyCare Advantage plan.)

You may file a request under the Medical Benefit Program (at left in this section) for a review by an independent decision-maker (an "External Review") within four months after (1) the day you receive a denial of your second-level appeal, or in the case of urgent claims, first-level appeal or initial adverse benefit determination, or (2) the day your claim is deemed denied on second-level appeal, or in the case of urgent claims, receipt of an initial adverse benefit determination or completion of your first-level appeal. You may request an external review if the denial was based on any of the following:

- Clinical reasons.
- Exclusions for experimental or investigational treatment or procedures.
- Rescission of coverage (coverage that was cancelled or discontinued retroactively).
- Or any other reason for claim denial that requires the offer of an external review under applicable law.

Your request should be submitted to the Claims Administrator for the benefit program or benefit program option at issue. The four-month deadline may be modified as illustrated in the following examples: If the day you receive the denial notice is October 30, because there is no February 30, the request must be filed by March 1. If the filing deadline would fall on a Saturday, Sunday, or federal holiday, the deadline is extended to the next day that is not a Saturday, Sunday, or federal holiday.

Preliminary Eligibility Determination for External Review

Within six business days the Claims Administrator will provide you with a written notice of its determination. If your request is complete but does not meet the requirements for an external review, the notice will include the reasons the request is ineligible as well as contact information for the Employee Benefits Security Administration. If your request is not complete, the notice will describe the information or materials needed to complete the request. Your deadline for completing the request is the end of the four-month period described under "Request for external review" (at left in this section) or, if later, 48 hours after you received the notice that the request was incomplete.

External Review

If your request qualifies for external review, it will be assigned to one of the qualified independent reviewers with which the Claims Administrator has a contract. Within five business days after assigning your request to the reviewer, the Claims Administrator must provide the reviewer the documents and information that were considered in making the denial.

The reviewer will give you written notice of the acceptance of your request for external review. The notice will include a statement that you have 10 business days to submit additional written information. The reviewer must consider this information in its review. The reviewer also may agree to consider additional information submitted after 10 business days. Within one business day after receiving additional information from you, the reviewer must forward the information to the Claims Administrator. The Claims Administrator may reconsider the denial based on this additional information. If the Claims Administrator decides to reverse its denial and provide coverage or payment, it must provide written notice to you and to the reviewer within one business day after making the decision. The reviewer will terminate the external review if it receives this notice.

Unless the Claims Administrator reverses its decision, the reviewer will review all of the information and documents that you submit by the deadline. In reaching its decision, the reviewer will make its own independent decision of the claim and will not be bound by any decisions or conclusions reached during the benefit program's internal claim and appeal process.

In addition to the documents and information provided by you and the Claims Administrator, the reviewer will consider the following information or documents if they are available, and the reviewer 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 Claims Administrator, unless the criteria are inconsistent with the terms of the plan or with applicable law.
- The opinion of the reviewer'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 them appropriate.

The reviewer will provide written notice of its decision to you and the plan within 45 days after the reviewer receives your request. The notice will contain:

- A general description of the reason for the request 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 the reviewer received the request and the date of its decision.
- References to the evidence or documents (including the 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 relied on 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 you or the plan.
- A statement that review by a judge may be available to you.
- Current contact information, including a phone number, for any office of health insurance consumer assistance or ombudsman.

The reviewer will maintain records of all claims and notices associated with the external review process for six years and make these records available for examination by you, the plan, or a state or federal oversight agency upon request (except where disclosure would violate state or federal privacy laws).

Expedited External Review

You may file a request for an expedited (faster) external review in certain circumstances involving emergency services or where a longer review period could put you in jeopardy. Specifically, you may file this type of request if you receive:

- A denial that involves a medical condition for which the time allowed for completion of an expedited appeal under the plan's internal appeal process would seriously jeopardize your life or health, or would jeopardize your ability to regain maximum function, and you have filed a request for an expedited internal appeal with the Claims Administrator, or
- A denial, if you have a medical condition where the time allowed for completion of a standard external review would seriously jeopardize your life or health, or would jeopardize your ability to regain maximum function, or
- A denial that concerns an admission, availability of care, continued stay, or a health care item or service for a condition for which you received emergency services if you have not been discharged from the facility.

The processing of your request will be substantially the same as described above for other requests, with the following exceptions:

- The decision and notice of eligibility on the preliminary review will be made immediately upon the Claims Administrator's receipt of your request.
- If the request is eligible for external review, the Claims Administrator will transmit required information and documents to the reviewer electronically, by telephone or facsimile, or any other fast, available method.

The reviewer will provide you and the Claims Administrator notice of its decision as quickly as your medical condition or circumstances require, but in no event more than 72 hours after the reviewer receives the request for an expedited external review. If the reviewer's notice is not provided in writing, within 48 hours after the date of providing that notice, the reviewer will provide written confirmation of the decision to you and the Claims Administrator.

Claims for Continued Eligibility of a Disabled Dependent Child

If your health care claim of appeal is for the continued eligibility of a disabled dependent child (see "Eligible Dependent(s)" on page M-4), it will be processed in the same time frame and manner as other health care claims and appeals, except that your written notice of denial will include, in addition to the other information described herein, the following information:

At each level of the claim review process:

- A discussion of the decision, including an explanation of the basis for disagreeing with or not following:
  - The views of the health care professionals who are treating your child and the vocational professionals who evaluated him/her, and
  - The views of any medical or vocational experts whose advice was obtained on behalf of the plan in connection with your claim, without regard to whether the advice was relied upon in deciding to deny your claim, and
  - Your child's Social Security Administration disability determination.
- Identification of any medical or vocational experts whose advice was obtained on behalf of the plan in connection with your claim, without regard to whether the advice was relied upon in deciding to deny your claim.
- Either the specific internal rules, guidelines, protocols, standards or other similar criteria of the plan relied upon in deciding to deny your claim or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria or the plan do not exist.

- A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim.
- If required by law, a statement indicating how you may access the plan's language services.

At the second-level appeal stage of the process:

- The statement regarding your right to bring a civil action under Section 502(a) of *ERISA* will describe the two-year contractual limitations period applicable to your right to bring such an action, and it will include the calendar date upon which this two-year contractual limitation period expires. See "Exhaustion of claims" at right of this section, for more information.

Claims Regarding Eligibility or Enrollment

If your health care claim relates to your or your dependent's eligibility to participate in the Medical Benefit Program, Dental Benefit Program, Vision Benefit Program or Health Care Account Program or your enrollment elections with respect to one or more of those programs, it will be processed in the same time frame and manner as other health care claims and appeals, except:

- There is only one level of appeal (i.e., no Second-Level Appeal) and, if your appeal is denied, in whole or in part, the notice of denial will include all information required to be included in a final adverse benefit determination, as set forth in "Time limits for second-level appeal and notice of decision" on page L-10; and
- Initial claims and First-Level Appeals of claims regarding eligibility or enrollment are decided by the *Plan Administrator* and should be submitted to the *Plan Administrator's* address listed in "ERISA Plan Information" charts beginning on page L-20.

Exhaustion of Claims

You cannot bring any legal action against the plan for any reason unless you first complete all the steps in the appeal process (excluding a request for external review) as described in this section. However, you may be treated as having completed all these steps with respect to a claim if the plan fails to comply with its obligations at any point in the claims and appeal process, unless the plan's failure to comply is de minimis, non-prejudicial, attributable to good cause or matters beyond the plan's control, in the context of an ongoing, good-faith exchange of information, and not reflective of a pattern or practice of non-compliance. After completing the claims and appeals process, if you want to bring such a legal action you must do so within two years of the date you are notified of the final decision on your appeal or, if you choose to make a request for external review, within two years of the date you are notified of the final decision on external review, or you lose any rights to bring such an action.

Authorized Representative

You may appoint an authorized representative to act on your behalf in pursuing a benefit claim or an appealed claim. Such an appointment is not the same as an assignment of benefits or claims, which is prohibited. (See "Non-Assignment of Benefits" on page L-3.) The purpose of appointing an authorized representative is to relieve you, or your beneficiaries, of the burden of completing claims paperwork by yourself; for example, if you are incapacitated due to a medical condition or for any other reason.

In order to appoint an authorized representative, you must provide the *Plan Administrator* or the Claims Administrator 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 the *Plan Administrator* or Claims 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 the *Plan Administrator* or Claims Administrator.

If you identify an individual or entity as your authorized representative but do not describe the scope of the authority of this individual or entity, the *Plan Administrator* or the Claims Administrator will assume that your designated authorized representative has full powers to act with respect to all matters pertaining to your benefit claim or appeal.

