HESS CORPORATION EMPLOYEES' HEALTH AND WELFARE PLAN

SUMMARY PLAN DESCRIPTION

FOR HESS EMPLOYEES

2025

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INTRODUCTION

This book serves as the summary plan description ("SPD") for the Hess Corporation ("Company") Employees' Health and Welfare Plan ("Plan"). The governing plan documents for the Plan are the Hess Corporation Employees' Health and Welfare Plan Wrap Document ("Wrap Document"), this SPD, the Anthem Medical Benefit Booklet prepared by the claims administrator for self-insured medical benefits offered under the Plan, and the insurance policies or contracts, including individual certificates or booklets and other insurance documentation, issued in connection with the insured benefits offered under the Plan, if any.

PLAN ADMINISTRATION

Except as otherwise noted herein, the Plan is self-insured. This means that no insurance company collects premiums and pays benefits. Instead, Members make contributions to cover a portion of the cost of their benefits, and the rest of the cost is paid directly from Company assets.

The Plan contracts with Anthem Blue Cross and Blue Shield, a third party administrator ("Claims Administrator"), to handle administration of the medical and vision benefits.

Anthem makes medical claim determinations based on the Plan's guidelines and processes the claims. Anthem also provides a network of providers who charge discounted rates to Participants.

Contact information for the Claims Administrator

For customer service questions, please call:

1-800-854-1834

Claims submittal address:

Anthem Blue Cross Blue Shield

P.O. Box 105187

Atlanta, GA 30348-5187

The plan contracts with Express Scripts, Inc. ("Express Scripts") a third party pharmacy benefits manager, to handle administration of prescription drug benefits.

Express Scripts makes prescription drug claim determinations based on the Plan's guidelines and processes the claims. Express Scripts also provides a network of pharmacies, including a mail service pharmacy and a specialty pharmacy, that charge discounted rates to Participants.

Contact information for the Express Scripts Pharmacy Benefits Manager

For customer service questions, please call:

1-800-858-1678

Retail Claims submittal address:

Express Scripts, Inc.

Attention: Commercial Claims

P.O. Box 14711

Lexington, KY 40512-4711

Fax: 608-741-5475

Home Delivery Service Claims submittal address:

Express Scripts, Inc.

Home Delivery Service

P.O. Box 66566

St. Louis, MO 63166-6566

GENERAL INFORMATION

This SPD sets forth the terms for eligibility for the Hess benefit programs listed below:

- Short-term Disability
- Long-Term Disability
- Medical and Vision programs through Anthem
- Prescription Drugs program through Express Scripts
- Dental program through Delta Dental
- Employee Assistance Program through Health Advocate
- Life Insurance programs through MetLife
- Short-term Disability through salary continuation
- Long-term Disability Insurance through Reliance Standard
- Family Accident Insurance through AIG
- Business Travel Accident Insurance through AIG
- Critical Illness Insurance through Voya
- Accident Insurance through Voya
- Identity Theft Protection through LifeLock

Most of the benefits described herein are administered through a cafeteria plan, which means that you may choose which benefits you want to receive. The cafeteria plan allows you to elect to receive health care benefits (including medical & dental) or group insurance benefits (including life and accidental death and dismemberment coverage).

BASIC BENEFITS

The following basic benefits are provided to you automatically. The Company pays the entire cost of these benefits. You do not pay anything for these benefits:

- Basic Life Insurance
- Business Travel Accident Insurance
- Employee Assistance Program
- Short Term Disability*
- Long Term Disability

* The Short-term Disability benefits that the Company offers, which Matrix administers, are not considered an "employee welfare benefit plan" under ERISA and, therefore, are not subject to ERISA. As such, references in this SPD to your ERISA rights and to documents that may be made available under ERISA do not apply to the Short-term Disability benefits.

OPTIONAL BENEFITS

All other benefits under the Plan are optional. You and the Company share the cost of the following optional benefits.

- Medical and Dental Benefits. Your contribution for these benefits is based on the type of coverage you select.

  Thereafter, your contribution for benefits may be adjusted by the Company effective January 1 of each year based on a variety of factors, including the type of coverage you select and the claims and administration expenses for the type of coverage you select. Contribution rates are distributed with enrollment materials when you become eligible and during annual open enrollment periods. You can obtain this information from The Benefits Center.

You pay the entire cost of the following optional benefits:

- Supplemental and Dependent Life Insurance
- Family Accident Insurance
- Critical Illness Insurance
- Accident Insurance
- Identity Theft Protection

INFORMATION ABOUT THIS SPD

This SPD summarizes the terms of the Plan in effect at the date of publication. The Company, however, reserves the right, in its sole discretion, to terminate or amend the Plan (including amendments to reduce or eliminate benefits or changes to the premium and/or contribution rates) for all Members or a specific class of Members, including current and Former Employees, for any reason, without notice. If the Plan is amended or modified, the ability of employees and their family members to participate in the Plan and receive benefits from the Plan, as well as the type and amount of benefits provided by the Plan, may be changed. No Employee, Former Employee or family member has a vested or non-forfeitable right to receive benefits from the Plan.

Please take time to review this SPD to completely understand your benefits. In the event that the provisions of this SPD or any benefits booklet, insurance policy or certificate, conflict with the terms of the Wrap Document, the provisions of the Wrap Document control. Except as otherwise provided in this SPD, in the event that the provisions of any benefits booklet or any insurance policy or certificate conflict with the terms of this SPD, the provisions of this SPD control. However, with respect to fully insured benefits, the terms of the certificate of insurance coverage or evidence of coverage control when describing specific benefits that are covered or insurance-related terms.

Information obtained during calls to the Company or to any Plan service provider does not waive any provision or limitation of the Plan. Information given or statements made on a call or in an e-mail do not guarantee payment of benefits. In addition, benefits quotes that are given by phone are based wholly on the information supplied at the time. If additional relevant information is discovered, it may affect payment of your claim. All benefits are subject to eligibility, payment of premiums, limitations, and exclusions outlined in the Wrap Document and applicable insurance policies.

You can request a copy of the Wrap Document or the SPD and/or any applicable benefit booklets or brochures, or insurance policy/certificates by contacting the Plan Administrator.

Employee Benefit Plans Committee

Hess Corporation

1501 McKinney St.

Houston, TX 77010

Telephone: 713-496-4000

LEGAL, TAX & INVESTMENT ADVICE

The Company cannot provide personal legal or tax advice pertaining to the Plan or any individual Benefit Program. For this purpose, you should seek advice from your own legal or tax advisor.

DEFINED TERMS

Certain capitalized words in this SPD have special meanings with respect to the Plan and Benefit Programs. A glossary of terms used in this SPD is included in the last section of this SPD.

DEADLINE TO FILE A CLAIM OR BRING ACTION

You and your Dependents must exhaust the applicable claims procedures described in the Wrap Document or the benefits booklets prepared by the Plan's administrators before taking action in any other forum regarding a claim for benefits under the Plan. If you or your Dependents do not file an initial claim for benefits or an appeal within the time periods specified under the applicable claims procedures, you and/or your Dependents will have permanently waived and abandoned such claim and the claim shall be precluded. Any suit or legal action initiated by you or your Dependents under the Plan must be brought by you and/or your Dependents no later than one year following a final decision on the claim for benefits under these claims procedures. The one-year statute of limitations on suits for benefits applies in any forum where you or your dependents initiate such suit or legal action. If a civil action is not filed within this period, you and/or your Dependents' claim is deemed permanently waived and abandoned, and you and/or your Dependents will be precluded from asserting it.

IMPORTANT FACTS

Fraudulent statements on Plan enrollment forms or on electronic submissions will invalidate any payment or claims for services and be grounds for voiding the Participant's coverage.

The Plan Administrator, the Claims Administrator, and Express Scripts, the pharmacy benefits manager, are relieved of their responsibilities without breach, if their duties become impossible to perform by acts of God, war, terrorism, fire, ice storms, hurricanes, tornados, or similar events hampering travel and access to facilities.

NON-ALIENATION OF BENEFITS

Except as otherwise provided in the Plan, you may not assign your legal rights or rights to any payments under this Plan. However, the Plan may choose to remit payments directly to health

care providers with respect to covered services, if authorized by you or your dependents, but only as a convenience to you. Health care providers are not, and shall not be construed as, either "participants" or "beneficiaries" under this Plan and have no rights to receive benefits from the Plan or to pursue legal causes of action on behalf of (or in place of) you or your dependents under any circumstances.

APPLICABLE LAW

The Plan and all rights hereunder are governed by and construed, administered, and regulated in accordance with the provisions of ERISA, HIPAA, and the Code to the extent applicable, and to the extent not preempted by ERISA, the laws of New York, without giving effect to its conflicts of laws provision. The Plan may not be interpreted to require any person to take any action, or fail to take any action, if to do so would violate any applicable law.

ELIGIBILITY & ENROLLMENT

You are eligible for benefits under the Plan if you are a regular full-time employee of the Company who is scheduled to work at his or her job at least 30 hours per week and you are eligible to participate in one or more of the Benefit Programs.

Solely for purpose of determining eligibility for Medical, Dental, Prescription Drug, and Employee Assistance, expatriates working in the U.S. on long-term assignment shall be deemed to be Active Full-Time Employees.

Solely for purpose of determining eligibility for Cigna Global Health Benefits, Employee Assistance Program, Supplemental and Dependent Life Insurance, Basic Life Insurance, Long-term Disability Insurance, and Business Travel Accident Insurance, Family Accident Insurance Benefits, U.S. expatriates working outside of the U.S. on long-term assignment shall be deemed to be Active Full-time Employees.

DEPENDENT ELIGIBILITY

If you are eligible for benefits under the Plan, you also may elect coverage for your Dependents. Except as otherwise provided below, your Dependents include:

- Your Spouse;
- Your eligible same sex or opposite sex Domestic Partner;
- Your Eligible Children through the end of the calendar year in which they attain age twenty-six (26);
- Your Disabled Children.

Please note that your child must be at least fourteen (14) days old to be eligible for dependent life insurance.

DOMESTIC PARTNER ELIGIBILITY

Under federal law, Domestic Partners are not considered as “married” individuals or “spouses” for purposes of the Internal Revenue Code. Consequently, unless your Domestic Partner qualifies as your dependent under the Internal Revenue Code, the cost of health plan coverage provided to your Domestic Partner is considered taxable income to you. Similarly, unless the children of your Domestic Partner qualify as your dependent(s), the cost of health plan coverage provided to them is considered taxable income to you. Income will be reported to you on a Form W-2 in an amount equal to the value of the coverage provided to your Domestic Partner (and any children of your enrolled Domestic Partner) that do not qualify as your dependent under the Internal Revenue Code. You must attest to your Domestic Partner, and his

or her dependents, being your dependents under the Internal Revenue Code before health benefits will be provided to you on a before-tax basis.

The above requirement does not apply to a same sex spouse.

ELIGIBLE CHILDREN INCLUDE

- Your natural and adopted children, regardless of where they live;
- Stepchildren who live with you;
- Your eligible disabled children;
- Children who are placed with you for adoption;
- Children for whom you have legal guardianship issued by a court;
- Children of your same sex or opposite sex Domestic Partner provided the domestic partner is covered under the Plan;
- A minor child who qualifies as a dependent under the Internal Revenue Code of 1986, as amended;
- Children who must be covered under a QMCSO, as mentioned later in this section of the SPD.

DISABLED CHILD ELIGIBILITY

A child is disabled if he or she is permanently and totally physically or mentally handicapped, regardless of age, provided that disability began before the child reached age twenty-six (26). This coverage may continue for so long as the Employee has dependent coverage under the Plan. In such cases, proof of the child's continuing disability may be required. Such children are not eligible under this Plan if they are already twenty-six (26) or older at the time coverage is effective.

- If a dependent child age twenty-six (26) or older is enrolled for Medical or Dental Benefits, you must complete an online affidavit/questionnaire verifying that the child is disabled. If your dependent child is disabled, you will be asked to contact the carrier to submit substantiation of Disabled status.
- If you and your Spouse are both Eligible Employees, only one of you may elect to cover your dependent children.

APPEALING AN ENROLLMENT OR ELIGIBILITY STATUS DECISION

This section describes the appeals process that applies to enrollment and eligibility only. If you disagree with the Plan Administrator's determination regarding your enrollment or eligibility status, you have 365 days from your eligibility enrollment event to appeal in writing to the following address:

Employee Benefits Plans Committee

Hess Corporation

1501 McKinney St.

Houston, TX 77010

Telephone: 713-496-4000

Your appeal will be handled within 60 days from the date it is received by the Plan, unless an extension is required.

The 60-day period may be extended if it is determined that an extension is necessary due to matters beyond the Plan's control. You will be notified prior to the end of the 60-day period if an extension or additional information is required. Appeals of enrollment or eligibility decisions are not eligible for external review but will be eligible for voluntary review.

PLAN'S RIGHT TO RECOVER OVERPAYMENT

Payments are made in accordance with the provisions of the Plan. If it is determined that payment was made for benefits that are not covered by the Plan, for a participant who is not covered by the Plan, when other insurance is primary or other similar circumstances, the Plan has the right to recover the overpayment. The Plan will try to collect the overpayment from the party to whom the payment was made. However, the Plan reserves the right to seek overpayment from you and/or Dependents. Failure to comply with this request will entitle the Plan to withhold benefits due you and/or Dependents. The Plan has the right to refer the file to an outside collection agency if internal collection efforts are unsuccessful. The Plan may also bring a lawsuit to enforce its rights to recover overpayments. For medical claims, the Plan will not seek overpayments, except in the case of nonpayment of premiums, fraud, or intentional misrepresentation. If a network provider to whom an overpayment was made has patients who are participants in other health and welfare plans administered by the Third Party Administrator, the Third Party Administrator may reduce payments otherwise owed to the network provider from such other health plans by the amount of the overpayment.

QUALIFIED MEDICAL CHILD SUPPORT ORDERS

Federal law requires the Plan to provide medical and dental benefits to any Dependent of a Member pursuant to a court order that satisfies the conditions required to be a QMCSO.

A QMCSO is a final court or administrative agency order that generally results from a divorce or legal separation that: (a) designates one parent to pay for a child's health plan coverage; (b) specifies the name and last known address of the parent required to pay for coverage and the name and mailing address of each child covered by the QMCSO; (c) contains a reasonable description of the type of coverage to be provided under the designated parent's health care plan or the manner in which the coverage is to be determined; (d) states the period for which the order applies; and (e) identifies each health plan to which the order applies.

When the Plan receives a medical child support order, the Hess Benefits Center will determine whether the order is a QMCSO. Such determination is binding on the employee, the child, the other parent, and any other party acting on behalf of the child.

Plan Response to a QMCSO

- If an order is determined to be a QMCSO, and if the employee is covered by the Plan, the Benefits Center will so notify the parents and each child and advise them of the procedures that must be followed to provide coverage for the dependent children.
- The Company will accept enrollment of the dependent children specified by the QMCSO from either the employee or the custodial parent and, if required by the QMCSO, the Company will accept contributions for that coverage from a parent who is not covered by the Plan. The child's enrollment will be effective immediately and subject to the same limitations as any other enrollment under the Plan, to the extent permitted by applicable law.
- If the employee is not covered by the Plan at the time the QMCSO is received (but is eligible for coverage), and the QMCSO orders the employee to provide coverage for his or her dependent children, the Company will accept the enrollment of the employee and the dependent children specified by the order. Enrollment will be effective immediately and subject to the same limitations as any other enrollment under the Plan, to the extent permitted by applicable law.
- In addition to the child support order of a court or state administrative agency, the Company will treat as a QMCSO an appropriately completed National Medical Child Support Notice that it receives with respect to a child of a non-custodial parent-employee, provided that the notice meets the requirements set forth above.

- An order will not be accepted by the Company as a QMCSO if it requires the Plan to provide any type or form of benefit or any option that the Plan does not otherwise provide, or if it requires an employee who is not eligible for coverage under the Plan to provide coverage under the Plan for a dependent child, except as required by a state's Medicaid-related child support laws. For a state administrative agency order to be a QMCSO, state law must provide that such order will have the force and effect of law, and the order must be issued through an administrative process established by state law.
- Coverage of dependent children under a QMCSO will terminate when coverage of the employee-parent terminates for any reason, including failure to pay required contributions, subject to the dependent children's right to elect COBRA coverage if that right applies.
- If you have any questions about QMCSOs, or you would like a copy of the Company's QMCSO Procedures, please contact The Benefits Center at 1-877-511-4377, option 1.

INITIAL ENROLLMENT

You may enroll yourself and Dependents in the medical and dental care plans within 30 days of the first day of your regular, full–time employment.

To enroll, you may complete the medical coverage, dental coverage, and dependent information section online at: empyrean.hess.com or by calling the Benefits Center at 1-877-511-4377, option 1 and speaking with a customer service professional.

Completion of enrollment serves as your authorization to the Company to reduce your pay by the amounts that you must contribute to the cost of your coverage.

Once elections are received, the Effective Date of coverage will be your first day of regular, full- time employment. Benefits will not be provided for health services that you receive before the Effective Date of coverage.

EMPLOYEE NOT ACTIVELY AT WORK

Generally, if an Employee is not actively at work on the date his or her coverage is to be effective, the Effective Date will be postponed until the date the Employee returns to active status. If an Employee is not actively at work due to health status, this provision will not apply. An Employee is also a person still employed by the Employer, but not currently active due to health status.

OPEN ENROLLMENT

If you do not enroll yourself and/or Dependents when you first become eligible to participate in the Plan, you can enroll during the annual open enrollment period. Each year, you will have the opportunity to enroll or change your level of coverage during the open enrollment period. You will receive information in advance of the open enrollment period. You can do one of the following during the open enrollment period:

- Enroll;
- Change the number of persons covered;
- Increase or decrease coverage (including, but not limited to "employee only" increased to "employee plus one", or "employee and family" reduced to "employee only");
- Keep the same coverage; or
- Cancel coverage.

Whatever election you make during this period begins the following January 1st and stays in effect throughout the following calendar year. The only exception to this rule is if you have a "change in status," as explained below. If you do not change coverage during the open enrollment period, you will be deemed to have consented to automatic re-enrollment in your current medical or dental coverage and your payroll deductions will be adjusted accordingly. Such coverage will continue for the following year, although your premiums may increase.

