Dimensions
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SUMMARY PLAN DESCRIPTION

SHELL OIL COMPANY COMPREHENSIVE WELFARE BENEFITS PLAN

CARE

MEDICAL **DENTAL** VISION **HSM** PREVENTION **IMMUNIZATION**
WELL-BABY CARE **ANNUAL PHYSICAL** PREVENTIVE SCREENING
HOSPITAL SERVICES PRESCRIPTIONS **PHYSICIAN SERVICES**
OUTPATIENT **SURGICAL EXPENSES** MATERNITY CARE
MENTAL HEALTH AND SUBSTANCE ABUSE CARE EAP
PRIMARY CARE PHYSICIAN WELLNESS **NETWORK PROVIDER**

PROTECTION

DISABILITY INCOME **LIFE INSURANCE** SHORT-TERM DISABILITY
LONG-TERM DISABILITY INCOME PROTECTION INSURANCE
SURVIVOR INCOME COMPANY PAID LIFE INSURANCE
GROUP LIFE INSURANCE DEPENDENT LIFE INSURANCE
GROUP LEGAL VOLUNTARY PERSONAL ACCIDENT INSURANCE
BUSINESS TRAVEL ACCIDENT INSURANCE BACK-UP CARE

IMPORTANT TELEPHONE NUMBERS AND WEBSITES

This directory lists places you can go to online (www.netbenefits.com/shell) to access additional information about your benefits.

FORMS AVAILABLE UNDER *ALL HEALTH & INSURANCE FORMS*
Claim Forms
Beneficiary Forms
Be Well @ Shell Wellness Check Form
Affidavit of Domestic Partnership
Statement of Dependent Eligibility beyond Limiting Age Due to Mental or Physical Disability

DOCUMENTS AVAILABLE UNDER *REFERENCE LIBRARY*
Be Well @ Shell Resources
Dental and Vision Benefits Summaries
Enrollment Guides
Medical Summaries of Benefits and Coverage

Directions to All Health & Insurance Forms and Reference Library: 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 and you will see links to **All Health & Insurance Forms** and **Reference Library.**

GENERAL BENEFITS		
Shell Benefits Service Center	1-800-307-4355 (1-800-30-SHELL) 1-800-847-0348 (TDD)[1]	www.netbenefits.com
Benefits Information available on the Shell Intranet		HR Online > My Benefits

CARE		
UnitedHealthcare Customer Care	1-800-752-8982	www.myuhc.com
NurseLine	1-855-677-3411	
Teladoc	1-800-835-2362	Teladoc.com
CVS Caremark	1-866-221-4207	www.caremark.com
Beacon Health Options® (Mental Health and Substance Abuse Care)	1-800-543-8114	www.achievesolutions.net/shell
Cigna Dental PPO Cigna Dental Care	1-800-244-6224 (1-800-CIGNA24)	www.cigna.com
Vision Service Plan	1-800-877-7195	www.vsp.com

CARE *continued*		
Centers of Excellence		
CHI St. Luke's Hospital (Adult Cardiac Care)	1-800-457-9269	www.cvcpdocs.com
M.D. Anderson Cancer Center (Adult Oncology Care)	1-800-354-2647	
Texas Children's Hospital (Pediatric Cardiac and Oncology Care)	1-877-647-4355	
PROTECTION		
MetLife	1-800-438-6388 (1-800-GETMET8)	www.metlife.com
Hyatt Legal Plans, Inc. a MetLife Company	1-800-821-6400	www.legalplans.com
Beacon Health Options®	1-800-543-8114	www.achievesolutions.net/shell
Bright Horizons Family Solutions® (Back-Up Care)	1-877-242-2737	backup.brighthorizons.com[2]

For further contact information regarding HSM or other health care options, please refer to your medical identification card.

[1] 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**.)

[2] To access the Back-Up Care website — Username: Shell; Password: care4you

A B O U T T H I S B O O K

This book is designed to be a summary of the Shell Care and Protection Programs. It also meets our legal obligation to provide you with a summary plan description (SPD) on each of the benefit programs described in this book.

To help you locate information, this SPD is divided into the following sections:

- **Care**, which summarizes Shell's health care programs, including medical, dental, and vision care;
- **Protection**, which summarizes Shell's life, accident and disability income benefits, as well as other protection coverage; and
- **Preparing for Retirement**, which offers important information for employees as they plan for their retirement.

The book also contains General Plan Information, a comprehensive Glossary, and an Index to help you find the specific information you need quickly.

Italicized terms throughout this book are defined in the Glossary section.
The information in this SPD reflects plan provisions in effect as of January 1, 2016, except as otherwise noted.

Shell intends to continue to offer *employees* a competitive benefits package. However, 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 booklet conflicts with, contradicts, or causes to be unclear any provision in the official *Plan* document, the provision in the official *Plan* document will control unless otherwise specifically provided. However, with regard to any insured benefits described in this SPD booklet, documents provided by the insurance provider describing the insured benefits will control unless any provision contained in those documents is contrary to applicable law.

Employees involved in the divestment or integration of a business may have special provisions that apply to their health care and insurance programs. Those *employees* will receive supplemental communications concerning such special provisions.

CARE

CARE

When it comes to selecting health care coverage, we all have different needs, and those needs change depending upon your health, family status, and stage of life. Because Shell appreciates that your health care needs are unique, we offer you flexibility in choosing the programs that are right for you and your family.

The Shell Care programs are designed to support your efforts to maintain good health and to encourage you to take charge of your health improvement opportunities.

1.0 Medical Benefit Program

With the Shell Medical options, you and your dependents have access to comprehensive coverage, including routine exams and wellness care, treatment of ongoing conditions, complex surgeries, or specialized treatment for a life-threatening illness or injury.

1.1 Participation

a. Eligibility

You are eligible to enroll in the Shell Medical Benefit Program if you are a *regular full-time* or *regular part-time employee* of a *participating company.* If you enroll in the Medical Benefit Program, you can also enroll your *eligible dependent(s).*

ELIGIBLE DEPENDENT(S) **INCLUDE:**

- **Your spouse;**
- **Your *domestic partner*;**
- **Your child(ren) through the end of the year in which they turn 26;***
- **Your unmarried child(ren) age 26 or over who are physically or mentally disabled and covered under the program, or another plan sponsored through your previous employment, on the day before reaching their 26th birthday, and who remain disabled and permanently dependent upon 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 and who are not employed full-time; and**
- **The unmarried child(ren) of your spouse or *domestic partner*† age 25 or over who were physically or mentally disabled and covered under the program, or another plan sponsored through your previous employment, on the day before reaching their 25th birthday, and who remain disabled and permanently dependent upon you for financial support.**

For these purposes, the term *child* or *children* means a biological child, stepchild, adopted child, or foster child.

***Note that some HMOs/PPOs extend coverage only through the end of the month in which the child turns age 26. Therefore, if you select an HMO/PPO option, you will need to check with that health plan option to verify its eligibility policy.**

†The child(ren) of your spouse or *domestic partner* also must live with you in a regular, parent-child relationship.

b. Enrollment

For You

If you are a *regular full-time* or *regular part-time employee* who is newly eligible, you will receive enrollment materials from the Shell Benefits Service Center. If you wish to enroll, you must 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 fail to enroll for coverage within 31 days after your hire date or eligibility date, or if you were enrolled in the Medical Benefit Program, subsequently canceled your coverage, and later wish to re-enroll, you may enroll within 31 days after a *qualified status change* or during the next *group annual enrollment period*. (See Section 1.1f, "Changing Coverage" or Section 15.0 "Glossary," for more information on *qualified status changes.*) You are not permitted to enroll at any other time.

For Your Dependent(s)

If you want to cover any of your *eligible dependent(s)* under your medical option, you need to enroll them within 31 days after:

- Your hire date or eligibility date; or
- The date they become eligible for coverage.

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

If you do not meet the 31-day deadline, you generally cannot enroll your *eligible dependent(s)* until the next *group annual enrollment period*, unless you have a subsequent *qualified status change* in your family or employment status. (For details on *qualified status changes*, see Section 1.1f, "Changing Coverage" or Section 15.0 "Glossary.")

Coverage for *eligible dependent(s)* enrolled when you enroll begins the day your coverage begins. Coverage for newborns begins at birth, but only if you enroll them by contacting the Shell Benefits Service Center within 31 days after the date of their birth.

c. Levels of Coverage

In most cases, the Medical Benefit Program options allow you to choose from these levels of coverage:

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

If both you and your spouse or *domestic partner* are eligible to enroll in the Medical Benefit Program as *employees,* and you both wish to be covered:

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

d. Cost

You and the Company share the cost of medical coverage. Your election to participate in the Program constitutes an election to pay your contributions by pre-tax salary reduction. Contributions for *domestic partner* coverage cannot be made by pre-tax payroll deduction as a result of federal tax law. If you elect to cover a *domestic partner* under *Participant plus spouse/domestic partner* or *Family coverage* under the Program, all of your contributions in excess of the cost of Participant only coverage will be made by payroll deduction on an after-tax basis.

e. Coverage Options

The coverage options listed below are all part of the Medical Benefit Program. Please note that depending on your coverage option, some parts of your benefits description may be located in a separate document(s). As such, this SPD incorporates the information found in the following separate documents: the Be Well @ Shell Kelsey-Seybold Health Plan Membership Guide, the US GEMS Membership Guide, and any certificates of coverage, booklet certificates, or other similar booklets you receive from an insurance company or HMO/PPO providing benefits to you under the Program.

The Company offers you the choice of these coverage options:

- Hospital Surgical Medical (HSM) options, which include the HSM, the Enhanced HSM, the HSM for Other Locations, and the Enhanced HSM for Other Locations. The HSM options provide benefit coverage for medical care you receive from any licensed health care provider anywhere in the world. The HSM and Enhanced HSM options also include a designated network of doctors and other health care professionals. Each time you or your family needs medical care, you can choose to use a network provider and receive a higher level of benefit reimbursement;
- Be Well @ Shell Kelsey-Seybold Health Plan (available in the Greater Houston-Galveston area only). The Be Well @ Shell Kelsey-Seybold Health Plan ("Be Well Kelsey Plan") is available to employees in the Greater Houston-Galveston. The Be Well Kelsey Plan is a comprehensive offering of medical care delivered and coordinated by Kelsey-Seybold Clinic physicians. The program is administered through Cigna, and details of the Be Well Kelsey Plan benefit provisions are included in the Be Well @ Shell Kelsey-Seybold Health Plan Membership Guide located on the Shell intranet in HR Online and at NetBenefits; or
- Regional Health Maintenance Organization (HMO) and PPO Options. These options deliver health care through a network of doctors and 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.

HMOs offer standard benefit plan designs which, in addition to different benefits and cost structures, may not duplicate the participation and enrollment provisions outlined in this book. Because each HMO provides its own summary plan description, information on the HMO options can be obtained by contacting each HMO directly. Contact information for your HMO is on your membership I.D. card. In addition, the Shell Benefits Service Center can provide you with the telephone number and website for each HMO.

Additionally, *employees* on "Long Term International Assignment" or "Local Non National" terms pursuant to the Shell International Mobility Policies are offered coverage under the US Global Expatriate Medical Scheme (US GEMS). The program is administered through Cigna and provides worldwide health coverage for care received by enrolled *employees* and their eligible family members. Details of US GEMS benefit provisions are included in the US GEMS Membership Guide located at www.CignaEnvoy.com, on the Shell intranet in HR Online, and at NetBenefits.

f. Changing Coverage

You may only change your coverage each year during the *group annual enrollment period* or if you experience a *qualified status change*. (For further information on what constitutes a *qualified status change*, see Section 15.0, "Glossary.")

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

- You submit your request to change your coverage within 31 days after the *qualified status change*. However, if your *qualified status change* pertains to the loss of coverage under Medicaid or SCHIP or gaining of eligibility for a premium assistance subsidy under Medicaid or SCHIP, you must submit your request to change your coverage within 60 days from the day that your Medicaid or SCHIP coverage is terminated or the eligibility determination is made; and
- Except with respect to *qualified status changes* that are considered special enrollment rights, the change in coverage must be consistent with the *qualified status change* event.

The change becomes effective on the date of your *qualified status change*.

1.2 Be Well @ Shell Prevention and Rewards Program

The **Be Well @ Shell Prevention and Rewards** Program is the wellness component of the Medical Benefit Program. It is a voluntary, confidential initiative available to certain adult participants in the Shell Medical Benefit Program, and there is no additional cost to participate. The wellness program encourages adult participants to:

- Complete an annual wellness check and earn a medical premium discount;
- Get engaged on the wellness program health portal; and
- Participate in other wellness activities to earn gift card rewards.

The **Be Well @ Shell Prevention and Rewards** guide contains detailed information about who is eligible to participate, timelines/requirements for earning a medical premium discount, the gift card rewards, and much more. You can access the current guide by logging on to http://bewellatshell.com (click Resources) or http://www.netbenefits.com (click Menu > Health & Insurance > Reference Library).

1.3 HSM Options — Network and Cost Information

a. A Word about the HSM Network

The HSM options provide you benefit coverage for medical care you receive from any licensed health care provider anywhere in the world. Each time you need medical care, you have a choice to use, or not use, the HSM network.

If you have questions, call UnitedHealthcare's Customer Service Center at 1-800-752-8982. You can call Monday through Thursday from 8:00 A.M. to 7:00 P.M. Central time, and Friday from 9:00 A.M. to 7:00 P.M. Central time. Or, visit their website at www.myuhc.com.

The HSM network is comprised of separately administered networks for medical, surgical, and diagnostic services (UnitedHealthcare), prescription drug benefits (CVS Caremark), and mental health/substance abuse benefits (Beacon Health Options®). Each of these networks are described in more detail below, and those descriptions together with the HSM Options Schedules of Benefits, payment provisions and other details provided in this SPD will help you understand the impact of your decision to use, or not use, the HSM network.

b. The HSM Medical, Surgical, and Diagnostic Network

Most HSM participants have access to the UnitedHealthcare 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 UnitedHealthcare network, the HSM options offer a higher level of benefits because the network providers have contractually agreed with UnitedHealthcare to provide care at lower agreed upon costs.

In some rural areas of the country, the UnitedHealthcare network is not available. If you live outside of the network area, you will have access to the HSM Other Location options. The HSM Other Location options will pay benefits for covered services received from any qualified doctor or health care provider as if you used a network provider, subject to a competitive fee determination as discussed in Section 1.4 "Covered Expenses."

When you use the UnitedHealthcare network, you:

- Receive a higher level of benefits. For example, you pay only a *copayment* for each covered office visit or emergency room treatment. Once your share of covered expenses reaches the network out-of-pocket limit for the year, the HSM options pay 100% of most covered expenses for the rest of that year;
- Receive 100% coverage for preventive care office visits and screenings; and
- Do not have to file a claim form or call UnitedHealthcare's Personal Health Support Department to certify a *hospital* admission. The network provider takes care of those requirements for you.

The HSM options allow you to receive medical, surgical, and diagnostic services outside the UnitedHealthcare network. Except in the case of emergency care, when you receive care from a non-network provider, you will:

- Pay a higher share of the cost;
- May be required to file your own claim for reimbursement; and
- If you need to be hospitalized, be required to call UnitedHealthcare's Personal Health Support Department to provide notification of your *hospital* admission, or your benefit reimbursement will be reduced by a $250 *non-notification penalty*. (See Section 1.5b, "Personal Health Support" for more information.)

c. The Prescription Drug Benefits Network

The HSM options provide prescription drug coverage through CVS Caremark. You can fill your prescriptions at any pharmacy in the CVS Caremark network, which includes most major pharmacy chains, most independent pharmacies, and the CVS Caremark mail-order pharmacy. You may also choose to fill your prescriptions outside the CVS Caremark network.

Your share of prescription drug expenses are subject to a separate annual prescription drug *out-of-pocket maximum*.

Prescription Drug Purchases at a Retail Pharmacy

A CVS Caremark prescription drug card is issued to you when you enroll in an HSM option. You must present the card when you fill a prescription at a network pharmacy. Your *copayment* is based upon whether you purchase a generic drug, a formulary brand-name drug or a non-formulary brand-name 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 UnitedHealthcare for reimbursement.

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.

Certain long-term and maintenance medications may be available for a 90-day supply at your local CVS Pharmacy. Please contact CVS Caremark for more information at 1-866-221-4207.

Mail-Order Prescriptions

The HSM options offer you a money-saving alternative to having your prescription filled at a local pharmacy. You can fill long-term maintenance prescriptions, like high blood pressure or cholesterol medications, through CVS Caremark's mail-order pharmacy. With CVS Caremark, you can mail-order up to a 90-day supply of maintenance medications prescribed by your doctor. Your *copayment* is based upon 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* expense.

Covered Prescription Drug Expenses

Most medications approved by the Federal Drug Administration (FDA) are covered under the HSM options if indicated and prescribed for an illness or injury. Some medications are subject to FDA dispensing guidelines, quantity limits, or pre-authorization. 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 HSM options.

d. Mental Health and Substance Abuse Benefits Network

Beacon Health Options® can help you get the care you need, or understand your mental health and substance abuse benefits. If you have any questions or need claim forms, call Beacon Health Options Customer Service at 1-800-543-8114.

The HSM options provide coverage for mental health and substance abuse care through the Beacon Health Options® program. Beacon Health Options® has a national network of mental health care professionals (including psychiatrists, psychologists, and other qualified licensed therapists), who provide inpatient and outpatient care, as well as day treatment and residential care. For further details about your benefits for mental health and substance abuse care, call Beacon Health Options at 1-800-543-8114. Your benefits for behavioral health treatment will be the same as benefits currently available for medical/surgical care under the HSM 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 Beacon Health Options® and UnitedHealthcare.

When you use the Beacon Health Options® network:

- Beacon Health Options® providers are carefully selected, credentialed, and knowledgeable about Beacon Health Options® procedures, as well as the HSM options; and
- You receive a higher level of benefits because the network providers have contractually agreed with Beacon Health Options® to provide care at lower costs; and
- You are not responsible for any fees above these agreed upon costs; and
- You do not have to file a claim and wait for reimbursement.

You can use the network by calling the Beacon Health Options® toll-free Clinical Referral Line, 1-800-543-8114, at any time, day or night. Your call is answered by a licensed Clinical Care Manager who will provide referral assistance. Care that is certified by Beacon Health Options® is covered at the network benefit level. Network benefits are also payable for emergency admissions if certified within 72 hours of the admission.

The HSM options allow you to receive mental health or substance abuse care services outside of the Beacon Health Options® network. When you receive services outside of the network, you are responsible for a greater share of the cost than if you had received network services.

If you choose to receive mental health or substance abuse care without making arrangements through Beacon Health Options®, your provider must be a qualified and licensed provider of mental health and substance abuse care in order for benefits to be considered. All treatment must also be considered medically necessary and appropriate. In addition, you must file a claim for reimbursement. Claims should be sent to the address on the Beacon Health Options® claim form, located on NetBenefits.

e. Paying Your Share of HSM 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.