The *Plan Administrator* or the Claims Administrator may reject your appointment of an authorized representative if the *Plan Administrator* or Claims Administrator determines that the appointment is intended to circumvent, or effectively circumvents, the anti-assignment rules of the plan, which are described in this SPD in "Non-Assignment of Benefits" on page L-3.

For example, your appointment could be rejected if the person or entity appointed as authorized representative would also be the person or entity (or is acting on behalf of such person or entity) who performed the services which are the subject of your benefit claim or appeal (such as a medical provider who is seeking payment for services rendered to you).

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.

Further, the *Plan Administrator* may at any time review and reject an appointment of an authorized representative as invalid on any grounds described here or in the plan, regardless of whether the Claims Administrator has previously communicated with the appointed person or entity without challenging their appointment as an authorized representative, including by communicating with the appointed person or entity under the plan's claims and appeals process or approving any claims submitted by that person or entity.

Claim and Appeal Procedures for Disability Programs

For details on filing claims and appeals for Income Protection Insurance Program benefits, see "Claim Information" on page H-12. For specific information on filing claims and appeals for Long-Term Disability Program benefits, see "Claim Information" on page H-20. Claims and appeals under the Disability Benefit Plan are not subject to the rules described herein. (For a description of procedures to be followed in applying for benefits under the Disability Benefit Plan, see "The Application Process," page H-6.)

All Other Care and Protection Plans and Programs

Initial Claim Decision

If your claim is wholly or partially denied, the Claims Administrator will notify you of the decision in writing within a reasonable period of time, but not later than 90 days of receipt of the claim, unless the Claims Administrator determines that special circumstances require an extension of time for processing your claim. In such a case, the Claims Administrator will provide you written notice of these special circumstances and the date the Claims Administrator expects to provide you the benefit determination prior to the termination of the initial 90-day period, and the extension will not exceed a period of 90 days from the end of the initial 90-day period. If a claim is denied, in whole or in part, the Claims Administrator's written notice shall include:

- The specific reason(s) for the denial.
- Specific reference to pertinent plan provisions on which the denial is based, if applicable.
- A description of any additional information that should be submitted by the claimant to explain or perfect his or her claim and an explanation of why this material or information is necessary.
- An explanation of the plan's claim review procedures, the time limits applicable to such procedures, and a statement of your right to bring a civil action under Section 502 of *ERISA* following an adverse benefit determination on review.

Appealing a Denial

If you disagree with a coverage decision or denial, you may request a full review by the Claims Administrator. You must submit this request within 60 days after you receive the denial notice. In connection with your appeal, you can submit written comments, documents, records, and other information relating to your claim.

Additionally, you may access (upon request and free of charge) copies of all documents, records, and other information relevant to your claim. (If you want to appeal a decision on benefits, send your appeal to the applicable Claims Administrator listed in the charts beginning on page L-20.) Your appeal will be reviewed, and the appeal will take into account all comments, documents, records, and other information submitted by you without regard to whether such information was submitted or considered in the initial benefit determination. Someone other than the person who made the first decision on your claim must make this review.

Your appeal must be in writing and must include the following information:

- Name of *employee* or *retiree*.
- Name of individual claiming benefits.
- Name of plan or program.
- Name of Claims Administrator.
- Reference to the initial decision.
- Explanation of why the initial determination is being appealed.

The Claims Administrator will notify you of the decision on appeal in writing within a reasonable period of time, but not later than 60 days of receipt of the claim, unless the Claims Administrator determines that special circumstances require an extension of time for processing your claim. In such a case, the Claims Administrator will provide you written notice of these special circumstances and the date the Claims Administrator expects to provide you the benefit determination prior to the termination of the initial 60-day period, and the extension will not exceed a period of 60 days from the end of the initial 60-day period.

If your claim appeal is denied, in whole or in part, the Claims Administrator's written notice shall include:

- The specific reason(s) for the denial.
- Specific reference to pertinent plan provisions on which the denial is based, if applicable.
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits.
- A statement of your right to bring a civil action under Section 502 of *ERISA*.

Claims Regarding Eligibility or Enrollment

If your claim relates to your or your dependent's eligibility to participate or your enrollment elections with respect to one or more of the Care and Protection plans or programs, it will be processed in the same time frame and manner as described in the "Initial Claim Decision" and "Appealing a Denial" provisions (on pages L-15 and L-16, respectively) applicable to all other Care and Protection Plans and Programs, except claims and appeals regarding eligibility or enrollment are decided by the *Plan Administrator* and should be submitted to the *Plan Administrator's* address listed in the charts beginning on page L-20.

Exhaustion of Claims

You cannot bring any legal action against the plan for any reason unless you first complete all the steps in the appeal process (excluding a request for external review) as described in this section. However, you may be treated as having completed all these steps with respect to a claim if the plan fails to comply with its obligations at any point in the claims and appeal process, unless the plan's failure to comply is de minimis, non-prejudicial, attributable to good cause or matters beyond the plan's control, in the context of an ongoing, good-faith exchange of information, and not reflective of a pattern or practice of non-compliance. After completing the claims and appeals process, if you want to bring such a legal action, you must do so within two years of the date you are notified of the final decision on your appeal or, if you choose to make a request for external review, within two years of the date you are notified of the final decision on external review, or you lose any rights to bring such an action.

Authorized Representative

You may appoint an authorized representative to act on your behalf in pursuing a benefit claim or an appealed claim. Such an appointment is not the same as an assignment of benefits or claims, which is prohibited. (See "Non-Assignment of Benefits" on page L-3.) The purpose of appointing an authorized representative is to relieve you, or your beneficiaries, of the burden of completing claims paperwork by yourself; for example, if you are incapacitated due to a medical condition or for any other reason.

In order to appoint an authorized representative, you must provide the *Plan Administrator* or the Claims Administrator 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 the *Plan Administrator* or Claims 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 the *Plan Administrator* or Claims Administrator.

If you identify an individual or entity as your authorized representative but do not describe the scope of the authority of this individual or entity, the *Plan Administrator* or the Claims Administrator will assume that your designated authorized representative has full powers to act with respect to all matters pertaining to your benefit claim or appeal.

The *Plan Administrator* or the Claims Administrator may reject your appointment of an authorized representative if the *Plan Administrator* or Claims Administrator determines that the appointment is intended to circumvent, or effectively circumvents, the anti-assignment rules of the plan, which are described in this SPD in "Non-Assignment of Benefits" on page L-3.

For example, your appointment could be rejected if the person or entity appointed as authorized representative would also be the person or entity (or is acting on behalf of such person or entity) who performed the services which are the subject of your benefit claim or appeal.

Further, the *Plan Administrator* may at any time review and reject an appointment of an authorized representative as invalid on any grounds described here or in the plan, regardless of whether the Claims Administrator has previously communicated with the appointed person or entity without challenging their appointment as an authorized representative, including by communicating with the appointed person or entity under the plan's claims and appeals process or approving any claims submitted by that person or entity.

The Health Insurance Portability and Accountability Act (HIPAA)

Federal law (the Health Insurance Portability and Accountability Act, or "HIPAA") gives you certain rights to privacy concerning your health information. These rights designate certain types of information as protected health information. Protected health information is any information that could be used to identify you as an individual that relates to past, present, or future health conditions, past, present, or future health care payments, or provision of health care. Under HIPAA, you have the right to receive notice of your privacy rights, policies, and procedures (HIPAA privacy notice), obtain access to your own information, and amend your information. You will be provided with one or more HIPAA privacy notices depending upon the health care program(s) in which you enroll.

Your Rights and Privileges Under the Employee Retirement Income Security Act of 1974 (ERISA)

Under the Employee Retirement Income Security Act of 1974 *(ERISA)*, you and all other plan participants have certain rights and protections. These include the right to receive certain plan information and to file suit if you believe your rights were violated. Specifically, *ERISA* provides that you and all the other plan participants have the right to the following.

Receive Information About Your Plan and Benefits

- 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 *Plan Administrator* may make a reasonable charge for the copies.
- Receive a summary of the plan's annual financial report. The *Plan Administrator* is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

Continue health care coverage for yourself, your spouse, or your dependent(s) if there is a loss of coverage under the plan as a result of a *qualifying event*. You or your dependent(s) may have to pay for such coverage. Review this summary plan description and the documents governing the plan on the rules governing your continuation of coverage rights under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA).

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 benefit plan. The people who operate your plan, called fiduciaries of the plan, have a duty to do so prudently and in the interest of you and other plan participants and *beneficiary(ies)*. 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 welfare benefit or exercising your rights under *ERISA*.