MID-YEAR ELECTION CHANGES: CHANGE IN STATUS EVENTS

If any of these change in status events occur, you may change your election during the calendar year, provided that the change is consistent with a change in status event that affects eligibility for coverage (e.g., change from employee-only to employee-plus-one due to marriage). Changes must be provided to the Benefits Center within 30 days of the change in status. The Plan Administrator will then notify the claims administrator.

A "change in status" occurs under one or more of the following conditions:

- Change in employee's legal marital status (marriage, death of Spouse, divorce, legal separation, annulment).
- Change in number of dependents (birth, death, adoption, placement for adoption).
- Change in employment status of employee, Spouse or dependent (termination or commencement of employment, strike or lockout, commencement of or return from an unpaid leave of absence, change in worksite, or change in employment status that affects eligibility for coverage under this or another employer's plan).
- Dependent satisfies or ceases to satisfy eligibility requirements for coverage.

In addition, you may also change your election mid-year if you experience a change listed below:

- Special Enrollment Event: The events listed below as Special Enrollment Events
- Receipt of a judgment, decree or order resulting from a divorce, legal separation, annulment, or change in legal custody, including a QMCSO that requires medical coverage for an employee's child.

MID-YEAR ENROLLMENT: HIPAA SPECIAL ENROLLMENT EVENTS

If you decline enrollment for yourself or your eligible dependents because of other health insurance or group health plan coverage, you may be able to enroll yourself and your eligible dependents in the benefits under this Plan mid-year if you or your eligible dependents lose eligibility for that other coverage (or if the other employer stops contributing towards your or your eligible dependents' other coverage). However, you must request enrollment within 30 days after your eligible dependents' other coverage ends (or after the other employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll both yourself and any eligible dependents within 30 days after the marriage, birth, adoption, or placement for adoption.

You also may enroll in medical benefits mid-year if you or your eligible dependents no longer are eligible for Medicaid or a state Children's Health Insurance Program (CHIP) coverage, or if you or your eligible dependents become eligible for a state's premium assistance program under Medicaid or CHIP. You must request enrollment within 60 days from the date of the Medicaid/CHIP event.

To request enrollment under these HIPAA special enrollment rules or to obtain more information, including possible extensions of time for enrollment in certain circumstances, contact the Benefits Center at 1-877-511-4377, option 1.

ENROLLMENT CHANGES AND REQUESTING ENROLLMENT

Except for making an enrollment change pursuant to a QMCSO (as described above) or a change in entitlement under Medicaid or CHIP, you must elect coverage, or change your coverage election, within 30 days of the occurrence of a change in status event .

If you or a Dependent is no longer eligible under Medicaid or CHIP, or you or a Dependent becomes eligible for assistance for Plan Coverage under Medicaid or CHIP, you must request enrollment within 60 days of the prior coverage terminating or becoming eligible for assistance.

Your benefits coverage begins after you satisfy the Plan's eligibility requirements, and enroll for the benefit, as set forth in the chart on the following page.

BENEFIT	WHEN COVERAGE BEGINS...
Medical	• If you enroll during initial enrollment, your first day of employment • Date of enrollment due to a change in status event will be the date the election change was submitted to the Plan. However, coverage is retroactive to the date of birth, adoption or placement for adoption. • If you enroll during open enrollment, January 1 of the year immediately following open enrollment • Enrollment includes prescription drug and vision coverage
Dental	• If you enroll during initial enrollment, your first day of employment • Date of enrollment due to a change in status event will be the date of the event • If you enroll during open enrollment, January 1 of the year immediately following open enrollment
Basic Life Insurance	• First day of employment, provided you are actively at work that day (no enrollment is necessary)
Supplemental And Dependent Life Insurance	• If you enroll during initial enrollment, your first day of employment • If you enroll during open enrollment, January 1 of the year immediately following open enrollment • If you are required to submit Evidence of Insurability, the date on which the Insurer approves the Evidence of Insurability
Family Accident Insurance	• If you enroll during initial enrollment, your first day of employment, provided you are actively at work that day • If you enroll during open enrollment, January 1 of the year immediately following open enrollment

BENEFIT	WHEN COVERAGE BEGINS...
	• Date of enrollment due to change in status will be the date of the event
Business Travel Accident Insurance	• First day of employment, provided you are actively at work that day (no enrollment is necessary)
Long-Term Disability Insurance	• First day of employment, provided you are actively at work that day (no enrollment is necessary)
Employee Assistance Program	• First day of employment, provided you are actively at work that day (no enrollment is necessary)

IMPORTANT NOTICES

WOMEN'S HEALTH AND CANCER RIGHTS ACT

If you receive plan benefits in connection with a mastectomy, you are entitled to coverage for the following under the Plan:

- Reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses and treatment for physical complications for all stages of a mastectomy, including lymphedemas (swelling associated with the removal of lymph nodes).

The Plan will determine the manner of coverage in consultation with you and your attending doctor. Coverage for breast reconstruction and related services will be subject to deductibles and co-insurance amounts that are consistent with those that apply to other benefits under the Plan.

RIGHTS UNDER THE NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT

Under federal law, the Plan may not restrict benefits for a mother or newborn child to less than:

- 48 hours for any child-birth related hospital stay following a vaginal delivery;
- 96 hours following a delivery by Caesarean section.

However, the mother's or newborn's attending physician may discharge the mother or newborn earlier than 48 hours (or 96 hours as applicable) after consulting with the mother. In any case, the Plan or a health insurance issuer, 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).

ACTS BEYOND REASONABLE CONTROL (FORCE MAJEURE)

Should the performance of any act required by this coverage be prevented or delayed by reason of any act of God, strike, lock-out, labor troubles, restrictive government laws or regulations, or any other cause beyond a party's control, the time for the performance of the act will be extended for a period equivalent to the period of delay, and nonperformance of the act during the period of delay will be excused. In such an event, however, all parties shall use reasonable efforts to perform their respective obligations.

CARE RECEIVED OUTSIDE THE UNITED STATES

You will receive Plan benefits for care and treatment received outside the United States. Plan provisions will apply. Any care received must be a covered service. Please pay the provider of

service at the time you receive treatment and obtain appropriate documentation of services received including bills, receipts, letters and medical narrative. This information should be submitted with your claim. All services will be subject to appropriateness of care. The Plan will reimburse you directly. Payment will be based on eligible charges and based on the allowed amount of the Participant's legal residence. Assignments of benefits to foreign providers or facilities cannot be honored.

IMPORTANT NOTICE FROM HESS CORPORATION ABOUT YOUR PRESCRIPTION DRUG COVERAGE AND MEDICARE

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Hess Corporation and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1) **Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.**
2) **Hess Corporation has determined that the prescription drug coverage offered by the Company Medical Plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.**

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th through December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan. For example, you can delay enrollment in Medicare, including Medicare prescription drug coverage, until you leave Hess employment, at which time you can join Medicare and Medicare prescription drug coverage, if eligible for Medicare, without penalty (as long as you join within 63 continuous days after your current coverage ends).

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan while you are still employed at Hess and enrolled in Hess medical coverage, your current Hess Corporation coverage may be affected. For those individuals who elect Part D coverage, coverage under the entity's plan will end for the individual and all covered dependents. Please see pages 7-9 of the CMS Disclosure of Creditable Coverage To Medicare Part D Eligible Individuals Guidance (available at http://www.cms.hhs.gov /Creditable Coverage/), which outlines the prescription drug plan provisions/options that Medicare eligible individuals may have available to them when they become eligible for Medicare Part D.

If you do decide to join a Medicare drug plan and drop your current Hess Corporation coverage, be aware that you and your dependents may not be able to get this coverage back.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with Hess Corporation and don't join a Medicare drug plan within 63 continuous days after your current coverage ends you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice or Your Current Prescription Drug Coverage…

Contact the Hess Benefits Center for further information by calling 1-877-511-4377, Option 1. You may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage…

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at: www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

PREMIUM ASSISTANCE UNDER MEDICAID AND THE CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or www.insurekidsnow.gov to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at www.askebsa.dol.gov or call 1-866-444-EBSA (3272).

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2024. Contact your State for more information on eligibility –

ALABAMA – Medicaid	**ALASKA – Medicaid**
Website: http://myalhipp.com/ Phone: 1-855-692-5447	The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS – Medicaid	**CALIFORNIA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Health Insurance Premium Payment (HIPP) Program Website: http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**FLORIDA – Medicaid**

Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/State Relay 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ HIBI Customer Service: 1-855-692-6442	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268
GEORGIA – Medicaid	**INDIANA – Medicaid**
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: 678-564-1162, Press 2	Health Insurance Premium Payment Program All other Medicaid Website: https://www.in.gov/medicaid/ http://www.in.gov/fssa/dfr/ Family and Social Services Administration Phone: 1-800-403-0864 Member Services Phone: 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)	**KANSAS – Medicaid**

Medicaid Website: Iowa Medicaid | Health & Human Services Medicaid Phone: 1-800-338-8366 Hawki Website: Hawki - Healthy and Well Kids in Iowa | Health & Human Services Hawki Phone: 1-800-257-8563 HIPP Website: Health Insurance Premium Payment (HIPP) | Health & Human Services (iowa.gov) HIPP Phone: 1-888-346-9562	Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660
KENTUCKY – Medicaid	**LOUISIANA – Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kynect.ky.gov Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms	Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)
MAINE – Medicaid	**MASSACHUSETTS – Medicaid and CHIP**

Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com
MINNESOTA – Medicaid	**MISSOURI – Medicaid**
Website: https://mn.gov/dhs/health-care-coverage/ Phone: 1-800-657-3672	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
MONTANA – Medicaid	**NEBRASKA – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
NEVADA – Medicaid	**NEW HAMPSHIRE – Medicaid**

Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 15218 Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov
NEW JERSEY – Medicaid and CHIP	**NEW YORK – Medicaid**
Medicaid Website: http://www.state.nj.us/humanservices/ dmahs/clients/medicaid/ Phone: 1-800-356-1561 CHIP Premium Assistance Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710 (TTY: 711)	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	**OREGON – Medicaid and CHIP**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid and CHIP	**RHODE ISLAND – Medicaid and CHIP**

Website: https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid	**SOUTH DAKOTA - Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059
TEXAS – Medicaid	**UTAH – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services Phone: 1-800-440-0493	Utah's Premium Partnership for Health Insurance (UPP) Website: https://medicaid.utah.gov/upp/ Email: upp@utah.gov Phone: 1-888-222-2542 Adult Expansion Website: https://medicaid.utah.gov/expansion/ Utah Medicaid Buyout Program Website: https://medicaid.utah.gov/buyout-program/ CHIP Website: https://chip.utah.gov/
VERMONT– Medicaid	**VIRGINIA – Medicaid and CHIP**

Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427	Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924
WASHINGTON – Medicaid	**WEST VIRGINIA – Medicaid and CHIP**
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP	**WYOMING – Medicaid**
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2024, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

HEALTH CARE PROGRAMS

MEDICAL

The Plan's medical benefit is a high deductible plan ("HDP") administered by Anthem Blue Cross Blue Shield (the "Anthem HDP Plan"), with a health savings account ("HSA") administered by Fidelity.

Anthem Medical and Vision Benefits

The medical and vision benefits available to you under the Anthem HDP Plan are administered by the Claims Administrator.

Mental health and substance abuse benefits are provided through Anthem.

Enrollees in the Anthem HDP Plan may access a network of vision providers and discounts through Blue View Vision. A description of the benefits is available at hessbenefits.com.

Health Savings Account

The HSA is administered by Fidelity, the custodian and trustee for the HSA. Enrollees in the Anthem HDP will automatically have an HSA opened for them with Fidelity and must activate their account with Fidelity to ensure they can make and receive HSA contributions. Debit cards and claims are managed at Fidelity through netbenefits.com.

Prescription Drug Benefits

The prescription drug benefits available to you under the Hess Medical Plan are administered by Express Scripts. A summary of prescription drug benefits is included in the next major section of this Summary Plan Description.

Terms and Conditions

The terms and conditions of the Anthem HDP Plan, including the description of covered benefits, limitations and exclusions, coordination of benefits, subrogation, claims procedures, and pre-certification are set forth in greater detail in the Anthem Medical Benefit Booklet for Hess Corporation Health Savings Account Plan.

This benefit booklet is incorporated by reference and made a part of this SPD. This benefit booklet is available online at hessbenefits.com or, at no cost, by calling the Benefits Center at 1-877-511-4377, option 1 and speaking to a Benefits Specialist.

The terms of this SPD shall not enlarge the rights of any Member, Dependent, or beneficiary to any benefit that is specified under any benefits booklet or any insurance policy or contract issued by the Claims Administrator or the Express Scripts pharmacy benefits manager, including an individual insurance certificate or other insurance documentation.

SCHEDULE OF MEDICAL AND PRESCRIPTION DRUG BENEFITS

The following chart provides a high level overview of medical benefits provided through the Plan. For details on coverage, please refer to the Anthem Medical Benefit Booklet for Hess Corporation Health Savings Account Plan.

Key Features	In Network	Out of Network
Deductible		
Employee Only	$1,650	$3,300
Employee + One	$3,300	$6,600
Employee + Family	$3,300	$6,600
Out of Pocket Maximum		
Employee Only	$2,750	$5,000
Employee + One	$5,500	$10,000
Employee + Family	$5,500	$10,000
Hess HSA Contribution		
Employee Only	$500	
Employee + One	$1,000	
Employee + Family	$1,000	
Medical Benefits		
Preventive Care	100%	Up to $500 annual allowance, then 65% after deductible

Key Features	In Network	Out of Network
Office Visits	85% after deductible	65% after deductible
Emergency Room	85% after deductible	85% after deductible
Hospital	85% after deductible	65% after deductible
Lab and X-ray	85% after deductible	65% after deductible
Prescription Drug Benefits (retail and mail)		
Preventive Generic	100%	60% after deductible
Preventive Brand	85%	40% after deductible
Other Generic	85% after deductible	60% after deductible
Other Brand	85% after deductible	40% after deductible

The annual Hess contribution to your HSA is a lump sum deposit in January for employees hired prior to the current calendar year. The annual Hess contribution is prorated for new hires in the current calendar year based on calendar quarter of hire date.

The deductibles noted in the chart above cross apply between in network and out of network services. This means that you are not required to meet both deductible amounts before benefits can begin. In network and out of network claims are combined toward meeting the deductible.

Additionally, the deductibles cross apply between medical and prescription drug claims. This means that all medical and prescription drug claims are combined toward meeting the deductible.

HEALTH SAVINGS ACCOUNT (HSA)

Eligibility Requirements

In order to be eligible to make or receive HSA contributions for any given month, you must *be enrolled* in a qualified High Deductible Plan ("HDP"), like the Hess Medical Plan on the first day

of the month, and *not enrolled* in any other non-high deductible health plan, including Medicare, or covered as a dependent under your spouse's non-HDP meaning any plan that does not qualify as a high deductible plan, which includes a regular health care flexible spending arrangement (FSA).

You may, however, enroll in the following "permitted" or "disregarded coverage" such as:

- Accident
- Disability
- Dental care
- Vision care
- Long term care
- Worker's Compensation
- Property, Tort and Ownership
- Specified disease or illness (e.g. cancer only)
- Indemnity Insurance

If you would like to continue contributing to your HSA after becoming eligible for Medicare (e.g. by reaching age 65), you must delay enrollment in Medicare. In order to delay Medicare enrollment, you must delay receiving your Social Security benefits too. If you decide to delay your Medicare enrollment and later wish to enroll in Medicare, you must cease contributing to your HSA at least 6 months before enrolling into Medicare.

Opening Your Account

An HSA is an individually owned trust or custodial account as described in Code section 223 that can be used to set aside funds on a tax-advantaged basis for medical expenses. An Eligible Employee who established an HSA with a custodian or trustee who has entered into an agreement with the Company to receive salary reduction contributions directly from the Company's payroll may contribute to the HSA on a pre-tax basis through salary reduction, and may receive contributions from the Company.

You cannot make or receive contributions to your HSA unless your account is open. Closed accounts and inactive accounts cannot receive contributions.

To facilitate the opening of health savings accounts for employees who have enrolled in the Hess Medical Plan, the Company has entered into an agreement with the HSA custodian and trustee to automatically open all employee accounts for new enrollees in the Plan. Additionally, the Hess Corporation Cafeteria Plan was amended to include this automatic enrollment feature. However, all enrollees must activate their account to make and receive HSA contributions. An open account

is not the same as an activated account. You can activate your account on the Fidelity NetBenefits website.

You can check on the status of your HSA online at: netbenefits.com.

Once your HSA is open and activated, the Company and you can make contributions to the account. For employees who are eligible January 1 of a calendar year, the Company contributes the full annual amount of $500 for single coverage or $1,000 for family coverage. For employees who first become eligible after the start of the calendar year, the Company contributions are made based on the schedule noted below:

Hire Date	%	Employee Only HSA	Family HSA	Company Contributions Made
First Quarter	75%	$375.00	$750.00	April of current year
Second Quarter	50%	$250.00	$500.00	July of current year
Third Quarter	25%	$125.00	$250.00	October of current year
Fourth Quarter	0%	$0.00	$0.00	N/A

In addition to the Company contribution, you may also make voluntary contributions to your HSA on a pre-tax basis, subject to the annual IRS maximum. The IRS sets an annual contribution limit, which is subject to adjustment annually.

For 2025, the maximum annual contribution to your HSA, including Company contributions and your contributions, is:

- $4,300 for employee only coverage; or
- $8,550 for family coverage.

If you are age 55 or older, you can make an additional contribution of $1,000 annually, called a catch-up contribution. Your annual contributions plus the Company contributions (plus any after-tax contributions made to your HSA outside of payroll) cannot exceed the IRS limits or you will be subject to income tax and penalties.

Your HSA is credited as of each date compensation is paid to you (including the final date on which compensation is paid for termination of employment), an amount equal to the reduction made in such compensation in accordance with your election form and compensation reduction agreement. You are not required to make contributions to your HSA.