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 upon the HSM option you select, 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.*

Copayments

Copayments are fixed charges that represent your portion of covered medical expenses.

Coinsurance

Coinsurance is your percentage of a covered expense. Your *coinsurance* depends upon which HSM option you select and whether you use the network.

Out-of-Pocket Maximum

The HSM options protect you from catastrophic medical costs by limiting the amount you must 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 HSM 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.

Your share of prescription drug expenses are subject to a separate annual prescription drug out-of-pocket maximum.

The following 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; and
- Charges for non-covered services.

Your Primary Care Physician

The HSM options do not require you to designate a primary care physician (PCP); you can see any doctor you choose. 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 PCPs.

PCPs include:

- Family Practice providers;
- General Practice providers;
- Internists;
- Pediatricians; and
- OB/GYN providers.

All other licensed, qualified providers are considered specialists under the HSM 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 (e.g., a non-network provider who tells you that it can provide services to you at a cost similar to a network provider). 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 1.6 "Expenses Not Covered under HSM Options."

f. Schedule of Benefits

Below is an overview and comparison of the benefits available under the HSM options. Please note: HSM Network and Enhanced HSM Network benefits apply to the HSM Other Location options, subject to covered expense limits as described below. The overview is broken into three sections:

- HSM medical, surgical, and diagnostic benefits administered by UnitedHealthcare;
- HSM prescription drug benefits administered by CVS Caremark; and
- HSM mental health/substance abuse benefits administered by Beacon Health Options®.

HSM Options Benefits

	HSM		Enhanced HSM	
	Using the Network	Not Using the Network	Using the Network	Not Using the Network
Annual *Deductible* (calendar year)	$325/person $650/family	$1,000/person	$150/person $300/family	$750/person
Out-of-Pocket Maximum (calendar year)	$3,500/person $7,000/family (excludes prescription drug *copayments*)	$6,000/person $12,000/family (excludes prescription drug *copayments*)	$3,500/person $7,000/family (excludes prescription drug *copayments*)	$6,000/person $12,000/family (excludes prescription drug *copayments*)
Prescription Drug *Out-of-Pocket Maximum* (calendar year)	$2,950/person $5,900/family		$2,950/person $5,900/family	
Your Expenses	You pay some *copayments* and 20% *coinsurance* after the annual *deductible*	You pay 30% *coinsurance* after the annual *deductible*	You pay some *copayments* and 10% *coinsurance* after the annual *deductible*	You pay 30% *coinsurance* after the annual *deductible*
Maximum Lifetime Benefit	Unlimited		Unlimited	

HSM Medical, Surgical and Diagnostic Benefits Administered by UnitedHealthcare

Preventive Care	You pay $0	You pay 30% after the annual *deductible*	You pay $0	You pay 30% after the annual *deductible*
Physician Services				
Office Visits				
– PCP	You pay a $30 *copayment*/visit	You pay 30% after the annual *deductible*	You pay a $30 *copayment*/visit	You pay 30% after the annual *deductible*
– Specialists	You pay a $50 *copayment*/visit	You pay 30% after the annual *deductible*	You pay a $40 *copayment*/visit	You pay 30% after the annual *deductible*
	UnitedHealthcare Premium Network Specialist Office Visit Copay $40	You pay 30% after the annual *deductible*	UnitedHealthcare Premium Network Specialist Office Visit Copay $30	You pay 30% after the annual *deductible*
Diagnostic X-rays and laboratory tests (in doctor's office or laboratory)	You pay $0 (when office visit *copayment* is satisfied)	You pay 30% after the annual *deductible*	You pay $0 (when office visit *copayment* is satisfied)	You pay 30% after the annual *deductible*
Inpatient *Hospital* Services	You pay a $300 *copayment*/admission, then 20% *coinsurance* after the annual *deductible*	You pay 30% *coinsurance* after the annual *deductible*; if you do not notify UnitedHealthcare's Personal Health Support Department, you pay an additional $250 *non-notification penalty*	You pay a $150 *copayment*/admission, then 10% *coinsurance* after the annual *deductible*	You pay 30% *coinsurance* after the annual *deductible*; if you do not notify UnitedHealthcare's Personal Health Support Department, you pay an additional $250 *non-notification penalty*
Outpatient *Hospital* Services	You pay 20% *coinsurance* after the annual *deductible*	You pay 30% *coinsurance* after the annual *deductible*	You pay 10% *coinsurance* after the annual *deductible*	You pay 30% *coinsurance* after the annual *deductible*
Emergency Care[1]	You pay a $200 *copayment*/visit (*copayment* waived if you are admitted)			
Ambulance Services	You pay $0 for emergency ambulance services			

	HSM		Enhanced HSM	
	Using the Network	Not Using the Network	Using the Network	Not Using the Network
Urgent Care Clinic (after hours)	You pay a $30 *copayment*/visit	You pay 30% *coinsurance* after the annual *deductible*	You pay a $30 *copayment*/visit	You pay 30% *coinsurance* after the annual *deductible*
Urgent Care Teladoc	You pay a $10 *copayment*/use		You pay a $10 *copayment*/use	
Diabetic Supplies (except insulin and syringes)	You pay 20% *coinsurance*		You pay 10% *coinsurance*	
Hospice Care	You pay $0 for covered expenses	You pay 30% *coinsurance* after the annual *deductible*	You pay $0 for covered expenses	You pay 30% *coinsurance* after the annual *deductible*
Other Covered Services	You pay 20% *coinsurance* after the annual *deductible*	You pay 30% *coinsurance* after the annual *deductible*	You pay 10% *coinsurance* after the annual *deductible*	You pay 30% *coinsurance* after the annual *deductible*

1 Emergency care is treatment required because permanent disability or endangerment to life or limb is likely to result if the condition goes untreated.

HSM Prescription Drug Benefits Administered by CVS Caremark

	HSM		Enhanced HSM	
	Using the Network	Not Using the Network	Using the Network	Not Using the Network
Prescription Drugs (for short-term and immediate prescriptions up to a 34-day supply)	At CVS Caremark Participating Pharmacies,[1] You pay:	At any other pharmacy,	At CVS Caremark Participating Pharmacies,[1] You pay:	At any other pharmacy,
(includes diabetic supplies when obtained through retail/mail order pharmacy)	–A $5 *copayment* for generic drugs –A $50 *copayment* for formulary brand-name drugs –A $70 *copayment* for non-formulary brand-name drugs	You pay 30% *coinsurance* after the annual *deductible*. You must pay for the prescription in full and then file a claim with UnitedHealthcare for reimbursement.	–A $5 *copayment* for generic drugs –A $50 *copayment* for formulary brand-name drugs –A $70 *copayment* for non-formulary brand-name drugs	You pay 30% *coinsurance* after the annual *deductible*. You must pay for the prescription in full and then file a claim with UnitedHealthcare for reimbursement.
Prescription Drugs (for long-term, maintenance medications up to a 90-day supply)	Using the CVS Caremark Mail Order Pharmacy,[2] You pay:	At any other pharmacy,	Using the CVS Caremark Mail Order Pharmacy,[2] You pay:	At any other pharmacy,
(includes diabetic supplies when obtained through retail/mail order pharmacy)	–A $10 *copayment* for generic drugs –A $90 *copayment* for formulary brand-name drugs –A $110 *copayment* for non-formulary brand-name drugs	You pay 30% *coinsurance* after the annual *deductible*. You must pay for the prescription in full and then file a claim with UnitedHealthcare for reimbursement.	–A $10 *copayment* for generic drugs –A $90 *copayment* for formulary brand-name drugs –A $110 *copayment* for non-formulary brand-name drugs	You pay 30% *coinsurance* after the annual *deductible*. You must pay for the prescription in full and then file a claim with UnitedHealthcare for reimbursement.

HSM Mental Health/Substance Abuse Benefits Administered by Beacon Health Options®

	HSM		Enhanced HSM	
	Using the Network	Not Using the Network	Using the Network	Not Using the Network
Mental Health/Substance Abuse Care				
–Office Visit	You pay a $30 *copayment*/visit	You pay 30% *coinsurance* after the annual *deductible*	You pay a $30 *copayment*/visit	You pay 30% *coinsurance* after the annual *deductible*
–Inpatient coverage	You pay a $300 *copayment*/admission then 20% *coinsurance* after the annual *deductible*	You pay 30% *coinsurance* after the annual *deductible*	You pay a $150 *copayment*/admission then 10% *coinsurance* after the annual *deductible*	You pay 30% *coinsurance* after the annual *deductible*
–Facility based visits and all other coverage	You pay 20% *coinsurance* after the annual *deductible*	You pay 30% *coinsurance* after the annual *deductible*	You pay 10% *coinsurance* after the annual *deductible*	You pay 30% *coinsurance* after the annual *deductible*

1 Using your CVS Caremark Card.
2 Certain maintenance medications may be eligible for a 90-day supply at your local CVS Pharmacy. Contact CVS Caremark at 1-866-221-4207 for more information.

g. Program Payments for HSM Covered Expenses

The amount the HSM 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 upon negotiated fees between the provider and UnitedHealthcare (or Beacon Health Options® in the case of Mental Health and Substance Abuse Care).

When not using a UnitedHealthcare (or Beacon Health Options®) network provider, the HSM options determine benefits based upon the amount of the billed charges for covered treatment, but the billed charges are capped at the 95th percentile of the competitive fee for the geographic area. For example, if a non-network provider's bill for covered treatment is $10,000, and the 95th percentile of the competitive fee for the geographic area is $9,000, only $9,000 will be used for purposes of the HSM options' cost-sharing provisions. If a non-network provider's bill for covered treatment is at or below the 95th percentile of the competitive fee for the geographic area, the full billed amount will be used for purposes of the HSM options' cost-sharing provisions. Billed amounts in excess of the 95th percentile are not covered expenses under the HSM options. You are responsible for any excess charges.

You are responsible for confirming your providers' network participation prior to receiving treatment. This is especially important where your provider refers you for additional specialty care, diagnostic laboratory or imaging services, or to an outpatient surgical center (e.g., 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 UnitedHealthcare 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 Beacon Health Options® at 1-800-543-8114 or online at www.achievesolutions.net/shell.

Please note that the HSM 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 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 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 Section 14.1e, "Non-Assignment of Benefits."

1.4 HSM Options – Covered Expenses

Covered expenses under the HSM options fall into the following 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, Vision, and Hearing Care; and
- Other Expenses.

a. Preventive Care

The HSM options cover preventive care, including:

- An annual physical examination;
- Pap smear — one lab fee per year for each female *employee* or covered family member;
- 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;
- 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; and

- Breast Pumps;
  - 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. Benefits for breast pumps also include the cost of purchasing one breast pump per pregnancy in conjunction with childbirth;
  - Benefits are only available if breast pumps are obtained from a DME provider, *hospital* or physician.

b. Diagnosis and Treatment

The HSM options cover diagnosis and treatment of illness or injury, including:

- Office visits;
- Telephonic consultations through Teladoc
- Diagnostic X-rays;
- Laboratory tests; and
- Drugs and medicines prescribed for the treatment of an illness or injury.

Teladoc provides 24/7 access to U.S. board-certified doctors and nurses by phone or online video. Teladoc can diagnose, recommend treatments and prescribe medication for conditions including sinus problems, allergies, pediatric care and non-emergency medical assistance. Call 1-800-835-2362 or go to Teladoc.com for more information.

c. Inpatient *Hospital* Care

The HSM options cover the following inpatient *hospital* services:

- A *hospital*'s 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; and
- Surgery by a qualified surgeon.

A *hospital* is 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 HSM options, a *hospital* must meet certain criteria. (See Section 15.0, Glossary for more information.)

d. Outpatient *Hospital* and Ambulatory Care

The HSM 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; and
- 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. To qualify for coverage under the HSM options, an *ambulatory surgical center* must meet certain criteria.

e. Maternity Care

Female *employees* and female *eligible dependents* enrolled in an HSM option are eligible for covered maternity benefits.

The HSM options cover:

- The charges of an obstetrician and an anesthesiologist for prenatal care and *hospital* delivery;
- The charges for an approved birth center; and
- The charges for *hospital*, surgical, or other medical services and supplies as described under Section 1.4c "Inpatient Hospital Care." 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.

A birth center is a specialized facility for delivering newborns following a normal, uncomplicated pregnancy. To qualify for coverage under the HSM options, a birth center must be operated under the full-time supervision of a licensed doctor (M.D.) or registered nurse (where permitted by state law) and meet several other standards. To ensure that the birth center you are considering meets these standards, call UnitedHealthcare's Customer Service Center at 1-800-752-8982.

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 that coverage for newborns begins at birth, but only if you contact the Shell Benefits Service Center within 31 days after the date of the birth.

NEWBORNS' AND MOTHERS' HEALTH PROTECTION 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).

f. Convalescent and Home Health Care

The HSM 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 HSM options also cover services for convalescent care received at home through a *Medicare*-approved home health agency. For benefits to be paid:

Custodial care is not covered under the HSM options, except in conjunction with hospice care.

- 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.

g. Hospice Care

The HSM 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, which are provided by a home health care agency; and
- 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.

A hospice is an agency that provides counseling and incidental medical services for the terminally ill. Room and board may also be provided. To qualify as a covered expense under the HSM options, a hospice must meet certain requirements. To ensure that the hospice you are considering meets these requirements, call UnitedHealthcare's Customer Service Center at 1-800-752-8982.

h. Accidental/Surgical Expenses for Dental, Vision, and Hearing Care

The HSM options cover certain dental, vision, and hearing expenses, including the following:

- Oral surgery for treatment of fractures and dislocations of the jaw, other cutting procedures in the oral cavity, and administration of anesthesia (care of teeth and gums and surgical repair following removal of teeth are not covered);
- 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; and
- Hearing aids, or their fittings, that are required as a result of surgery to the ear or due to an accidental injury.

i. Other Expenses

The HSM options 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 HSM options cover the expense of a third surgical opinion;
- Services of a qualified physiotherapist;
- Services of a speech therapist for a child(ren) up to age seven (7) and under certain specific circumstances (laryngectomy, stroke, brain damage due to accidental injury, or surgery that requires rehabilitation involving speech therapy);
- Covered drugs and medicines prescribed for the treatment of a physical 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 or abdominoplasty following significant and sustained weight loss, for adults 18 and older, and subject to pre-authorization and approval by UnitedHealthcare;
- Treatment of Gender Identity Disorder, in adults 18 or older, and subject to pre-authorization and approval by UnitedHealthcare. The treatment plan must conform to the World Professional Association for Transgender Health (WPATH) standards, version 6;
- 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; and
- Replacement of prosthetic devices and appliances, ordered by a physician, provided once every three calendar years.

1.5 HSM Options – Additional Covered Expenses

a. Centers of Excellence (COE) Program

HSM CENTERS OF EXCELLENCE (COE):
The Centers of Excellence program provides HSM participants with access to nationally renowned medical care when they are diagnosed with heart or cancer conditions.

The HSM options offer active *employees* and their eligible covered dependents and non-*Medicare pensioners* and their non-*Medicare* eligible covered dependents access to world-class providers, as well as enhanced patient services through the COE program. The COE program provides participants in the HSM options with access to nationally renowned medical care when they are diagnosed with heart or cancer conditions. The COE program has contracts with several nationally recognized medical institutions in the Texas Medical Center to provide a special package of services for these medical conditions:

- Cardiovascular Care Providers, Inc./Texas Heart Institute (CHI St. Luke's Hospital) for adult cardiovascular care;
- M.D. Anderson Physician Network (M.D. Anderson Cancer Center) for adult oncology care; and
- Baylor MedCare (Texas Children's Hospital) for pediatric cardiovascular and oncology care.

Description of COE Services

To obtain coverage under the COE program, you must be enrolled in an HSM option and you must register with each of the COE program providers before your first visit. Participation in the COE program is completely voluntary and is available to you and your covered dependents if you require medical care and treatment for cardiac or cancer-related illness. Under the COE program, covered physician and/or *hospital* services, including personalized assistance such as call center support, appointment scheduling, valet parking (first visit only), and expedited *hospital* admission, are covered at 100%. *No deductibles*, *copayments*, or *coinsurance* apply. You are eligible to enroll in the program, regardless of where you live, but travel and lodging expenses you incur while receiving care from a COE program provider are not considered covered expenses under the HSM COE program.

You can enroll or obtain additional information for each COE provider by calling the appropriate telephone number listed below:

Adult Cardiac Care (18 and over) **1-800-457-9269 or www.cvcpdocs.com**
Cardiovascular Care Providers, Inc./Texas Heart Institute
(CHI St. Luke's Hospital)

Adult Oncology Care (18 and over) **1-800-354-2647**
M.D. Anderson Cancer Manager Program
(M.D. Anderson Cancer Center)

Pediatric Cardiac and Oncology Care (under 18) **1-877-647-4355**
Baylor MedCare
(Texas Children's Hospital)

Remember, in order to participate in the Center of Excellence program, you must enroll by registering with the COE provider prior to your first COE visit. If you do not enroll first, covered expenses and payable benefits will be determined under the HSM options without regard to the COE program.

b. Personal Health Support

UnitedHealthcare provides a program called Personal Health Support designed to encourage personalized, efficient care for you and your covered dependents.

UnitedHealthcare reviews the medical necessity of *hospital* admissions and lengths of stay using nationally accepted medical standards. This Personal Health Support program is designed to help avoid unnecessary *hospital* admissions and inappropriate lengths of stay. It also maximizes the use of cost-effective alternative treatment settings, when appropriate.

The primary features of UnitedHealthcare's Personal Health Support are:

- Pre-admission review of non-emergency admissions and post-admission review of emergency admissions to help ensure that suitable care is provided in the most appropriate setting;
- Concurrent monitoring of inpatient care, which is conducted throughout a patient's hospital stay. The goals of concurrent monitoring are to
  - Evaluate the continuing need for hospital-level care,
  - Identify any inappropriate delay in necessary hospital care,
  - Initiate discharge planning as soon as appropriate after admission,
  - Identify opportunities to initiate case management intervention, and
  - Generate data to identify current patient care practices and associated activities;
- Surgical necessity review, which provides an evaluation of medical necessity and the appropriateness of all proposed surgeries; and
- Post-release patient follow-up.

If you require hospitalization or surgery and you use the network, your network doctor will provide notification for you through UnitedHealthcare's Personal Health Support Department. If you do not use the network, you are responsible for this notification. If you do not notify UnitedHealthcare's Personal Health Support Department, you must pay an additional $250 *non-notification penalty.*

Personal Health Support Nurses center their efforts on prevention, education, and closing any gaps in your care. The goal of the program is to ensure you receive the most appropriate and cost-effective services available. A Personal Health Support Nurse is notified when you or your provider calls the toll-free number on your ID card regarding an upcoming treatment or service.