Enforce Your Rights

- If your claim for a welfare 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 plan documents or the latest annual report from the plan and do not receive the requested materials within thirty (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.
- Provided you complied with the requirements of the appropriate claims procedures described in the "Claims and Appeals" section of this document, if your claim for benefits is denied or ignored, in whole or in part, you may file suit in a state or federal court.
- 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 *Plan Administrator*. If you have any questions about this summary plan description 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 at 1-866-444-3272.

ERISA Plan Information

The charts on the following pages provide administrative information on the plans and programs described in the previous sections of this book that are covered by *ERISA* (except the Dependent Day Care Program) and have a plan year of January 1 to December 31.

Care

The following *component programs* are part of the Shell USA, Inc. Health & Wellbeing Plan (501).

Component Program of the Shell USA, Inc. Health & Wellbeing Plan (501)	Employer/Plan Administrator*	Claims Administrator and Insurance Carrier**	Trustee	Agent(s) for Service of Legal Process
Medical Benefit Program	Shell USA, Inc. 150 N. Dairy Ashford Road Houston, TX 77079 Attn: US Benefits Manager 1-800-307-4355	**Claims Administrator:** (US PPO, US HDHP, Kelsey-Seybold Greater Houston, Shell Medicare Complementary options) UnitedHealthcare P.O. Box 30555 Salt Lake City, UT 84130-0555 **Claims Administrator:** (Shell Medicare Advantage PPO) UnitedHealthcare P.O. Box 740800 Atlanta, GA 30374-0800 (KelseyCare Advantage) KelseyCare Advantage P.O. Box 841649 Pearland, TX 77584 **Claims Administrator:** (US PPO, US HDHP, Kelsey-Seybold Greater Houston — Optum Behavioral Health) UnitedHealthcare P.O. Box 30555 Salt Lake City, UT 84130-0555 *(continued)*	Principal Trust Company 711 High Street Des Moines, IA 50392	*Plan Administrator*

(continued)

Component Program of the Shell USA, Inc. Health & Wellbeing Plan (501)	Employer/Plan Administrator*	Claims Administrator and Insurance Carrier**	Trustee	Agent(s) for Service of Legal Process
Medical Benefit Program *(continued)*		**Claims Administrator:** (US PPO, US HDHP, Kelsey-Seybold Greater Houston options) CVS Caremark P.O. 52136 Phoenix, AZ 85072-2136 **Claims Administrator:** (US GEMS) Cigna Global Health Benefits P.O. Box 15800 Wilmington, DE 19850		
Dental Benefit Program	Shell USA, Inc. 150 N. Dairy Ashford Road Houston, TX 77079 Attn: US Benefits Manager 1-800-307-4355	**Claims Administrator:** (PPO) Cigna P.O. Box 188045 Chattanooga, TN 37422 **Insurance Carrier:** (DHMO) Cigna Dental Health P.O. Box 188045 Chattanooga, TN 37422	Principal Trust Company 711 High Street Des Moines, IA 50392	*Plan Administrator*
Vision Benefit Program	Shell USA, Inc. 150 N. Dairy Ashford Road Houston, TX 77079 Attn: US Benefits Manager 1-800-307-4355	**Claims Administrator and Insurance Carrier:** Vision Service Plan VSP Corporate Headquarters 3333 Quality Drive Rancho Cordova, CA 95670	N/A	*Plan Administrator*

(continued)

Component Program of the Shell USA, Inc. Health & Wellbeing Plan (501)	Employer/Plan Administrator*	Claims Administrator and Insurance Carrier**	Trustee	Agent(s) for Service of Legal Process
Health Care Account and/or Dependent Day Care Account Program	Shell USA, Inc. 150 N. Dairy Ashford Road Houston, TX 77079 Attn: US Benefits Manager 1-800-307-4355	**Claims Administrator:** HealthEquity/WageWorks (formerly WageWorks) P.O. Box 14053 Lexington, KY 40512 Phone: 877-924-3967 Website: www.wageworks.com	N/A	*Plan Administrator*
Employee Assistance Program	Shell USA, Inc. 150 N. Dairy Ashford Road Houston, TX 77079 Attn: US Benefits Manager 1-800-307-4355	**Claims Administrator:** Optum Behavioral Health UnitedHealthcare P.O. Box 30555 Salt Lake City, UT 84130-0555	N/A	*Plan Administrator*

* Any communication with the *Plan Administrator* should be directed to the US Benefits Manager.

** Note that claims and appeals related to eligibility and enrollment matters under the health care programs are decided by the *Plan Administrator*, as described in the claims and appeals procedures. You should direct such eligibility and enrollment claims and appeal requests to the US Benefits Manager at 150 N. Dairy Ashford Road, Houston, TX 77079.

Protection

The following *component programs* are part of the Shell USA, Inc. Health & Wellbeing Plan (501).

Component Program of the Shell USA, Inc. Health & Wellbeing Plan (501)	Employer/Plan Administrator*	Claims Administrator and Insurance Carrier**	Trustee	Agent(s) for Service of Legal Process
Income Protection Insurance Program (Open States)	Shell USA, Inc. 150 N. Dairy Ashford Road Houston, TX 77079 Attn: US Benefits Manager 1-800-307-4355	**Insurance Carrier:** Metropolitan Life Insurance Company 200 Park Avenue New York, NY 10166 **Claims Administrator:** Metropolitan Life Insurance Company 1300 Hall Boulevard Bloomfield, CT 06002	N/A	*Plan Administrator*

(continued)

Component Program of the Shell USA, Inc. Health & Wellbeing Plan (501)	Employer/Plan Administrator*	Claims Administrator and Insurance Carrier**	Trustee	Agent(s) for Service of Legal Process
Long-Term Disability Program	Shell USA, Inc. 150 N. Dairy Ashford Road Houston, TX 77079 Attn: US Benefits Manager 1-800-307-4355	**Insurance Carrier:** Metropolitan Life Insurance Company 200 Park Avenue New York, NY 10166 **Claims Administrator:** Metropolitan Life Insurance Company 1300 Hall Boulevard Bloomfield, CT 06002	N/A	*Plan Administrator*
Survivor Benefit Program	Shell USA, Inc. 150 N. Dairy Ashford Road Houston, TX 77079 Attn: US Benefits Manager 1-800-307-4355	**Insurance Carrier:** Metropolitan Life Insurance Company 200 Park Avenue New York, NY 10166 **Claims Administrator:** Metropolitan Life Insurance Company P.O. Box 6100 Scranton, PA 18506	N/A	*Plan Administrator*
Occupational Accidental Death Benefit Program	Shell USA, Inc. 150 N. Dairy Ashford Road Houston, TX 77079 Attn: US Benefits Manager 1-800-307-4355	**Insurance Carrier:** Metropolitan Life Insurance Company 200 Park Avenue New York, NY 10166 **Claims Administrator:** Metropolitan Life Insurance Company P.O. Box 6100 Scranton, PA 18506	N/A	*Plan Administrator*

(continued)

Component Program of the Shell USA, Inc. Health & Wellbeing Plan (501)	Employer/Plan Administrator*	Claims Administrator and Insurance Carrier**	Trustee	Agent(s) for Service of Legal Process
Group Life Insurance Program	Shell USA, Inc. 150 N. Dairy Ashford Road Houston, TX 77079 Attn: US Benefits Manager 1-800-307-4355	**Insurance Carrier:** Metropolitan Life Insurance Company 200 Park Avenue New York, NY 10166 **Claims Administrator:** Metropolitan Life Insurance Company P.O. Box 6100 Scranton, PA 18506	N/A	*Plan Administrator*
Retiree Life Insurance Program	Shell USA, Inc. 150 N. Dairy Ashford Road Houston, TX 77079 Attn: US Benefits Manager 1-800-307-4355	**Insurance Carrier:** Metropolitan Life Insurance Company 200 Park Avenue New York, NY 10166 **Claims Administrator:** Metropolitan Life Insurance Company P.O. Box 6100 Scranton, PA 18506	N/A	*Plan Administrator*
Voluntary Personal Accident Insurance Program	Shell USA, Inc. 150 N. Dairy Ashford Road Houston, TX 77079 Attn: US Benefits Manager 1-800-307-4355	**Insurance Carrier:** Metropolitan Life Insurance Company 200 Park Avenue New York, NY 10166 **Claims Administrator:** Metropolitan Life Insurance Company P.O. Box 6100 Scranton, PA 18506	N/A	*Plan Administrator*

(continued)