All contributions to your HSA are yours to keep, even after you leave the Company. Upon termination of employment, you may continue to make contributions to your account on a post-tax

basis directly with the custodian. However, you are no longer eligible for the employer contribution. You will also have a monthly fee deducted from your account upon termination of employment or termination of coverage in the Anthem HDP Plan. You should contact your HSA custodian for any questions about your account and IRS rules that may apply.

Triple Tax Advantage

The triple tax advantage of contributing to an HSA is:

1. Tax-free contributions;
2. Tax-free earnings; and
3. Tax-free distribution if used for Qualified Medical Expenses.

You can use your HSA to pay for Qualified Medical Expenses that are incurred after the date the HSA is established on a tax-free basis now or in the future. Your account balance may earn interest on a tax-free basis and will roll-over from year to year. Additionally, you can invest your money in fund options available through the trustee.

Distributions

A distribution from your HSA is tax-free and penalty-free, as long as it's used for your or a Dependent's Qualified Medical Expenses that are incurred after the date the HSA is established. Any other distribution is classified as a non-qualified distribution that is subject to ordinary income tax and may be subject to an additional 20% tax. Non-qualified distributions due to death, after age 65, or if disabled are not subject to the additional 20% tax, but are subject to income tax.

Treatment of Your HSA upon Divorce

If you divorce and a divorce decree requires that the funds in your HSA be divided between you and your former spouse, a separate HSA may be established in your former spouse's name. If this happens, the distribution is not taxable or subject to the additional 20% tax.

Treatment of Your HSA upon Death

If you die, any amounts remaining in your HSA will transfer to your named beneficiary, if you have designated one. The HSA is treated one of two ways, depending upon whether your beneficiary is your surviving spouse. If your beneficiary is your surviving spouse, then your surviving spouse becomes the account holder of the HSA and the transfer is not taxable. Distributions to your surviving spouse would only be subject to income tax to the extent they were not used for Qualified Medical Expenses.

If the beneficiary is someone other than your surviving spouse, then the HSA ceases to be an HSA and an amount equal to the fair market value of the account assets as of the date of your death is

includible in your beneficiary's gross income (or, if the beneficiary is your estate, includable in the gross income for the year in which the death occurred). In certain cases, your beneficiary may reduce the includable amount by the amount of any payments made from the HSA for qualified medical expenses incurred by you before your death.

Long-term HSA Value

An HSA is allowed to grow on a tax-advantaged basis over time and can add value in retirement, where many individuals on taxable fixed incomes will face higher than usual medical expenses. Paying for out-of-pocket medical costs and Medicare premiums with tax-free dollars is a good way to help stabilize financial security in retirement.

As an employee of Hess, you can contact Fidelity at 1-877-511-4377, option 2 at no cost and receive professional financial guidance at any time.

PRESCRIPTION DRUG BENEFITS

Express Scripts administers the prescription drug benefit program and provides clinical management services (the "Prescription Drug Plan"). The coverage overview is noted in the schedule of benefits.

You can get your prescriptions filled at a retail pharmacy or through the mail service. Specialty medications are filled only through Accredo, the Express Scripts specialty pharmacy.

Retail

Your prescription drug coverage with Express Scripts includes a broad, national network of retail pharmacies. Here, you can fill your short-term prescriptions, such as antibiotics, for up to a 30-day supply. You can also fill your maintenance medications, such as cholesterol lowering drugs. However, you should use the mail service whenever possible for your maintenance medications.

Mail Service

In addition to filling your maintenance medications at a retail pharmacy, Express Scripts has a cost saving alternative for prescription drugs that you may take to treat or control a chronic medical condition. The mail service option provides up to a 90-day supply of maintenance medication delivered to your home. It's convenient and saves money for you and helps control costs in the benefit plan.

Specialty Pharmacy

Accredo is a specialty pharmacy contracted with Express Scripts to fill specialty medications. If you are taking a specialty medication, it must be filled exclusively through Accredo. Using a specialty pharmacy ensures the lowest cost for you and the benefit plan.

Description of Benefits Coverage

The Prescription Drug Plan pays the prescription drug coinsurance shown in the **Schedule of Benefits** per prescription or prescription refill and you pay the balance.

Your benefit design, as shown in the **Schedule of Benefits**, will determine the coinsurance of your prescription drug plan for generic drugs and brand name drugs.

The management and other services Express Scripts provides include, among others, making recommendations to, and updating the covered prescription drug list (also known as a formulary), establishing a network of retail pharmacies, and operating a Mail Service pharmacy. Express Scripts, in consultation with the Claims Administrator also provides services to promote and enforce the appropriate use of pharmacy benefits, such as review for possible excessive use; recognized and recommended dosage regimens; Drug interactions or Drug/pregnancy concerns.

The Prescription Drug Plan provides coverage for drugs on the following Express Scripts drug lists (collectively, the "covered Prescription Drug list"), which are available on the Hess and Express Scripts websites:

- ACA Preventive Drug List
- Basic Formulary
- Standard Plus Preventive Drug List
- Specialty Drug List

The covered Prescription Drug list is subject to periodic review and amendment. Inclusion of a drug or related item on the covered Prescription Drug list is not a guarantee of coverage.

Prescription Drugs, unless otherwise stated below, must be medically necessary and not Experimental/Investigative, in order to be covered services. For certain Prescription Drugs, the prescribing Physician may be asked to provide additional information before Express Scripts and/or the Claims Administrator can determine medical necessity. The Plan may, in its sole discretion, establish quantity and/or age limits for specific Prescription Drugs which Express Scripts will administer. Covered services will be limited based on medical necessity, quantity, and/or age limits established by the Plan or utilization guidelines.

Prior authorization may be required for certain prescription drugs (or the prescribed quantity of a particular drug). Prior authorization helps promote appropriate utilization and enforcement of guidelines for prescription drug benefit coverage. At the time you fill a prescription, the network pharmacist is informed of the prior authorization requirement through the pharmacy's computer system. Express Scripts uses pre-approved criteria, developed by the Pharmacy and Therapeutics Committee which is reviewed and adopted by the Claims Administrator. The Claims Administrator or Express Scripts may contact your provider if additional information is required

to determine whether prior authorization should be granted. The Claims Administrator communicates the results of the decision to both you and your provider.

If prior authorization is denied, you have the right to appeal through the appeals process outlined in the ”Claims and Appeals” section at the end of this chapter.

For a list of the current drugs requiring prior authorization, please contact the customer service telephone number on your identification card. The covered Prescription Drug list is subject to periodic review and amendment. Inclusion of a drug or related item on the covered Prescription Drug list is not a guarantee of coverage. Refer to the prescription drug benefit sections in this Benefit Booklet for information on coverage, limitations, and exclusions. Your provider or network pharmacist may check with the Claims Administrator to verify covered prescription drugs, any quantity and/or age limits, or applicable brand or generic drugs recognized under the Plan.

At the time your prescription is being filled, present your identification card at the participating pharmacy. The participating pharmacist will complete and submit the claim for you. If you do not go to a participating pharmacy, you will need to submit the itemized bill to be processed.

Benefits

The Prescription Drug Plan provides coverage for drugs which, under federal law, may only be dispensed with a prescription written by a physician. Insulin, which can be obtained over the counter, will only be covered under the Prescription Drug Plan when accompanied by a prescription.

Under the Prescription Drug Plan, a 30-day supply may be dispensed for the Coinsurance amount determined by the Plan. Drug quantities exceeding FDA safety standards will be limited to those recommendations. Covered prescription inhalants will not be subject to a day limit.

This Plan allows for refills of a prescription within one year of the original prescription date, as authorized by your physician.

Drugs Requiring Prior Authorization

Some medications are covered only for specific medical conditions or for specific quantity and duration. Examples of medications that may require review are noted below; however, this list is not comprehensive and is subject to change:

- Oral chemotherapeutic agents
- Dermatology drugs
- All growth hormones/growth factors

- Gonadotropin-releasing hormones
- Respiratory drugs
- Rheumatoid arthritis/anti-TNF therapy
- Non-narcotic analgesics
- Oral impotence drugs (for males only)
- Specialty drugs

This list is subject to change. To determine if a drug requires pre-authorization, please call the Customer Service telephone number on your identification card or visit www.express-scripts.com.

Preferred Drug List

Retail prescription medications shall, in all cases, be dispensed according to the Preferred Drug List for prescriptions written and filled network and out-of-network. The preferred drug list may be amended from time to time.

A Member or prospective Member shall be entitled upon request, to a copy of the Preferred Drug List, please call the Customer Service telephone number on your identification card or visit www.anthem.com.

Home Delivery (Mail Order Service)

Complete the Order and Patient Profile Form. You will need to complete the patient profile information only once. You may mail written prescriptions from your physician, or have Your physician fax the prescription to Express Scripts' Home Delivery (Mail Service). Your physician may also phone in the prescription to Express Scripts Home Delivery (Mail Service) Pharmacy. You will need to submit the applicable coinsurance and/or copayment amounts to Express Scripts' Home Delivery (Mail Service) when you request a Prescription or refill.

Specialty Drugs

Specialty drugs are typically high cost drugs that are injected or infused in the treatment of acute or chronic diseases ("Specialty Drugs"). Specialty Drugs often require special handling such as temperature-controlled packaging and expedited delivery. Specialty Drugs require preauthorization to be considered medically necessary. You may obtain the list of Specialty Drugs by contacting Customer Service or online at www.anthem.com.

Specialty Drugs are available exclusively through Accredo and are shipped directly to you or to a network provider. Your treatment plan and specific prescription will determine where administration of the drug will occur and by whom. In order to better support your treatment plan, Specialty Drug prescriptions that exceed 30 days may be dispensed in more than one shipment.

When this occurs, please note that your total cost for multiple shipments will not exceed the amount you would have incurred for a single shipment.

Additionally, your copayment and/or coinsurance may be prorated to support the method of distribution and treatment. If Accredo charges an administration fee for Specialty Drugs, that amount would be separate from the cost of the Mail Order (Home Delivery) shipment(s).

Please note that Specialty Drugs may also be obtained from a local pharmacy that agrees to accept the same payment terms as the Mail Order (Home Delivery) Pharmacy, although your portion of the payment is subject to change.

Preventive Over-the-Counter Medications

If you are enrolled in the Plan, costs of certain over-the-counter ("OTC") medications are covered at 100% when they are prescribed by a physician and you purchase them at network pharmacies (retail or mail-order). Covered OTC preventive care medications are those required by regulations issued under the Affordable Care Act. (Please note that the Plan's coverage of OTC preventive care medications may change as additional regulations are issued.) For the full list of covered preventive care OTC medications, please call the customer service number on your identification card or visit www.express-scripts.com.

Where the Plan covers preventive generic medications at 100%, the Plan will cover brand-name medications at 100% when medically necessary. If your attending physician believes a brand-name preventive medication is medically necessary, you may request a review for coverage of the brand-name drug, by calling Express Scripts at (800) 946-3979.

Contraceptives for Women

The Plan covers all FDA-approved contraceptive methods, including approved OTC variations for women, as required by the Affordable Care Act. Under the terms of the Affordable Care Act, all generic contraceptives (and brand name contraceptives when medically necessary) will be covered at 100%, when prescribed by a physician. If your attending physician believes a brand-name contraceptive is medically necessary, you may request a review for coverage of the brand-name drug, by calling Express Scripts at (800) 946-3979.

Covered Prescription Drug Expenses

All FDA approved drugs requiring a prescription to dispense are covered, unless specifically excluded or limited under this plan. For questions about the prescription drug program, such as to obtain prior authorization and how to locate network pharmacies, including specialty pharmacies,

or to inquire about specific drugs or medication not listed in this Plan, please call the customer service number on your identification card.

Covered expenses include but are not limited to:

- Legend drugs (except where excluded or limited)
- State restricted drugs
- Compound drugs when a commercially available dosage form of a medically necessary medication is not available, all the ingredients of the compound drug are FDA approved and require a prescription to dispense, and are not essentially the same as an FDA approved product from a drug manufacturer. Non-FDA approved, non-proprietary, multisource ingredients that are vehicles essential for compound administration may be covered.
- Prescription contraceptives, limited to oral, injectable, patch and ring. Note that the Plan will cover as preventive all FDA-approved contraceptive methods, as described above under "Contraceptives for Women."
- Syringes, for use other than insulin
- Prescription prenatal vitamins
- Prescription vitamins
- Legend smoking deterrents
- Insulin and diabetic supplies, including lancets, glucose strips, ketone test strips, glucagon, alcohol wipes, insulin needles and insulin syringes. Diabetic testing equipment (e.g., glucose monitors) may be considered under the medical portion of this Plan.
- Appetite Suppressants (Anorexiants)
- Dietary supplements, fluoride supplements/rinses (prescription topical), anabolic steroids or irrigation solutions.
- Self-administered drugs. These are drugs that do not need administration or monitoring by a provider in an office or Facility. Injectables and infused drugs that need provider administration and/or supervision are covered under the "Prescription Drugs Administered by a Medical Provider" benefit.
- Nutritional dietary supplements, administered intravenously or through a gastrointestinal tube as a medically necessary course of treatment.
- Ostomy supplies

Non-covered Drug Expenses

The following are not Covered Services under this Plan:

- Prescription drug products for any amount dispensed which exceed the FDA clinically recommended dosing schedule.
- Medication for which the cost is recoverable under any worker's compensation or occupational disease law, or from any state or governmental agency.
- Non-prescription contraceptive devices, including, but not limited to, condoms and spermicidal agents (except as otherwise required to be covered as a preventive medication).
- Drugs dispensed in unit doses when bulk packaging is available.
- Prescription drugs received through an Internet pharmacy provider.
- Non-legend drugs, including, but not limited to, vitamins and over-the-counter pre-natal vitamins (except as otherwise required to be covered as a preventive medication).
- Non-legend smoking cessation aids, including, but not limited to, nicotine replacement drugs (except as otherwise required to be covered as a preventive medication).
- Over-the-counter items (except otherwise required to be covered as a preventive medication).
- Cosmetic drugs, drugs to stimulate hair growth (e.g., Propecia)
- Allergy injections (benefits may be considered under the medical portion of this Plan).
- Injectable contraceptives given in a physician's office. Benefits may be considered under the medical portion of this Plan.
- The administration or injection of any prescription drug or any drugs or medicines.
- Prescription drugs which are entirely consumed or administered at the time and place where the prescription order is issued.
- Prescription refills in excess of the number specified by the physician, or any refill dispensed after one year from the date of the prescription order.
- Prescription drugs for which there is no charge or which were paid under any other plan of the employer
- Charges for items such as therapeutic devices, artificial appliances, or similar devices, regardless of their intended use. Benefits may be considered under the medical portion of this Plan.
- Prescription Drugs for use as an inpatient or outpatient in a hospital and prescription drugs provided for use in a convalescent care facility or nursing home, which are ordinarily furnished by such facility for the care and treatment of Inpatients.
- Charges for delivery of any prescription drugs.

- Drugs and medicines which do not require a prescription and that are not prescription drugs (except otherwise required to be covered as a preventive medication).
- Prescription drugs provided by a physician whether or not a charge is made for such Prescription drugs.
- Prescription drugs which are not medically necessary or which the Plan determines are not consistent with the diagnosis.
- Prescription drugs which the Plan determines are not provided in accordance with accepted professional medical standards in the United States.
- Any services or supplies which are not specifically listed as covered under this prescription drug program.
- Extemporaneous or compounded dosage forms of natural estrogen or progesterone, including, but not limited to, oral capsules, suppositories and troches.
- Prescription drugs which are experimental or investigational in nature as explained in the "Limitations and Exclusions" section.
- Fertility drugs.

Filing Claims and Appeals

CLAIMS FOR BENEFITS: DEADLINE TO FILE CLAIMS

You must file a claim for benefits within the timeframe required by Express Scripts. You should file your claim for benefits with Express Scripts.

CLAIMS FOR BENEFITS: INITIAL CLAIMS

Your claim for benefits will be processed under the procedures described below.

Urgent Claims

An urgent claim is any claim for medical care or treatment where making a determination under the normal timeframes could seriously jeopardize your life or health or your ability to regain maximum function, or, in the opinion of a physician with knowledge of your medical condition, would subject you to severe pain that could not adequately be managed without the care or treatment that is the subject of the claim.

For urgent claims, notice of the Plan's determination will be sent as soon as possible taking into account the medical exigencies and in no case later than 72 hours after receipt of the claim.

You may receive notice orally, in which case a written notice will be provided within 3 days of the oral notice. If your urgent claim is determined to be incomplete, you will receive a notice to this effect within 24 hours of receipt of your claim, at which point you will have 48 hours to provide additional information.

If you request an extension of urgent care benefits beyond an initially determined period and make the request at least 24 hours prior to the expiration of the original determination, you will be notified within 24 hours of receipt of the request.

Pre-Service Claims

A pre-service claim is a claim for services that have not yet been rendered and for which the Plan requires prior authorization.

If your pre-service claim is improperly filed, you will be sent notification within five days of receipt of the claim.

If your pre-service claim is filed properly, a claims determination will be sent within a reasonable period of time appropriate to the medical circumstances, but no later than 15 days from receipt of the claim.

If Express Scripts determines that an extension is necessary due to matters beyond control of the Plan, this time may be extended 15 days. You will receive notice prior to the extension that indicates the circumstances requiring the extension and the date by which the Express Scripts expects to render a determination. If the extension is necessary to request additional information, the extension notice will describe the required information, and you will be given at least 45 days to submit the information. Express Scripts then will make its determination within 15 days from the date the Plan receives your information, or, if earlier, the deadline to submit your information.

Post-Service Claims

A post-service claim is a claim for services that already have been rendered, or where the Plan does not require prior authorization.

Notice of the Plan's determination will be sent within a reasonable time period but not longer than 30 days from receipt of the claim.

If Express Scripts determines that an extension is necessary due to matters beyond control of the Plan, this time may be extended 15 days. You will receive notice prior to the extension that indicates the circumstances requiring the extension and the date by which Express Scripts expects

to render a determination. If the extension is necessary to request additional information, the extension notice will describe the required information, and you will be given at least 45 days to submit the information. Express Scripts then will make its determination within 15 days from the date the Plan receives your information, or, if earlier, the deadline to submit your information.