If you are living with a chronic condition or dealing with complex health care needs, UnitedHealthcare may assign to you a primary nurse, referred to as a Personal

Health Support Nurse, to guide you through your treatment. This assigned nurse will answer questions, explain options, identify your needs, and may refer you to specialized care programs. The Personal Health Support Nurse will provide you with their telephone number so you can call them with questions about your conditions, or your overall health and well-being.

Personal Health Support Nurses will provide a variety of different services to help you and your covered family members receive appropriate medical care. Program components are subject to change without notice. As of the publication of this SPD, the Personal Health Support program includes:

- **Admission counseling** — For upcoming inpatient *hospital* admissions for certain conditions, a Treatment Decision Support Nurse may call you to help answer your questions and to make sure you have the information and support you need for a successful recovery;
- **Inpatient care management** — If you are hospitalized, a nurse will work with your physician to make sure you are getting the care you need and that your physician's treatment plan is being carried out effectively;
- **Readmission management** — This program serves as a bridge between the *hospital* and your home if you are at high risk of being readmitted. After leaving the *hospital*, if you have a certain chronic or complex condition, you may receive a phone call from a Personal Health Support Nurse to confirm that medications, needed equipment, or follow-up services are in place. The Personal Health Support Nurse will also share important health care information, reiterate, and reinforce discharge instructions, and support a safe transition home; and
- **Risk management** — Designed for participants with certain chronic or complex conditions, this program addresses such health care needs as access to medical specialists, medication information, and coordination of equipment and supplies. Participants may receive a phone call from a Personal Health Support Nurse to discuss and share important health care information related to the participant's specific chronic or complex condition.

If you do not receive a call from a Personal Health Support Nurse but feel you could benefit from any of these programs, please call the toll-free number on your ID card.

c. Transplant Resource Services (TRS) Program

The HSM options provide special services for HSM participants who require qualified organ transplants. Through UnitedHealthcare's United Resource Network, the TRS program provides 100% coverage for transplant services at recognized medical centers nationwide.

Qualified organ transplants include the following:

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

TRANSPLANT RESOURCE SERVICES (TRS):
The TRS program offers HSM participants access to "best of class" institutions, which can result in shorter stays, fewer complications, and lowers the chance that re-transplantation services will be needed. The TRS program typically covers all transplant-related charges, including evaluation, transplant, and 90 days of follow-up care. You can find more information by calling UnitedHealthcare at 1-800-752-8982.

Covered health services and supplies from a UnitedHealthcare 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; and
- 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; and
- 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 UnitedHealthcare 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 HSM options without regard to the TRS program.

1.6 Expenses Not Covered under HSM Options

The following expenses are excluded under the HSM 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 which 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;
- Artificial insemination, including in vitro fertilization and gamete intra-fallopian transfer expenses;
- 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, except cutting procedures in the mouth or as the result of accidental damage to natural teeth, as described in Section 1.4h;
- 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;
- Hearing aids, except as required because of accidental injury or surgery to the ear or any parts of the ear;

- Services of a social worker, other than Beacon Health Options®–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;
- Speech therapy for a child(ren) who is age seven (7) or older. The exception to this exclusion includes speech therapy for a child(ren) who is age seven (7) or older that is needed as the result of laryngectomy, stroke, brain damage due to accidental injury, or surgery 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 as a dependent of another *employee* under the Medical Benefit Program;
- Services provided for the treatment of weight loss, unless certified to be medically necessary by UnitedHealthcare;
- Nutritional supplements;
- Any treatment that is not provided in-person, except treatment provided over the telephone by Teladoc; and
- Charges in excess of the amount determined to be a covered expense in accordance with Section 1.3g "Program Payments for HSM Covered Expenses."

Certain other expenses not specifically listed may not be covered under the HSM options. If you are not sure if your treatment is a covered expense, you should call UnitedHealthcare's Customer Service Center at 1-800-752-8982 for a benefit determination before incurring any expenses.

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 Beacon Health Options®. (For information about Beacon Health Options®, see Section 1.3d, "Mental Health and Substance Abuse Benefits Network.");
- 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; and
- Any services or supplies not provided or billed through the hospice program and approved by the attending physician.

1.7 Other Important Information

a. Filing Claims for HSM Benefits

When Using the HSM Network

Generally, you do not have to file a claim for benefits when using the HSM network because your participating provider files the claim for you.

When Not Using the HSM Network

If your provider does not agree to file your claim, you will need to obtain a claim form from UnitedHealthcare or, in the case of Mental Health and Substance Abuse Care, from Beacon Health Options®. You may also use your provider's itemized service statement to submit your charges. Be sure to include the HSM 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 delays 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. Benefits are not paid on claims filed later than the end of the calendar year following the one in which expenses were incurred. Therefore, you must file all claims by the end of the following calendar year to receive benefits.

If you have any questions about how or where to file your claim, refer to the HSM contact information located at the front of this summary plan description. For information regarding the Plan's formal claims and appeals procedures, see Section 14.2, "Claims and Appeals."

b. Coordination of Benefits

The HSM 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 100% of the allowable medical expenses you incur during a calendar year.

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 paid without coordination of benefits and the amount of benefits actually paid may be credited to the covered person. After the *deductibles* are satisfied, the HSM options apply any credit toward *coinsurance* paid and future claims in the same calendar year automatically;
- If benefits are coordinated with a group dental plan, any such credit applies only to the claim that was coordinated; and
- If your spouse or *domestic partner* is covered under another group plan, that plan provides primary coverage for him or her and the HSM options provide secondary coverage.

Coordination of benefits for dependent child(ren) covered under the HSM options and other group medical plans 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 HSM Claims Administrator.

c. Right of Recovery

The HSM options have 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 HSM options provide a benefit for you or your 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 dependent(s) by the amount of the overpayment.

d. 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 Section 7.0, "Right to Subrogation."

e. Events Affecting Coverage

Leaves of Absence — Disability, Personal, and Military

If you are on a leave of absence, your benefits may be impacted. (For further information, see Section 12.0, “Leaves of Absence and Your Other Company Benefits.”)

Loss of Eligibility

Coverage for you 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, see Section 6.0, “Continuation of Coverage.”)

Change in Number of Hours Worked

If your employment status changes to *part-time employee* status, your coverage ends; however, you may be able to continue coverage. (see Section 6.0, “Continuation of Coverage.”) Conversely, if your employment status changes from *part-time employee* status to *regular part-time employee* or *regular full-time employee* status, you become eligible to participate in the Medical Benefit Program, effective on the date of your change in status.

Layoff or Termination of Employment

Your coverage ends on the last day of the month if you are laid off due to lack of work or if your employment is terminated; however, you may be able to continue coverage. (For details, see Section 6.0, “Continuation of Coverage.”)

Retirement

Employees hired or rehired on or after January 1, 2017, are not eligible for retiree coverage under the Shell Medical Benefit Program. Please refer to Section 13.0, “Preparing for Retirement” for additional information.

Death

Applicable to *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 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 dependents may continue coverage for 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)*. The Company continues to subsidize coverage until your dependent(s) no longer qualify for coverage.

Applicable to *Employees* Hired or Rehired before January 1, 2017

If you die while you are an *employee*, before you meet the *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, your dependent(s) may continue coverage by paying the required premium contributions until they no longer meet the definition of *eligible dependent(s)*. The Company continues to subsidize coverage until your dependent(s) no longer qualify for coverage.

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.

f. Continuation of Coverage

You and your *eligible dependent(s)* may be eligible to continue medical coverage under COBRA (Consolidated Omnibus Budget Reconciliation Act of 1985) if you would otherwise lose coverage as the result of a COBRA-*qualifying event*. (For details, see Section 6.0, “Continuation of Coverage.”)

g. 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 to the Shell Benefits Service Center, QMCSO Processing, P.O. Box 770003, Cincinnati, OH 45277-0071 for processing and a determination of whether it constitutes a QMCSO. 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 above address or by calling 1-800-30-SHELL.

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), should be sent to the above address for processing.

h. *Medicare* Eligibility for *Domestic Partners*

If your *domestic partner* fails to enroll in *Medicare* when he or she first becomes *Medicare* eligible, there may be late enrollment penalties and other limitations. Please see www.medicare.gov for more information.

i. Conversion Privilege

The HSM options, US GEMS, and the Be Well Kelsey Plan do not allow you to convert your coverage to an individual policy.

If you are enrolled in an HMO/PPO option, you should contact the insurer directly for information regarding the availability of a conversion privilege.

2.0 Dental Benefit Program

Regular dental checkups and good dental hygiene play an important role in your overall health. The Dental Benefit Program is designed to promote and encourage preventive dental care and provide benefits for services that are essential to the proper care of teeth and gums.

2.1 An Overview

The Company generally offers two coverage options:

- The Cigna Dental *PPO* option, which is administered by Cigna, offers coverage for dental care from any qualified provider. This option requires a higher monthly premium than the Cigna Dental Care option, and 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 also may require that the patient meet a *deductible*; and
- The Cigna Dental Care option offers dental coverage through the Cigna Dental Health network of dental providers. This option features relatively low monthly premiums and patient *copayments* for most covered services, and no annual maximum benefit or orthodontic lifetime maximum benefit. In this option, you must use designated dental providers to receive benefits. Each enrolled family member must designate a primary care dentist (PCD) to coordinate their individual dental care needs.

Some locations offer different dental coverage instead of the Cigna plans. For more information contact the Shell Benefits Service Center at 1-800-30-SHELL.

2.2 Participation

a. Eligibility

You are eligible to enroll in the Dental Benefit Program if you are a *regular full-time* or *regular part-time employee* of a *participating company*. If you enroll in the Dental Benefit Program, you can also enroll your *eligible dependent(s)*.

***ELIGIBLE DEPENDENT(S)* INCLUDE:**

- Your spouse;
- Your *domestic partner*;
- Your child(ren) through the end of the year in which they turn 26;
- Your unmarried child(ren) age 26 or over who are physically or mentally disabled and covered under the program, or another plan sponsored through your previous employment, on the day before reaching their 26th birthday, and who remain disabled and permanently dependent upon 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 and who are not employed full-time; and
- The unmarried child(ren) of your spouse or *domestic partner** age 25 or over who were physically or mentally disabled and covered under the program, or another plan sponsored through your previous employment, on the day before reaching their 25th birthday, and who remain disabled and permanently dependent upon you for financial support.

For these purposes, the term *child* or *children* means a biological child, stepchild, adopted child or foster child.

***The child(ren) of your spouse or *domestic partner* also must live with you in a regular, parent-child relationship.**

b. Enrollment

For You

If you are a *regular full-time* or *regular part-time employee* who is newly eligible, you will receive enrollment materials from the Shell Benefits Service Center. If you wish to enroll, you must 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 fail to enroll for coverage within 31 days after your hire date or eligibility date, or if you were enrolled in the Dental Benefit Program, subsequently canceled your coverage, and later wish to re-enroll, you may enroll within 31 days after a *qualified status change* or during the next *group annual enrollment period*. (For details on *qualified status changes,* see Section 2.2e, “Changing Coverage,” or Section 15.0, “Glossary.”) You are not permitted to enroll at any other time.

For Your Dependent(s)

If you want to cover any of your *eligible dependent(s)* under your dental option, you need to enroll them within 31 days after:

- Your hire date or eligibility date; or
- The date they become eligible for coverage.

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

If you do not meet the 31-day deadline, you generally cannot enroll your *eligible dependent(s)* until the next *group annual enrollment period*, unless you have a subsequent *qualified status change* in your family or employment status. (For details on *qualified status changes*, see Section 2.2e, “Changing Coverage,” or Section 15.0, “Glossary.”)

Coverage for *eligible dependent(s)* enrolled when you enroll begins the day your coverage begins. If you do not wish to enroll your child(ren) under age four, you may add them to your coverage within 31 days of their fourth birthday or during the next *group annual enrollment period*.

c. Levels of Coverage

In most cases, the Dental Benefit Program options allow you to choose from these levels of coverage:

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

If both you and your spouse or *domestic partner* are eligible to enroll in the Dental Benefit Program as *employees* and you both wish to be covered:

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

d. Cost

You and the Company share the cost of dental coverage. Your election to participate in the Program is also your election, to the extent applicable, to pay your contributions by pre-tax salary reduction. Contributions for *domestic partner* coverage are made by payroll deduction but on an after-tax basis.

e. Changing Coverage

You may only change your coverage each year during the *group annual enrollment period* or if you experience a *qualified status change*. (For further information on what constitutes a *qualified status change*, see Section 15.0, “Glossary.”)

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

- You submit your request to change your coverage within 31 days after the *qualified status change*. However, if your *qualified status change* pertains to the loss of coverage under Medicaid or SCHIP or gaining of eligibility for a premium assistance subsidy under Medicaid or SCHIP, you must submit your request to change your coverage within 60 days from the day that your Medicaid or SCHIP coverage is terminated or the eligibility determination is made; and
- Except for with respect to *qualified status changes* that are considered special enrollment rights, the change in coverage must be consistent with the *qualified status change* event

The change becomes effective on the date of your *qualified status change*.

2.3 How the Dental Benefit Program Options Work

The Dental Benefit Program offers you access to care through two separate options.

a. Cigna Dental *PPO* Option

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 the Cigna 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.

REASONABLE AND CUSTOMARY CHARGES

The Cigna Dental *PPO* option limits covered expenses to reasonable customary charges. Charges are considered to be reasonable and customary if they are the 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. In determining the reasonable and customary charge, Cigna considers 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.

Pretreatment Review

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," page 46.) To obtain a Pretreatment Review, call Cigna's Dental Claims Office at 1-800-244-6224 for assistance.

b. Cigna Dental Care Option

When you enroll in the Cigna Dental Care 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 the Cigna Dental Care option.

Call Cigna Dental Health at 1-800-244-6224 for a Patient Charge Schedule or more information.

The Cigna Dental Care option uses the Cigna Dental Health Network, 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 Care option because your *copayments* are established under the Patient Dental Charge Schedule.

2.4 How the Dental Benefit Program Options Compare

a. Paying Your Share

Although the Dental Benefit Program options pay much of the cost of covered services, you share in a portion of the covered expense. These cost-sharing features vary between the options and can have a big impact on your out-of-pocket expenses.

Annual Deductible

The *deductibl*e 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 Care 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 1st through December 31st 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.

Orthodontic benefits under the Cigna Dental PPO are available only to dependent child(ren) under age 19 and are subject to a lifetime benefit maximum.

The Cigna Dental Care 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 Care 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 Care 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.

b. Schedule of Benefits

The following chart summarizes the benefits under both the Cigna Dental *PPO* and Cigna Dental Care options. The *copayments* listed under the Cigna Dental Care 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.

	Cigna Dental *PPO* Option	Cigna Dental Care Option
Annual Deductible[1] (calendar year)	$50/person $100/family	None
Diagnostic Services Routine exams X-rays Emergency treatment **Preventive Services** Teeth cleaning Fluoride	You pay $0, subject to the annual benefit maximum	You pay $0; a $54 copayment applies for after-hours emergency care
Basic Services Fillings	You pay 20% *coinsurance* after the *deductible*, subject to the annual benefit maximum	You pay: $0
Endodontics		$185 *copayment* for molars, $20 for bicuspids or $10 other teeth
Oral Surgery		$45 *copayment* for partial bony impaction $85 *copayment* for full bony impaction $5 for simple extractions $10 for most other extractions
Periodontal services: – Evaluation/treatment plan – Periodontal scaling – Osseous surgery – Gingivectomy		 $30 *copayment* $60 *copayment*/quadrant $305 *copayment*/quadrant $125 *copayment*/quadrant
Major Services Inlays Onlays Crowns Bridgework Dentures (partial) Dentures (full) 	You pay 50% *coinsurance* after the *deductible*, subject to the annual benefit maximum	You pay: $280 *copayment* $325 *copayment* $280 – $345 *copayment* $315 *copayment*/unit $265 *copayment*/upper $265 *copayment*/lower $355 *copayment*/upper $355 *copayment*/lower
Orthodontic Services Evaluation Treatment plan Banding Interceptive care Retainer Comprehensive full-banded treatments 	For dependent child(ren) under the age of 19: You pay 50% coinsurance after the deductible, subject to the lifetime benefit maximum.	For adults and child(ren), You pay: $50 *copayment* $150 *copayment* $400 *copayment* $375 *copayment* $300 *copayment* $1,200 *copayment* (child) $1,800 *copayment* (adult)
Annual Maximum Benefit (calendar year)	$2,000/person	None
Orthodontic Lifetime Maximum Benefit	$1,500/child under 19	None

[1] The *deductible* does not apply to diagnostic and preventive services.

2.5 Covered Expenses

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

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

a. Diagnostic and Preventive Services

The Cigna Dental *PPO* option and the Cigna Dental Care 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; and
- 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; and
- 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 Care 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; or
  - 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.

b. Basic Services

The Cigna Dental *PPO* option and the Cigna Dental Care 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); and
- Endodontic treatment, including root canal therapy, except molars and bicuspids.

c. Major Services

The Cigna Dental *PPO* option and the Cigna Dental Care 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; and
- 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; and
- Implants — a dental restoration replacing a missing tooth.

d. Orthodontic Services

Cigna Dental PPO Option

The Cigna Dental *PPO* option does not cover orthodontic services for adults or child(ren) age 19 and older. The Cigna Dental *PPO* option covers the following orthodontic services for child(ren) under age 19:

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

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

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

If your covered child(ren) under age 19 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.

Coverage is extended for up to 12 months after your child(ren) reaches age 19 if the orthodontic treatment was in progress before the child(ren)'s 19th birthday and if the child(ren) continues to be your *eligible dependent(s)*.

Cigna Dental Care Option

With the Cigna Dental Care 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 Care option, the benefit is prorated for the period that continued care is required, based upon a 24-month treatment plan.

e. Treatment in Progress

The Cigna Dental *PPO* option and the Cigna Dental Care 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.

2.6 Expenses Not Covered

The following expenses are not covered by the Cigna Dental *PPO* option or the Cigna Dental Care 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; and
- 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;
- Orthodontic services for adults and dependent child(ren) age 19 and older;
- Porcelain or acrylic veneers of crowns or pontics on, or replacing, the upper or lower first, second, and third molars; and
- Fees in excess of reasonable and customary charge limits.

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

- Fixed prosthodontic, removable prosthodontic, and root canal treatment in progress before Cigna Dental Care 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*; and
- 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.

2.7 Other Important Information

a. 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.

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

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.

Instructions on the claim form explain how to complete it. 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. You must file all claims by the end of the following calendar year to receive benefits. Benefits are not paid on claims filed later than the end of the calendar year following the year in which expenses were incurred.