Component Program of the Shell USA, Inc. Health & Wellbeing Plan (501)	Employer/Plan Administrator*	Claims Administrator and Insurance Carrier**	Trustee	Agent(s) for Service of Legal Process
Business Travel Accident Insurance Program	Shell USA, Inc. 150 N. Dairy Ashford Road Houston, TX 77079 Attn: US Benefits Manager 1-800-307-4355	**Insurance Carrier:** Metropolitan Life Insurance Company 200 Park Avenue New York, NY 10166 **Claims Administrator:** Metropolitan Life Insurance Company P.O. Box 6100 Scranton, PA 18506	N/A	*Plan Administrator*
Group Legal Program	Shell USA, Inc. 150 N. Dairy Ashford Road Houston, TX 77079 Attn: US Benefits Manager 1-800-307-4355	**Insurance Carrier:** Metropolitan Property and Casualty Insurance Company 700 Quaker Lane Warwick, RI 02886 **Claims Administrator:** MetLife Legal Plans, Inc. 1111 Superior Avenue Cleveland, OH 44114	N/A	*Plan Administrator*
Long-Term Care Program	Shell USA, Inc. 150 N. Dairy Ashford Road Houston, TX 77079 Attn: US Benefits Manager 1-800-307-4355	**Claims Administrator and Insurance Carrier:** John Hancock Life Insurance Company (U.S.A.) ATTN: Group Long-Term Care Division P.O. Box 111 Boston, MA 02117	N/A	*Plan Administrator*
Back-Up Care Program	Shell USA, Inc. 150 N. Dairy Ashford Road Houston, TX 77079 Attn: US Benefits Manager 1-800-307-4355	**Claims Administrator:** Bright Horizons Family Solutions 200 Talcott Avenue South Watertown, MA 02472	N/A	*Plan Administrator*
Severance Pay Plan	Shell USA, Inc. 150 N. Dairy Ashford Road Houston, TX 77079 Attn: US Policy Manager 1-800-307-4355	**Claims Administrator:** Shell USA, Inc. 150 N. Dairy Ashford Road Houston, TX 77079	N/A	*Plan Administrator*

* Any communication with the *Plan Administrator* should be directed to the US Benefits Manager.

** Note that claims and appeals related to eligibility and enrollment matters are decided by the *Plan Administrator* as described in the claims and appeals procedures. You should direct such eligibility and enrollment claims and appeal requests to the US Benefits Manager at 150 N. Dairy Ashford Road, Houston, TX 77079.

Glossary

Accredited Service

Accredited service is generally defined as all your time of employment with the *Company* or time credited to you for time not worked or for other reasons. Specifically, if you are a *regular full-time employee* or *regular part-time employee*, you earn one year of accredited service if you work or receive credit for a one-year "Period of Service" which is generally defined as follows:

- Each 12-month period of service starting on your hire date or re-hire date (if any) and ending on the earlier of:
  - Termination of employment, or
  - The last day of the first 12 months of each authorized leave of absence.
- In most cases, you will be credited with one month of service for each calendar month in which you are credited with one or more hours of service. However, this service counting convention does not apply when determining service credit for purposes of establishing *occupational disability* and *non-occupational disability* banks and maximum Income Protection Insurance (IPI) Program benefits. Additionally, the post-retirement medical subsidy for *employees* hired before January 1, 2006, will continue to be determined based upon completed years of service.
- Any period required to be credited as a "Period of Service" by other federal law, such as *The Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA)*.

For purposes of determining service credit for establishing *occupational disability* and *non-occupational disability* banks and maximum Income Protection Insurance (IPI) Program benefits, you receive a year of accredited service on each anniversary of your hire date. Special rules apply if you have had a break in service.

The following may be credited, as exceptions:

- The entire period that you are absent due to war or national emergency.
- The period approved under the *Company's* military leave policy.
- Up to one year if you are absent in accordance with the family and medical leave policies of the *Company* (you must return to work to get this credit for *occupational disability* and *non-occupational disability* banks, IPI benefits).

Actively at Work

Actively at work means that you are performing all of the material duties of your job where these duties are normally carried out. If you were actively at work on your last scheduled working day, you will be deemed actively at work:

- On a scheduled non-working day.
- Provided you are not disabled.

Affiliated Company

An affiliated company is generally defined as a non-participating entity that has at least an 80% ownership connection with Shell USA, Inc. or other *participating companies*. For purposes of *eligibility service*, vesting service, and participation service, an affiliated company is a non-participating entity that has more than a 25% ownership connection with Shell USA, Inc. or other *participating companies*.

Beneficiary(ies)

The person(s) designated to receive a plan benefit in the event of the death of a plan participant.

Child(ren) (with respect to the Survivor Benefit Program, the Occupational Accidental Death Benefit Program, and the Business Travel Accident Insurance Program)

For the purposes of these programs, child(ren) include:

- Natural and legally adopted child(ren) of you, your spouse, or your *domestic partner*, and
- Child(ren) eligible for coverage under Shell's benefit plans.

For the purposes of these programs, child(ren) does not include the child(ren) of a former spouse or *domestic partner*, unless:

- The child(ren) is your natural or legally adopted child(ren), or
- The marriage or domestic partnership ended due to the death of your spouse or *domestic partner* rather than the dissolution of the relationship at the initiative of either or both parties to the relationship.

This definition is applied to the extent permitted under law (e.g., applicable state law may define child(ren) for purposes of receiving death benefits of a parent).

For a definition of child(ren) with respect to medical, dental and vision benefits, see "Eligible Dependents" on page M-4.

Child(ren) Only (coverage)

A coverage level for eligible children of *retirees* enrolled in a Shell medical option for *Medicare*-eligible *retirees*.

Coinsurance

Coinsurance is the percentage of a covered medical or dental expense payable by the participant.

Company (generally)

Throughout this book, the term Company or Shell refers to all of the *participating companies* listed on page M-7.

Company (with respect to the Severance Pay Plan)

For purposes of the Severance Pay Plan, the term Company includes all of the individual companies listed in the chart in the *participating company* definition on page M-7 except for Shell US Hosting Company.

Component Program (of the Shell USA, Inc. Health & Wellbeing Plan)

A benefit program selected by the *Company* and designated as such in the plan document.

Copayment

A fixed charge that represents a participant(s)' share of a covered medical, dental, or vision care expense.

Custodial Care (with respect to Medicare)

Care that primarily helps a person meet personal hygiene needs or perform the activities of daily living, such as getting out of bed, bathing, dressing, eating, and administering medication. Custodial care may also include supervised living arrangements under which little or no medical, mental health, or substance abuse treatment is being rendered.

Custodial Care (with respect to the Shell Medical Benefit options)

Personal health care, wherever furnished and by whatever name called, that is designed primarily to assist an individual in performing his or her activities of daily living. Such services include, without limitation, assistance in walking, getting in or out of bed, bathing, dressing, feeding, or using the lavatory, preparation of special diets, and supervision of medication schedules. Custodial care may also include supervised living arrangements under which little or no medical, mental health or substance use disorder treatment is being rendered.

Deductible or Deductible Amount

The amount of covered medical or dental expenses that the participant must pay each calendar year for care received from a health care provider. Generally, the deductible amount must be satisfied before most benefits are payable under the plan.

Dental DHMO

A dental plan option that requires you to use designated providers in order for services to be covered, typically in exchange for lower premiums. Each covered person must select a primary care dentist.

Dental PPO

A dental plan option that allows use of any qualified dental provider, but may save you money if you use a dentist who has agreed to negotiated fees as part of a preferred provider network.

Domestic Partner

A person of the same or opposite sex who meets the following criteria:

- Maintains a spouse-like relationship with you.
- Is at least 18 years old and mentally competent to enter into a contract.
- Is not legally married to anyone else or in a domestic partner arrangement with anyone else.
- Has shared the same residence with you for at least 12 months and intends to do so indefinitely.
- Is someone with whom you are jointly responsible for each partner's common welfare.
- Is financially interdependent.
- Is unrelated to you by blood or marriage in a way that would prohibit a legal marriage in your state of residence.
- Jointly signs a domestic partnership affidavit with you attesting to all the above, including responsibility for notifying the *Company* if this relationship changes.

In addition to the above criteria, domestic partner also includes a person whose domestic partnership with you is currently registered with a governmental body pursuant to state or local law authorizing such registration.

Eligibility Service

Eligibility service is used to determine your eligibility for certain benefits. Your eligibility service is your *accredited service* plus certain other service recognized under the Shell Pension Plan. It generally includes service with an *affiliated company*.