CLAIMS FOR BENEFITS: APPEALS

You must file your appeal within the deadlines set out below. Requests for appeals should be sent to the address specified in the denial notice.

You will have the opportunity to submit written comments, documents, or other information in support of your appeal and you will have access to all documents that are relevant to your claim. Your appeal will be conducted by a person different from the person who made the initial decision. No deference will be afforded to the initial determination.

If your claim involves a medical judgment question, Express Scripts will consult with an appropriately qualified health care practitioner with training and experience in the field of medicine involved. If a health care professional was consulted for the initial determination, a different health care professional will be consulted on appeal. Upon request, Express Scripts will provide you with the identification of any medical expert whose advice was obtained on behalf of the Plan in connection with your appeal.

A final decision on appeal will be made within the time periods specified below.

Urgent Claims

You must submit your appeal within 180 days of the date of your initial denial notice (or first level appeal notice, for second level appeals).

You will be notified of the determination as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the claim.

Pre-Service Claims

You must submit your appeal within 180 days of the date of your initial denial notice (or first level appeal notice, for second level appeals).

For both the first and second levels of appeal of a pre-service claim, you will be notified of the determination within a reasonable period of time taking into account the medical circumstances,

but no later than 15 days from the date your request is received (30 days if there is only one level of appeal).

Post-Service Claims

You must submit your appeal within 180 days of the date of your initial denial notice (or first level appeal notice, for second level appeals).

For both the first and second levels of appeal of a post-service claim, you will be notified of the determination within a reasonable period of time, but no later than 30 days from the date your request is received (60 days from the date if there is only one level of review).

CLAIMS FOR BENEFITS: NOTICE OF DETERMINATION

If your claim or appeal is in part or wholly denied, you will receive notice of an adverse benefit determination that will:

- state specific reason(s) of the adverse determination;
- reference specific Plan provision(s) on which the benefit determination is based;
- describe additional material or information, if any, needed to perfect the claim and the reasons such material or information is necessary (initial claim only);
- describe the Plan's claims review procedures and the time limits applicable to such procedures (initial claim only);
- include a statement of your right to bring a civil action under section 502(a) of ERISA following appeal;
- state that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim for benefits (appeal only);
- describe any voluntary appeal procedures offered by the plan and your right to obtain information about such procedures (appeal only);
- disclose any internal rule, guidelines, or protocol relied on in making the adverse determination (or state that such information will be provided free of charge upon request);

- if the denial is based on a medical necessity or experimental treatment or similar limit, explain the scientific or clinical judgment for the determination (or state that such information will be provided free of charge upon request);

- include information sufficient to identify the claim involved, including date of service, health care provider, and claim amount;

- include the denial code and corresponding meaning;

- include a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning and treatment code and its corresponding meaning;

- describe the Claims Administrator's or insurer's standard, if any, used in denying the claim;

- describe the external review process, if applicable; and

- include a statement about the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman established under health care reform laws to assist individuals with internal claims and appeals and external review processes.

For initial claims, you also will receive notification of approval if your claim is an urgent or pre-service claim. For appeals, you will receive a notice if your appeal is approved.

CLAIMS FOR BENEFITS: EXTERNAL REVIEW

If you are not satisfied with the outcome of your internal appeal review and the appeal involves medical judgement, a rescission of coverage, or an adverse determination for surprise bills (medical and air ambulance bills, including a determination of whether an adverse determination is subject to surprise billing provisions), you may request your appeal be referred to an Independent Review Organization (IRO). Your external review will be conducted by an independent review organization not affiliated with the Plan. This independent review organization may overturn the Plan's decision, and the independent review organization's decision is binding on the Plan. Your appeal denial notice will include more information about your right to file a request for an external review and contact information. You must file your request for external review within four months of receiving your final internal appeal determination. Filing a request for external review will not affect your ability to bring a legal claim in court. When filing

a request for external review, you will be required to authorize the release of any medical records that may be required to be reviewed for the purpose of reaching a decision on the external review.

VISION COVERAGE SCHEDULE OF BENEFITS

When you enroll for medical coverage, you get vision coverage automatically.

Anthem administers the vision program, and its key features are noted below. Using network providers will save you money.

	In Network	Out of Network
Covered Services (every 12 months)		
Annual Exam	100%	$40 allowance
Frames	$200 allowance, plus 20% discount of any remaining balance	$45 allowance
Single vision lenses	100% after $20 co-pay	$25 allowance
Bifocal lenses	100% after $20 co-pay	$40 allowance
Trifocal lenses	100% after $20 co-pay	$55 allowance
Lenticular lenses	100% after $20 co-pay	$75 allowance
Elective Contacts (conventional)	$200 allowance, plus 15% discount of any remaining balance	$105 allowance
Elective Contacts (disposable)	$200 allowance	$105 allowance
Medically necessary contacts	100%	$210 allowance

Contact lens fitting	100%	Not covered

Options such as extra thin lenses or special lens coatings may increase your out-of-pocket costs.

DENTAL COVERAGE SCHEDULE OF BENEFITS

BENEFIT PROVISIONS	IN-NETWORK	OUT-OF-NETWORK
Annual Deductible	N/A	$50 individual $150 family
Choice of Doctor	Service must be provided by a participating provider in Delta Dental's network	Your choice of provider.
Preventive **Teeth Cleaning, Fluoride Treatment, Space Maintainers, Sealers**	100%*; no deductible; does not apply toward annual maximum benefits	100%; no deductible
Diagnostic **Exams & X-rays**	100%*; no deductible	100%*; no deductible
Basic Restorative **Fillings**	80%*; no deductible	70%*; after deductible
Oral Surgery **Extractions & Oral Surgery Procedures**	80%*; no deductible	70%*; after deductible
Endodontics **Root Canal Therapy**	80%*; no deductible	70%*; after deductible
Periodontics **Treatment of gum disorders (both surgical and non-surgical)**	80%*; no deductible	70%*; after deductible

BENEFIT PROVISIONS	IN-NETWORK	OUT-OF-NETWORK
Prosthodontics **Dentures, Bridgework, Implants**	60%*; no deductible	60%*; after deductible
Major Restorative **Inlays, Onlays, Crowns**	60%*: no deductible	60%*; after deductible
Orthodontics (children and adults)	50%*; no deductible	50%*; after deductible
TMJ **Treatment of temporomandibular joint**	50%*; no deductible	50%*; after deductible
Additional General Anesthesia **Injectable Antibiotics** **Local Anesthesia**	80%*; no deductible	70%*; after deductible
Orthodontics Lifetime Maximum	$2,500 per person	$2,500 per person
Annual Maximum Benefits	$2,000 per person **Note:** Costs of preventive care do not apply toward the $2,000 annual maximum benefits.	$1,500 per person

* Percentage is based on Delta's applicable Maximum Plan Allowance or the dentist's fee, whichever is less (the Allowed Amount). The Delta payment under the program, plus the patient payment, equals the Allowed Amount, which is accepted by Delta participating dentists as full payment. Participating dentists are paid directly by Delta, and by agreement cannot bill you more than the applicable copayment, deductible or charges where maximums have been exceeded for covered services.

By selecting a participating dentist, you always limit your out-of-pocket costs. For services performed by non- participating dentists, Delta sends the benefit payment directly to you. You are responsible for paying the non- participating dentist's total fee, which may include amounts in addition to your share of Delta's Allowed Amount. Out-of-pocket costs may also include applicable copayments, deductibles, charges where maximums have been exceeded, and services not covered by the Group Dental Service Contract

Dental benefits are provided through Delta Dental ("Delta"). To enroll, you must complete the Dental Coverage section online at:

- empyrean.hess.com; or
- By calling the Benefits Center at 1-877-511-4377, option 1 and speaking with a customer service professional.

Note that capitalized terms used in this chapter are defined in the Delta Dental Summary of Benefits.

The Program provides flexibility for you to seek care either with a provider who participates in the Delta Dental PPO or Delta Dental Premier Network or with a dentist that does not participate with Delta. Delta's network is in every state, Puerto Rico and St. Croix. For a directory of local dentists, please access Delta Dental's 'Find a Dentist' online directory at www.deltadentalins.com.

Services performed by PPO participating dentists are paid by Delta on the basis of the PPO Allowed Amount, as set forth in the Delta Dental Summary of Benefits. PPO participating dentists have agreed to accept the PPO Allowed Amount as payment in full for covered services.

Delta calculates its share of the PPO Allowed Amount and sends its share to the PPO participating dentist. Delta advises you of any charges for which you are responsible. This is generally your share of the PPO Allowed Amount – i.e., copayments, deductibles, charges where maximums have been exceeded. Services performed by Delta Dental Premier participating dentists are paid by Delta on the basis of the Premier Allowed Amount, as set forth in the Dental Coverage Schedule of Benefits in this SPD. Premier participating dentists have agreed to accept the Premier Allowed Amount as payment in full for covered services.

Delta calculates its share of the Premier Allowed Amount and sends its share to the participating dentist.

Delta advises you of any charges for which you are responsible. This is generally your share of the Premier Allowed Amount—i.e., copayments, deductibles, charges where maximums have been exceeded—and services not covered.

Payment for services performed for you by nonparticipating dentists is also calculated by Delta on a Premier Allowed Amount basis, but Delta pays its share to you. You are responsible for payment of the non- participating dentist's total fee, which may include amounts in addition to the Premier Allowed Amount and services not covered by the Plan.

Your total out-of-pocket payment is least if you visit a Delta Dental PPO participating dentist, is more if you visit a Delta Dental Premier participating dentist, and likely will be highest if you visit a non- participating dentist.

An overview of your dental benefits, including deductibles and maximum benefit amounts, is provided in the Dental Coverage Schedule of Benefits.

Deductible

There is no deductible if you visit a Delta Dental PPO or Premier participating dentist. If you visit a non- participating dentist you may have to meet a deductible as set forth in the Dental Coverage Schedule Summary of Benefits.

Pre-determination of Benefits

Pre-determination allows you and your dentist the opportunity to know in advance what the total coverage will be for any service that may be in question. Delta Dental recommends pre-determination if total charges are expected to exceed $300.

Your dentist should submit the claim form before performing services. Delta Dental will act promptly in returning the predetermination to your dentist indicating patient eligibility, the services that are covered, how much of the proposed charges will be paid by Delta, and how much is your responsibility.

Once the service is completed, the voucher with service dates should be submitted to Delta for prompt payment.

Covered Dental Services

DIAGNOSTIC

Diagnostic coverage provides, when necessary and customary as determined by the standards of generally accepted dental practice, procedures to assist the dentist in evaluating the existing conditions to determine the required dental treatment. Diagnostic services include visits, exams, diagnoses, and x-rays.

PREVENTIVE

Preventive coverage provides, when necessary and customary as determined by the standards of generally accepted dental practice, procedures to prevent the occurrence of all disease. These services include:

- Prophylaxis-cleaning twice per calendar year, three times per calendar year for pregnant women.
- Topical application of fluoride solutions for children under age 19, once per calendar year.
- Space maintainers when used to maintain existing space for children under age 19.
- Sealants for children up to age 14, covered once in a 36-month period on unfilled permanent first and second molars.

BASIC RESTORATIVE

Basic coverage provides, when necessary and customary as determined by the standards of generally accepted dental practice, amalgam (silver), gold, composite (white) fillings, synthetic porcelain and plastic restorations for treatment of carious lesions.

SURGICAL PERIODONTICS

Surgical periodontics coverage provides for surgical treatment of disease of the gums and supporting structures of the teeth.

GENERAL ANESTHESIA

General anesthesia coverage provides for general anesthesia when administered by a dentist for a covered oral surgery procedure.

ORAL SURGERY

Oral surgery coverage provides for extraction and other oral surgery including pre-and post-operative care.

ENDODONTICS

Endodontics coverage provides for pulpal therapy and root canal filing.

NON-SURGICAL PERIODONTICS

Non-surgical periodontics coverage provides for non-surgical treatment of disease of the gums and supporting structures of the teeth.

PROSTHODONTICS

Prosthodontics coverage provides for materials and procedures for construction of bridges, and partial and complete dentures.

SINGLE CROWNS

Coverage for crowns provides, when necessary and customary as determined by the standards of generally accepted dental practice, single crowns, inlays, gold or cast restorations when teeth cannot be restored with amalgam, synthetic porcelain or plastic restorations.

ORTHODONTICS

Coverage provides materials, devices and procedures for the correction of mal-positioned teeth for children and adults.

Not Covered

- Treatment or supplies that are provided to a subscriber by any federal or state government agency, except Medicaid, or by any municipality, county or other political subdivision.
- Charges for which benefits are provided to subscriber by any hospital, medical or dental service corporation, any group insurance, franchise or other prepayment program for which an employer, union trust or association makes contributions or payroll deductions.
- Treatment or supplies with respect to congenital malformations, except that this limitation shall not apply to congenital anomalies of a Covered Dependent or affect children otherwise eligible as newborn children.
- Treatment of devices that increase the vertical dimension of an occlusion, restore an occlusion to normal, replace tooth structure lost by attrition or erosion, or otherwise.
- Treatment or supplies for cosmetic purposes.
- Treatment or supplies for which the covered employee or dependent would have no legal obligation to pay in the absence of this or any other similar coverage.
- Services provided, supplies furnished or devices started prior to the effective eligibility date of a covered employee or dependent.
- Preventive plaque control programs, including oral hygiene programs.
- Periodontal splinting, equilibration and gnatholigical recordings.
- Myofunctional therapy.
- General anesthesia, except when administered by a dentist for a covered oral surgery.
- Experimental procedures which have not been accepted by the American Dental Association.

Benefit Limitations

LIMITATION ON OPTIONAL TREATMENT PLAN

In all cases in which there are optional plans of treatment carrying different treatment costs, payment will be made only for the applicable percentage of the least costly course of treatment, so long as such treatment will restore the oral condition in a professionally accepted manner, with the balance of the treatment cost remaining the responsibility of the employee.

LIMITATION ON INLAYS, CROWNS AND JACKET

If a tooth can be restored with amalgam, synthetic porcelain or plastic, but the employee and the dentist select another type of restoration, the obligation of Delta shall be only to pay the applicable percentage of the fee appropriate to the least costly restorative procedure. The balance of the treatment shall be considered a dental treatment excluded from coverage of the dental care program provided by the Plan. Replacement of crowns, jackets, inlays and onlays shall be provided no more often than once in any five-year period and then only in the event that the existing crown, jacket, inlay or onlay is not satisfactory and cannot be made satisfactory. The five-year period shall be measured from the date on which the restoration was last supplied, whether paid for under the provisions of the Plan, under any prior dental care contract, or by the employee.

LIMITATION ON DIAGNOSTIC AIDS

Full mouth X-rays and panorex X-rays accompanied by bitewing X-rays are limited to once in any 3 year period. Bitewing X-rays are limited to twice in any calendar year. Periodic examinations of the full mouth are limited to twice in any calendar year.

LIMITATION ON PROPHYLAXIS AND FLUORIDE

Prophylaxis and fluoride application may be performed either together or separately. Prophylaxis is limited to two in any calendar year period, three times if pregnant. Fluoride applications as a benefit are limited to once per calendar year period for dependent children up to age 19.

LIMITATION ON PROSTHODONTIC BENEFITS

Replacement of an existing denture will be completed only if it is unsatisfactory and cannot be made satisfactory. Services which are necessary to make such appliances fit will be provided. Prosthodontic appliances and abutment crowns will be replaced only after five years have elapsed following any prior provision of such appliances and abutment crowns whether paid for under the provisions of the Plan, under any prior dental care contract, or by the employee. The initial installation of fixed bridgework or removable partial or full dentures, including inlays and crowns to form abutments is limited to the replacement of one or more natural teeth extracted after the Effective Date of the employee's coverage under the Plan, or during the period of dental coverage under the Group Health and Dental Program.

LIMITATION ON ORTHODONTIC BENEFIT

Orthodontic benefits are limited to devices and procedures for the correction of mal-positioned teeth of dependent children up to age 19, through the completion of the procedures or to the date eligibility terminates, whichever occurs first. The obligation of Delta to make monthly or other periodic payments for orthodontic treatment will cease upon termination of treatment for any

reason, prior to completion of the procedure. Delta will not make any payment for repair or replacement of Orthodontic appliances.

Limitation on Sealants

Sealants are limited to dependents up to age 14 and are only covered once in any 36-month period on unfilled permanent first and second molars.

Limitation on Space Maintainers

Space maintainers are limited to dependents up to age 19.

Offset for Workers' compensation

Services or supplies for injuries or conditions which are compensable under Workers' Compensation or Employers' Liability laws (including the Jones Act) shall be an offset against amounts payable under this Plan. The offset shall be credited against the obligation of Delta and employee in the percentages set forth in the Dental Coverage Schedule of Benefits.

Making a Claim for Benefits

Delta Dental PPO/Delta Dental Premier Providers

Delta Dental participating PPO and Premier Providers are paid directly by Delta Dental for your Covered Dental Services. Delta's participating dentists agree to accept Delta's Maximum Plan Allowance or the dentist's actual fee—whichever is less—as payment in full. You are responsible for paying any applicable copayments, deductibles or amounts that exceed the annual maximum to a participating dentist at the time of service, or upon receipt of a bill from the participating provider. Participating dentists will submit claim forms to Delta Dental for you. It may be helpful to provide a claim form to the participating dentist at the time of your visit so that the participating dentist has the appropriate address to submit your claim. You can obtain a claim form from the Benefits Center.

Non-Participating Provider

When you receive Covered Dental Services from a dentist who is not a participating Delta Dental provider, you are responsible for paying the non-participating dentist's actual fee and then requesting reimbursement from Delta. Before your appointment, you can obtain a claim form from the Benefits Center and present it to the dentist at the time of the visit. The following information must be provided to Delta Dental when requesting payment of benefits for Covered Dental Services:

- Employee's name and address.
- The patient's name, age and relationship to the Employee.
- The subscriber number stated on your ID card.
- A claim form or an itemized bill from your provider that includes the following:
  - Patient Diagnosis
  - Date(s) of service
  - Procedure code(s) and description of service(s) rendered
  - Charge for each service rendered
  - Name, Address, License Number, and Tax Identification Number of the Provider

You must submit your request for payment of benefits within one year after the date of service.