If a claim for benefits is denied, you may file an appeal. (For details, see Section 14.2a, "Health Care Benefits Claims Procedure.")

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 Care Option

The Cigna Dental Care 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.

b. Coordination of Benefits

The Dental Benefit Program coordinates the benefits it pays by taking into account any coverage you or your covered dependent(s) may have under any group medical or dental plan. As a result of this coordination of benefits, it is possible for you to receive reimbursement for up to 100% of allowable dental expenses you incur during a calendar year.

Here is how coordination of benefits works under the Dental Benefit Program:

- For any covered dental service that is also covered under a group medical plan, the medical plan is considered the primary plan and therefore processes the claim first. Benefits coordinated with a medical claim apply to that claim only. No credit applies to future claims;
- If benefits are coordinated with another group dental plan, the Dental Benefit Program will pay up to the amount it would have paid in the absence of the other coverage, less any applicable *deductible*;

- For the Cigna Dental *PPO* option only: Any remaining amount that the Dental Benefit Program would have paid if it had been the primary plan is credited to the covered person who, after having satisfied any applicable *deductible*, can apply that credit toward future *coinsurance* in the same calendar year; and
- If your spouse or *domestic partner* is covered under another group dental plan, that plan provides primary coverage for him or her and the Dental Benefit Program provides secondary coverage.

Coordination of benefits for dependent child(ren) covered under the Dental Benefit Program and other group dental plans 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.

c. Right of Recovery

The Dental 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 Dental Benefit Program provides a benefit for you or your 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 dependent(s) by the amount of the overpayment.

d. Events Affecting Coverage

Leaves of Absence — Disability, Personal, and Military

If you are on a leave of absence, your benefits may be impacted. (For further information, see, Section 12.0, “Leaves of Absence and Your Other Company Benefits.”)

Loss of Eligibility

Coverage for you or your *eligible dependent(s)* ends on the last day of the month in which you or that dependent no longer meets the eligibility requirements. However, you may be able to continue coverage. (For details, see Section 6.0, “Continuation of Coverage.”)

Change in Number of Hours Worked

If your employment status changes to *part-time employee* status, your coverage ends; however, you may be able to continue coverage. (For details, see Section 6.0, “Continuation of Coverage.”) Conversely, if your employment status changes from *part-time employee* status to *regular part-time employee* or *regular full-time employee* status, you become eligible to participate in the Dental Benefit Program, effective on the date of your change in status.

Layoff or Termination of Employment

Your coverage ends if you are laid off due to lack of work or if your employment is terminated; however, you may be able to continue coverage. (For details, see Section 6.0, “Continuation of Coverage.”)

Retirement

For information about continuing your Dental Benefit Program benefits in retirement, see Section 13.0, “Preparing for Retirement”.

Death

If you have dependent coverage and die while you are employed, your dependent(s) is covered for three months following the month in which you die. The Company pays all contributions during this period. Continuation of coverage for your dependents beyond this period is determined as follows:

- If you die while you are an *employee*, before you meet the *retiree coverage eligibility* requirements, and you had dependent coverage at the time of your death, your dependent(s) may continue coverage for up to 33 additional months by paying the full cost of coverage (employer and employee portions of the premium) plus a 2% COBRA (Consolidated Omnibus Budget Reconciliation Act of 1985) administration fee. (For details, see Section 6.0, “Continuation of Coverage.”)
- 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 until they no longer meet the definition of *eligible dependent(s)*. The *eligible dependent(s)* must pay the full cost of coverage (employer and *employee* portions of the premium) after the first three months.

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) incurred covered expenses before the Program was amended or terminated, benefits are paid according to the Program provisions in effect before the change.

e. Continuation of Coverage

You and your *eligible dependent(s)* may be eligible to continue dental coverage under COBRA (Consolidated Omnibus Budget Reconciliation Act of 1985) if you would otherwise lose coverage as the result of a *qualifying event*. (For details, see Section 6.0, “Continuation of Coverage.”)

f. 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 Care Option

The Cigna Dental Care 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

3.0 VISION BENEFIT PROGRAM

The Vision Benefit Program, offered through VSP, makes it easy to get the eye care you need. VSP provides coverage for the cost of routine eye exams, eyeglasses, and contact lenses for you and your family. The Program covers the scheduled cost of eye care through a network of preferred providers and affiliate providers or partially reimburses you for charges by other providers.

3.1 Participation

a. Eligibility

You are eligible to enroll in the Vision Benefit Program if you are a *regular full-time* or *regular part-time employee* of a *participating company*. If you enroll in the Vision Benefit Program, you can also enroll your *eligible dependent(s)*.

- Your spouse;
- Your *domestic partner;*
- Your child(ren) through the end of the year in which they turn 26;
- Your unmarried child(ren) age 26 or over who are physically or mentally disabled and covered under the program, or another plan sponsored through your previous employment, on the day before reaching their 26th birthday, and who remain disabled and permanently dependent upon 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 and who are not employed full-time; and
- The unmarried child(ren) of your spouse or *domestic partner** age 25 or over who were physically or mentally disable and covered under the program, or another plan sponsored through your previous employment, on the day before reaching their 25th birthday, and who remain disabled and permanently dependent upon you for financial support.

For these purposes, the term *child* or *children* means a biological child, stepchild, adopted child, or foster child.

***The child(ren) of your spouse or *domestic partner* also must live with you in a regular, parent-child relationship.**

b. Enrollment

For You

If you are a *regular full-time* or *regular part-time employee* who is newly eligible, you will receive enrollment materials from the Shell Benefits Service Center. If you wish to enroll, you must 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 fail to enroll for coverage within 31 days after your hire date or eligibility date, or if you were enrolled in the Program, subsequently canceled your coverage, and later wish to re-enroll, you may enroll within 31 days after a *qualified status change* or during the next *group annual enrollment period*. (For details about *qualified status changes*, see Section 3.1e, "Changing Coverage," or Section 15.0 "Glossary.") You are not permitted to enroll at any other time.

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

For Your Dependent(s)

If you want to cover any of your *eligible dependent(s)* under your vision option, you need to enroll them within 31 days after:

- Your hire date or eligibility date; or
- The date they become eligible for coverage.

If you do not meet the 31-day deadline, you generally cannot enroll your *eligible dependent(s)* until the next enrollment period, unless you have a subsequent *qualified status change* in your family or employment. (For details on *qualified status changes*, see Section 3.1e, "Changing Coverage," or Section 15.0, "Glossary.")

Coverage for *eligible dependent(s)* enrolled when you enroll begins the day your coverage begins.

c. Levels of Coverage

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

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

If both you and your spouse or *domestic partner* are eligible to enroll in the Vision Benefit Program as *employees* and you both wish to be covered:

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

d. Cost

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 is also your election, to the extent applicable, to pay your contributions by pre-tax salary reduction. Contributions for *domestic partner coverage* are made by payroll deduction but on an after-tax basis on account of federal tax law.

e. Changing Coverage

You may only change your coverage each year during the *group* annual enrollment *period* or if you experience a *qualified status change*. (For further information on what constitutes a *qualified status change*, see Section 15.0, "Glossary.") If you have a *qualified status change*, you may change your coverage only if:

- You submit your request to change your coverage within 31 days after the *qualified status change*. However, if your *qualified status change* pertains to the loss of coverage under Medicaid or SCHIP or gaining of eligibility for a premium assistance subsidy under Medicaid or SCHIP, you must submit your request to change your coverage within 60 days from the day that your Medicaid or SCHIP coverage is terminated or the eligibility determination is made; and
- Except for with respect to *qualified status changes* that are considered special enrollment rights, the change in coverage must be consistent with the *qualified status change* event.

The change becomes effective on the date of your *qualified status change*.

3.2 How the Vision Benefit Program Works

VSP manages a network of more than 29,000 eye care professionals nationwide. You may choose to use a VSP preferred provider 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.

a. Using VSP Preferred and Affiliate Providers — The Choice Is Yours

Each time you need vision care, you have a choice:

- You can use VSP preferred providers or affiliate providers who discount the cost of their services. 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. To access benefits, simply select a VSP preferred provider 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; or

- You can choose any licensed ophthalmologist, optometrist, or optician who is not a VSP preferred provider 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 Section 3.5a, "Applying for Benefits.")

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

b. Paying Your Share

Copayments

When you incur a covered vision expense from a VSP preferred provider 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 $130. (For more expensive frames, you pay the difference in cost at wholesale prices.) 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 below; and
- Optional cosmetic processes.

Discounts on Contact Lenses

Each calendar year, you may exchange your lens and frame benefits for a contact lens benefit of up to $125, 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.

Contact lenses are considered medically necessary when certain benefit criteria is met (after cataract surgery to correct extreme visual acuity problems that cannot be corrected with eyeglass lenses, or to correct certain conditions of anisometropia and keratoconus).

Discounts on 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 preferred provider 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.

Discounts on Laser Surgery

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

The maximum you will pay is:

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

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

3.3 Covered Expenses

In addition to expenses related to eye examinations and the fitting of glasses or contact lenses, VSP also offers a low-vision benefit. This benefit provides special aid for people who have severe visual problems, not correctable by regular lenses, and who often are referred to as partially sighted. The Program covers the full cost of vision analysis and diagnosis of severe vision problems.

a. Schedule of Benefits

The following chart highlights the covered expenses under the Vision Benefit Program.

	When you see a VSP Preferred Provider or Affiliate Provider, the Program pays…	When you see Other Providers, the Program reimburses…
Vision exam: Once every calendar year	100% after a $10 *copayment*	Up to $45
After you pay $25 toward the cost of each set of lenses, the Program pays…		
Basic lenses: Once every calendar year		
– Single vision	100%	Up to $30
– Lined bifocal	100%	Up to $50
– Lined trifocal	100%	Up to $65
– Lenticular	100%	Up to $100
Frames: Once every calendar year	Wholesale allowance up to $130 retail; if you choose more expensive frames, you pay the difference in wholesale cost $70 allowance at Costco	Up to $70
Contact lenses: In place of lenses and frames once every calendar year:		
– Medically necessary	Professional fees and materials: 100%, after a $25 *copayment* when certain benefit criteria are met	Professional fees and materials: Up to $210
– Elective	Professional fees and materials: Up to $125, with a 15% discount on evaluation and fitting	Professional fees and materials: Up to $125
Severe vision problems:		
– Vision analysis, diagnosis, and prescription of lenses	100% (prior authorization required)	Up to $125 (prior authorization required)
– Low-vision therapy	75% of cost, up to $1,000 maximum benefit (excluding *copayments*) every two years (prior authorization required)	75% (prior authorization required)

3.4 Expenses Not Covered

The Vision Benefit Program does not cover:

- 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; and
- Services or supplies not specifically listed above.

3.5 Other Important Information

a. Applying for Benefits

You do not have to file a claim if you go to a VSP preferred provider 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 Section 3.3a, "Schedule of Benefits." Contact VSP at 1-800-877-7195 or visit the Shell Benefits Service Center at www.netbenefits.com to obtain a claim form.

b. Coordination of Benefits

The Vision Benefit Program coordinates the benefits it pays by taking into account any coverage you or your covered dependent(s) may have under any group medical or vision plan. As a result of this coordination of benefits, it is possible for you to receive reimbursement for up to 100% of allowable vision expenses you incur during a calendar year.

Here is a summary of how coordination of benefits works under the Vision Benefit Program:

- For any covered vision service that is also covered under a group medical plan, the medical plan is considered primary and must process the claim first. Benefits coordinated with a medical claim apply to that claim only. No credit applies to future claims;
- For any covered vision service that is also covered under 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; and
- If your spouse or *domestic partner* is covered under another group vision plan, that plan provides primary coverage and the Vision Benefit Program provides secondary coverage.

Coordination of benefits for *eligible child(ren)* in the Vision Benefit Program and other group vision plans 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.

c. Events Affecting Coverage

Leaves of Absence — Disability, Personal, and Military

If you are on a leave of absence, your benefits may be impacted. (For further information, see, Section 12.0, “Leaves of Absence and Your Other Company Benefits.”)

Loss of Eligibility

Coverage ends for you or your *eligible dependent(s)* on the last day of the month in which you or the dependent(s) no longer meets the eligibility requirements. Your dependent children that age out at 26 will be covered through the end of the year they turned 26. However, you may be able to continue coverage. (For details, see Section 6.0, “Continuation of Coverage.”)

Change in Number of Hours Worked

If your employment status changes to *part-time employee* status, your coverage ends; however, you may be able to continue coverage. (For details, see Section 6.0, “Continuation of Coverage.”) Conversely, if your employment status changes from *part-time employee* status to *regular part-time employee* or *regular full-time employee* status, you become eligible to participate in the Vision Benefit Program, effective on the date of your change in status.

Layoff or Termination of Employment

Your coverage ends on the last day of the month if you are laid off due to lack of work or if your employment is terminated; however, you may be able to continue coverage. (For details, see Section 6.0, “Continuation of Coverage.”)

Retirement

For information about continuing your Vision Benefit Program benefits in retirement, see Section 13.0, “Preparing for Retirement”.

Death

If you die while you are an *employee,* before you meet the *retiree coverage eligibility* requirements, and you had dependent coverage at the time of your death, your dependent(s) may continue coverage under COBRA (Consolidated Omnibus Budget Reconciliation Act of 1985) for up to 36 months by paying the full cost of coverage plus a 2% COBRA administration fee. (For details, see Section 6.0, “Continuation of Coverage.”)

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 until they no longer meet the definition of *eligible dependent(s)*. The *eligible dependent(s)* must pay the full cost of coverage.

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) incurred covered expenses before the Program was amended or terminated, benefits are paid according to the Program provisions in effect before the change.

d. Continuation of Coverage

You and your *eligible dependent(s)* may be eligible to continue vision coverage under COBRA (Consolidated Omnibus Budget Reconciliation Act of 1985) if you would otherwise lose coverage as the result of a *qualifying event*. (For details, see Section 6.0, “Continuation of Coverage.”)

e. Conversion Privilege

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

4.0 Health Care and Dependent Day Care Account Programs

The Company offers Health Care and Dependent Day Care Accounts, called Flexible Spending Accounts (FSAs), as a smart and convenient way to stretch your benefit dollars and receive real tax savings. Although FSAs require a little planning on your part, you may find that the financial rewards are worth the effort.

4.1 An Overview

Shell offers the Health Care Account Program and the Dependent Day Care Account Program, which allow you to make pre-tax contributions that can be used to reimburse you for eligible health care and dependent day care expenses. You can choose to participate in these programs, and participation in each program is separate. You cannot use money from one of the programs to reimburse expenses covered by another program.

- The Health Care Account Program may be used to reimburse certain expenses you and your family incur for medical, dental, vision, and hearing care that are not paid or reimbursed through an insurance or benefit plan, and that you do not take as a deduction for tax purposes; and
- The Dependent Day Care Account Program 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, and that you do not take as a dependent day care federal tax credit.

4.2 Participation

a. 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.*

b. Enrollment

You may enroll in an FSA:

- During the *group annual enrollment period*;
- Within 31 days after your eligibility date; or
- Within 31 days after a *qualified status change*. (For information on *qualified status changes*, see Section 4.2d, "Changing Your Contributions," or Section 15.0, "Glossary.")

You must enroll by contacting the Shell Benefits Service Center and specifying the monthly 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.

c. Contributions

Contributions to both of the Account Programs are made through pre-tax payroll deductions.

Before you enroll in an FSA, you should carefully estimate your expected expenses. Because of the special tax advantages that FSAs offer, the IRS applies strict rules and limitations regarding their use. There are no refunds of unused FSA contributions. You forfeit any unused funds remaining in either Account Program.

Your Health Care Account Program

You may contribute up to $2,550 annually, subject to a $120 minimum annual contribution.

Your Dependent Day Care Account Program

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).

d. Changing Your Contributions

Federal tax law prohibits mid-year changes to your FSA participation/contributions during the year unless you have a *qualified status change*. This means that you must continue making your elected monthly contributions for the full Program year unless you have a *qualified status change* (For further information on what constitutes a *qualified status change*, see Section 15.0, “Glossary.”)

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

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

The change becomes effective on the date of your *qualified status change*. If you change your contributions to either the Health Care Account or the Dependent Day Care Account 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 limits established under the Program. (For details, see “4.3 How the FSA Options Work,” below.)

4.3 How the FSA Options Work

a. General Features that Apply to FSAs

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 Account Program, so it is important to carefully estimate your expenses when determining your contribution amount;
- FSAs are subject to non-discrimination testing requirements, which could make it necessary to reduce or terminate your contributions. You will be notified if such reductions are required; and
- 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.

b. The Health Care Account Program

Expenses reimbursed through the Health Care Account Program must be eligible expenses — that is, health care expenses that qualify as allowable tax deductions for services provided during the period when you participated in the Health Care Account 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.

Reimbursable health care expenses are those incurred by the following persons:

- **You and your spouse;**
- **Your tax dependents;**
- **Your child who is under age 27 at the end of your tax year; and**
- **Any person you could have claimed as a dependent except that the person filed a joint tax return, had gross income of $4,000 or more, or you (or your spouse if filing jointly) could be claimed as a dependent on someone else's tax return.**

Eligible and Ineligible Health Care Expenses

Here are examples of eligible and ineligible health care expenses.

Examples of Eligible Health Care Expenses	Examples of Ineligible Health Care Expenses
Medical expenses incurred by you or your family, such as annual *deductibles*, *copayments*, or *coinsurance*	Over-the-counter medicine or drugs (other than insulin) without a prescription or items used for general health, such as vitamins or toothpaste
Mental health and substance abuse care expenses incurred by you or your family	Cosmetic surgery
Dental expenses incurred by you or your family such as – Adult orthodontics, – Dental educational programs (e.g., plaque control and dental hygiene instruction), and/or – Treatment for temporomandibular joint (TMJ) dysfunction or other services excluded under your dental plan	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
Vision expenses incurred by you or your family, such as routine eye examinations; eyeglasses; contact lenses, including all necessary supplies and equipment; or LASIK or PRK surgery	Payroll deductions for contributions to Company-sponsored medical, dental, and/or vision plans
Hearing expenses incurred by you or your family such as – Routine hearing examinations, and/or – Hearing aids and their repair	Contributions to health plans that are not Company-sponsored Smoking-cessation or weight-loss programs not prescribed by a doctor

Before you decide to contribute, you should know that health care expenses that are claimed under the Health Care Account Program 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 should speak with your tax advisor to determine whether the Health Care Account Program 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 (which are available at www.irs.gov).

c. The Dependent Day Care Account Program

Expenses reimbursed through the Dependent Day Care Account must be incurred during the period in which you participate in the Dependent Day Care Account Program for the care of 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.