Eligible Dependents

Eligible dependent(s) include:

- Your spouse.
- Your *domestic partner*.
- Your child(ren) (biological child, stepchild, adopted child, foster child, or grandchild of whom you have legal guardianship) through the end of the month in which they turn 26.
- Your unmarried child(ren) age 26 or over who were physically or mentally disabled on the day before reaching their 26th birthday and were covered under the program, or under another plan sponsored through your or your spouse/domestic partner's previous employment, and who remain disabled and permanently dependent on you for financial support.
- The unmarried child(ren) of your spouse or *domestic partner* who are under age 25, live with you in a regular parent-child relationship, are not employed full-time, and whose medical expenses are eligible for deduction on your federal tax return.
- The unmarried child(ren) of your spouse or *domestic partner* age 25 or over who were physically or mentally disabled on the day before reaching their 25th birthday and were covered under the program, or under another plan sponsored through your or your spouse/domestic partner's previous employment, and who remain disabled, live with you in a regular parent-child relationship and are permanently dependent upon you for financial support.

Employee(s)/Eligible Employee(s) (with respect to all the Component Programs under the Plan, except the Severance Pay Plan)

Any employee (including summer hires and interns) who is a *regular full-time* or *regular part-time employee* of a *participating company* who receives a regular and stated compensation (other than a retainer) directly from such *participating company*, as determined and recorded by such *participating company*. Except as otherwise provided by a Shell USA, Inc. Health & Wellbeing Plan Component Program, the employee or eligible employee shall not include:

- A person whose compensation is paid solely in the form of commissions.
- A person who is employed temporarily by or assigned to a *participating company* because of a transfer from a foreign associated company. However, a person who would otherwise be excluded may be an exception under the following circumstances:
  - If the person's compensation and benefits are determined based on the categories of "Local Plus," "Local Non-National," or "Alternate" pursuant to the International Mobility Policies, he or she shall be included as an employee or eligible employee for purposes of enrolling as a participant in a) only the US GEMS option under the Medical Benefit Program and b) any other *Component Program* under the *Plan*.
  - If the person is classified as being on "Long Term International Assignment" pursuant to the International Mobility Policies, he or she is included as an employee or eligible employee solely for purposes of enrolling as a participant in US GEMS under the Medical Benefit Program with the option to provide coverage for his or her *eligible dependent(s)*.
- A leased employee within the meaning of Section 414 of the Internal Revenue Code.
- A person whose contract of employment or engagement letter or contract for services explicitly states or implicitly provides that the person is not entitled to participate in the benefits described in this book, in particular, or the employee benefit plans of one or more *participating companies*, in general.
- A person designated by the relevant *participating company* as an independent contractor.
- A fixed-term employee, other than a fixed-term contract employee of Shell US Hosting Company.

Employee(s) (with respect to the Severance Pay Plan)

A person who is in the full-time or part-time service of, and receives a regular salary or wage from, the *Company* and from whose pay the *Company* withholds federal income tax. Persons on a retainer, or whose compensation is paid solely in the form of commissions, are not considered employees.

Employee Assistance Program (EAP)

A voluntary, confidential program that offers assistance with personal and work-related problems at no cost. *Employees* and their families can receive assessment, short-term counseling, referrals and follow-up services related to a broad scope of issues, ranging from anger management and alcohol/drug dependence to elder care, childcare and work/life balance.

ERISA

Employee Retirement Income Security Act of 1974, as amended.

Family Coverage

Coverage for a participant and his or her *eligible dependent(s)*, as elected by the *employee*.

Flexible Spending Account (FSA)

An account sponsored by an employer to allow *employees* to set aside funds on a pre-tax basis to pay for eligible expenses. Shell offers a Health Care FSA (HCA) and a Dependent Day Care FSA (DDCA). FSA funds are not portable and must be used during the specified period or they are forfeited.

Group Annual Enrollment Period

The period each calendar year during which *employees* and *retirees* have the opportunity to enroll and make changes in the plans and programs outlined in this book. Coverage elected during this period will take effect January 1st of the following calendar year or when coverage is approved by the insurance provider, whichever is later.

Health Savings Account (HSA)

A tax-advantaged savings account to be used in conjunction with a *High Deductible Health Plan (HDHP)* to reimburse qualified medical expenses that are not covered by the *HDHP*. An HSA is administered by a financial institution and owned and funded by the *employee*. An employer may contribute to an *employee's* HSA.

High Deductible Health Plan (HDHP)

A health plan option that offers a lower monthly premium than traditional health plans in exchange for requiring participants to meet a higher out-of-pocket *deductible* before the plan pays benefits for any non-preventive services. An HDHP can be combined with a *Health Savings Account (HSA)* to help cover the *deductible* and other qualified medical expenses.

Hospital

An accredited facility engaged primarily in providing medical care and treatment to ill and injured persons at the patient's expense. To qualify for coverage under the Shell Medical Benefit options, a hospital must meet the following criteria:

- Be accredited by the Joint Commission on Accreditation of Hospitals.
- Be qualified to participate and eligible to receive payments under and in accordance with *Medicare*.
- Provide the following on its premises:
  - Diagnostic and therapeutic facilities for surgical and medical diagnosis and treatment of sick and injured persons by or under the supervision of a staff of duly qualified *physicians*.
  - Continuous 24-hour nursing service under the supervision of a registered nurse.
  - Facilities for performing surgery.

In-Network

Refers to health care providers that participate in your insurer's network and have agreed to negotiated fees for services. Typically, when you use in-network providers you receive a higher level of benefits and do not have to file a claim for reimbursement.

Medicare

The Health Insurance for the Aged and Disabled Program under Title XVIII of the Social Security Act, as amended.

Non-Occupational Disability

Under the Disability Benefit Plan, a disability that is caused by a non-work-related illness or injury.

Occupational Disability

Under the Disability Benefit Plan, a disability that results from a work-related illness or injury.

Out-of-Network

Refers to health care providers that **do not** participate in your insurer's network. If your coverage allows non-emergency use of out-of-network providers, doing so will typically cause you to pay a higher share of the cost of the service and may require you to file a claim for reimbursement.

Out-of-Pocket Maximum

The maximum amount that a participant or *eligible dependent(s)* will have to pay for covered medical expenses during a calendar year.

Participant Only Coverage

Coverage for an *employee* or *retiree* only.

Participant Plus Child(ren) Coverage

Coverage for an *employee* or *retiree* and his or her child or children.

Participant Plus Spouse/Domestic Partner Coverage

Coverage for an *employee* or *retiree* and his or her spouse or, where applicable, coverage for an *employee* or *retiree* and his or her *domestic partner*.

Participating Company

Throughout this book, these companies also may be referred to as the "Company" or "Shell." From time to time, companies may begin or stop participating in the plans. In this regard, each of the companies may continue or terminate coverage for their own *employees* or *retirees* under the plans. The companies participating in the plans described in this book, other than the Severance Pay Plan, include:

Participating Company	Employer Identification Number (EIN)
Equilon Enterprises LLC d/b/a Shell Oil Products US	52-2074528
Pecten Middle East Services Company Limited	98-0137631
Pecten Producing Company	74-2211531
Pennzoil-Quaker State Company d/b/a SOPUS Products	76-0200625
Shell Catalysts & Technologies US LP	76-0665402
Shell Chemical LP	76-0641749
Shell Downstream Inc.	33-1115091
Shell Energy Resources Company	77-0599130
Shell Expatriate Employment US Inc.	76-0696736
Shell Exploration & Production Company	76-0457926
Shell Global Solutions (US) Inc.	30-0032507
Shell Information Technology International Inc.	76-0460697
Shell International Exploration and Production Inc.	76-0551934
Shell Marine Products (US) Company	76-0588338
Shell North America Gas & Power Services Company	76-0551935
Shell Offshore Inc.	74-2211530
Shell Oil Products Company LLC	76-0672445
Shell USA, Inc.	13-1299890
Shell Pipeline Company LP	52-2074531
Shell Trademark Management Inc.	45-3030966
Shell Trading North America Company	76-0659720
Shell Trading Risk Management, LLC	76-0480645
Shell Trading Services Company	76-0659593
Shell Trading (US) Company	76-0580508
Shell US Gas & Power LLC	76-0559211
Shell US Hosting Company	27-2830621
Shell Windenergy Services Inc.	76-0665780
SOPC Southeast Inc.	65-1163125
SWEPI LP	76-0073231

Part-Time Employee

A person reflected in Shell's system as being scheduled to work less than the basic workweek schedule and less than 20 hours a week, and who is generally not eligible for participation in the plans and programs described in this book. (See the "Eligibility" section for each plan and program for information on *eligible employees*.) Regardless of the number of hours worked, part-time *employees* are eligible to participate in the Shell Provident Fund and Shell Pension Plan, per the terms of each plan.