Claims & Appeals

Claim Denials

If your post-service claim is denied in whole or in part, Delta will notify you and the attending dentist of the denial in writing within 30 days after the claim is filed, unless special circumstances require an extension of time, not exceeding 15 days, for processing. If there is an extension, you and the attending dentist will be notified of the extension and the reason for the extension within the original 30 day period. If an extension is necessary because either you or the attending dentist did not submit the information necessary to decide the claim, the notice of extension will specifically describe the required information. You or the attending dentist will be afforded at least 45 days from receipt of the notice within which to provide the requested information. The extension period (15 days)—within which a decision must be made by Delta—will begin to run from the date on which your response is received by Delta (without regard to whether all of the requested information is provided) or, if earlier, the end of the 45-day period within which you were required to furnish the requested information. The notice of denial will explain the specific reason or reasons why the claim was denied (in whole or in part), including a specific reference to the pertinent Plan provisions on which the denial is based, a description of any additional material or information necessary to perfect the claim and an explanation as to why such information is necessary. The notice of denial will also contain an explanation of Delta's claim review and appeal process and the time limits applicable to such process, including a statement of your right to bring a civil action under ERISA upon completion of Delta's second level of review. The notice will refer to any internal rule, guideline or protocol that was relied upon (and state that a copy will be provided free of charge upon request). The notice will also state that if the claim denial is based on lack of dental necessity, experimental treatment or a clinical judgment in applying the terms of the Plan, an explanation is available free of charge upon request.

FIRST LEVEL APPEALS

If you (or the attending dentist) want the denial of benefits reviewed, then you (or the attending dentist) must write to Delta within 180 days of the date of the denial letter. In the letter requesting a review of the claim denial, you (or the attending dentist) should state why the claim should not have been denied. You should also provide any other documents, data, information or comments that you believe are relevant to the review, including a copy of the denial notice. You (or the attending dentist) are entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the denied claim.

The review will take into account all comments, documents, records, or other information, regardless of whether such information was submitted or considered in the initial benefit determination. The review will be conducted on behalf of Delta by a person who is neither the individual who denied the claim that is the subject of the review, nor the subordinate of such individual. If the claim denial was based in whole or in part on a clinical judgment in applying the terms of the Plan, Delta will consult with a dentist who has appropriate training and experience in the pertinent field of dentistry and who is neither the Delta dental consultant who made the claim denial nor the subordinate of such consultant. The identity of the Delta dental consultant whose advice was obtained in connection with the denial of the claim (whether or not the advice was relied upon in making the benefit determination) is also available to you or the attending dentist upon request. In conducting the review, Delta will not afford deference to the initial adverse benefit determination. If, after review, Delta affirms its initial denial of the claim, Delta will notify you (and the attending dentist, if an in-network provider) in writing of the decision within 30 days of the date the request is received. Delta will send you (and the attending dentist, if an in-network provider) a notice setting forth the specific reason or reasons for the adverse determination and referencing the specific Plan provisions on which the benefit determination is based. The notice will state that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the claim for benefits. The notice will refer to any internal rule, guideline or protocol that was relied upon (and state that a copy will be provided free of charge upon request). The notice will also state that if the claim denial is based on lack of dental necessity, experimental treatment or a clinical judgment in applying the terms of the Plan, an explanation is available free of charge upon request. In addition, the notice will state that you have a right to bring a civil action under ERISA upon completion of Delta's second level of review.

Second Level Appeals

If you (or the attending dentist) wish to file a second level appeal of a denied claim, you may do so by advising Delta not later than 180 days after your receipt of Delta's denial of the claim. The matter will then be referred to Delta's Dental Affairs Committee. This stage can include a clinical examination, if not done previously, and a hearing before Delta's Dental Affairs Committee if requested by you or the attending dentist. The Dental Affairs Committee will render a decision within 30 days of the request for further consideration. The decision of the Dental Affairs Committee shall be final and binding on all persons. Delta will send you a notice that includes the same information referenced above under "First Level Appeals."

Delta does not condition receipt of a benefit, in whole or in part, on approval of the benefit in advance of obtaining dental care. Additionally, Delta does not conduct concurrent review relating to continued or extended health care services, or additional services for an insured undergoing a course of continued treatment.

No action may be brought under ERISA until you have exhausted the claims and appeals procedures described in this SPD.

The Plan Administrator has delegated to Delta Dental the sole and absolute discretionary authority to interpret and administer the provisions of the Plan and to make all decisions relating to claims and appeals. Delta Dental's decisions are final and binding on all parties.

EMPLOYEE ASSISTANCE PROGRAM (EAP)

An Employee Assistance Program ("EAP") is an organized, professional counseling program to help employees resolve personal problems, such as family conflict, drug or alcohol abuse, stress, marital discord, personal finances, and other personal problems, and to provide training, consultation, and other management services relating to the effective utilization of the EAP by an employer and its employees.

The EAP can help you and your Dependents with things like marital and family problems, child and elder care referrals, financial or legal worries, alcohol or drug abuse, retirement issues, separation or divorce, parenting or job related stress.

Eligibility

This service is provided by HealthAdvocate to all Employees and their household members regardless of medical election. Your coverage and coverage of your eligible household members is automatic; you do not need to take any steps to enroll.

Services

To obtain EAP services, simply call toll free 1-877-583-8787. EAP representatives are available 24 hours a day, seven days a week. Spanish- speaking representatives and counselors are also available. You can call as many times as you need assistance. When you call the EAP, an EAP Vendor representative will:

- Ask questions to help identify the problem and how it is affecting you,
- Find out what solutions you have tried and explore other solutions and resources, and
- Help you develop a plan to solve the problem.

If you desire to work on your problem through in-person sessions with an EAP counselor or if it appears that your problem cannot be adequately addressed in a telephone consultation, the EAP Vendor representative will refer you to an EAP counselor or another resource in your community, as appropriate. The EAP provides up to eight (8), in person sessions with a qualified counselor at no cost to you. For problems that require extended treatment, the EAP can assist with referrals to qualified counselors for ongoing treatment. You can also access information, self-help tools, and other resources through HealthAdvocate's website. You can reach this website directly at: www.healthadvocate.com/hess.

For callers with medical benefits that include mental health coverage, HealthAdvocate's staff and network providers strive to assist the member in navigating care so that services are coordinated among benefits. HealthAdvocate's participants may remain in counseling with an in-network provider after the allowable EAP visit limit is exhausted, assuming they follow the guidelines of their health insurance carrier. However, HealthAdvocate is not involved in charging or authorizing participants for services they receive beyond the employer's purchased EAP plan. It is always the member's ultimate responsibility when accessing their medical benefit to ensure that their provider is in their mental health network. While developing a plan of action with participants, HealthAdvocate's counselors help participants identify appropriate and affordable resources. This often includes referrals to local service agencies and other community-based resources if an individual does not have health insurance or cannot afford coinsurance.

Your HealthAdvocate benefit and your family's HealthAdvocate benefit ends upon your termination of employment for any reason, but your HealthAdvocate coverage will automatically be continued, at no cost, for you and your dependents throughout the applicable COBRA period under the Plan.

CIGNA GLOBAL HEALTH BENEFITS

Cigna Global Health Benefits is a program under the Plan that provides insured medical, prescription drug, dental, and vision benefits to certain U.S. expatriates and their dependents. These benefits are insured by Cigna.

As described in the "Eligibility & Enrollment" chapter, U.S. Expatriates working outside the U.S. on long-term assignment are eligible for the following Plan benefits provided to U.S. Active Full-Time Employees: Supplemental and Dependent Life Insurance, Basic Life Insurance, Short-Term Disability, Long-Term Disability Insurance, and Business Travel/Family Accident Insurance Benefits. U.S. Expatriates working outside the U.S. on long-term assignment are not eligible for the Plan's other Plan's optional benefits (e.g., Critical Illness Insurance, Accident Insurance, and Identity Theft Protection). U.S. Expatriates working outside the U.S. on long-term assignment are eligible for an international employee assistance plan.

Unless otherwise specified in this section, all other provisions of this Summary Plan Description apply to Cigna Global Health Benefits.

Eligibility

You are eligible for Cigna Global Health Benefits if you are a regular full-time employee of the Company who is scheduled to work at his or her job at least 30 hours per week, and you are classified as a U.S. Expatriate working outside of the U.S. on long-term assignment.

If you are eligible for Cigna Global Health Benefits, you also may elect coverage for your Dependents. Dependent eligibility is described in the "Eligibility & Enrollment" chapter.

Medical, Prescription Drugs, Dental, and Vision Benefits

Cigna Global Health Benefits are insured by Cigna and include medical benefits, prescription drug benefits, dental benefits, vision benefits, and employee assistance services.

The terms and conditions of Cigna Global Health Benefits, including the description of covered benefits, limitations and exclusions, coordination of benefits, subrogation, claims procedures, and pre-certification, are set forth in greater detail in the Certificate Booklet provided by Cigna.

This Cigna Certificate Booklet is incorporated by reference and made a part of this SPD. This Certificate Booklet is available by contacting Cigna.

LIFE & DISABILITY BENEFITS

LIFE AND ACCIDENT INSURANCE OVERVIEW

Insurance Program	Coverage
Basic Life	2 times annual base pay up to maximum coverage $1.5 million
Business Travel Accident	5 times annual base pay up to maximum coverage $2.5 million
Optional Life – Self	1x – 4x annual base pay up to maximum coverage $1.5 million
Optional Life – Spouse	50% of your coverage up to a maximum coverage $50,000 guaranteed issue, or up to $100,000 with statement of health
Optional Life - Children	14 days to six months old - $5,000 Six months – 26 years old - $20,000
Family Accident – Self	$10,000 units from minimum $10,000 to maximum of $1.0 million or, if less, 10 times annual base pay
Family Accident – Spouse	60% of your coverage
Family Accident – Children	15% of your coverage up to a maximum coverage $50,000 per child

Note that unless otherwise indicated, capitalized terms used in this chapter are defined in the applicable insurance certificates/evidences of coverage.

BASIC LIFE INSURANCE

Eligibility

All Employees, as defined in the Glossary, are eligible for Basic Life Insurance benefits. The Company pays the full cost of Basic Life Insurance Coverage. If you are disabled, the Company will continue paying the premium and your life insurance coverage will remain in force under Continuation of Coverage provisions up to age 65 as long as you are disabled.

Life insurance benefits provided under the Plan are insured by MetLife. The full cost of Basic Life Insurance is paid by the Company. The full amount of your Basic Life Insurance coverage will be paid to your beneficiary if you die while you are covered under the Plan.

The Company provides you with coverage in the amount of two times your annual base pay, rounded to the next higher multiple of $1,000, subject to a maximum coverage of $1,500,000.

You have an option to limit coverage to $50,000 to avoid the IRS imputed income rules that require you to pay tax on the Company's cost of providing coverage exceeding $50,000. If you elect this option and later enroll for 2x annual base pay coverage, you will be required to provide a statement of health to prove evidence of insurability.

BUSINESS TRAVEL ACCIDENT

This benefit is insured by National Union Fire Insurance Company of Pittsburgh, PA, a subsidiary of AIG of New York.

Eligibility

The Company automatically provides Active Full-Time Employees and US expatriates working outside of the U.S. on long-term assignment, with business travel accident insurance coverage that provides financial protection if you die or are seriously injured while traveling on Company business. If you suffer a serious injury, benefits are paid to you. If you die, the benefit is paid to your beneficiaries. Benefits will be paid if you suffer loss of limb or sight, paralysis, or death that occurs within one year (365 days) of the accident.

Benefits

Named Executives, Officers, Vice Presidents

Twenty-four (24) hour coverage for accidents occurring both on and off the job is provided in the amount of 5x your Annual Salary, as defined below, up to a maximum coverage of $2.5 million (minimum $100,000).

Members

Twenty-four hour (24) hour coverage for accidents occurring while traveling on Company business away from the premises of permanent assignment is provided in the amount of 5x your Annual Salary, as defined below, up to a maximum coverage of $2.5 million (minimum $100,000).

A person shall be considered to be traveling on Company business while traveling to and from a regular workplace, provided that the travel is at the expense, direction, and for the purpose of furthering the Company's business.

Annual Salary

Annual Salary includes your base salary or annualized hourly pay.

GUESTS, DIRECTORS, AND CONSULTANTS

The Plan provides 24-hour accident insurance in the amount of $250,000 for guests, directors, and consultants who travel on behalf of the Company and at the Company's expense.

ADDITIONAL BENEFITS

- Coverage is provided to otherwise eligible individuals who are riding as a passenger or pilot (company-approved) in any policyholder owned/leased or chartered aircraft.
- For insured persons assigned outside of their country of permanent residence, coverage applies to public conveyance travel by such individual while on home leave, provided the Company pays for this travel expense.
- In the event of the death of an insured individual who was wearing a seat belt at the time of the accident and who suffered a loss of life, the Plan pays an additional benefit equal to 10 percent of the principal sum benefit up to a maximum of $50,000.
- Spouses and dependent children will be covered in the following amounts when traveling with an insured person on a business or relocation trip authorized and paid for by the Company:
  - Spouse $250,000
  - Dependent Children $25,000.

For purposes of this travel accident benefit, a dependent child is an insured person's unmarried child through the end of the calendar year in which the child attains age twenty-six (26).

AIRCRAFT ACCIDENTS

The Plan pays an aggregate maximum of $40,000,000 on behalf of all covered individuals injured in a single aircraft accident.

Not Covered

The Plan does not pay benefits for injury or death caused by:

- Suicide or any attempt thereat by the insured person while sane or self-destruction or any attempt threat while insane;
- Disease of any kind;
- Hernia of any kind;
- Declared or undeclared wars in the United States or the insured person's country of permanent residence;
- Service in the military, naval, or air service of any country; or
- Any aircraft which requires a special permit or waiver.

Terms and Conditions

You or your beneficiaries may file a claim for benefits by contacting the Benefits Center at 1-877-511-4377.

SUPPLEMENTAL & DEPENDENT LIFE INSURANCE

Supplemental and Dependent Life Insurance Benefits are optional benefits that are not automatically provided to you under the Plan. These are voluntary benefits for which you pay the total premium cost.

Eligibility and Enrollment

If you want the extra life insurance protection this coverage provides, you must enroll and pay the full premium cost. You may enroll online at empyrean.hess.com or by calling the Benefits Center at 1-877-511-4377, option 1.

Coverage Starts

Coverage starts on the date you become eligible if you enroll within 30 days of your eligibility date.

If you enroll late, more than 30 days after the date you first become eligible, coverage will not be available without Evidence of Insurability.

Evidence of Insurability is information about a person's health from which MetLife can determine if coverage or increases in coverage will be effective. Information may include questionnaires, physical exams, or written documentation as required by MetLife. Inquiries as to the status of your submission of Evidence of Insurability should be addressed to MetLife. MetLife will notify you of approval or disapproval in writing.

Evidence of Insurability must be provided at your own expense.

Coverage for which MetLife requires Evidence of Insurability will become effective on the later of:

- The date you become eligible; or
- The date approved by MetLife.

All Effective Dates of coverage are subject to the Deferred Effective Date provision.

Deferred Effective Date Provision for Employees

If you are absent from work due to a physical or mental condition on the date your insurance, an increase in coverage or a new benefit added to the policy would otherwise have become effective,

the Effective Date of your insurance, any increase in insurance or the additional benefit will be deferred until the date you return to work as an Active Full-time Employee.

DEPENDENT LIFE INSURANCE

If you want the extra life insurance protection this coverage provides, you must enroll and pay the full premium cost. You may enroll online at: empyrean.hess.com or by calling the Benefits Center at 1-877-511-4377, option 1.

Your spouse and/or children will become insured for coverage when they are first eligible if you enroll them for coverage within 30 days of their eligibility.

If you enroll late for dependent coverage, more than 30 days after you are first eligible, coverage will not be available without Evidence of Insurability.

Coverage for which MetLife requires Evidence of Insurability is effective the later of:

- The date you become eligible; or
- The date approved by MetLife.

Coverage for which MetLife requires Evidence of Insurability will be effective once approved by MetLife.

Dependent Coverage will not become effective before the date you become insured.

Effective Dates of coverage are subject to the Deferred Effective Date provision for Dependents.

Deferred Effective Date Provision for Dependents

If a Dependent, other than a newborn, is confined at home, in a hospital or elsewhere because of a physical or mental condition on the date insurance, and an increase in coverage or a new benefit added to the Policy would otherwise have become effective, the Effective Date of insurance and any increase or additional benefit will be deferred until the Dependent is discharged from the hospital or no longer confined and has engaged in substantially all the normal activities of a healthy person of the same age for a period of at least 15 days in a row.

“Confined elsewhere” means the individual is unable to perform, unaided, the normal functions of daily living, or leave home or other place of residence without assistance.

Benefits Available for Dependents

For your Dependent Spouse:

- 50% of your coverage

- maximum amount of dependent spouse coverage: $50,000, or $100,000 with statement of health

For your Dependent Children:

- 14 day(s) but less than 6 month(s) of age: $5,000
- 6 month(s) of age or older up to age 26: $20,000

Evidence of Insurability Exceptions

This requirement will be waived for your spouse and/or children, if:

1. You do not elect spousal coverage when first eligible to do so, but, within 30 days following the date you acquire your first child, you elect spousal coverage; or
2. Your spouse and children were previously covered for life benefits provided by your spouse's employer group plan; and
    a. Your spouse and children have ceased to be covered under the employer's group plan due to your spouse's loss of employment or cancellation of that group plan;
    b. Your spouse and children provide MetLife with proof of prior coverage, including the date of termination, when applying for Dependent Coverage; and
    c. Coverage with MetLife is requested within 30 days of your spouse's loss of coverage.

SUPPLEMENTAL LIFE INSURANCE

- A Non-Medical Issue Amount equal to the lesser of 1, 2 or 3 times your Annual Base Pay or
- $500,000 without Evidence of Insurability; or
- A maximum amount equal to 1, 2, 3 or 4 times your Annual Base Pay, subject to a maximum of $1,500,000 with Evidence of Insurability, rounded to the next higher multiple of $1,000, if not already such a multiple.