QUALIFIED DEPENDENT(S) UNDER THE DEPENDENT DAY CARE ACCOUNT

According to IRS rules, a qualified dependent(s) is:

- **Your child(ren) under age 13; or**
- **A spouse or other relative who is physically or mentally incapable of self-care, depends upon you for more than half of his or her financial support, and spends at least eight hours a day in your home.**

To be reimbursed for dependent day care expenses related to individuals other than children under age 13, the covered individual must have personal income that is less than the amount of the federal income tax personal exemption allowance for that calendar year.

You may not use the funds in your Dependent Day Care Account to reimburse yourself for care or services provided by:

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

Eligible and Ineligible Dependent Day Care Expenses

Here are examples of eligible and ineligible dependent day care expenses.

Examples of Eligible Dependent Day Care Expenses	Examples of Ineligible Dependent Day Care Expenses
Charges from a babysitter whether in or out of the home when the care is related to employment for you and your spouse	Charges by a neighbor or individual babysitter/day care provider when the care is not related to employment for you and your spouse
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 well-being 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, you should know that dependent day care expenses that are claimed under the Dependent Day Care Account Program are not eligible to be claimed as a federal income tax credit (or, in some states, a state tax credit) for dependent day care expenses. Depending upon 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).

4.4 FSA Reimbursement Process

Wageworks processes requests for reimbursement under the FSAs. If you have questions about an FSA claim, call WageWorks at 1-877-924-3967 or the Shell Benefits Service Center at 1-800-30-SHELL.

a. Timing

Health Care Account Program	Dependent Day Care Account Program
Timing for incurring health care expense (services giving rise to the expense): In order for expenses to be eligible for reimbursement under your Health Care Account, expenses must be incurred by March 15th of the year following the year in which your enrollment in the Program is effective. *Timing for filing your claim:* 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 May 1st of the calendar year following the Program year (January 1st – December 31st). For example, you will be able to use your 2016 Health Care Account election amount to reimburse eligible expenses you incur from January 1, 2016 through March 15, 2017, and the filing deadline for 2016 Health Care Account reimbursement is May 1, 2017.	*Timing for incurring dependent day care expense:* Your Dependent Day Care Account will reimburse you for eligible expenses you incur while participating in the Program through December 31st of the current Program year. *Timing for filing your claim:* Claims for reimbursement must be filed no later than March 31st of the calendar year following the Program year (January 1st – December 31st). 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, you will be reimbursed from your 2016 Dependent Day Care Account for eligible expenses you incur from January 1, 2016 through December 31, 2016, as long as you file by March 31, 2017.

b. Application Process

You will be required to submit appropriate proof of expenses as explained during the application for reimbursement process. Appropriate proof of expenses includes:

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

Claims for reimbursement from your Health Care Account or Dependent Day Care Account can be submitted under several options:

- On the 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 WageWorks EZ Receipts® free mobile app on your smartphone; or
- By fax or mail. You can download the reimbursement form at www.wageworks.com.

c. Additional Reimbursement Options for Health Care Account Program Only:

- Using your WageWorks debit card:
  - Upon enrollment in the Health Care Account Program, you will receive a WageWorks health care card ("debit card"). You can use your debit card at health care providers and pharmacies to pay 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; or
- Via automatic reimbursement linked to your HSM options Medical Benefit Program expenses:
  - Out-of-pocket expenses that you incur for medical, prescription drugs, mental health and substance abuse care under the Hospital Surgical Medical (HSM) 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 WageWorks®, which administers the Health Care Account Program, and request to file your claims directly for reimbursement. Because only those expenses not reimbursed by any insurance or benefit plan are eligible to be paid from your Health Care Account, you must notify WageWorks® if any expenses included in an HSM claim are covered under another benefit program and, as a result, are not eligible for reimbursement. Note that if you use the WageWorks® debit card, you are not eligible for this automatic reimbursement option.

4.5 Events Affecting Participation

Your 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 Health Care Account contributions continue on an after-tax basis. (See Section 6.0, "Continuation of Coverage.") 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 and Your Other Company Benefits," on page 164.)

Change in Number of Hours Worked

If your employment status changes to *part-time employee* status, your coverage ends. However, you may be able to continue your Health Care Account contributions on an after-tax basis. (See Section 6.0, "Continuation of Coverage.") Conversely, if your employment status changes from *part-time employee status to regular part-time employee* or *regular full-time employee* status, you become eligible to participate in the FSAs, effective on the date of your change in status. 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 eligible to have your Health Care Account contributions continue on an after-tax basis. (See “Continuation of Coverage,” page 71.)

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.

5.0 EMPLOYEE ASSISTANCE PROGRAM (EAP)

Beacon Health Options® offers *employees* and their household family members access to lifestyle and behavioral health resources and referral services to help you balance both work and personal priorities.

The EAP is available to *employees* and their household family members, 24 hours a day, seven days a week at 1-800-543-8114 or online at www.achievesolutions.net/shell. Shell members have access to five EAP sessions per problem per year, at no cost to you.

The EAP can help with things like:
- **Balancing work and family;**
- **Time management;**
- **Finding child care;**
- **Elder care issues;**
- **Alcohol or drug dependencies;**
- **Anger management; and**
- **Much more.**

The Program provides information, advice, and support on a range of everyday issues, including but not limited to:

- Confidential consultation on personal issues 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 for retirement planning, saving for college, tax questions, and more; and
- Access to counseling professionals in a variety of fields.

Information is also available on the Achieve Solutions® website, which includes educational materials and a national database of child and elder care resources.

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 Section 6.0, “Continuation of Coverage.”)

6.0 CONTINUATION OF COVERAGE (COBRA)

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) gives employees 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*.

6.1 Participation

a. Eligibility

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

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.

In order to be eligible for COBRA coverage, you and/or your covered *eligible dependent(s)* must have a *qualifying event.*

Qualifying events result in loss of coverage on account of:

- Your death;
- Termination of your employment (other than for gross misconduct);
- Reduction in work hours;
- Divorce or legal separation;*
- Your entitlement to *Medicare*;†
- Loss of dependent eligibility;*
- Reorganization of the Company under Chapter XI of the Bankruptcy Code; or
- Termination of the *domestic partner* relationship between the *employee* and his or her *domestic partner*.*

*See "Notice Requirements" in Section 6.1d.

†Your entitlement to Medicare is only a qualifying event for your covered *eligible dependent(s).*

b. Enrollment

Once the COBRA Administrator becomes aware that a *qualifying event* has occurred, you and/or your covered *eligible dependent(s)* will receive a notice of your right to elect continuation of coverage, which will contain further information about how to elect COBRA coverage. You must elect coverage within 60 days of the date of that notice.

c. Period of Coverage

COBRA coverage begins on the first day that there is a loss of coverage as the result of a *qualifying event*. However, until a COBRA election is made, you will not have coverage. Once the election is made, coverage will continue retroactively from the date you lost coverage as a result of the *qualifying event*.

The maximum period of coverage available to you or your covered *eligible dependent(s)* under COBRA varies depending on the *qualifying event* resulting in the coverage loss as follows:

18 months if you or your covered *eligible dependent(s)* lose coverage as a result of one of the following *qualifying events*:

- 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 first *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.

36 months if 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*; or
- They no longer qualify as *eligible dependent(s)*.

Multiple qualifying events for *eligible dependent(s):*
If more than one qualifying event occurs during an initial 18-month or 29-month COBRA period, your *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.

d. When Continuation Coverage Ends

Continuation coverage ends when:

- The covered person becomes covered under another group medical, dental, and/or vision plan;*
- The period during which COBRA coverage was applied ends;
- The cost of the continued coverage is not paid on or before the date it is due;
- 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; or
- The Company terminates all group health plans for all *employees*.

*Notice Requirements

You or your covered *eligible dependent(s)* must notify the Shell Benefits Service Center at 1-800-30-SHELL 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.

e. 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.

f. Cost of COBRA Continuation Coverage

Generally

You are required to pay the full cost of coverage (employer and *employee* portions) 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.

g. Continuing Participation under the Health Care Account Program

For the Current Year

Unless you elect otherwise, your contributions and coverage under the Health Care Account end on the date you are no longer eligible to participate in the Program as a *regular full-time employee* or *regular part-time employee*. However, you can continue to apply for reimbursement from your Health Care Account, up to the amount you elected to contribute for the year, for eligible health care expenses you incurred before your coverage termination date. Reimbursement requests must be submitted by May 1st following the end of the current calendar year.

You may continue your participation in the Health Care Account by paying your contributions (plus the 2% COBRA administration fee) for the remainder of the year (i.e., through December 31st) on an after-tax basis. If you choose this option, you may apply for reimbursement from your Health Care Account, up to the amount you elected to contribute for the year, for eligible health care expenses you incur through March 15th of the following year. Your claims must be filed no later than May 1st of the calendar year following the Health Care Account Program year (January 1st – December 31st).

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 can be reimbursed for prior expenses incurred while still enrolled. Filing time limits apply for reimbursement.

After the Current Year

If your employment terminates for any reason (other than your gross misconduct), you can elect to continue participating in the Health Care Account Program for the current year. If you choose this option, you and your covered dependent(s) also may elect to continue participating in each consecutive year that begins within 18 months after your termination date. In that case, you may participate until the end of that year, and you will be required to pay your contributions on an after-tax basis (plus the 2% COBRA administration fee, or plus 50% for the last 11 months of the 29-month disability coverage period).

If you die or are divorced, your former spouse and other covered dependent(s) who are not covered under any other FSA may choose to continue participating in the Health Care Account Program on an after-tax basis in each consecutive year that begins within the following 36 months. If you are divorced, you or your former spouse must notify the Shell Benefits Service Center within 60 days after the event to be eligible.

Your covered child(ren) who is not covered under any other FSA may choose to continue participating in the Health Care Account Program in each consecutive year that begins within the 36 months after they no longer qualify as covered dependent(s) under the terms of the Program. For this option to be available to your covered child(ren), you must notify the Shell Benefits Service Center within 60 days after the child(ren) is no longer an *eligible dependent(s)*.

7.0 RIGHT TO SUBROGATION

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.

If the Hospital Surgical Medical (HSM) options, the US GEMS option or the Be Well Kelsey Plan 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. 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.

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:

SUBROGATION — EXAMPLE
Suppose you are injured in a car accident that is not your fault, and you receive benefits under HSM to treat your injuries. Under subrogation, 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.

- 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; or
- 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.

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.

PROTECTION

In addition to health care coverage to meet your ongoing needs, you may be concerned about protection against the unexpected. What protection would you have if you became disabled and were unable to work? What if a family member died or became seriously injured as the result of a sudden illness or accident? Would you and your family have financial resources to deal with the loss? The insurance benefits that are part of your Dimensions Protection plans are designed to address those needs.

Shell provides you with basic limited disability, survivor insurance, and business travel accident coverage at no cost to you.

In addition, Shell offers optional insurance coverage designed to meet a broad range of individual needs. These options include additional disability coverage for you, which supplement the Company-paid Disability Benefit Plan. Shell also offers access to different Group Life Insurance, Voluntary Personal Accident Insurance, Legal Insurance, Group Auto and Home Insurance options for you and your family. Back-Up Care is available to assist you with short-term care needs for yourself, your children or elders.

8.0 DISABILITY INCOME PROGRAM

You depend on your pay to meet your financial responsibilities. Those responsibilities do not end when an illness or injury prevents you from working. The Company's Disability Income Program provides 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 through:

- The Disability Benefit Plan, a Company-paid plan that continues your pay in the event of an *occupational* or *non-occupational disability*; and
- The Income Protection Insurance Program, an *employee*-paid optional program that provides income in the event your pay is reduced or ceases due to a *non-occupational disability*.

Long-term income protection is available through:

- The Long-Term Disability Program, an *employee*-paid optional program that provides income if you become totally disabled for an extended period of time; and
- The Shell Pension Plan, a Company-paid 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.)

8.1 Disability Benefit Plan

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

An *occupational disability* results from a work-related illness or injury. A *non-occupational disability* is caused by a non-work-related illness or injury.

a. Participation

You are eligible for *occupational disability* benefits if:

- You are a *regular full-time* or *regular part-time employee* of a *participating company*; and
- You have an *occupational disability* and are unable to work.

You are eligible for *non-occupational disability* 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.

b. Enrollment

If you are hired as a *regular full-time employee* or *regular part-time employee*, you are automatically enrolled for Disability Benefit Plan coverage as of your hire date. Otherwise, you are automatically enrolled for coverage as of the date your employment status changes to *regular full-time employee* or *regular part-time employee* status.

c. Cost

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

d. 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" below.) Straight-time pay includes any night-shift bonus but excludes overtime, premium pay, bonuses, and other extra compensation. Straight-time pay is based upon one of two rates as established by your local management:

- 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, one for *occupational disabilities* and one for *non-occupational disabilities.*

Occupational Disabilities – Maximum Benefit Period

If you suffer an *occupational disability*, you may receive a maximum of 26 weeks of full pay and 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 can 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[1]	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

How to Determine the Duration of Benefits

Your maximum benefit period is described above for *occupational disabilities* and *non-occupational disabilities*. 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 any exclusion and limitations described below:

- 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;
- When you receive disability benefits, your remaining disability benefits are reduced accordingly and do not refresh until you have a refresh event (explained below);

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

- You may not carry over unused benefits from year to year;
- Your maximum benefit period refreshes on January 1st 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 1st), 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; and
- 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.

The following examples help you understand 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 1st (assuming he is actively at work on that date).

Example 2: Assume the facts of 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.

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 1st 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.

e. 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 (generally 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; and
- 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.

f. 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; or
- On active military leave if the injury or illness was incurred in the performance of military duties.

If you have excessive absences because of accidents or sickness, 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 (meaning the ability to 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.

g. Events Affecting Coverage

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* status, your coverage ends. Conversely, if your employment status changes from *part-time employee* status to *regular part-time employee* or *regular full-time employee* status, you become eligible to participate in the Disability Benefit Plan, effective on the date of your change in status.

Layoff, Termination of Employment, or Retirement

Your coverage and any disability benefits end when your employment terminates.

Death

Coverage ends as of the date of your death.

Plan Amendment or Termination

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

h. ERISA

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

8.2 Income Protection Insurance Program

Through the Income Protection Insurance (IPI) Program, which is underwritten by Metropolitan Life Insurance Company (MetLife), you may purchase additional insurance to supplement any pay you receive under the Disability Benefit Plan when you are unable to work because of a *non-occupational disability*.

a. Participation

You are generally eligible to enroll in the IPI Program if you are a *regular full-time* or *regular part-time employee* of a *participating company.* However, if you work in California, Rhode Island, or Puerto Rico, you cannot participate in the IPI Program described in this SPD because you are covered by the applicable state disability law listed below:

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

b. Enrollment

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* who is 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 may do so within 31 days after your eligibility date. If you enroll in the IPI Program within 31 days after your initial eligibility date, you are not required to provide evidence of insurability acceptable to MetLife, and your coverage takes effect as of your hire date or initial eligibility date. If you are not *actively at work* on the date you apply, your coverage begins when you return to work.

To enroll, call the Shell Benefits Service Center at 1-800-30-SHELL.

If you do not enroll within 31 days after your hire date or initial eligibility date, or if you wish to raise your benefit level, you can apply for coverage by contacting the Shell Benefits Service Center. You must provide evidence of insurability acceptable to MetLife before your application can be approved. MetLife "Statement of Health" forms are available from the Shell Benefits Service Center or online at NetBenefits®. 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. 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 your coverage and later wish to reapply, you are subject to this late enrollment procedure.

EVIDENCE OF INSURABILITY
Any statement of proof of a person's physical condition and/or other factual information affecting his or her acceptance for insurance. Also may be called "proof of good health."

c. 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 and 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.

d. 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. (For information about straight-time pay for both *regular full-time* and *regular part-time employees*, see Section 8.1d, "Benefit Amount.")

- If you choose 50% of pay, the maximum weekly benefit is $2,500;
- If you choose 25% of pay, the maximum weekly benefit is $1,250.

No benefits are paid for an unscheduled workday.

Here are some examples of what your weekly benefit looks like at certain annual base pay increments, depending upon 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

How to Determine the Duration of Benefits

Your maximum benefit period is described above and is based upon 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 Section 8.1d, "How to Determine the Duration of Benefits."

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 1st. 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/wk	-	-	$650/wk
Next 20	-	$325/wk	$325/wk	$650/wk
Next 26	-	-	$325/wk	$325/wk
Total 52 Weeks of Disability				

e. 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

While a claim is pending, 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.

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

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.

f. 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; or
- You commit a felony.

g. Events Affecting Coverage

Leaves of Absence

If you are on a leave of absence, your benefits may be impacted. (For further information, see Section 12.0, "Leaves of Absence and Your Other Company Benefits.")

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.

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* status to *regular part-time employee* or *regular full-time employee* status, 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 of Employment, or Retirement

Your coverage ends when your employment terminates, unless you are totally disabled at the time of termination, 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.

Death

Coverage ends as of the date of your death.

Plan 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.

h. Claim Information

Initial Determination

A claim for IPI 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 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 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 in the "General Plan Information" section of this summary plan description 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 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 have the right to file a lawsuit under Section 502(a) of *ERISA*.

Discretionary Authority

In carrying out their respective responsibilities under the Program, the Plan Administrator and other *Plan* fiduciaries shall have discretionary authority to interpret the terms of the Program and to determine eligibility for and entitlement to program benefits in accordance with the terms of the Program. Any interpretation or determination made pursuant to such discretionary authority shall be given full force and effect, unless it can be shown that the interpretation or determination was arbitrary and capricious.

8.3 Long-Term Disability Program

The Company's long-term disability insurance coverage, which is underwritten by Metropolitan Life Insurance Company (MetLife), is designed to provide you with financial protection if you are unable to work for an extended period of time because of illness or injury.

a. Participation

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

b. Enrollment

To enroll, call the Shell Benefits Service Center at 1-800-30-SHELL.

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. 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 31 days after your hire date or initial eligibility date, you can apply for coverage by contacting the Shell Benefits Service Center. You will also need to provide evidence of insurability acceptable to MetLife. (MetLife "Statement of Health" forms are available from the Shell Benefits Service Center or online at NetBenefits®.) 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. 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 your coverage and later wish to reapply, you are subject to this late enrollment procedure.

c. Cost

You pay the 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.

d. 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 upon 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 on page 94. 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; and
- 50% of rehabilitative employment earnings, for up to two years. After two years, your LTD benefit is reduced by 100% of such earnings (See Section 8.3g, “Rehabilitation.”)

Your monthly LTD benefit is reduced by the amount of income you receive from any of the sources listed previously; however, 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.

Here 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; and
- 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]	$1,012	$1,003	$930
Shell Pension Plan	$834	-[2]	-[2]
Monthly LTD benefit	$254	$797	$570

[1] 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.