Physician

Any Doctor of Medicine or Doctor of Osteopathy who is properly licensed and qualified by law. **Please note:** Any podiatrist, dentist, psychologist, chiropractor, optometrist or other provider who acts within the scope of his or her license will be considered on the same basis as a physician. The fact that a provider is described as a physician does not mean that benefits for services from that provider are available to you under the *Plan*.

Plan

The Shell USA, Inc. Health & Wellbeing Plan.

Plan Administrator

The entity with the authority to control and manage the operation and administration of the benefit plans, and discretion to interpret their provisions, as outlined in the plan documents. The Plan Administrator for the plans in the Shell USA, Inc. Health & Wellbeing Plan is Shell USA Inc. (known as Shell Oil Company prior to March 1, 2022).

Preferred Provider Organization (PPO)

A health care plan option providing access to negotiated-price discounts when plan participants receive care from designated providers.

Qualified Status Change

A qualified status change means any of the following:

Status changes:

- Marriage.
- Divorce.
- The birth or placement for adoption of a child or children.
- Gaining a *domestic partner* or dependent(s).
- The death of a spouse, *domestic partner*, or child(ren).
- Loss of dependent(s)' eligibility.

A qualified change in employment status:

- Your termination or commencement of employment.
- A *Company*-authorized transfer requiring a change in your work location and relocation of your residence that results in a change in available coverage.
- The employment or unemployment of your spouse or *domestic partner*.

Other qualified changes:

- A change in your status from a *regular full-time employee* to a *part-time employee* who is not eligible for participation in the plans and programs described in this book.
- A change in your status from a *part-time employee* who is not eligible for participation in the plans and programs described in this book to a *regular full-time employee*.
- A change in your status from a *regular part-time employee* to a *part-time employee* who is not eligible for participation in the plans and programs described in this book.
- A change in your status from a *part-time employee* who is not eligible for participation in the plans and programs described in this book to a *regular part-time employee*.
- A change in your status from a *regular full-time employee* to a *regular part-time employee*, or a change from a *regular part-time employee* to a *regular full-time employee*, or a change between full-time and part-time status for your spouse or *domestic partner*. However, this does not constitute a qualified status change for the Health Care Account Program.

- A change in your residence that results in a change in available coverage.
- A significant change in coverage or cost of your, your spouse's or *domestic partner's* plan.
- Eligibility of the *employee* or *retiree*, spouse, *domestic partner*, or child(ren) for *Medicare* or Medicaid.
- A judgment, decree, or order that requires you or your spouse to provide medical coverage for a dependent child resulting from divorce, legal separation, annulment, or a change in legal custody (including a QMCSO).
- Your taking FMLA or USERRA leave (for revocation of elections only).

Special enrollment rights:

- Exhaustion of your, or your spouse's, *domestic partner's*, or dependent(s)' COBRA coverage.
- Loss of eligibility for your, your spouse's, *domestic partner's*, or dependent(s)' coverage under another group health plan.
- Reaching a lifetime limit for all benefits under another group health plan or under that option you are enrolled in under the Medical Benefit Program or Dental Benefit Program, but not all options.
- Your or your spouse's, *domestic partner's*, or dependent(s)' loss of coverage under Medicaid or a state children's health insurance program ("SCHIP") as the result of loss of eligibility.
- Your or your spouse's, *domestic partner's*, or dependent(s)' eligibility for a premium assistance subsidy under Medicaid or SCHIP.

In addition, for the Dependent Day Care Account Program, a qualified change includes a change in childcare or elder care provider, a significant cost increase imposed by a childcare or elder care provider, and a change in hours worked by your childcare or elder care provider.

Note: A qualified status changes only allows you to make benefit coverage changes that are relevant to the status change. For example, marriage would allow you to add dependents to your coverage, but not to change plans.

Qualifying Event

A qualifying event is an event creating eligibility for COBRA coverage as described on page F-2 of this SPD.

Regular Full-Time Employee

An *employee** who regularly works the basic workweek for his or her job classification or position, but not less than 20 hours a week, and whose employment is not fixed or limited specifically to 30 consecutive calendar days or less.

* See definition of Employee/Eligible Employee.

Regular Part-Time Employee

A person reflected in Shell's systems as being scheduled to work less than the basic workweek schedule but at least 20 hours a week on an indefinite basis. Generally, only *employees** who meet these criteria are eligible for the regular part-time employee benefits described in this book. Regardless of hours worked, regular part-time employees are eligible to participate in the Shell Provident Fund and Shell Pension Plan.

* See definition of Employee/Eligible Employee.

Retiree (also Retired Employee)

As defined in the Shell USA, Inc. Health & Wellbeing Plan. It generally means a person who terminated employment from a *participating company* with *retiree coverage eligibility*.

Retiree Coverage Eligibility*

At your termination of employment, you must either:

- Have attained at least age 50, and have your *eligibility service* plus your age equal at least 80, or
- Terminate employment at age 65 or older with eligibility for a Regular Pension under the Shell Pension Plan, or
- Terminate employment with eligibility for a disability pension under the Shell Pension Plan, or
- Satisfy the 70-Point Eligibility rules (have attained age 50 with 20 or more years of *eligibility service* and your termination of employment results from one of the following reasons: your serious ill health, which is expected to continue for the foreseeable future (a medical report is required); the sale or closing of a facility, office or plant; the sale or dissolution of a *participating company*; or the restructuring, reorganization, or reduction of the workforce of a *participating company*).

* Note that *employees* hired or rehired on or after January 1, 2017, are not eligible for *retiree* coverage under the Shell Medical Benefit Program.

Spouse/Domestic Partner Only Coverage

A coverage level for non-*Medicare*-eligible spouses or *domestic partners* of *retirees* who are enrolled in a Shell medical option for *Medicare*-eligible *retirees*.

Spouse/Domestic Partner Plus Child(ren) Coverage

A coverage level for non-*Medicare*-eligible spouses or *domestic partners* and children of *retirees* who are enrolled in a Shell medical option for *Medicare*-eligible *retirees*.

Standard Hours Election

An election that must be made by *regular part-time employees* of one of five levels of standard weekly hours (20, 24, 28, 32, or 36) to qualify for benefits. Disability Benefit Plan, Income Protection Insurance Program, Group Life Insurance Program, and other benefits are based on a *part-time employee's* standard hours election. *Part-time employees* with a standard hours election of less than 20 hours a week are not eligible for benefits.

The Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), as amended

A federal law that provides for employment and reemployment rights for those who served, are serving, or plan to serve in the U.S. Armed Forces (including the Army, Navy, Air Force, Marines, and Coast Guard), the Army National Guard, the Air Force National Guard, or the Public Health Service, and any other category of persons designated by the President of the United States in time of war or national emergency.

Appendix

Table of Contents

The following programs are no longer offered to new participants. The information in this Appendix is provided for the convenience of current participants. Please refer all questions to the applicable claims administrator for the program, whose contact information is listed on page vi of this book.

- Long-Term Care Insurance
- Retiree Life Insurance

Long-Term Care Insurance

Long-term care insurance is intended to help pay costs for long-term care that are not covered by medical insurance or *Medicare*. This program is administered by John Hancock.

Participation

Effective January 1, 2012, John Hancock suspended new enrollments into the program. The information in this SPD applies only to those already enrolled in Long-Term Care Insurance.

Changing Coverage

You may apply for the following coverage changes at any time, if eligible:

- Add new or terminate existing coverage, and/or
- Increase or decrease the daily maximum benefit.

Please note that if you are adding coverage or increasing the daily maximum benefit, you will be required to provide evidence of insurability.

Cost

The cost of coverage is based on your coverage selections, the state in which you reside, and your age at the time your coverage takes effect. The younger you were when you enrolled, the lower your premium. After enrollment, premiums do not increase because you get older, your health changes, or you receive plan benefits.

You pay the entire cost of coverage. You can choose to have the cost automatically deducted from your bank account, or you can be billed directly.

How the Program Works

Coverage

The long-term care plan provides the following coverage:

- Coverage for nursing home care.
- Alternate care facilities such as an assisted living facility.
- Community-based professional care.
- Informal care.
- Stay-at-home benefit.

The stay-at-home benefit can be used to pay for long-term care expenses not ordinarily covered. Services include:

- A care planning visit.
- Home modification.
- Emergency response system.
- Durable medical equipment.
- Caregiver training.
- Home safety checks.
- Provider care checks.