Your Amount of Life Insurance will be reduced by any life benefit paid to you under an accelerated death benefit.

Suicide Exclusion

No Supplemental Life or Supplemental Dependent Life benefit will be payable if death results from suicide, whether sane or insane, within 2 years of the Effective Date of your coverage. Additionally, if death resulting from suicide, whether sane or insane, occurs within 2 years of the Effective Date of an increase in your coverage, the death benefit payable is limited to the amount

of coverage in force prior to the increase. The 2-year period includes the time coverage was in force under a Prior Plan.

Disability extension of coverage

A Disability extension is a provision that allows you to continue life insurance coverage while you are Disabled. The Disability extension applies only to your Life insurance. The extension is not available for Dependent Life Insurance.

If, for any reason, you are no longer Disabled, and you return to work as an Eligible Employee, all of your coverages will be reinstated subject to the terms of the insurance policies in effect on the reinstatement date.

If you do not return to work within an Eligible Class, and you are not eligible for any other group life insurance, you may convert your coverage.

Disabled

For purposes of your life insurance coverage, Disabled means that you have a condition that prevents you from doing any work for which you are or could become qualified by education, training or experience and have provided proof satisfactory to MetLife.

Making a Claim

A completed claim form, a certified copy of the death certificate and your enrollment form must be sent to the Company or MetLife. When the required claim papers are received and approved by MetLife, the Amount of Life Insurance will be paid.

Your death benefit will be paid in a lump sum to the beneficiary(ies) designated by you in writing and on file with the Company.

Unless you have requested something different, payment will be made as follows:

- If more than one beneficiary is named, each will be paid an equal share.
- If any named beneficiary dies before you, his share will be divided equally among the named surviving beneficiaries.
- If there is no Beneficiary designated or no surviving Beneficiary at your death, MetLife will determine the Beneficiary according to the following order:

  (i) Your Spouse, if alive;

  (ii) Your children, if there is no surviving Spouse;

  (iii) Your parents, if there is no surviving child;

  (iv) Your siblings, if there is no surviving parent; or

(v) Your estate, if there is no surviving sibling.

Any payment made in good faith will discharge MetLife's liability to the extent of such payment.

If a Beneficiary or a payee is a minor or incompetent to receive payment, MetLife will pay that person's guardian.

If there is no guardian, the monies are placed on a "minor deposit account", for which the minor cannot access until they are 18 years old.

If a death benefit payable meets our guidelines, then the benefit is payable into a checking account. Your beneficiary owns the checking account. A lump sum payment may be elected by writing a check for the full amount in the checking account.

Accelerated Benefits Provision

If you are diagnosed as being Terminally Ill and proof of such diagnosis is provided by an attending physician licensed to practice in the United States, and you are:

- less than Normal Retirement Age; and
- insured for at least $10,000, you may request that a portion of your Amount of Life Insurance be paid to you prior to death.

This benefit is not available to you if you have entered into a severance agreement with the Company.

Your request cannot exceed 80% of the in-force Amount of Life Insurance, and is subject to a minimum of $3,000 and a maximum of $500,000. You may exercise this option only once per person.

Example

If you have an Amount of Life Insurance equal to $20,000 and you are Terminally Ill, you can request any portion of the life insurance from $3,000 to $16,000 to be paid to you now instead of to your beneficiary at your death. However, if you decide to request only $3,000 now, you cannot request the additional $13,000 in the future.

Receipt of any benefits in accordance with this provision will reduce Life Insurance benefits payable upon death.

If a person is diagnosed as no longer Terminally Ill, coverage may or may not remain in force. Coverage which remains in force will be reduced by any amount of Accelerated Death Benefits received and premium due for this reduced amount. If coverage does not remain in force, then the reduced amount of coverage may be converted.

The Accelerated Death Benefit provision will be subject to all applicable terms and conditions of the Basic Life and Supplemental Life Insurance Policy.

No Accelerated Death Benefit will be paid if you are required by law to accelerate benefits to meet the claims of creditors, or if a government agency requires you to apply for benefits to qualify for a government benefit or entitlement.

If you have executed an assignment of rights and interest with respect to your Amount of Life Insurance, in order to pay benefits to you under this provision, you must provide MetLife with a release from the individual to whom the assignment was made before any benefits are payable.

Conversion Privilege

If your insurance or any portion thereof, terminates, you may convert your life insurance to a conversion policy without providing Evidence of Insurability.

If the qualifying event is policy termination or termination of coverage for a class, then the individual must have been insured for at least five (5) years under the Policy in order to be eligible for this conversion privilege.

Conversion Policy Type

The conversion policy will:

- Be on one of the life insurance policy forms, except term insurance, then customarily issued by MetLife for conversion purposes;
- Contain no disability, supplementary or AD&D benefits; and
- Be effective on the 32nd day after group life insurance terminates.

Conversion Policy Amount

If the qualifying event is policy termination, termination of coverage for a class, or your Employer is no longer a Participant Employer then the amount which may be converted is limited to the lesser of:

> The amount of group coverage in force prior to the qualifying event, reduced by the amount of any other group coverage for which the individual becomes covered within 31 days of termination of group coverage, or $2,000.

If conversion is due to retirement or any other qualifying event, the full amount of coverage lost may be converted.

Converting Coverage

To convert life insurance, you must, within 31 days of the date group coverage terminates, make written application to MetLife and pay the premium required for age and class of risk.

Death during Election Period

If the individual should die within the 31 day conversion election period, MetLife will, upon receipt of acceptable proof of death, pay the Amount of Life Insurance that the individual was entitled to convert.

Assignment of Life Insurance

You may assign all of your rights to life insurance benefits under the Plan, including, but not limited to, the right to designate and change the beneficiary and the right to exercise any conversion privilege.

No assignment of rights and interest shall be binding on MetLife until its home office acknowledges receipt of an original of the form documenting the assignment or a true copy of such form.

Designating or Changing Beneficiaries

Any designation or change in a beneficiary can be made online at empyrean.hess.com or by calling the Benefits Center at 1-877-511-4377, option 1. MetLife will recognize only those beneficiaries who are filed with the Company prior to your death.

Designations will become effective as of the date you make the election, even if you have since died. MetLife is not liable for any amounts paid before receiving notice of a beneficiary change from the Company. In no event may a beneficiary be changed by a Power of Attorney.

Termination of Coverage

Unless continued in accordance with the Exceptions to Termination section, your insurance will terminate on the earliest of:

- Date the Policy terminates;
- Last day of the period for which you made any required premium contribution, if you fail to make any further required contribution;
- Date on which you are no longer in a class eligible for coverage;
- Date the Company terminates your employment; or
- Date you are absent from work as an Active Fulltime Employee.

Waiver of Premium

Waiver of premium is a provision that allows for continued employee or Dependent life insurance, without payment of premium, while you are disabled. If you are disabled, your premium is waived and your life insurance coverage will remain in force under Waiver of Premium provisions up to age 65 as long as you are disabled. These provisions apply only to your Supplemental Life Insurance. Waiver of Premium does not apply to Dependent life insurance.

Waiver of Premium Requirements

You must be less than age 60, insured and Disabled; and you must furnish acceptable proof of your condition to MetLife within one year of your last day of work as an Active Full-time Employee.

For purposes of life insurance benefits under this Plan, "Disabled" means that you have a condition that prevents you from doing any work for which you are or could become qualified by education, training or experience and it is expected that this condition will last for at least six consecutive months from your last day of work as an Active Full-time Employee; or you have been diagnosed with a life expectancy of 6 months or less.

MetLife will waive premium upon its approval of proof that you are Disabled provided by an attending physician licensed to practice in the United States.

Continued coverage will be subject to any age reductions provided by any part of the life insurance policy.

Proof of Disability

During the first two years following the date you qualify as Disabled, MetLife may have you examined at reasonable intervals. Thereafter, MetLife will only require an annual examination to confirm that you continue to be Disabled. If you fail to submit any required proof or refuse to be examined as required, your coverage will terminate.

If, for any reason, you are no longer Disabled, your premium will no longer be waived. On that date, you may or may not return to work.

If you return to work in a position eligible for coverage, your benefits will be reinstated subject to the terms of the life insurance policy in effect on the reinstatement date.

If you do not return to work within an Eligible Class, and you are not eligible for any other group life insurance, then you are entitled to convert your benefits. You may convert the Amount of Life Insurance that is in force for you and your dependents on the date it is determined that you are no longer Disabled.

Duration for Waiver of Premium

Premiums will be waived and your coverage will be continued until you attain age 65.

If you do not return to work on the date the waiver of premium terminates, you are entitled to convert the amount of coverage that is in force on the date waiver of premium terminates.

If the Policy terminates before you qualify for waiver of premium, you may be eligible to convert. Additionally, you may later be approved for waiver of premium.

If the Policy terminates after you qualify for waiver of premium, termination of the Policy will not affect your coverage under the terms of this provision.

Termination of Dependent Coverage

Dependent coverage will terminate on the earliest of:

- Date on which your coverage terminates;
- Last day of the period for which any required premium contribution is made, if you fail to make any further required contribution;
- Date on which you are no longer eligible for dependent coverage;
- Date the dependent no longer meets the definition of dependent; or
- Date MetLife or the Company terminates dependent coverage.

Exceptions to Termination

If a Covered Dependent child reaches the age at which he would otherwise cease to be a Dependent as defined, and the Dependent child is:

- Disabled and incapable of earning his own living; and
- Unmarried and primarily dependent on you for support and maintenance

…then Dependent coverage will not terminate solely due to age if you submit satisfactory proof of the Dependent child's disability to MetLife within 31 days of the date the Dependent child reaches such age.

Coverage will continue while the Policy remains in force as long as:

- The child continues to meet the required conditions; and
- Any required premium is paid.

MetLife has the right to require satisfactory proof that the child continues to meet the required conditions as often as necessary during the first two years of continuation, but not more than once a year after that.

Conversion & Assignment

You have the same rights to convert and/or assign your supplemental benefits as you do your Basic Life Insurance Benefits. Contact the Benefits Center for more information.

The Plan Administrator has delegated to MetLife the sole and absolute discretionary authority to interpret and administer the provisions of the Plan and to make all decisions relating to claims and appeals. MetLife's decisions are final and binding on all persons.

No action may be brought under ERISA until you have exhausted the claims and appeals procedures described in this SPD.

For a complete description of your benefits, please refer to MetLife's Certificate of Insurance. This SPD only shows a high-level overview of your benefits. In the event that the provisions of any benefits booklet or any insurance policy or certificate conflict with the terms of this SPD, the provisions of the certificate control.

Estate Resolution Services

If you enroll for Supplemental Life insurance, will preparation and probate services are available through a network of attorneys in the Hyatt Legal group. Will preparation and probate services are provided at no cost to you if you use the services of a Hyatt Legal attorney. If you prefer to use an attorney not in the Hyatt Legal network, the plan will reimburse you up to a specified maximum amount.

You will have unlimited access to the Hyatt Legal attorneys, a choice of face-to-face or telephone consultations, and a personal resource to help with updates.

For more information about these services, please contact Hyatt Legal at 1-800-821-6400.

FAMILY ACCIDENT INSURANCE

You are required to enroll for family accident insurance benefits and must contribute to the costs. You may enroll online at empyrean.hess.com or by calling the Benefits Center at 1-877-511-4377, option 1.

Family Accident Insurance pays a benefit if you are seriously injured or die as the result of an accident. If you are injured, you receive all or a portion of the benefit, depending on the nature of the injury. If you die, your beneficiary receives the full benefit amount. Benefits will be paid if death, dismemberment, or paralysis occurs within one year (365 days) of the accident.

Injury means bodily injury: (1) which is sustained as a direct result of an unintended, unanticipated accident that is external to the body and that occurs while the injured person's

coverage under this policy is in force and (2) which directly (independent of sickness, disease, mental incapacity, bodily infirmity or any other cause) causes a covered loss.

This Plan is insured and administered by National Union Fire Insurance Company of Pittsburgh, PA, a subsidiary of AIG of New York.

Eligibility

You are eligible to enroll in the Family Accident Insurance Plan if you are an Active Full-Time Employee or a U.S. Expatriate working outside of the U.S. on long-term assignment. You may also enroll your dependents in the Family Accident Insurance Plan. You can elect to participate or change your coverage at any time. You do not have to provide Evidence of Insurability.

The term "dependent" means (1) your Spouse your Domestic Partner, or (2) your eligible dependent children. The term "eligible dependent children" means the Insured's unmarried children, including natural children from the moment of birth, step or foster children, children of your same sex or opposite sex Domestic Partner provided the domestic partner is covered under the Plan or adopted children from the moment of placement in the home of the Insured, under age 26 and primarily dependent on the Insured for support and maintenance.

Any Eligible Dependent Children of the Insured covered under the Policy before reaching the age limit specified above, who are incapable of self-sustaining employment by reason of mental or physical incapacity, and who are primarily dependent on the insured for support and maintenance, may continue to be eligible under the Policy beyond that age limit for as long as the Policy is in force, but only if they remain continuously covered under the Policy. National Union Fire Insurance Company of Pittsburgh, PA (the "Company") may request that the Insured submit satisfactory proof of the Eligible Children's incapacity and dependency to the "Company" within 31 days after the Eligible Dependent Children reach the age limit specified above. If the Insured fails to furnish the requested proof, coverage for the Eligible Dependent Children will not be extended past the age limit. If coverage is extended, the "Company" may request that the Insured submit satisfactory proof of the Eligible Dependent Children's continued incapacity and dependency to the Company on an annual basis. If the Insured fails to furnish the requested proof within 31 days of the request, coverage for the Eligible Dependent Children will terminate at the end of that 31-day period.

Coverage Amount

You can elect coverage in multiples of $10,000, up to a maximum of $1,000,000. However, you cannot elect an amount that is more than 10 times your annual salary rounded to the next higher $10,000.

Family coverage amounts are based on your level of coverage:

- If you elect coverage for you and your spouse only, or coverage for you, your spouse and dependent children, your spouse will receive coverage equal to 60% of your coverage amount up to a maximum of $50,000.
- If you elect coverage for you and your dependent children only, each dependent child will be insured for 15% of your elected insurance amount, up to a maximum of $50,000.

Additional Coverage

Seatbelt and Airbag Benefit

An additional 10% of your Principal Sum benefit to a maximum of $50,000 is payable, if you suffer loss of life as a result of a covered accident while wearing your seatbelt.

Day Care Benefit

Upon your death, the least of: (1) the actual cost of care charged by a day care center for that year, (2) 5% of your Principal Sum or (3) $15,000, is payable for up to 4 years for your dependent children under age 13, who must be enrolled in Day Care (dependent children must be enrolled in the program for this benefit to be payable).

Tuition Benefit - Children

Upon your death, the least of: (1) the actual tuition (exclusive of room and board) charged by that institution, (2) 5% of your Principal Sum benefit or (3) $25,000 is payable for up to 4 consecutive years for your dependent children under age 26 enrolled as a Full-time Student in any institution of higher learning (dependent children must be enrolled in the program for this benefit to be payable).

Tuition Benefit - Spouse

Upon your death, the least of: (1) the total tuition (exclusive of room and board) charged by those institutions, (2) an additional 5% of your Principal Sum, or (3) $15,000 is payable for up to 4 years for your spouse who must enroll in any professional or trade school for purposes of securing employment (your spouse must be enrolled in the program).

Common Disaster

If you elect family coverage and your spouse suffers accidental death in the same accident within 365 days of the accident and it is determined to be a covered accident under this policy, your

spouse's benefit will be increased to equal your Principal Sum benefit to a maximum of $1,000,000.

FAMILY INCOME BENEFIT

If you elect family coverage, and you suffer accidental death in a covered accident, a monthly benefit is payable equal to 1% of your Principal Sum. This benefit is payable for up to 12 consecutive months or until the death of the last surviving insured dependent, whichever is earlier. Only one monthly benefit will be payable regardless of the number of insured dependents.

REHABILITATION BENEFIT

If you suffer an accidental dismemberment or paralysis which is payable under this policy, an additional $25,000 will be payable in the event rehabilitative expenses are incurred within 2 years from the date of the accident causing the injury.

COMA BENEFIT

If Injury renders an Insured Person Comatose within 365 days of the date of the accident that caused the Injury, and if the Coma continues for a period of 30 consecutive days, National Union Fire Insurance Company of Pittsburgh, PA (the "Company") will pay a monthly benefit of 1% of the Principal Sum. No benefit is provided for the first 30 days of Coma. The benefit is payable monthly as long as the Insured Person remains Comatose due to that Injury, but ceases on the earliest of: (1) the date the Insured Person ceases to be Comatose due to that Injury; (2) the date the Insured Person dies; or (3) the date the total amount of monthly Coma benefits paid for all Injuries caused by the same accident equals 100% of the Principal Sum. The Company will pay benefits calculated at a rate of $1/30^{th}$ of the monthly benefit for each day for which the Company is liable when the Insured Person is Comatose for less than a full month. Only one benefit is provided for any one month of Coma, regardless of the number of Injuries causing the Coma.

The Company reserves the right, at the end of the first 30 consecutive days of Coma and as often as it may reasonably require thereafter, to determine, on the basis of all the facts and circumstances, that the Insured Person is Comatose, including, but not limited to, requiring an independent medical examination provided at the expense of the Company.

PARALYSIS BENEFIT

If injury to an Insured Person results in any one of the types of paralysis specified below, a benefit is paid as a percentage of the Principal Sum shown for that type of paralysis:

Type of Paralysis	Percentage of Principal Sum
Quadriplegia	100%
Paraplegia	75%
Hemiplegia	75%

Quadriplegia is the complete and irreversible paralysis of both upper and both lower limbs.

Paraplegia is the complete and irreversible paralysis of both lower limbs.

Hemiplegia is the complete and irreversible paralysis of the upper and lower limbs of the same side of the body.

Limb means entire arm or entire leg. If the Insured Person suffers more than one type of paralysis as a result of the same accident, only one benefit amount, the largest, will be paid.

Cost of Coverage

Your monthly cost for Family Accident Insurance is based on the level of coverage you elect and the amount of insurance elected, as shown in the following table.