[2] 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.

e. 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; and

- 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 Proof of Claim Must Be Given

Written proof of a claim must be given to MetLife no later than 90 days following the end of the 52-week elimination period. However, written proof of a claim to establish your disability on the basis of the Notice of Award of Social Security disability benefits must be given 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;" and
- "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.

f. 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.

g. 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 Section 8.3d, “Offsetting Benefits.”)

Rehabilitation program means a program that has been approved by MetLife for the purpose of helping 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; or
- 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 below, for each eligible family member, which are incurred during the first 24 months of monthly benefit payments.

Eligible family member means a person who is both:

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

Eligible family care expenses mean the monthly expenses incurred by you in order for you to 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. You must give MetLife proof that the eligible family member is incapable of caring for himself or herself and is chiefly dependent upon you for support. The proof must be satisfactory to MetLife.

h. 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; or
- 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; and
- 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.

i. Events Affecting Coverage

Leaves of Absence

If you are on a leave of absence your benefits may be impacted. (For further information, see Section 12.0, “Leaves of Absence and Your Other Company Benefits.”)

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.

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* status to *regular part-time employee* or *regular full-time employee* status, you become eligible to participate in the Long-Term Disability 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 of Employment, or Retirement

Your coverage ends when your employment terminates, unless you are totally disabled (as defined in Section 8.3e, “To Qualify for Benefits”). 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.

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 three 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.

Plan 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 Section 8.3e,"To Qualify for Benefits") when the Program terminates, benefits are paid until you recover or your benefits are exhausted.

j. 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.

9.0 SURVIVOR INCOME PROGRAMS

The Survivor Income Programs provide financial protection for your survivors so that they will be able to 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.

To accomplish those goals, 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[1] and/or the Voluntary Personal Accident Insurance Program;[1] and
- Additional Company-paid protection for you while traveling on Company business through the Business Travel Accident Insurance Program.

9.1 Survivor Benefit Program and Occupational Accidental Death Benefit Program (OADBP)

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).

a. Participation

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*.

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

b. *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.

c. Cost

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

d. Survivor Benefit Program Benefit Amount

The 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.

e. OADBP Benefit Amount

The OADBP provides a benefit of $500,000 if you die as the direct result of an accident while at work.

f. 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.

BENEFICIARY(IES)

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; or
- If 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.

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 discuss the impact of this option.

g. 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; and
- 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.

h. 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.

i. Funeral Discount and Planning Services

A special discount program is available to eligible participants of the Survivor Benefit Program. Dignity Memorial is a brand name used to identify a network 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 employees and their families make confident decisions;
- Planning Services to help make final wishes easier to manage; and
- Bereavement Travel Services to assist with time-sensitive travel arrangements to be with loved ones (when services are provided through a Dignity Memorial location).

The services are available for the employee (insured) and extended family, which includes the insured’s spouse, insured’s children, the parents of the insured, parents of the insured’s spouse, the grandparents of the insured, grandparents of the insured’s spouse, the great-grandparents of the insured, and the great-grandparents of the insured’s spouse.

The employee and/or their family member will have to identify themselves at the Dignity Memorial funeral home location as being eligible for the discount by way of the MetLife/Dignity program.

If you have questions about the funeral discount and planning services, call Final Wishes Planning at 1.866.853.0954 or log onto www.finalwishesplanning.com.

j. Events Affecting Coverage

Leaves of Absence

If you are on a leave of absence your benefits may be impacted. (For further information, see Section 12.0, “Leaves of Absence and Your Other Company Benefits.”)

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* status to *regular part-time employee* or *regular full-time employee* status, you become eligible to participate in the Survivor Benefit Program and the OADBP, effective on the date of your change in status.

Layoff, Termination of Employment, 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.

Plan Amendment or Termination

Your coverage changes or ends on the date this Program is amended or terminated.

k. 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.

9.2 Group Life Insurance Program

You may purchase additional active group life insurance, as well as post-retirement 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.

a. Participation

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.

b. *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*.

c. 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 five 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 Section 9.2d, "Changing Your Coverage.")

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 on the date your coverage is approved, your coverage begins when you return to work.

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; or
- 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.

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.

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 five 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, although post-retirement coverage and cost are based upon 40 hours (see Section 9.2e, "Retiree Life Insurance Benefit Amount.")

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.

Here is an example: If your annual base pay is $35,100 and you choose coverage equal to three 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.

d. 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 one times your base pay (for example, from three to three and one-half or four 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 one times your base pay (for example, from three to four and one-half times your base pay);
- You request an increase in coverage amount that is greater than five 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.

BENEFICIARY(IES)

It's important that you name a *beneficiary(ies)* to receive your Group Life Insurance Program 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, or you may designate your *beneficiary(ies)* online via NetBenefits. You will also need to designate a *beneficiary(ies)* for your spouse's or *domestic partner's* death benefits.

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

You are automatically the beneficiary of each child's Group Life Insurance Program benefits.

You may make an absolute assignment of your insurance benefits. It is important to understand that once the assignment is made you cannot revoke it, although the one to whom you made the assignment may do so. Therefore, before making an absolute assignment, you should seek an attorney's advice regarding the legal and tax implications of such an assignment.

e. *Retiree* Group Life Insurance

Enrollment

If you are age 35 or older on your hire date or eligibility date and you enroll in at least one times base pay active group life insurance coverage, you are automatically enrolled in the Option III post-retirement life insurance coverage. You may elect a lower coverage level or decline coverage altogether. (For more information, see "*Retiree* Life Insurance Benefit Amount," below.)

If you are under age 35 when you enroll in active group life insurance coverage, you are automatically enrolled in the Option III post-retirement life insurance coverage when you reach age 35, unless you elect a lower coverage level or decline coverage.

You are not eligible to elect post-retirement life insurance if:

- You decline coverage when you are first eligible to enroll; or
- You are over age 35 and you enroll in group life insurance more than 31 days after your hire date or eligibility date (whichever occurs first).

If you elect or drop to a lower post-retirement coverage option, you cannot later elect a higher coverage option. Also, if you elect and later drop post-retirement coverage for any reason, you cannot re-enroll.

Retiree Life Insurance Benefit Amount

If you enroll in at least one times your annual base pay active group life insurance coverage, the Program offers three post-retirement life insurance coverage options. Benefits are determined as follows:

If you retire with *retiree coverage eligibility* before you reach age 65, your benefit is based upon 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…[1]		
	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 and after	20%	30%	40%

If you retire at age 65 or later, your benefit is based upon the number of years that passed since you retired and the post-retirement option you elected.

On…	Your post-retirement life insurance benefit is…[1]		
	Option I	**Option II**	**Option III**
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	20%	30%	40%

Once you have made your election, you may not increase your coverage, but you may decrease or cancel your coverage at any time.

Cost

You will receive information regarding the cost of *retiree* coverage in the enrollment materials you receive 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.

1 As a percentage of your final annual base pay.

Retiree life insurance coverage continues at no cost to you when you leave the Company if you:

- Were continuously covered under the *retiree* life option for at least 15 years immediately preceding your retirement; and
- Retire with *retiree coverage eligibility*.

For more information about *retiree* life insurance when you leave the Company, please refer to Section 13.4, "Participation in Retiree Life Insurance."

Accelerated Benefits

The Group Life Insurance Program includes an accelerated benefits provision. Under this provision, at least a portion of your or your covered spouse's or *domestic partner's* benefit amount may be paid prior to death if medical certification shows that your or your covered spouse's or *domestic partner's* 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 you are retired and 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; or
- Your or your covered spouse's or *domestic partner's* Accelerated Benefit Option (ABO) Eligible Group Life Insurance is scheduled to end within six months after the date you request an accelerated benefit.

f. 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.

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.

g. Exclusions and Limitations

There are no exclusions or limitations other than the maximum coverage limits previously discussed in Section 9.2c.

h. 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.

i. Events Affecting Coverage

Leaves of Absence

If you are on a leave of absence, your benefits may be impacted. (For further information, see Section 12.0, "Leaves of Absence and Your Other Company Benefits.")

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* status to *regular part-time employee* or *regular full-time employee* status, 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 of Employment

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 Section 9.2j, “Active Group Life Insurance Portability,” and Section 9.2k, “Active Group Life Insurance Conversion Privilege.”)

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 Section 9.2j, “Active Group Life Insurance Portability,” and Section 9.2k, “Active Group Life Insurance Conversion Privilege.”)

For information about continuing your *Retiree* Group Life Insurance coverage in retirement, see 13.4, “Participation in *Retiree* Life Insurance”.

Plan Amendment or Termination

Your coverage changes or ends on the date this Program is amended or terminated.

j. 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. The minimum portable coverage amounts are:

- *Employee* $20,000;
- Spouse or *domestic partner* $10,000; and
- *Eligible Child(ren)* $1,000

The *employee* coverage amount is reduced 50% on January 1st of the year you turn age 70. The maximum duration of portable coverage is:

➢ *Employee*	January 1st of the year you reach age 80. You may convert the reduced or terminated portable amounts to an individual life insurance policy;
➢ Souse or *domestic partner*	The date that your spouse or *domestic partner* reaches age 70. You can convert the terminated amounts to an individual life insurance policy; and
➢ *Eligible Child(ren)*	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.

k. 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, that 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.

9.3 Voluntary Personal Accident Insurance Program

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.

a. Participation

You are eligible to participate in the Voluntary Personal Accident Insurance Program if you are a *regular full-time employee* 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).*

b. Enrollment

You may enroll in the Voluntary Personal Accident Insurance Program:

- Within 31 days after your hire date; or
- During the *group annual enrollment period*.

To enroll, call the Shell Benefits Service Center at 1-800-30-SHELL.

If you are an *employee* who is newly eligible to enroll in the Voluntary Personal Accident Insurance 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.

You and your spouse or *domestic partner* are eligible to participate in the Voluntary Personal Accident Insurance Program if you are both *employees* of a *participating company*. However, you and your spouse or *domestic partner* cannot be covered as both an *employee* and a dependent(s). One *employee* may enroll and elect *family coverage* or you may each enroll for individual 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 *employee*-only coverage, *family coverage* can be added 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 Section 15.0, “Glossary”). Coverage takes effect as of the date of the election.

c. Changing Coverage

You cannot change coverage during the year unless you and/or your qualified dependent(s) have a *qualified status change.* You must request your change within 31 days of the *qualified status change* event. The requested change in coverage must be consistent with the *qualified status change*.

d. Types of Coverage

The Voluntary Personal Accident Insurance Program provides you with coverage for accidental death, dismemberment, or paralysis 24 hours a day, 365 days a year, on and off the job.

e. Cost

By purchasing coverage through the Voluntary Personal Accident Insurance Program, 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 Voluntary Personal Accident Insurance 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.

BENEFICIARY(IES)
It is important that you name a *beneficiary(ies)* to receive your Voluntary Personal Accident Insurance Program 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, or you may designate your *beneficiary(ies)* online via NetBenefits®. You also need to designate a *beneficiary(ies)* for your spouse's or *domestic partner's* death benefits.

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

You are automatically the *beneficiary* of each child's Voluntary Personal Accident Insurance Program benefits.

f. Benefit Amount

The benefit amount you receive under the Voluntary Personal Accident Insurance 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. Your dependent(s)' benefit amount 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 *benefits* 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 *children*	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); and
- 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 persists 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) lapse 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.

g. Special Benefits

Seat Belt Benefit

If you or your covered dependent(s) die as the result of a covered accidental injury that occurs while driving or riding in a private passenger car, the Voluntary Personal Accident Insurance 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) die as the result of a covered accidental injury that occurs while driving or riding in a private passenger car, the Voluntary Personal Accident Insurance 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) are involved in a covered accident that results in hospitalization, the Voluntary Personal Accident Insurance 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) suffer dismemberment or paralysis as the result of a covered accidental injury, the Voluntary Personal Accident Insurance Program pays the lesser of:

- The actual charge for the rehabilitation;
- 50% of the full amount of the Voluntary Personal Accident Insurance 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* die as the result of a covered accidental injury, the Voluntary Personal Accident Insurance 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 qualify 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* die as the result of a covered accidental injury, the Voluntary Personal Accident Insurance 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 qualify 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 Voluntary Personal Accident Insurance Program pays your spouse or *domestic partner* a monthly survivor benefit equal to 1% of your benefit amount for six months after your death, up to $25,000.

h. Total Disability Premium Waiver

The Voluntary Personal Accident Insurance Program provides that 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, premiums 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.

i. 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. They will also be required to provide proof that premiums have been paid.

j. Applying for Benefits

Payment of Benefits

If you or your covered dependent(s) suffer 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.

Filing a Claim

To file a claim under the Voluntary Personal Accident Insurance Program, contact the Shell Benefits Service Center to obtain a claim form and assistance with submitting the form to MetLife.

k. Exclusions and Limitations

Voluntary Personal Accident Insurance 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; and
- Losses incurred during the voluntary intake of poison, gas, or fumes.

I. Events Affecting Coverage

Leaves of Absence

If you are on a leave of absence, your benefits may be impacted. (For further information, see Section 12.0, “Leaves of Absence and Your Other Company Benefits.”)

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* status to *regular part-time employee* or *regular full-time employee* status, you become eligible to participate in the VPAI, effective on the date of your change in status.

You can enroll within 31 days after your eligibility date or during *group annual enrollment period.*

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.

Layoff, Termination of Employment, or Retirement

If your employment is terminated for any reason, your coverage ends immediately, except as may be provided under Section 9.3h “Total Disability Premium Waiver.”

Plan Amendment or Termination

Your coverage changes or ends on the date this Program is amended or terminated.

9.4 Business Travel Accident Insurance Program

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.

a. Participation

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.

BENEFICIARY(IES)

It is important that you name a *beneficiary(ies)* to receive your Business Travel Accident Insurance Program 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, or you may designate your *beneficiary(ies)* online via NetBenefits®. You also need to designate a *beneficiary(ies)* for your spouse's or *domestic partner's* death benefits.

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

You are automatically the *beneficiary* of each child's Business Travel Accident Insurance Program benefits.

b. 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.

c. Cost

The Company pays the entire cost of coverage under the BTAI Program.

d. 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; or
- 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 is not done during chargeable vacation time or leaves of absence. For example: adding additional vacation time 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 you or your *eligible dependent(s)* body is not found within one year of the date:

- 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 conveyances is operated by a common carrier;
- The aircraft or other vehicle in which you were traveling disappears, sinks, is stranded, or wrecked; or
- You or your *eligible dependent(s)* are reported missing to the authorities if traveling in any other aircraft or vehicle.

e. Benefit Amount

Employees

Your BTAI Program benefit equals one 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) die 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 total and permanent disability — the benefit 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 dependent(s) or guests; and
- 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.

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) lapse 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.

f. Special Benefits

Seat Belt Benefit

If you, your *eligible dependent(s),* or guest(s) dies or are 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* die 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 qualify for this benefit on the date of you 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.

g. 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.

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.

h. 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; and
- 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.

i. Events Affecting Coverage

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* status to *regular part-time employee* or *regular full-time employee* status, you automatically begin participation in the BTAI, effective on the date of your change in status.

Layoff, Termination of Employment, or Retirement

Your coverage ends when your employment terminates.

Plan Amendment or Termination

Your coverage changes or ends on the date this Program is amended or terminated.

10.0 Other Protection Plans and Programs

The Company recognizes that there are additional demands outside of work. We offer programs that help you with those everyday challenges and child care needs. We also offer programs that focus on additional protection for your family.

10.1 Back-Up Care Program

The Back-Up Care Advantage Program® provides temporary solutions when normal care arrangements for your child or adult/elder dependent are unavailable. This benefit is offered through Bright Horizons Family Solutions®.

a. Participation

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.

b. 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.

Examples of when back-up care could be used:

- 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; or
- Your loved one is mildly ill or recovering from surgery.

Mildly Ill Care is defined 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.

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 80 hours of back-up care per calendar year to use for your dependent(s) or self. A combination of care arrangements (in-home and center-based) is allowed regardless of the type of care arrangement or the dependent(s) (including self-care) for whom they are used. The 80 hours are cumulative over the contract year for each *employee*.

c. 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).

d. 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:

- $2 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; and
- 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.

e. Events Affecting Coverage

Leaves of Absence – Disability, Personal and Military

If you are on a leave of absence, your back-up care benefit may be impacted. (For further information, see Section 12.0, "Leaves of Absence and Your Other Company Benefits.")

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* status to *regular part-time employee* or *regular full-time employee* status, you become eligible for Back-Up Care Program benefits, effective on the date of your change in status.

Layoff, Termination of Employment, Retirement, or Death

Your eligibility to participate in this benefit ends on the day employment is terminated.

f. Back-Up Care Program Amendment or Termination

Your back-up care benefit changes or ends on the date the Back-Up Care Program is modified or terminated.

g. Registering for Service

To begin using the Back-Up Care Advantage Program, register online at backup.brighthorizons.com. Or, register by phone at 1-877-BH-CARES (1-877-242-2737). See HR Online > My Benefits > Protection > Back-Up Care for Children and Adults for the initial user name and password.

10.2 Group Automobile and Home Insurance Plan

You may purchase voluntary insurance for your car, home or apartment, and other personal property through Metropolitan Property and Casualty Insurance Company and affiliates (Met P&C).

a. Participation

You are eligible to purchase coverage under the Group Automobile and Home Insurance Plan if you are a *regular full-time* or *regular part-time employee* of a *participating company.*

You can call Met P&C directly at 1-800-438-6388.

b. 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 Met P&C directly at 1-800-438-6388. Questions about group automobile and home insurance should also be directed to Met P&C. The Group Automobile and Home Insurance Plan is not administered by the Shell Benefits Service Center.

c. Cost

If you choose coverage under the Group Automobile and Home Insurance Plan, you pay a premium, which is deducted from your pay each pay period on an after-tax basis, or you can choose to have your premium deducted automatically from your bank account, or you can be billed directly by Met P&C.

d. 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; and
- Excess liability.

e. 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.

f. Events Affecting Coverage

If 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), 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 Met P&C for coverage to continue.

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 pay the premium directly to Met P&C for coverage to continue.

(For further information, see Section 12.0, “Leaves of Absence and Your Other Company Benefits,” and the “Preparing for Retirement” section.)

g. Extending Coverage

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 directly to Met P&C.

If you terminate from the Company for any other reason, your policy continues through the end of its term as long as you continue to pay the premiums. You have to arrange either to be billed directly or to have your premium deducted automatically from your bank account.

10.3 Group Legal Program

You may purchase coverage for certain personal legal services at a low monthly rate through Hyatt Legal Plans, Inc. (Hyatt), a MetLife Company.

a. Participation

To enroll, call the Shell Benefits Service Center at 1-800-30-SHELL.

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).*

b. 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.

c. 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.

d. Obtaining Legal Services

Hyatt Legal Plans makes all determinations regarding attorneys' fees and what constitutes covered services. Hyatt maintains a nationwide network of participating law firms. Lawyers in this network are called Plan Attorneys. To use the Group Legal Program, visit Hyatt's website at www.legalplans.com or call Hyatt 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.