Services under the stay-at-home benefit must be provided while an insured is living in his or her home except for the care planning visit.

The total benefits payable for caregiver training cannot exceed 5 times the nursing home daily maximum benefit.

The total stay-at-home-benefit is equal to 30 times the nursing home daily maximum benefit and is available during the qualification period described in "Applying for Benefits" on page N-4.

The total stay-at-home benefit does not reduce the lifetime maximum benefit. It is not available if coverage is in reduced, paid-up status under the non-forfeiture provision and cannot be restored under the restoration of benefits provision.

Community-based professional care includes:

- Home health care.
- Adult day care.
- Hospice care at home.
- Homemaker services by a licensed provider.

Daily Benefit Amount

When you apply for coverage, you have to select the daily maximum benefit amount you would like for your nursing home, alternate care facility, community-based professional care, and informal care coverage. The daily maximum benefits are:

	Option 1	Option 2	Option 3	Option 4	Option 5
Nursing home (100%)	$75.00	$100.00	$150.00	$200.00	$250.00
Alternate care facility (100%)	$75.00	$100.00	$150.00	$200.00	$250.00
Community-based professional care (80%)	$45.00	$60.00	$90.00	$120.00	$150.00
Informal care (50%)*	$37.50	$50.00	$75.00	$100.00	$125.00

* Informal care has a calendar year maximum of 30 times the informal care daily maximum benefit.

Lifetime Maximum Benefit Options

Applicants can choose between a three-year, five-year, or ten-year lifetime maximum benefit.

Lifetime Maximum Benefit	Option 1	Option 2	Option 3	Option 4	Option 5
Three years[1]	$82,125	$109,500	$164,250	$219,000	$273,750
Five years[2]	$136,875	$182,500	$273,750	$365,000	$456,250
Ten years[3]	$273,750	$365,000	$547,500	$730,000	$912,500

[1] Nursing home daily maximum benefit times number of days in three years (1,095).

[2] Nursing home daily maximum benefit times number of days in five years (1,825).

[3] Nursing home daily maximum benefit times number of days in ten years (3,650).

Applying for Benefits

To qualify for benefits, a licensed health care practitioner must certify that you require substantial assistance (hands-on or standby) from another person to perform at least two activities of daily living due to loss of functional capacity, which is expected to continue for at least 90 days, or that you need substantial supervision due to a cognitive impairment. You must also complete the qualification period. All services must be specified in a written plan-of-care prescribed by a licensed health care practitioner. You must provide proof of claim satisfactory to John Hancock.

Activities of Daily Living Dependence

The six activities of daily living are:

- Bathing.
- Maintaining continence.
- Dressing.
- Toileting.
- Eating.
- Transferring.

Cognitive Impairment

Cognitive impairment is deterioration or loss of intellectual capacity that is comparable to, and includes, Alzheimer's disease and similar forms of irreversible dementia. The need for substantial supervision due to severe cognitive impairment must be established by clinical evidence and standardized tests that reliably measure impairment in a person's short-term or long-term memory; orientation as to person, place, or time; deductive or abstract reasoning; or judgment as it relates to safety awareness.

Qualification Period

The qualification period is the period of time you must wait from the date you meet the policy benefit triggers (as described in "Applying for Benefits") until the date benefits are payable for covered charges you incur. John Hancock determines the start of the qualification period based on your medical information and claim file. The qualification period is 90 days and needs to be met only once as long as you remain continuously insured. This means that if you qualified for benefits more than once while you remained insured:

- You do not have to complete a new qualification period if you have already completed one, or
- If you recover before completing your qualification period, any days you completed will count toward the total remaining qualification period days you need to complete if you meet the policy benefit triggers again.

No expenses need to be incurred during this period of time, but John Hancock must verify your qualification for benefits. You must remain eligible for benefits during this period, but you do not have to receive long-term care services or be hospitalized. The policy will pay benefits for covered charges you incur after the qualification period is met as long as you continue to meet the policy benefit triggers.

Additional Features

Non-Forfeiture Provision

If elected at the time of enrollment, you may elect to stop paying premiums after at least three years of continuous coverage and keep your full daily maximum benefit amount at a lower lifetime maximum benefit (reduced paid-up status).

The value of the reduced lifetime maximum benefit will be the greater of the sum of premiums paid into the plan or 30 times the nursing home daily maximum benefit. If exercised after 10 years of continuous coverage, the reduced lifetime maximum benefit would be equal to the greater of 90 times the nursing home daily maximum benefit or the sum of premiums paid.

Contingent Non-Forfeiture Provision

If you do not elect the non-forfeiture provision at the time of enrollment, a contingent non-forfeiture benefit is included. This benefit can only be exercised in the event of a substantial premium increase. It allows you to stop premium payments and keep a reduced level of coverage equal to the greater of the amount of premiums paid since coverage was issued or 30 times the nursing home daily maximum benefit. A substantial premium increase would range from 10% at issue age 90 or older, to 200% at issue age 29 or younger.

Inflation-Adjustment Option

Future purchase option will be offered to eligible insureds as an option to purchase additional amounts of coverage, without evidence of good health, every three years. This increase to the daily maximum benefit will not be less than 5% compounded annually over the three-year period. The corresponding lifetime maximum benefit, as well as all other covered services (e.g., alternate care facilities, community-based professional care), will also increase proportionally. Because a statement of good health is never included and you may decline an unlimited number of these inflation adjustments, the premium for the increase in coverage will include an additional 20% charge to account for possible anti-selection. The offers are not available to anyone at the issue age of 85 or older, anyone who has met the benefit eligibility criteria in the last six months, or anyone whose coverage is in reduced paid-up status under a non-forfeiture benefit.

Refund of Premium Upon Death

This benefit provides a refund of a portion of premiums paid, less benefits paid or payable, if the insured dies prior to age 70, according to the following scale:

65 and younger	100%
66	80%
67	60%
68	40%
69	20%
70	0%

No benefit is payable if coverage is in reduced paid-up status.

Temporary Bed Holding Benefit

The plan will continue to pay a benefit to hold a nursing home or alternate care facility bed for up to 60 days per calendar year for you if your stay is interrupted for any reason.

International Benefits

John Hancock can pay benefits for covered services rendered while you are permanently residing outside the U.S. (50 states and the District of Columbia). John Hancock must receive satisfactory proof that you meet the benefit eligibility criteria (qualify for benefits) including having completed the qualification period, along with documentation that the provider is licensed or certified and services are being rendered in accordance with a plan-of-care. Each level of benefits will be payable up to 75% of the daily maximum benefit amount that would be payable in the U.S. The total benefits payable for all covered services on any day will not exceed 75% of the nursing home daily maximum benefit. Only amounts reimbursed will be deducted from the lifetime maximum benefit. John Hancock can pay international benefits for up to a six-year lifetime maximum benefit. Any amounts remaining under the policy must be used in the U.S. (50 states and the District of Columbia). No benefits will be payable under the stay-at-home benefit or for respite care. No benefits are payable during the qualification period. The same limitations and exclusions apply.

Alternate Plan-of-Care

An alternate plan-of-care can be established by mutual agreement between John Hancock and the insured if the care coordinator identifies alternatives to the current plan that are both appropriate to the insured and cost-effective. It may provide benefits for services or supplies not otherwise covered under the program. Benefits paid under the alternate plan-of-care will reduce the lifetime maximum benefit.

Expenses Not Covered

John Hancock will not pay benefits for conditions resulting from the following:

- Your intentionally self-inflicted injury.
- War, whether declared or not, or any act of war or service in any armed forces or auxiliary units.
- Your commission of or attempt to commit a felony.
- Your engagement in an illegal occupation.
- Your participation in an insurrection or riot.
- Care, services, or treatment required as a result of detoxification or rehabilitation for alcohol or drug addiction (unless drug addiction was a result of the administration of drugs as part of treatment by a *physician*).
- Charges normally not made in the absence of insurance.
- Care, treatment, or charges provided by a member of your immediate family, or by a person who ordinarily resides in your home (minimal exceptions apply) — except under the Informal Care Benefit.
- Care, services, or supplies furnished by or covered as a benefit under a program of any government or its subdivisions or agencies, except as required by law and except:
  - A program established by the federal government for its civilian employees,
  - *Medicare*, and
  - Medicaid (e.g., any state medical assistance program under Title XIX of the Social Security Act as amended from time to time).
- Any service or supply to the extent that charges for it are reimbursable under *Medicare* or would be so reimbursable but for the application of a *deductible* or *coinsurance* or *copayment* amount under *Medicare* (not including those instances where *Medicare* is determined to be secondary payor under applicable law).
- Care or treatment provided outside the U.S., except as described in the international benefits provision.