Monthly Cost of Coverage (Per $10,000 of Coverage)

Coverage Level	Premium
For You	$0.14
For You and Your Spouse	$0.20
For You and Children	$0.18
For You, Your Spouse and Your Children	$0.22

Benefit Reduction at Age 70

If you are an active employee and you reach age 70, your benefit amount is reduced as shown in the chart below.

Age	Benefit Reduced to:
70— 74	65% coverage

75— 79	45% coverage
80— 84	30% coverage
85 and over	15% coverage

Schedule of Benefits

Family Accident Insurance will pay benefits for a covered loss per the following schedule.

Covered Loss	For you	Your spouse*	Each child**
Life	100% of your covered amount	60% of your covered amount	15% of your covered amount, up to a maximum of $50,000.
Both hands or both feet or sight of both eyes; or one hand and one foot; or one hand or foot and sight of one eye; or speech and hearing in both ears; or quadriplegia	100% of your covered amount	100% of your spouse's Loss of Life covered amount	100% of your child's Loss of Life covered amount, subject to a maximum of $50,000
Paraplegia or Hemiplegia	75% of your covered amount	75% of your spouse's Loss of Life covered amount	75% of your child's Loss of Life covered amount, subject to a maximum of $37,500
One hand or foot, or speech or hearing in both ears; or sight of one eye	50% of your covered amount	50% of your spouse's Loss of Life covered amount	50% of your child's Loss of Life covered amount, subject to a maximum of $25,000.
Hearing in one ear or thumb and index finger of same hand	25% of your covered amount	25% of your spouse's Loss of Life covered amount	25% of your child's Loss of Life covered amount, subject to a maximum of $12,500

* The most paid for any combination of losses from any one accident per individual is the AD&D benefit. (No higher than 100% of coverage).

** The most paid for any combination of losses from any one accident is the AD&D benefit. (No higher than 100% of coverage).

No Coverage

No coverage shall be provided under this policy and no payment shall be made for any loss resulting in whole or in part from, or contributed to by, or as a natural and probable consequence of any of the following excluded risks even if the proximate or participating cause of the loss is an accidental bodily injury.

1. Sickness, disease, mental incapacity or bodily infirmity whether the loss results directly or indirectly from any of these.
2. Infections of any kind regardless of how contracted, except bacterial infections that are directly caused by botulism, ptomaine poisoning or an accidental cut or wound independent and in the absence of any underlying sickness, disease or condition including but not limited to diabetes.
3. Suicide or any attempt at suicide or intentionally self-inflicted injury or any attempt at intentionally self-inflicted injury or auto-eroticism.
4. Travel or flight in or on (including getting in or out of, or on or off of) any vehicle used for aerial navigation, if the insured person is:
    a. Riding as a passenger in any aircraft not intended or licensed for the transportation of passengers; or
    b. Performing, learning to perform, or instructing others to perform as a pilot of crew member of any aircraft.
5. Declared or undeclared war, or any act of declared or undeclared war.
6. Full-time active duty in the armed forces, National Guard or organized reserve corps of any country or international authority. (Unearned premium for any period for which the insured person is not covered due to his or her active duty status will be refunded). (Loss caused while on short-term National Guard or reserve duty for regularly scheduled training purposes is not excluded).

Making a Claim

You or your beneficiaries may file a claim for benefits by contacting the Benefits Center at 1-877-511-4377, option 1.

Conversion Privilege

If you are no longer eligible and coverage ends before you attain age 70, you may convert your policy to an individual accidental death and dismemberment policy within 31 days after coverage ends, without Evidence of Insurability. An Insured Dependent may convert only if he or she is the age of majority or over on the date coverage ends.

The initial premium for the individual policy will be based on the Insured Person's attained age, risk class, and amount of insurance provided at the time of application for the individual policy. Coverage under the individual policy may not be less than $100,000 and may not exceed the greater of: (1) the amount for the time the Insured Person was covered under the policy; or (2) $500,000.

SHORT-TERM DISABILITY BENEFITS

All Employees are automatically provided salary continuation benefits if disabled and unable to work for a period up to six (6) months. This six-month period satisfies the elimination period for long-term disability insurance benefits.

If you are disabled and unable to work at your regular job, the Company will continue your base salary at 100% for the first three months (13 weeks). If you remain disabled at the end of three months, the Company will continue your base salary at 60% for the next three months (13 weeks). If you continue to be disabled after six months (26 weeks), you are eligible to apply for long-term disability insurance benefits.

Short-term Disability leaves of absence are administered through Matrix, the Company's leave of absence administrator. Matrix is a sister company to Reliance Standard, the insurer for Long-term Disability.

As noted in the General Information section of this SPD, short-term disability benefits are not subject to ERISA.

LONG-TERM DISABILITY INSURANCE

To help safeguard yourself, your family and your savings in the event of a Disability, as described below, the Company provides a long-term disability benefit ("LTD Benefit Program"), insured by Reliance Standard. Note that unless otherwise indicated, capitalized terms used in this chapter are defined in the applicable insurance certificates/evidences of coverage.

Employment Status

Your employment status with the Company is classified as unpaid medical leave upon commencement of LTD benefits. Your employment status with the Company is classified as terminated when both of these conditions are met:

1. The LTD insurance carrier and administrator determine that you will not return to work at any gainful occupation; and
2. You have applied for and received Social Security Disability Benefits for 24 months and are enrolled in Medicare.

Eligible Employees will be automatically enrolled in the LTD Benefit Program. The Company's cost of providing this coverage to you is considered imputed income under IRS rules. You will pay tax on this imputed income that is added to your gross earnings each pay period, taxed accordingly as income, and then backed out of your gross pay once the tax is taken.

Disability

Disability or Disabled means that during the Elimination Period and for the next 24 months you are prevented by:

- Accidental bodily injury;
- Sickness;
- Mental Illness;
- Substance Abuse; or
- Pregnancy

from performing one or more Essential Duties of your Occupation, and as a result, your Current Monthly Earnings are no more than 80% of your Indexed Pre-disability Earnings. After that, you must be so prevented from performing one or more of the Essential Duties of Any Occupation and unable to earn more than 60% of your Indexed Pre-disability Earnings.

Your failure to pass a physical examination required to maintain a license to perform the duties of your Occupation does not alone mean that you are Disabled.

Benefits Reliance Standard provides benefits under this program.

The LTD Benefit Program will be an automatic benefit for Eligible Employees, which means premiums are paid by the Company. The LTD Benefit Program benefit is 60% of your Pre-disability Earnings with a monthly maximum benefit of $12,000.

Employees earning more than $240,000 annual base salary are capped at the maximum benefit amount of $12,000 per month.

$240,000 x 60% = $144,000 when divided by 12 = $12,000 per month

Enrollment

Employees are not required to enroll for this benefit program. The Company automatically enrolls all eligible employees.

Start of Coverage

Coverage for the LTD Benefit Program starts on the date you become an Eligible Employee.

If, however, you are absent from work on the date coverage is to start due to a "disabling condition," your coverage will not become effective until you are Actively at Work for one full day. "Disabling conditions" include:

- Accidental bodily injury;
- Sickness;

- Pregnancy;
- Mental Illness;
- Substance Abuse.

Benefits Payable

You will be paid a monthly benefit if:

- You become Disabled while insured under this Plan;
- You are Disabled throughout the Elimination Period (6 months);
- You remain Disabled beyond the Elimination Period;
- You are, and have been during the Elimination Period, under the Appropriate Care and Treatment of a Physician; and
- You submit Proof of Loss satisfactory to Reliance Standard.

Note: Benefits accrue as of the first day after the Elimination Period and are paid monthly.

Termination of Benefits

Benefit payments will terminate on the first to occur of the following:

- The date you are no longer Disabled;
- The date you fail to furnish Proof of Loss, when requested by Reliance Standard;
- The date you are no longer under the Appropriate Care and Treatment of a Physician, or refuse Reliance Standard's request that you submit to an examination by a Physician;
- The date your Current Monthly Earnings exceed:
  - 80% of your Indexed Pre-disability Earnings if you are receiving benefits for being Disabled from your Occupation;
  - An amount that is equal to 60% of your Indexed Pre-disability Earnings if you are receiving benefits for being Disabled from Any Occupation;
- The date determined from the Maximum Duration of Benefits Table, set forth below;
- The date no further benefits are payable under any provision in this Plan that limits benefit duration; or
- The date you refuse to participate in a Rehabilitation program, or refuse to cooperate with or try:
  - Modifications made to the work site or job process to accommodate your identified medical limitations to enable you to perform the Essential Duties of your Occupation;
  - Adaptive equipment or devices designed to accommodate your identified medical limitations to enable you to perform the Essential Duties of your Occupation;
  - Modifications made to the work site or job process to accommodate your identified medical limitations to enable you to perform the Essential Duties of Any Occupation,

if you were receiving benefits for being disabled from Any Occupation, provided a qualified Physician agrees that such modifications, Rehabilitation program or adaptive equipment accommodate your medical limitation; or

- The date you refuse to receive recommended treatment that is generally acknowledged by physicians to cure, correct or limit the disabling conditions.

Maximum Duration of Benefits

Age on Date of Disability	Maximum Benefit Period in Months
Before 63	To Normal Retirement Age or 48 months if greater
63	To Normal Retirement Age or 42 months if greater
64	36
65	30
66	27
67	24
68	21
69 Plus	18

Normal Retirement Age

Normal Retirement Age is the Social Security Normal Retirement Age as stated in the 1983 revision of the United States Social Security Act. It is determined by your date of birth, as set forth in the chart. If you were born on January 1, your normal retirement age is for the previous year.

Year of Birth	Normal Retirement Age
1937 or before	65
1938	65 and 2 months
1939	65 and 4 months

1940	65 and 6 months
1941	65 and 8 months
1942	65 and 10 months
1943 – 1954	66
1955	66 and 2 months
1956	66 and 4 months
1957	66 and 6 months
1958	66 and 8 months
1959	66 and 10 months
1960 and later	67

Benefit Limits for Mental Nervous and Substance Abuse

If you are disabled due to:

- Mental Illness that results from any cause;
- Any condition that may result from Mental Illness;
- Alcoholism; or
- Non-medical use of narcotics, sedatives, stimulants, hallucinogens, or any other such substance, then, subject to all other LTD Benefit Program provisions

Benefits will be payable:

- Only for so long as you are confined in a hospital or other place licensed to provide medical care for the disabling condition; or
- When you are not so confined, a total of 24 months for all such Disabilities during your lifetime.

Return to Work and Subsequent Disability

Attempts to return to work as an Active Full-Time Employee during the Elimination Period will not interrupt the Elimination Period provided no more than 30 such return-days are taken.

Any day that you were Actively at Work will not count towards the Elimination Period.

If, after the Elimination Period, you return to work as an Active Full-Time Employee, but then suffer another occurrence of Disability, and such Disability is:

- Due to the same cause; or
- Due to a related cause; and
- Within 180 days of your return to work,

the Period of Disability prior to your return to work and the recurrent Disability will be considered one Period of Disability, provided the LTD Benefit Program remains in force.

If you return to work as an Active Full-time Employee for 180 days or more, any recurrence of a Disability will be treated as a new Disability.

A new Disability is subject to a new Elimination Period and a new Maximum Duration of Benefits, as described above.

Rehabilitation Incentives

Under certain conditions, you can work while you are disabled.

If you remain Disabled after the Elimination Period but work while you are Disabled, MetLife offers rehabilitation incentives.

If you participate in an approved rehabilitation program, your monthly benefit will be increased by 10%. This increase will be applied before the monthly benefit is reduced by any other income.

If you return to work while Disabled and are receiving monthly benefits, your monthly benefit will be adjusted as follows:

- Your monthly benefit will be increased by your rehabilitation program incentive, if any; and
- Reduced by any other income benefits

The sum of your monthly benefit, income from working, and other income benefits you receive cannot exceed 100% of your pre-disability earnings.

If your combined Monthly Benefit from all sources is greater than your pre-disability earnings, your Monthly Benefit will be reduced by the amount of the excess. In addition, the minimum monthly benefit of $100 will not apply.

After the first 12 months following your elimination period, your monthly benefit will be reduced by 50% of the amount you earn from working while Disabled.

Other Income Benefits

We will reduce your Disability benefit by the amount of all Other Income. Other Income includes the following:

1. any disability or retirement benefits which you, your Spouse or children receive because of your disability or retirement under:
   a. Federal Social Security Act;
   b. Railroad Retirement Act;
   c. any state or public employee retirement or disability plan; or
   d. any pension or disability plan of any other nation or political subdivision thereof.
2. any income received for disability or retirement under the Policyholder's Retirement Plan, to the extent that it can be attributed to the Policyholder's contributions.
3. any income received for disability under a group insurance policy to which the Policyholder has made a contribution such as:
   a. benefits for loss of time from work due to disability;
   b. Installment payments for permanent total disability;
   c. a no-fault auto law for loss of income, excluding supplemental disability benefits;
   d. a government compulsory benefit plan or program which provides payment for loss of time from your job due to your disability whether such payment is made directly by the plan or program, or through a third party;
   e. a self-funded plan or other arrangement if the Policyholder contributes toward it or makes payroll deductions for it;
   f. any sick pay, vacation pay or other salary continuation that the Policyholder pays to you;
   g. workers' compensation or a similar law which provides periodic benefits;
   h. occupational disease laws;
   i. laws providing for maritime maintenance and cure; or
   j. unemployment insurance law or program.
4. any income that you receive from working while Disabled to the extent that such income reduces the amount of your Monthly Benefit as described in Rehabilitation Incentives. This includes but is not limited to salary, commissions, overtime pay, bonus or other extra pay arrangements from any source.

Other Income Benefits will not include the portion, if any, of such retirement benefit that was funded by your after-tax contributions or Retirement benefits under:

- The Unites States Social Security Act or alternative plan offered by a state or municipal government;

- The Railroad Retirement Act;
- The Canada Pension Plan, the Canada Old Age Security Act; the Quebec Pension Plan or any provincial pension or disability plan; or
- Similar plan or act that you, your Spouse and children receive because of your retirement unless you were receiving them prior to being Disabled.

The amount of any increase in Other Income Benefits will not be included as Other Income Benefits if such increase:

- Takes effect after the date benefits become payable pursuant to this LTD Benefit Program; and
- Is a general increase applicable to all persons entitled to such benefit.

For purposes of this LTD Benefit Program, a Retirement Plan includes defined benefit or defined contribution plan that provides benefits for your retirement and which is not funded wholly by your contributions (excluding a profit sharing plan, a thrift, savings or stock ownership plan, a non-qualified deferred compensation plan); or an individual retirement account, a tax sheltered annuity, Keogh Plan, 401(k) plan or 403(b) plan.

Benefit Calculation for Partial Month

If a benefit is owed you for a period of less than one month, Reliance Standard will pay 1/30 of the Monthly Benefit for each day you were Disabled.

Survivor Income Benefits

If you die while receiving LTD benefits, a survivor benefit will be payable to:

- Your surviving "Spouse," as described below;
- Your surviving Children, in equal shares, if there is no surviving Spouse; or
- Your estate, if there is no surviving Spouse or child.

If a minor Child is entitled to benefits, Reliance Standard, at its option, may make benefit payments to the person caring for and supporting the Child until a legal guardian is appointed.

The survivor benefit payable under the Plan is a one-time payment of an amount equal to 3 times the lesser of:

- the Monthly Benefit you receive for the calendar month immediately preceding your death; or
- the Monthly Benefit you were entitled to receive for the month you die, if you die during the first month that Disability benefits are payable.

For purposes of the survivor benefit:

- "Spouse" shall mean your Spouse or Domestic Partner who: (i) is mentally competent; and (ii) was not legally separated from you at the time of your death.
- "Child" shall mean your son or daughter, or the son or daughter of your Domestic Partner under age 23 who is dependent on you for financial support.

Pre-existing Condition

Pre-existing Condition means a Sickness or accidental injury for which you:

- received medical treatment, consultation, care, or services;
- took prescribed medication or had medications prescribed; or
- had symptoms or conditions that would cause a reasonably prudent person to seek diagnosis, care or treatment;

in the 3-month period before your effective date.

Reliance Standard will not pay benefits for a Disability that results from a Pre-existing Condition, until you have been insured for 12 consecutive months after the date your Disability insurance takes effect.

In determining whether a Disability is due to a Pre-existing Condition, if within 60 days of the date your insurance takes effect you were covered under another plan providing group disability coverage, Reliance Standard will credit you for any time you were covered under such plan.

Not Covered

No benefit shall be paid for any Disability:

- Unless you are under the Appropriate Care and Treatment of a Physician;
- That is caused or contributed to by war or act of war (declared or not);
- Caused by your commission of or attempt to commit a felony; or
- Caused or contributed to by an intentionally self-inflicted injury.

If you are receiving or are eligible for benefits for Disability under a prior disability plan that:

- Was sponsored by the Company; and
- Was terminated before the Effective Date of this LTD Benefit Program

no benefits will be payable for the Disability under this Benefit Program.

You will be considered to be under the Appropriate Care and Treatment of a Physician if you are attended by a Physician, who is not related to you:

- With medical training and clinical experience suitable to treat your disabling condition; and

- Whose treatment is:
  - consistent with the diagnosis of the disabling condition;
  - according to guidelines established by medical, research and rehabilitative organizations; and
  - administered as often as needed, to achieve the maximum medical improvement.

Termination of Coverage

Your coverage under the Benefit Program will terminate on the earliest of the following dates:

- the date the Group Policy ends; or
- the date insurance ends for your class; or
- the end of the period for which the last premium has been paid for you; or
- the date you cease to be in an eligible class. You will cease to be in an eligible class on the date you cease Active Work in an eligible class, if you are not disabled on that date; or
- the date your employment ends; or
- the date you retire in accordance with the date your employment ends.

Insurance Continuation

If you are Disabled and you cease to be an Active Full-time Employee, your insurance will be continued:

- During the Elimination Period while you remain Disabled by the same Disability; and
- After the Elimination Period for as long as you are entitled to benefits under the LTD Benefit Program.

Waiver of Premium

No premium will be due for you:

- After the Elimination Period; and
- For as long as benefits are payable.