You can call Hyatt Legal Plans at 1-800-821-6400.

If you use Hyatt's 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 Hyatt 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, Hyatt 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 Hyatt Legal Plans.)

e. Covered Services

The Group Legal Program offers you prepaid legal assistance on a variety of personal matters, as discussed on the following pages. 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. It includes the hearing before an administrative board or agency over an adverse governmental action. It does not apply where services are available or are being provided by virtue of any form of insurance policy. It 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. It does not apply where services are available or are being provided by virtue of any form of insurance policy. It does not include family-law matters, post-judgment matters, matters with criminal penalties, or litigation of a job-related incident. Services do 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.

Identity 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. The 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. The service also provides you with online help and information about identity theft and prevention. It does 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.

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 (excludes driving-under-influence or vehicular homicide)

This service covers your representation in defense of any traffic ticket except driving-under-influence or vehicular homicide, including court hearings, negotiation with the prosecutor, and trial.

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.

Uncontested Adoption

This service covers all legal services and court work in a state or federal court for an uncontested adoption for you and your spouse or *domestic partner* if you are enrolled for *family coverage*. If an adoption becomes contested, you or your spouse or *domestic partner* must pay all additional legal fees.

Uncontested Guardianship or Conservatorship

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. If the proceeding becomes contested, you or your spouse or *domestic partner* must pay all additional legal fees. 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. It 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; or any matter where the creditor is affiliated with the sponsor or employer.

Personal Bankruptcy

To obtain legal services, call Hyatt's 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.

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. It does not include disputes with other tenants, actions to recover security deposits, or 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, in recovering a security deposit from your residential landlord for your primary residence; reviewing the lease and other relevant documents; and preparing a demand letter to the landlord for the return of the deposit. It also covers assisting you in prosecuting a small claims action; helping prepare documents; advising on evidence, documentation, and witnesses; and 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.

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 the Plan Attorney's 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.

An affidavit is a sworn, written statement generally witnessed by a notary public.

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.

f. 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; and
- 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, Hyatt 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.

g. Events Affecting Coverage

Disability, Leaves of Absence, or Reduction in Number of 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 the result of a leave of absence, you have to pay the premiums directly to the Shell Benefits Service Center for the remainder of the *Plan* year for coverage to continue. (For further information, see Section 12.0, “Leaves of Absence and Your Other Company Benefits.”)

Loss of Eligibility, Termination of Employment, 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 30 months at full cost after your eligibility for the Program ends by making payments directly to Hyatt. For more information on how to continue coverage, contact Hyatt directly at 1-800-821-6400.

Plan Amendment or Termination

Your coverage changes or ends on the date this Program is amended or terminated.

h. 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. Hyatt 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 Hyatt Legal Plans. Your complaint will be reviewed and you will receive a response within two business days of your call.

i. 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) are involved in a dispute with another *eligible employee* or that *employee's* dependent(s), Hyatt 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.

10.4 Long-Term Care Insurance

Effective January 1, 2012, John Hancock suspended new enrollments into the program.

The following information applies for those already enrolled in Long-Term Care Insurance.

a. 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.

b. Cost

The cost of coverage is based upon your coverage selections, the state in which you reside, and your age at the time your coverage takes effect. The younger you are when you enroll, the lower your premium. Once you enroll, premiums do not increase because you get older, your health changes, or you receive plan benefits.

If you are an active *employee*, you pay the entire cost of coverage for yourself and/or your spouse or *domestic partner* through monthly payroll deductions on an after-tax basis. Other participants will be billed directly for the cost of their coverage, or they may elect to pay their premium through automatic bank withdrawal.

c. How the Program Works

The Long-Term Care Program provides comprehensive coverage as follows:

- Coverage for nursing home care;
- Alternate care facilities such as an assisted living facility;
- Community-based professional care;
- Informal care; and
- Stay-at-home benefit.

Stay-at-home benefit can be used to pay for long-term care expenses not covered ordinarily. Services include:

- Care planning visit;
- Home modification;
- Emergency response system;
- Durable medical equipment;
- Caregiver training;
- Home safety checks; and
- Provider care checks.

Services 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 five 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 under “Qualification Period” in Section 10.4f.

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; and
- Homemaker services by a licensed provider.

d. 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 (60%)	$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.

e. Lifetime Maximum Benefit Options

Applicants can choose between a three-year, five-year, or 10-year lifetime maximum benefit.

[1] Nursing home daily maximum benefit times number of days in three years (1,095).

	Option 1	Option 2	Option 3	Option 4	Option 5
Three-Year Lifetime Maximum Benefit[1]	$82,125	$109,500	$164,250	$219,000	$273,750
Five-Year Lifetime Maximum Benefit[2]	$136,875	$182,500	$273,750	$365,000	$456,250
10-Year Lifetime Maximum Benefit[3]	$273,750	$365,000	$547,500	$730,000	$912,500

[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 10 years (3,650).

f. 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; and
- 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 previously 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 upon 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.

g. Additional Features

Non-forfeiture Provision

If elected at 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 (to your estate) 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 residing permanently outside the United States (50 states and the District of Columbia). Satisfactory proof must be received by John Hancock that you meet the Benefit Eligibility Criteria (qualifies 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 United States. 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 *Plan*. Benefits paid under the alternate plan-of-care will reduce the lifetime maximum benefit.

h. 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 engaging in an illegal occupation;
- Your participating 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;
- Except under the Informal Care Benefit, 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);
- 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 payer under applicable law); and
- Care or treatment provided outside the United States, 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 receive once you are approved for coverage will outline 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 will be issued to you when you become approved for coverage, and services and supplies must be provided in accordance with a plan-of-care prescribed by a licensed health care practitioner.

i. 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 Section 10.4h, “Expenses Not Covered.”)

j. 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 is issued to you when you become 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 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.

k. Events Affecting Coverage

Your Long-Term Care Insurance Program contributions are made from your pay. As a result, if your pay stops, so do your contributions. However, you may continue your coverage by continuing to pay your premium contributions via direct payment to John Hancock.

Leaves of Absence

If you are on a leave of absence, your benefits may be impacted. (For further information, see Section 12.0, “Leaves of Absence and Your Other Company Benefits.”)

Change in Number of Hours Worked

If your employment status changes to *part-time employee* status, you may continue coverage by paying premiums directly.

Retirement or Termination of Employment

If you retire or leave the Company, you can choose to continue your coverage. In that case, you must pay your premiums directly to John Hancock.

Death

If you die, your coverage ends on that day. Coverage for any other enrolled family member continues as long as premiums are paid.

I. 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.

11.0 SEVERANCE PAY PLAN

In the event that you lose your job through no fault of your own due to lack of work, you may be eligible to receive payment and/or benefits from the Company.

11.1 Participation

You are eligible to receive a severance payment under the Severance Pay Plan if you lose your job through no fault of your own 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.

11.2 Cost

The *Company* pays the entire cost of benefits under the Severance Pay Plan from the *Company*'s general assets.

11.3 How the Plan Works

a. 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 by the *Company* in connection with the sale of any part of the business.

b. 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 lost your job through no fault of your own due to lack of work), you may file a claim for benefits with your immediate manager. He or she will forward the claim to your local Human Resources Department. If you are no longer an *employee*, you should submit your claim directly to the Human Resources Department of the organization in which the claim arose.

11.4 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.

12.0 LEAVES OF ABSENCE AND YOUR OTHER COMPANY BENEFITS

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.
Military leave (annual weekend/weekly reserve duty)[1]	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.

[1] 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.
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)[1]	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.
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.

[1] 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 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 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.
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 eligible to participate.
Military leave (annual weekend/weekly reserve duty)[1]	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.

[1] 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*[1]	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*[1]	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*[1]	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*[1]	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[1]	You earn vacation credit for up to 30 days.	You are eligible to participate.	You are not eligible to participate.	You are not eligible to participate.
Dependent care leave *without pay*[1]	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*[1]	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)[2]	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*[2]	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.

1 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.

2 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.

Wealth (For more information, go to the "Wealth" SPD.)

Event or leave of absence	Shell Provident Fund *Employee* Contributions	Shell Provident Fund Company Contributions	Shell Pension Plan
Disability leave *with pay*	You may continue your contributions.	Company contributions are based upon your disability pay for the duration of the leave.	Accruals continue for up to one year.
Disability leave *without pay*	No contributions are permitted.	No contributions are permitted.	Accruals continue for up to one year.
Personal leave *with pay*	You may continue your contributions.	Company contributions are based upon your pay during the leave.	Accruals continue for up to one year.
Personal leave *without pay*	No contributions are permitted.	No contributions are permitted.	Accruals continue for up to one year.
Personal leave *without pay* for advanced education	No contributions are permitted.	No contributions are permitted.	Accruals continue for up to one year.
Dependent care leave *without pay*	No contributions are permitted.	No contributions are permitted.	Accruals continue for up to one year.
FMLA leave *without pay*	No contributions are permitted.	No contributions are permitted.	Accruals continue for up to one year.
Military leave (annual weekend/weekly reserve duty)[1]	You may continue your contributions.	Company contributions are based upon your Company pay during the leave.	Accruals continue for the duration of your leave.
Military leave (active service) *with* and *without pay*	Contributions are based upon your Company pay during the leave. "Make- up" contributions can be made upon your return to work, up to certain limits.	Company contributions are based upon your Company pay during the leave. Company contributions are "made up" automatically upon your return to work, up to certain limits.	Accruals continue for the duration of your leave.

[1] 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

As you near retirement, you will want to make sure that you are prepared to enjoy retirement in the ways you want and deserve. A key part of this process will be thinking about your retirement income and your expenses. The following section provides you with important information that will help you understand your Shell Care, Protection, and other *pensioner* benefits.

For a full description of these programs, please refer to the Summary Plan Description for Pensioners.

13.0 Shell Benefits During Retirement

Changing from active employment to retirement can be both exciting and challenging. To help with this transition, Shell offers *pensioners* access to certain programs.

13.1 Overview

With the Shell Medical, Dental, and Vision Benefit Programs, eligible *pensioners* and their *eligible dependent(s)* have access to comprehensive coverage during retirement. Generally, you may choose from the same medical, dental, and vision care options as active *employees*.

Additionally, eligible *pensioners* have the ability to continue certain Protection benefits after retirement. Shell also provides a *pensioner* Learning Account, available during your first year of retirement.

Please review the following information carefully to help you understand and transition your benefits into retirement. For further details on the Programs available to eligible *pensioners* and their families, refer to the Summary Plan Description for Pensioners available through the Shell Benefits Service Center or located online at www.netbenefits.com.

13.2 Eligibility

You must retire from Shell with *retiree coverage eligibility* in order to continue coverage under the Shell Medical, Dental, and Vision Benefit Programs. **However, employees hired or rehired on or after January 1, 2017, are not eligible for retiree coverage under the Shell Medical Benefit Program.**

13.3 Participation in the Medical, Dental, and Vision Benefit Programs

If you retire having met *retiree coverage eligibility*, you can continue coverage under the Shell Medical, Dental, and Vision Benefit Programs for yourself and your *eligible dependent(s)* by paying the required contributions. If you wish to change coverage, you can change your coverage during any *group annual enrollment period* or within 31 days after a *qualified status change.*

To reach *retiree coverage eligibility* at your termination you must either:

- Be at least age 50 and have your age plus eligibility service equal at least 80 points; or
- Terminate at age 65 or older; or
- Leave with a *disability pension*; or
- Satisfy the 70-Point eligibility rules.

If you are enrolled for coverage for yourself only and later acquire an *eligible dependent(s)*, you may enroll him or her within 31 days of the event or during a *group annual enrollment period*.

If you are enrolled for coverage and decide to terminate your participation in the Program(s) at retirement, you may again elect coverage during any *group annual enrollment period* or within 31 days after a *qualified status change*. 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.

If you were not enrolled prior to your retirement, you can elect coverage during any *group annual enrollment period* or within 31 days following your retirement or any other *qualified status change*.

a. Levels of Coverage

Eligible *pensioners* may choose from these levels of coverage:

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

b. Cost to You

Your contributions for post-retirement coverage under the Medical, Dental, and Vision Benefit Programs are made on an after-tax basis by a deduction from your pension payment or, in some cases, by direct payment via coupon or Automatic Bank Withdrawal (ABW).

While you pay the full premium cost for dental and vision coverage, your share of the premium cost for medical benefit coverage is based upon 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:

To reach *retiree coverage eligibility* at your termination you must either:

- Be at least age 50 and have your age plus eligibility service equal at least 80 points; or
- Terminate at age 65 or older; or
- Leave with a *disability pension*; or
- Satisfy the 70-Point eligibility rules.

- 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 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 *participant plus spouse/domestic partner* level of coverage for the HSM option at the time of your retirement;
- The historical five-year average rate of premium increase to the HSM 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).

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 *employee*s 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 the 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 HSM 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 *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 for the coming year toward your Company-sponsored *retiree* medical coverage in 10% increments from 0% to 80%.

Examples

Example 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. $400 worth of credits 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.

Example 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 upon 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.

To reach *retiree coverage eligibility* at your termination you must either:

- Be at least age 50 and have your age plus eligibility service equal at least 80 points; or
- Terminate at age 65 or older; or
- Leave with a *disability pension*; or
- Satisfy the 70-Point eligibility rules.

The following contribution schedule describes the percentage of the maximum Company contribution available to you based upon 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* at Retirement 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

The maximum dollar value of the Company subsidy for *retirees* enrolled in the same medical options as active *employees* is based upon 80% of the premiums established for the HSM option. For *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.

c. Medical Benefit Coverage Options

Non-Medicare Eligible Pensioners

In most areas of the country, the Company offers generally the same medical options to both *retirees* and active *employees*, including:

- Hospital Surgical Medical (HSM) options; or
- Health Maintenance Organization (HMO)/PPO options.

The Be Well Kelsey Plan is not available to *retirees*.

See Section 1.0, "Medical Benefit Program" for more information.

You will receive retirement information from the Shell Benefits Service Center that will include your available coverage options and the applicable premium cost.

Medicare-Eligible Pensioners

A *pensioner* and his or her *eligible dependent(s)* are eligible for supplemental *Medicare* benefits when they qualify for *Medicare* due to a disability or because one of them reaches age 65.

Once you or your dependent(s) qualify for *Medicare* benefits, *Medicare* becomes your primary medical plan. The Company offers coverage options that provide secondary or complementary benefits to *Medicare*-eligible participants. When you or your *eligible dependent(s)* qualify for *Medicare* due to age, you will receive information from the Shell Benefits Service Center regarding your available options and the applicable premium cost. If you or your *eligible dependent(s)* qualify for *Medicare* due to a disability prior to reaching age 65, you must contact the Shell Benefits Service Center to advise them of your *Medicare* entitlement and to receive the appropriate coverage and cost information.

For further details on the Shell Medical Benefit Program for eligible *pensioners* and their families, refer to the Summary Plan Description for Pensioners.

d. Dental and Vision Benefit Coverage

When you retire, you will have access to the same coverage options as active *employees*. You will pay the full premium cost for your coverage. (Refer to Section 2.0, "Dental Benefit Program," for more information.)

13.4 Participation in *Retiree* Life Insurance

If you were enrolled in *Retiree* Life Insurance (see Section 9.2e, "Retiree Group Life Insurance") as an active *employee* and you meet *retiree coverage eligibility* when you terminate employment, your coverage will continue when you retire. If you have not completed the required 15 years of participation in the Program prior to your retirement, you may complete your participation after retirement.

a. Cost to You for *Retiree* Life Insurance

Retiree Life Insurance coverage continues at no additional cost to you when you leave the Company if you:

- Were continuously covered 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 will be required to pay a monthly premium cost for coverage to continue after you retire. Your years of participation 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.

b. *Retiree* Life Insurance Benefit Amount

Your coverage is based upon the *retiree* life insurance benefit option you were enrolled in as an active *employee.* (For details on available options, see Section 9.2e, "*Retiree* Life Insurance Benefit Amount".) You will receive retirement information from the Shell Benefits Service Center that confirms your *retiree* coverage option.

c. *Retiree* Life Insurance Conversion Privilege

You have the option to convert any life insurance coverage you are losing at the time you retire. You can also convert any loss of coverage that takes place after you retire due to reductions in the benefit at scheduled ages.

For example, if you are retiring at age 60 with active coverage equal to five times your annual base pay and post-retirement Option III coverage, you can convert the lost group coverage (the difference between your active coverage of five times your annual base pay at age 60 and your retirement coverage of one and one-quarter times your annual base pay at age 60 under Option III). This difference amounts to coverage loss equaling three and three-quarters times your annual base pay, and you may convert up to this amount under an individual policy issued by MetLife. You also have the option to convert subsequent coverage loss at ages 65, 66, 67, and 68.

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.

13.5 Participation in the Long-Term Care Program

You may continue your long-term care coverage by contacting John Hancock and arranging for direct billing of your premiums. (For coverage details, see Section 10.4, "Long-Term Care Insurance.")

13.6 Participation in the Group Automobile and Home Insurance Plan

As an eligible *pensioner*, you may continue your coverage or enroll at any time by contacting Metropolitan Property and Casualty Insurance Company (Met P&C) directly. You will be responsible for paying your premiums on a direct billing basis. (For coverage information, see Section 10.0, "Other Protection Plans and Programs".)

13.7 Participation in the 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 30 months of legal service benefits on a direct billing basis. For more information on the available coverage and cost, contact Hyatt directly at 1-800-821-6400.

13.8 Participation in the Learning Account

Retired employees are eligible for a $1,000 Learning Account in the first year following retirement. 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.

a. Covered Expenses for *Retired Employees*

The *pensioner* 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; and
- Computer courses.

Requests for post-retirement educational reimbursement should be sent to:

Attn: *Pensioner* Relations
Shell Oil Company
P.O. Box 2463
Houston, TX 77252-2463

b. Expenses Not Covered for *Retired Employees*

The *pensioner* Learning Account does not provide reimbursement for such items as books, equipment, and tools.

c. Tax Implications for *Retired Employees*

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 deductible on your personal income tax return.

14.0 General Plan Information

This section provides you with 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 you with information you are required to be given 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.

14.1 *Plan* Information

a. 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, see Section 14.4f, "*ERISA* Plan Information.")

b. Funding

Medical Benefit Program

The Medical Benefit Program is funded through contributions made by the *Company* and the participants. The Shell Hospital Surgical Medical (HSM) options, the US GEMS option, the Be Well Kelsey Plan and the Medicare Complementary option (available to *retirees*) are self-insured. The 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 Wells Fargo Bank, N.A. as Trustee and are to be used solely for payment of claims by participants and beneficiaries, 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, HMO/PPO and *Medicare* option premiums, and administrative expenses.