These exclusions may not apply in all states and may vary depending upon the state in which you live. The Certificate of Insurance you received when you were approved for coverage outlines the exact exclusions for your state. If you move to another state, the state guidelines where the Certificate of Insurance was originally delivered to you will apply.

Long-term care providers must meet the qualifications specified in the Certificate of Insurance that was issued to you when you were approved for coverage, and services and supplies must be provided in accordance with a plan-of-care prescribed by a licensed health care practitioner.

Coordination of Benefits

The Long-Term Care Insurance program will coordinate with other group medical and government plans, but not *Medicare*, Medicaid, or individual long-term care plans. In order to receive tax-favored treatment, this policy includes a *Medicare* offset (see "Expenses Not Covered").

Notice

This is only a summary of the Long-Term Care Insurance program; it does not cover all the details. The Certificate of Insurance that was issued to you when you became approved for coverage contains a more detailed statement of the terms and conditions of your insurance coverage. If there is any conflict between this summary and the Certificate of Insurance, the terms of the Certificate will control. Please note that provisions may be changed or deleted in order to satisfy state requirements or other legal requirements and that Shell reserves the right to end or amend the program for any reason. If Shell discontinues the Long-Term Care Insurance program, existing insureds will be allowed to continue coverage through John Hancock.

Events Affecting Coverage

Death

If you die, your coverage ends on that day. Coverage for any other enrolled family member continues as long as premiums are paid.

Failure to Pay Premiums

As long as you continue to pay your premiums, John Hancock cannot cancel your coverage. However, if you fail to pay your premiums when due, coverage ends on the last day of the month for which John Hancock received your payment, unless you have been continuously insured with the non-forfeiture benefit for at least three years. You may request reinstatement within six months after the cancellation date. If you do, you must provide John Hancock with a statement of health, be accepted for coverage, and pay all past-due premiums.

If you fail to make a premium payment because of a cognitive impairment or loss of functional capacity, you may request reinstatement within five months of the cancellation date without having to provide John Hancock with a statement of good health. You must provide John Hancock with proof of the cognitive impairment or loss of functional capacity and pay all past-due premiums.

If you selected the non-forfeiture option and remained insured for 36 months or more, you retain a partial paid-up benefit.

Retiree Life Insurance

In order for you to have *retiree* life insurance coverage after you retire, you must have been enrolled in Retiree Group Life Insurance prior to January 1, 2022. Effective January 1, 2022, this program was not available to new enrollees.

If you are currently enrolled in Retiree Group Life Insurance, you cannot increase your coverage level after making your initial enrollment elections, but you may decrease or cancel your coverage at any time. If you drop post-retirement life insurance coverage for any reason, you cannot subsequently re-enroll. If you **are** currently enrolled in Retiree Group Life Insurance and you meet *retiree coverage eligibility* when you retire, your coverage will continue in retirement.

Your Cost for Retiree Life Insurance Coverage in Retirement

Enrollees will have received information regarding the cost of *retiree* life insurance coverage in the enrollment materials received from the Shell Benefits Service Center. Please remember the cost of *retiree* life insurance is in addition to the cost of active coverage. At age 55, you are no longer required to pay an additional premium cost for *retiree* life insurance but you must continue to participate in at least one times active group life coverage.

Retiree life insurance coverage continues at no additional cost to you when you leave the *Company* if you:

- Were continuously enrolled under the Retiree Group Life option for at least 15 years immediately preceding your retirement, and
- Retire having met *retiree coverage eligibility*.

If you retire with *retiree coverage eligibility* but have not met the 15-year participation requirement, you are required to pay a monthly premium cost to continue coverage after you retire. Your years of participation in the program as an active *employee* will be used to determine the additional time you need to reach the 15-year requirement. Once you have completed your 15 years of combined active and retired participation, your coverage continues at no additional cost.

Benefit Amount

Your coverage is based on the *retiree* life insurance benefit option you enrolled in as an active *employee*. If you elected at least 1 times your annual base pay for active life insurance, the program offered three post-retirement life insurance coverage options. If you are enrolled in the program, the Shell Benefits Service Center will provide retirement information confirming your *retiree* coverage option.

Retiree life insurance benefit amounts are paid as a percentage of your final base pay at retirement.

If you retired with *retiree coverage eligibility* before you reached age 65, your benefit percentage of final base pay will be based on your age at the time of your death and the post-retirement life insurance coverage option you elected.

If your age at the time of death is:	Your post-retirement life insurance benefit* is:		
	Option I	*Option II*	*Option III*
50 – 54	100%	130%	160%
55 – 59	100%	120%	140%
60 – 64	100%	112.5%	125%
65	80%	90%	100%
66	60%	70%	80%
67	40%	50%	60%
68 or older	20%	30%	40%

* As a percentage of your final average base pay.

If you retired with *retiree coverage eligibility* at age 65 or later, your benefit percentage of final base pay will be based on the number of years that have passed since you retired and the post-retirement option you elected.

Years from retirement	Your post-retirement life insurance benefit**		
	Option I	*Option II*	*Option III*
on your retirement date	80%	90%	100%
the 1st anniversary of your retirement date	60%	70%	80%
the 2nd anniversary of your retirement date	40%	50%	60%
the 3rd anniversary of your retirement date (or later)	20%	30%	40%

** As a percentage of your final average base pay.

Events Affecting Coverage

Leaves of Absence

If you are on a leave of absence, your participation in Retiree Life Insurance may be impacted. (For further information, see page J-16, "Leaves of Absence." The impact to Retiree Life Insurance is consistent with treatment of Group Life Insurance Program coverage.)

Changes in Employment Status

If your employment status changes to *part-time employee* status, your participation in Retiree Life Insurance ends. If your employment terminates before you have met the criteria for *retiree coverage eligibility*, you have the option of continuing Retiree Life Insurance by electing conversion to an individual policy and making premium payments directly to MetLife or portability to a MetLife group policy.

Plan Amendment or Termination

Your coverage changes or ends on the date this Program is amended or terminated.

Retiree Life Insurance Conversion Privilege

You can convert any loss of *retiree* life insurance coverage due to reductions in the benefit at scheduled ages. For example, you would be eligible to convert the 20% reduction in your post-retirement life insurance benefit to an individual policy when you reach age 66. You must apply to MetLife within 31 days after the coverage loss to exercise this option. Rates for individual conversion policies depend upon the type of insurance selected and the age and risk factors of the insured individual.

Accelerated Benefits

Shell's Retiree Life Insurance program includes an accelerated benefits provision. Under this provision, at least a portion of your benefit amount may be paid prior to death if medical certification shows that your life expectancy is reduced to 24 months or less. Accelerated benefits are payable at up to 100% of the coverage amount in effect, up to $500,000.

If your *retiree* life insurance coverage is scheduled to decrease within 24 months after the date the certification is accepted, your accelerated benefit is up to 100% of the reduced amount. However, if you die before your benefits are reduced, the full benefit amount is paid.

Accelerated benefits may be taxable, and if so, you or your *beneficiary(ies)* may incur a tax obligation. You should consult a personal tax advisor to assess the impact of this benefit.

Accelerated benefits are not paid if:

- Your benefits are assigned.
- The *Company* or MetLife was notified that all or a portion of the benefits are to be paid to a former spouse as part of a divorce agreement.
- Your life expectancy is reduced as the result of your attempted suicide or intentionally self-inflicted injury.
- Your Accelerated Benefit Option (ABO) Eligible Group Life Insurance is scheduled to end within six months after the date you request an accelerated benefit.

Payment of Benefits

When you die, benefits are paid to the *beneficiary(ies)* you named. If there is no *beneficiary(ies)* designated or no surviving *beneficiary(ies)* at your death, MetLife may determine the *beneficiary(ies)* to be one or more of the following who survive you:

- Your spouse or *domestic partner*.
- Your child(ren).
- Your parent(s).
- Your sibling(s).
- Your estate.

If a *beneficiary(ies)* or a payee is a minor or incompetent to receive payment, MetLife will pay that person's guardian.

Filing a Claim

To file a claim under the Retiree Life Insurance program, you or your *beneficiary(ies)* should contact MetLife at 1-800-438-6388.

Settlement Options

Payment can be made in a lump sum or in installments. MetLife pays benefits to the *beneficiary(ies)* as soon as possible after it receives the required proof of death and the *beneficiary(ies)'s* claim for benefits.

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