The Plan Administrator has an arrangement with certain service providers, including UnitedHealthcare (UHC), Beacon Health Options®, CVS Caremark, and Cigna, 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 Wells Fargo Bank, N.A. 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 and/or Dependent Day Care Account Program are 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;
- Voluntary Personal Accident Insurance Program;
- Group Automobile and Home Insurance Plan;
- Group Legal Program; and
- Long-Term Care Insurance Program.

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; and
- Employee Assistance Program.

The Back-Up Care Program is funded by general assets of the Company.

c. 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, 2016, 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 Section 14.4f, "*ERISA* Plan Information."

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.

d. 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.

e. 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 Section 1.3g "Program Payments for HSM Covered Expenses."

f. Forum & 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.

g. 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.

14.2 Claims and Appeals

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 upon 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 Section 14.4f, "*ERISA* Plan Information," 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 following Sections:

Benefit Plan or Program	Section		Section
Medical Benefit Program (HSM)	1.0	Occupational Accidental Death Benefit Program	9.1
Dental Benefit Program	2.0	Group Life Insurance Program	9.2
Vision Benefit Program	3.0	Voluntary Personal Accident Insurance Program	9.3
Health Care Account Program	4.4	Business Travel Accident Insurance Program	9.4
Dependent Day Care Account Program	4.4	Backup Care Program	10.1
Disability Benefit Plan	8.1	Group Legal Program	10.3
Income Protection Insurance Program	8.2	Long-Term Care Insurance Program	10.4
Long-Term Disability Program	8.3	Severance Pay Plan	11.0
Survivor Benefit Program	9.1		

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 benefit eligibility or amounts 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 upon 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.

a. 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: The Medical Benefit Program (HSM options, US GEMS option, the Be Well Kelsey Plan, and Medicare Complementary option only), the Dental Benefit Program (Cigna Dental PPO option only), and the 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.

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, a claim that initially met the urgent care criteria may be considered a pre-service or post-service claim on appeal, if your condition has improved. 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 time 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-Stage Review	**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-Stage Review	**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-stage review	**180 days** after receiving decision on first-stage review
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 stage review	**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

Time Limits for 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 tolled 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 to seek 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 tolled 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: (i) a denial, reduction, or termination of your benefit, (ii) the benefit program's failure to provide or make a payment (in whole or in part) for a benefit, or (iii) 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: (i) information sufficient to identify the claim involved, including the date or dates of service, the health care provider, and the claim amount (if applicable), (ii) 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, (iii) references to the specific plan provisions on which the denial is based, (iv) 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 (v) 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 below in Special Rules Regarding Claims.

First-Stage Review

If your initial claim for benefits is denied, you have the right to request a review of this denial (i.e., a "first-stage review"). The first-stage review 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-stage review. Requests for first-stage review 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 below.

Time Limits for First-Stage Review of Claims and Notice Requirements

The claims administrator will provide you with notice of its decision through an Explanation of Benefits (EOB) or letter within the following time periods:

(i) 72 hours after receiving such request, in the case of an urgent care claim;

(ii) 15 days after receiving such request, in the case of a pre-service claim; and

(iii) 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-stage review will include the information described in "Notice of a Denial of Initial Benefit Claim," 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 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 below in Special Rules Regarding Claims.

Second-Level Appeal

For claims other than urgent care claims, you may file a second-level appeal if your claim is denied on first-stage review. The second level of appeal is made to the Plan 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-stage review. 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 Plan Administrator will provide you with a notice of its decision on second-level appeal within: (i) 15 days after receiving your request, in the case of a pre-service claim, or (ii) 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: (i) all information required to be included in a notice of denial of a claim upon first-stage review, as set forth in "Time Limits for First-Stage Review of Claims and Notice Requirements" above, (ii) a discussion of the decision to deny the claim on second-level appeal, (iii) 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 (iv) 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 healthcare 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 — HSM options, US GEMS option, the Be Well Kelsey Plan, and Medicare Complementary option only)

You may file a request under the Medical Benefit Program (HSM options, US GEMS option, the Be Well Kelsey Plan, and Medicare Complementary option only) ("Request") for a review by an independent decision-maker (an "External Review") within four months after (i) the day you receive a denial of your second-level appeal, or in the case of urgent claims, first-stage review or initial adverse benefit determination, or (ii) 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-stage review (a "Denial"). 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
- As otherwise required by 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" above 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 ("Reviewers"). 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; and
- 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; and
- 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; and
- 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; and
- 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.

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. Section 14.1e, "Non-Assignment of Benefits." 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 Section 14.1e, “Non-Assignment of Benefits.”

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.

b. Claim and Appeal Procedures for Disability Programs

For details on filing claims and appeals for Income Protection Insurance Program benefits, Section 8.2h, “Claim Information.” For specific information on filing claims and appeals for Long-Term Disability Program benefits, Section 8.3j, “Claim Information.”

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 79.)

c. All Other Care and Protection Plans or 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; and
- 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 Section 14.4f.) 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*;
- Name of individual claiming benefits;
- Name of plan or program;
- Name of claims administrator;
- Reference to the initial decision; and
- 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; and
- A statement of your right to bring a civil action under Section 502 of *ERISA*.

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 Section 14.1e, "Non-Assignment of Benefits." 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 Section 14.1e, “Non-Assignment of Benefits.”

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.

14.3 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.

14.4 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:

a. 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; and
- 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.

b. 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).

c. 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 *employee* 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*.

d. 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 them 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; and
- 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.

e. 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.

f. *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 1st to December 31st.

Care

The following *Component Programs* are part of the Shell Oil Company Comprehensive Welfare Benefits Plan (501).

Component Program of the Shell Oil Company Comprehensive Welfare Benefits Plan (501)	Employer/Plan Administrator*	Claims Administrator and Insurance Carrier	Trustee	Agent(s) for Service of Legal Process
Medical Benefit Program	Shell Oil Company P.O. Box 2463 Houston, TX 77252 1-713-241-6161	**Claims Administrator:** UnitedHealthcare P.O. Box 30555 Salt Lake City, UT 84130-0555 **Claims Administrator:** Beacon Health Options® P.O. Box 1347 Lathan, NY 12110-8847 **Claims Administrator:** CVS Caremark P.O. 52136 Phoenix, AZ 85072-2136 **Claims Administrator:** **(Be Well Kelsey Plan)** Cigna Claims P.O. Box 182223 Chattanooga, TN 37422-7233 **Claims Administrator:** **(US GEMS)** Cigna Global Health Benefits P.O. Box 15050 Wilmington, DE 19850-5050	Wells Fargo Bank, N.A. Institutional Trust Group 1000 Louisiana Suite 630 Houston, TX 77002	Plan Administrator
Dental Benefit Program	Shell Oil Company P.O. Box 2463 Houston, TX 77252 1-713-241-6161	**Claims Administrator:** **(PPO)** Cigna P.O. Box 188045 Chattanooga, TN 37422 **Insurance Carrier:** **(DHMO)** Cigna Dental Health P.O. Box 188045 Chattanooga, TN 37422	Wells Fargo Bank, N.A. Institutional Trust Group 1000 Louisiana Suite 630 Houston, TX 77002	Plan Administrator
Vision Benefit Program	Shell Oil Company P.O. Box 2463 Houston, TX 77252 1-713-241-6161	**Claims Administrator and Insurance Carrier:** Vision Service Plan VSP Corporate Headquarters 3333 Quality Drive Rancho Cordova, CA 95670	N/A	Plan Administrator
Health Care Account and/or Dependent Day Care Account Program	Shell Oil Company P.O. Box 2463 Houston, TX 77252 1-713-241-6161	**Claims Administrator:** WageWorks Phone: 877-924-3967 Website: www.wageworks.com P.O. Box 14053 Lexington, KY 40512	N/A	Plan Administrator
Employee Assistance Program	Shell Oil Company P.O. Box 2463 Houston, TX 77252 1-713-241-6161	**Claims Administrator and Insurance Carrier:** Beacon Health Options® P.O. Box 1347 Lathan, NY 23220-8847	N/A	Plan Administrator

* Any communication with the Plan Administrator should be directed to the Manager, Health and Welfare Plan.

Protection

The following *Component Programs* are part of the Shell Oil Company Comprehensive Welfare Benefits Plan (501).

Component Program of the Shell Oil Company Comprehensive Welfare Benefits 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 Oil Company P.O. Box 2463 Houston, TX 77252 1-713-241-6161	**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
Long-Term Disability Program	Shell Oil Company P.O. Box 2463 Houston, TX 77252 1-713-241-6161	**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 Oil Company P.O. Box 2463 Houston, TX 77252 1-713-241-6161	**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 18505	N/A	Plan Administrator
Occupational Accidental Death Benefit Program	Shell Oil Company P.O. Box 2463 Houston, TX 77252 1-713-241-6161	**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 18505	N/A	Plan Administrator
Group Life Insurance Program	Shell Oil Company P.O. Box 2463 Houston, TX 77252 1-713-241-6161	**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 18505	N/A	Plan Administrator
Voluntary Personal Accident Insurance Program	Shell Oil Company P.O. Box 2463 Houston, TX 77252 1-713-241-6161	**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 18505	N/A	Plan Administrator

Protection (Continued)

Component Program of the Shell Oil Company Comprehensive Welfare Benefits Plan (501)	Employer/Plan Administrator*	Claims Administrator and Insurance Carrier	Trustee	Agent(s) for Service of Legal Process
Business Travel Accident Insurance Program	Shell Oil Company P.O. Box 2463 Houston, TX 77252 1-713-241-6161	**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 18505	N/A	Plan Administrator
Group Legal Program	Shell Oil Company P.O. Box 2463 Houston, TX 77252 1-713-241-6161	**Insurance Carrier:** Metropolitan Property and Casualty Insurance Company 700 Quaker Lane Warwick, RI 02887 **Claims Administrator:** Hyatt Legal Plans, Inc. 1111 Superior Avenue Cleveland, OH 44114	N/A	Plan Administrator
Long-Term Care Program	Shell Oil Company P.O. Box 2463 Houston, TX 77252 1-713-241-6161	**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 Oil Company P.O. Box 2463 Houston, TX 77252 1-713-241-6161	**Claims Administrator:** Bright Horizons Family Solutions 200 Talcott Avenue South Watertown, MA 02472	N/A	Plan Administrator
Severance Pay Plan 524	Shell Oil Company P.O. Box 2463 Houston, TX 77252 1-713-241-6161	**Claims Administrator:** Shell Oil Company P.O. Box 2463 Houston, TX 77252 1-713-241-6161	N/A	Plan Administrator

* Any communication with the Plan Administrator should be directed to the Manager, Health and Welfare Plan.

14.5 Affordable Care Act (ACA) Notice of Non-Discrimination

Discrimination is Against the Law
Federally Required Notice Concerning Nondiscrimination and Accessibility Requirements

The Shell Oil Company Comprehensive Welfare Benefits Plan (The Plan) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. The Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

The Plan:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters; and
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters; and
  - Information written in other languages

If you need these services, contact the Manager, Health and Welfare, Shell Oil Company, for assistance. If you believe that The Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with the Manager, Health and Welfare, Shell Oil Company, P.O. Box 2463, Houston, TX 77252, 1-713-241-6161. You can file a grievance in person or by mail.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at www.hhs.gov/ocr/office/file/index.html.

Language Assistance Services for Individuals with Limited English Proficiency

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-307-4355 (TTY: 1-800-847-0348).

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-307-4355 (TTY: 1-800-847-0348).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-307-4355（TTY：1-800-847-0348）

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-307-4355 (TTY: 1-800-847-0348)번으로 전화해 주십시오.

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن اللغوية المساعدة خدمات برقم اتصل بالمجان. تتوافر لك
والبكم الصم هاتف - 1-800-307-4355 (TTY: 1-800-847-0348)

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-307-4355 (ATS : 1-800-847-0348).

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-800-307-4355 (TTY: 1-800-847-0348).

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-307-4355 (TTY: 1-800-847-0348).

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-307-4355 (телетайп: 1-800-847-0348).

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-307-4355 (TTY: 1-800-847-0348).

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما
1-800-307-4355 (TTY: 1-800-847-0348) فراهم می باشد. با تماس بگیرید.

AANDACHT: Als u nederlands spreekt, kunt u gratis gebruikmaken van de taalkundige diensten. Bel 1-800-307-4355 (TTY: 1-800-847-0348)

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-307-4355 (TTY: 1-800-847-0348).

Wann du [Deitsch (Pennsylvania German / Dutch)] schwetzscht, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call 1-800-307-4355 (TTY: 1-800-847-0348).

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-307-4355 (TTY: 1-800-847-0348).

15.0 GLOSSARY

The terms in this Glossary appear throughout this book and are italicized.

Accredited Service

Accredited service is generally defined as all your time of employment with the *participating companies* 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 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; and
- 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 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; and
- 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 Oil Company 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 Oil Company or other *participating companies*.

Ambulatory Surgical Center

A specialized facility equipped to handle surgical procedures that require *hospital* facilities but do not require an extended *hospital* stay. To qualify for coverage under the HSM options, a surgical center must:

- Meet the requirements established by law in the area where it operates;
- Have an organized medical staff, including an anesthesiologist, under the supervision of a full-time doctor (M.D. or D.O.);
- Have physicians with surgery privileges at one or more local *hospitals*;
- Have equipment and supplies not usually available to a doctor outside a *hospital*, including operating rooms, a recovery room, diagnostic lab and X-ray facilities, emergency equipment, and a blood bank; and
- Have a written agreement with a nearby *hospital* to accept patients who develop complications.

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)

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.

Child(ren) do 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).

Coinsurance

Coinsurance is defined as the percentage of a covered medical or dental expense payable by the participant.

Company (generally)

See the *participating company* definition.

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 except for Shell US Hosting Company.

Component Program (of the Shell Oil Company Comprehensive Welfare Benefits 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 HSM options)

Non-medically necessary 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.

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*.

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; and
- 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, d*omestic partner* also includes a person who has a domestic partnership with you that 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.*

Eligibility service sometimes is referred to as "accredited *eligibility service.*"

Eligible Child(ren)

Your *child(ren)* and the *child(ren)* of your spouse or *domestic partner*:

- Who are unmarried;
- Who are under age 25;
- Whose medical expenses you are able to claim on your federal income tax return; and
- Who are not employed full time.

Unmarried *child(ren)* includes natural child(ren), stepchild(ren), and legally adopted child(ren). The *child(ren)* of your spouse or *domestic partner* also must live with you in a regular, parent-child relationship.

For medical, dental, vision, group life insurance, and voluntary personal accident insurance coverage, the age limit does not apply if the child(ren):

- Is physically or mentally disabled and covered under the program, or another plan sponsored through your previous employment, on the day before reaching age 25; and
- Is expected to remain permanently disabled and dependent upon you for financial support.

Eligible Dependent(s)

Eligible dependent(s) include:

- Your spouse;
- Your *domestic partner*;
- Your *child(ren)* through the end of the year in which they turn 26;*
- Your unmarried *child(ren)* age 26 or over who are physically or mentally disabled and covered under the program, or another plan sponsored through your previous employment, on the day before reaching their 26th birthday, and who remain disabled and permanently dependent upon 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 and who are not employed full-time; and

  The unmarried *child(ren)* of your spouse or *domestic partner*† age 25 or over who were physically or mentally disabled and covered under the program, or another plan sponsored through your previous employment, on the day before reaching their 25th birthday, and who remain disabled and permanently dependent upon you for financial support.

For these purposes, the term *child* or *children* means a biological child, stepchild, adopted child or foster child.

*Note that some HMOs/PPOs extend coverage only through the end of the month in which the child turns age 26. Therefore, if you select one of these options, you will need to check with the Claims Administrator to verify its eligibility policy.

†The child(ren) of your spouse or *domestic partner* also must live with you in a regular, parent-child relationship.

Employee(s)/Eligible Employee(s) (with respect to all Shell benefit plans, 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 Oil Company Comprehensive Welfare Benefits 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; provided, however, a person who would otherwise be excluded but (1) whose compensation and benefits are determined based upon the categories of "Local Plus," "Local Non-National," or "Alternate" pursuant to the International Mobility Policies, shall be included as an *employee* or *eligible employee;* and (2) who is classified as being on "Long Term International Assignment" pursuant to the International Mobility Policies 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; or
- 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*.

An *employee* of Pennzoil-Quaker State Company d/b/a SOPUS Products or a successor company who is represented by the Teamsters or a successor union at the Whippany, Alameda, Northeast, and Blue Coral locations is not eligible for benefits.

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*.

Group Annual Enrollment Period

The period each calendar year during which *employees* have the opportunity to enroll 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.

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 HSM 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*; and
- 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, and
  - Facilities for performing surgery.

Medicare

The Health Insurance for the Aged and Disabled Program under Title XVIII of the Social Security Act, as amended.

Non-Notification Penalty

An amount, in addition to the *deductible amount,* incurred by a participant or an *eligible dependent(s)* during a stay in a *hospital* that is not pre-certified. (For more information on pre-certification, see Section 1.5b, “Personal Health Support.”)

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-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* only.

Participant Plus Child(ren) Coverage

Coverage for an *employee* and his or her child or children.

Participant Plus Spouse/*Domestic Partner* Coverage

Coverage for an *employee* and his or her spouse or, where applicable, coverage for an *employee* 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* 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)
CRI U.S. LP	76-0665402
Equilon Enterprises LLC d/b/a Shell Oil Products US	52-2074528
Motiva Company	65-1163125
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 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 Oil Company	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
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 "Participation" 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.

An *employee* of Pennzoil-Quaker State Company d/b/a SOPUS Products or a successor company who is represented by the Teamsters or a successor union at the Whippany, Alameda, Northeast, or Blue Coral locations is not eligible to participate in any of the plans described in this book.

Pensioner

See Retired Employee.

Plan

The Shell Oil Company Comprehensive Welfare Benefits Plan.

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); and
- 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; or
- 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, spouse, *domestic partner*, or *child(ren)* for *Medicare* or Medicaid;
- A judgment, decree, or order which 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); and
- You 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; and
- 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 child care or elder care provider, a significant cost increase imposed by a child care or elder care provider, and a change in hours worked by your child care or elder care provider.

Qualifying Event

A *qualifying event* is an event creating eligibility for COBRA coverage as described in Section 6.1 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.*

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.*

Retired Employee (also sometimes referred to as a *Retiree* or *Pensioner*)

As defined in the Shell Oil Company Comprehensive Welfare Benefits Plan. It generally means a person who terminated employment from a *participating company* with *retiree coverage eligibility.*

Retiree

See Retired Employee.

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 (generally, attainment of age 50 with 20 or more years of *eligibility service* and termination of employment under special circumstances, such as a qualifying severance/reduction in force).

***Note that Employees hired or rehired on or after January 1, 2017, are not eligible for retiree coverage under the Shell Medical Benefit Program.**

Shell

See the participating company definition.

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 upon 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.