Benefits Continuation

If you are entitled to benefits while Disabled and the LTD Benefit Program terminates, benefits:

- Will continue so long as you remain Disabled by the same Disability; but
- Will not be provided beyond the date MetLife would have ceased to pay benefits had the insurance remained in force.

Family or Medical Leave

Basic LTD will automatically continue providing coverage during a period of family or medical leave. If you are enrolled in Additional LTD Benefits, such coverage will continue during a period of family or medical leave provided that you pay the cost of such coverage if your period of leave is unpaid.

Making a Claim

You must submit written notice of a claim for LTD benefits to Reliance Standard not later than 30 days after a Disability starts. If you are unable to provide notice within that period, you must provide such notice as soon as possible. Written notice should include: your name, your address, and the LTD Group Insurance Policy number.

Upon receipt of your notice of a claim, Reliance Standard will send you the forms to be used to provide the insurer with Proof of Loss, as described below. Reliance Standard generally sends these forms within 15 days of its receipt of your notice of claim. If you do not receive those forms, you may submit any other written proof which fully describes the nature and extent of your claim.

Proof of Loss

Proof of Loss may include, but is not limited to, the following:

- Documentation of:
  - The date on which your Disability began;
  - The cause of your disability;
  - The prognosis of your disability;
  - Your Earnings or income, including but not limited to copies of your filed and signed federal and state tax returns; and
  - Evidence that you are under the Appropriate Care and Treatment of a Physician of a Physician;
- Any and all medical information, including X-ray films and photocopies of medical records, including histories, physical, mental or diagnostic examinations and treatment notes;
- The names and addresses of all:
  - Physicians and medical practitioners you have seen or consulted;
  - Hospitals or other medical facilities in which you were seen or treated; and
  - Pharmacies which have filled your prescriptions within the past 3 years;
- Your signed authorization for Reliance Standard to obtain and release:
  - Medical, employment and financial information; and

    - Any other information Reliance Standard may reasonably require;
- Your signed statement identifying all Other Income Benefits; and
- Proof that you and your dependents have applied for all Other Income Benefits which are available.

You will not be required to claim any retirement benefits which you may only get on a reduced basis.

All proof submitted must be satisfactory to Reliance Standard.

Providing Proof of Loss

You must send written Proof of Loss within 30 days of the start of the period for which Reliance Standard owes payment. Reliance Standard may require, at reasonable intervals, additional written Proofs of Loss throughout your Disability. If you fail to provide proof by the date on which it is due, it will not affect your claim if:

- It was not possible to give proof within the required time; and
- Proof of Loss is provided as soon as possible.

As reasonably required, Reliance Standard may have you examined to determine if you are Disabled. Any such examination will be paid for by Reliance Standard.

Reliance Standard Payment of Benefits

Reliance Standard will make any benefit payments during your lifetime to you or your legal representative. Any payment made in good faith will discharge Reliance Standard from liability to the extent of such payment.

Upon your death, Reliance Standard will pay any amount that is or becomes due to your designated Beneficiary. If there is no Beneficiary designated or no surviving Beneficiary at your death, Reliance Standard will pay any benefit that is or becomes due, according to the following order:

i. Your Spouse, if alive;
ii. Your children if there is no surviving Spouse; or
iii. Your estate, if there is no such surviving child.

If more than one person is eligible to receive payment, Reliance Standard will divide the benefit amount in equal shares.

Payment to a minor or incompetent will be made to such person's guardian. The term "children" or "child" includes natural and adopted children.

Denial of Benefits

If your claim for benefits is denied in whole or in part, you will be furnished with written notification of the decision, which:

- Gives the specific reason(s) for the denial;
- Makes specific reference to the Policy provisions on which the denial is based;
- Provides a description of any additional information necessary to prepare a claim and an explanation of why it is necessary;
- Provides an explanation of the review procedure and the time limits applicable to such procedures;
- Includes a statement of your right to bring a civil action under section 502(a) of ERISA following an adverse benefit determination on review;
- Discloses any internal rule, guidelines, or protocol relied on in making the adverse determination (or states that such information will be provided free of charge upon request); and
- if the denial is based on a medical necessity or experimental treatment or similar limit, explains the scientific or clinical judgment for the determination (or states that such information will be provided free of charge upon request);
- A discussion of the decision, including an explanation of the basis for disagreeing with or not following:
    - the views of health care professionals treating the claimant and vocational professionals who evaluated the claimant;
    - the views of medical or vocational experts obtained by the plan, without regard to whether the advice was relied upon for the adverse benefit determination; and
    - any Social Security Administration disability determination regarding the claimant presented to the Plan;
- Either the specific rule, guideline, protocol, standards, or other similar criteria relied upon in making the adverse benefit determination, or a statement that such rules, guidelines, protocols, standards or other similar criteria do not exist;
- A statement that reasonable access to and copies of all documents, records, and other information relevant to the claimant's claim for benefits are available free of charge, upon request.

Appealing a Denied Claim

You or your representative may appeal to Reliance Standard for a full and fair review of your claim. You must submit a written request for review within 180 days of the claim denial. You

may request copies of all documents, records and other information relevant to your claim, and may submit written comments, documents, records, and other information relating to your claim.

Reliance Standard will decide your claim no more than 45 days after it receives your appeal unless it determines that special circumstances exist that require an extension of time to process the appeal. If such an extension is necessary, Reliance Standard will provide its decision, in writing, no more than 90 days after it receives your appeal. This written decision:

- Gives the specific reason(s) for the denial;
- Includes specific references to the Policy provisions on which the decision is based;
- Includes a statement of your right to bring a civil action under section 502(a) of ERISA following appeal;
- State that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim for benefits;
- Discloses any internal rule, guidelines, or protocol relied on in making the adverse determination (or states that such information will be provided free of charge upon request); and
- if the denial is based on a medical necessity or experimental treatment or similar limit, explains the scientific or clinical judgment for the determination (or states that such information will be provided free of charge upon request).

The Plan Administrator has delegated to Reliance Standard the sole and absolute discretionary authority to interpret and administer the provisions of the Plan and to make all decisions relating to claims and appeals. Reliance Standard's decisions are final and binding on all persons.

No action may be brought under ERISA until you have exhausted the claims and appeals procedures described in this SPD.

Applying for Social Security Disability Benefits

You must apply for Social Security Disability benefits when the duration of your Disability meets the minimum duration required to apply for such benefits. If the Social Security Administration denies your eligibility for benefits, you will be required:

- To follow the process established by the Social Security Administration to reconsider the denial; and
- If denied again, to request a hearing before an Administrative Law Judge of the Office of Hearings and Appeals.

Other Benefits while Receiving LTD Benefits

MEDICAL AND VISION

You are eligible for up to 30 months of employee only coverage at no cost. If you have dependents enrolled, you can continue their coverage for up to 30 months by paying the monthly premium for dependent coverage at the rate then in effect for employees. Coverage for you and your dependents terminates upon your termination of employment, as described earlier in this section. Your dependents are eligible for COBRA continuation of coverage after your termination of employment. You are not eligible for COBRA, since you are enrolled in Medicare.

HEALTH SAVINGS ACCOUNT

You are eligible to continue making and receiving contributions to your HSA. Your contributions must be on an after-tax basis, and you can take a credit against income when filing your taxes for the applicable tax year. The Company's contribution to your HSA continues while you are on an unpaid medical leave, and terminates upon your termination of employment.

DENTAL

You are eligible for up to 30 months of employee only coverage at no cost. If you have dependents enrolled, you can continue their coverage for up to 30 months by paying the monthly premium for dependent coverage at the rate then in effect for employees. Coverage for you and your dependents terminates upon your termination of employment, as described earlier in this section. You and your dependents are eligible for COBRA continuation of coverage after your termination of employment.

LIFE INSURANCE

Company provided Basic Life insurance continues until the earlier of your attaining age 65 or the date you are determined to be no longer disabled. If you are enrolled in the Optional Life insurance, coverage continues under premium waiver provisions until the earlier of your attaining age 65 or the date you are determined to be no longer disabled. If you are not approved for premium waiver, you must continue to pay the premium. You can convert Basic Life and Optional Life to individual policies after coverage ends.

FAMILY ACCIDENT INSURANCE

Your coverage continues for up to three months following commencement of LTD benefits. Once coverage ends, you may convert this accidental death and dismemberment coverage to an individual policy.

LONG-TERM DISABILITY INSURANCE

LTD continues at no cost to you, and your LTD benefits will continue to be paid according to the insurance policy provisions.

401(K) SAVINGS PLAN

Your contributions and contributions from the Company cease on the date that LTD benefits commence.

NON-QUALIFIED DEFERRED COMPENSATION PLAN

Your contributions cease on the date that LTD benefits commence.

PENSION PLAN

If you qualify for and elect Disability Retirement (10 years of vesting service and an award of Social Security Disability Benefits), your credited service will continue during your receipt of LTD benefits up to the earlier of your attainment of age 65 or the date you commence pension benefits.

If you do not qualify for Disability Retirement your vesting and credited service stop after termination of employment.

PENSION RESTORATION PLAN

If you have an accrued benefit, it will be paid to you within 90 days after termination of employment.

LONG-TERM INCENTIVE PLAN

If you are totally and permanently disabled and receive an award of Social Security Disability Benefits, your unvested, restricted stock will fully vest. Any stock options that have not been exercised will maintain their full term.

VACATION

You will not accrue vacation while receiving LTD benefits. Any unused, earned vacation at the end of the calendar year in which LTD commences will be paid out.

ADMINISTRATIVE INFORMATION

WHEN COVERAGE ENDS

This Section explains when Company-provided coverage under the Plan stops.

Termination of Employment

If your regular full-time employment with the Company ends for any reason other than Early Retirement as described below, coverage for you and your Dependents will terminate 30 days following your termination date. You may then elect COBRA Continuation Coverage as described in the COBRA section of the benefit booklet for the Anthem HDP Plan in which you are enrolled.

Retirement

If you retire on or after age 65, your coverage under this Plan will cease.

If you have reached age 55 and completed 10 years of service and retire from the Company due to normal retirement, early retirement, disability, as described below, or deferred retirement, (collectively, "Early Retirement") and, at the time you elect to retire, are currently enrolled in this Plan as a Participant, whether as an Employee or under the terms of a severance agreement, you may be eligible to enroll in the Hess Corporation Retirees' Medical Plan ("Retiree Medical Plan"). For purposes of receiving benefits under the Retiree Medical Plan, "retire" means that you are not employed by the Company. You may also be eligible for benefits under the Retiree Medical Plan if you retire from the Company due to disability under the terms of the Pension Plan, regardless of age (if under age fifty-five (55)) at time of disability and not enrolled in Medicare.

Absence

If your employment is not terminated, but you stop active work for any reason, you should immediately contact the Benefits Center to find out if you will be covered during your absence. Generally speaking, coverage will be continued during an absence that is caused by illness or injury. This includes a medical, family care or maternity leave of absence. If a leave is granted for other reasons, coverage is normally discontinued following the last day worked before your leave begins.

Disability

If you are not eligible for disability retirement:

- You can continue coverage until the earlier of Medicare eligibility or thirty (30) months from termination of employment at no cost.

- Your spouse, same sex or opposite sex Domestic Partner and/or Dependents can continue coverage for eighteen (18) months at 102% of full cost and an additional eleven (11) months at 150% of full cost.

In the event of your death during disability, your enrolled Spouse, same sex or opposite sex Domestic Partner, and Dependents, if still eligible for medical coverage, will receive free coverage for six months in the Retiree Medical Plan immediately following the date of your death. Thereafter, your Spouse may continue his or her coverage until the first of the month in which he or she turns age sixty-five (65) or becomes Medicare eligible, paying the full cost. Your dependent(s) may also continue to be covered under the Retiree Medical Plan until the age of twenty-six (26), so long as the Spouse has coverage and they are not employed full-time or Medicare-eligible, paying the full cost. A dependent disabled child may also continue to be covered under the Retiree Medical Plan until the later of age twenty-six (26) or the date the disabled child no longer meets the definition of "disabled", so long as the Spouse has coverage and they are not employed full-time or Medicare eligible, paying the full cost. The dependent(s) may then be eligible for coverage under COBRA provisions.

Death

Upon your death as an active Employee, any coverage then in effect with respect to your Dependents, if still eligible for coverage, will be continued immediately following the date of your death for six months at no cost, and then can be continued under COBRA for an additional thirty months at 102% of the full cost.

Although the Company presently intends to permit retired Employees to continue to participate in the Retiree Medical Plan as described above, circumstances or policies may change in the future. The Company reserves the right to increase retiree contributions, reduce benefits or terminate the participation of retirees at its discretion.

REESTABLISHING COVERAGE

Except as otherwise required under the Family and Medical Leave Act or the Uniformed Services Employment and Reemployment Rights Act, you re-establish coverage by satisfying the eligibility rules applicable to new employees.

Family and Medical Leave

The Family and Medical Leave Act of 1993 ("FMLA") generally allows qualifying employees to take up to 12 weeks of job protected leave:

- To care for a newborn child;
- Because of a placement of a child with the employee for adoption or foster care;

- To care for a family member with a serious health condition;
- Because the employee's own serious health condition prevents him or her from performing the essential functions of his or her job; or
- Because of any "qualifying exigency" arising out of the fact that an employee's spouse, child, or parent is on active duty or has been notified of an impending call or order to active duty.

And, up to 26 weeks of leave in a 12 month period to care for a covered service member who is a current member of the Armed Forces who has a serious injury or illness incurred in the line of duty while on active duty or on the temporary disability retired list for a serious injury or illness incurred in the line of duty while on active duty.

During any leave of absence governed by and conforming to the requirements of the FMLA, your health coverage will be continued on the same basis that it would have been if the leave had not taken place. However, if you choose to suspend coverage during your absence, you and your dependents will be covered immediately upon your return to work without being required to give evidence of insurability.

If your coverage terminates during leave for failure to pay the minimum or any other reason, your coverage will be re-established the day you return to work. If you immediately resume making the required payments, dependent coverage also will be re-established even if it was discontinued during your leave.

For more information, contact the Benefits Center.

Uniformed Services

Coverage for employees honorably discharged and returning from military service (active duty, inactive duty training, or full-time National Guard service), or from absences for the purposes of determining fitness to serve in the military will be reinstated if:

- The Plan receives advance notice of the Employee's absence, whenever possible;
- The cumulative length of absence for "eligible service" does not exceed 5 years; and
- The Former Employee reports or submits an application for re-employment within the prescribed time limits.

Former Employees must notify the Plan of their intent to return to work as follows:

- For service of less than 31 days or for an absence of any length to determine a person's fitness for uniformed service, the person must report by the first regularly scheduled work period after the completion of service plus a reasonable allowance for time and travel (8 hours);

- For service of more than 30 days but less than 181 days, the person must submit an application not later than 14 days following the completion of service; or
- For service of more than 180 days, the person must return to work or submit an application not later than 90 days following the completion of service.

However, if service ends, and you are hospitalized or convalescing from an injury or sickness sustained during uniformed service, you must report or submit an application, whichever is required, at the end of the period necessary for recovery. Generally, the period of recovery may not exceed two years.

No waiting periods may be imposed on reinstated coverage, and upon reinstatement, coverage shall be deemed to have been continuous for all Plan purposes.

Your rights to reinstate coverage are governed by the Uniformed Services Employment and Reemployment Rights Act ("USERRA"). If you have any questions, or if you need additional information, contact the Benefits Center.

SUBROGATION AND RIGHT OF RECOVERY

Reimbursement to Plan if You Recover Payment for an Injury or Illness

Unless otherwise stated in an applicable insurance policy/evidence of coverage, any benefits under the Plan will be subject to the reimbursement and subrogation rules below. This section applies to your Dependent the same as it applies to you.

This section applies if you or your legal representative, estate or heirs recover money or other property for an injury, sickness or other condition, or if you have made, or in the future may make, such a recovery, including a recovery from any insurance carrier.

The Plan will not cover either the reasonable value of the services to treat such an injury, sickness, or other condition or the treatment of such an injury, sickness, or other condition. These benefits are specifically excluded.

The Plan may, however, advance moneys or provide benefits for such an injury, sickness, or other condition, and, if so, you must promptly convey moneys or other property from any settlement, arbitration award, verdict, insurance payment , or other recovery from any party to the Plan in the amount of moneys or of the benefits advanced or provided by the Plan to you, regardless of whether or not (1) you have been fully compensated or made whole for your loss, (2) liability is admitted by you or any other party, or (3) your recovery is itemized or specified as a recovery for medical expenses incurred.

If a recovery is made, the Plan shall have first priority in payment over you or any other party to receive reimbursement of the moneys and value of the other benefits advanced on your behalf. This reimbursement shall be from any recovery made by you and includes, but is not limited to, uninsured and underinsured motorist coverage, any no-fault insurance, medical payment coverage (auto, homeowners, or otherwise), workers' compensation settlement, compromises or awards, other group insurance (including student plans), and direct recoveries from liable parties.

You must assign to the Plan any benefits you may have under any automobile policy or other coverage, to the extent of the Plan's claim for reimbursement. You must sign and deliver, at the request of the Plan or its agents, any documents needed to effect such assignment of benefits.

You must cooperate with the Plan and its agents and shall sign and deliver such documents as the Plan or its agents reasonably request to protect the Plan's right of reimbursement, provide any relevant information, and take such actions as the Plan or its agents reasonably request to assist the Plan making a full recovery of the reasonable value of the moneys or other benefits provided.

You shall not take any action that prejudices the Plan's rights of reimbursement and consents to the right of the Plan, by and through its agent, to impress an equitable lien or constructive trust on the proceeds of any recovery to enforce the Plan's rights under this section, and/or to set off from any future benefits otherwise payable under the Plan the value of moneys and other benefits advanced under this section to the extent not recovered by the Plan.

The Plan shall be responsible only for those legal fees and expenses to which it agrees in writing. You shall not incur any expenses on behalf of the Plan in pursuit of the Plan's rights. Specifically, no court costs or attorney's fees may be deducted from the Plan's recovery without the express written consent of the Plan. Any so-called "Fund Doctrine," "Common Fund Doctrine," "Attorney's Fund Doctrine," or other equitable defenses shall not defeat this right.

The Plan shall recover the full amount of moneys and the value of the benefits advanced and paid hereunder, without regard to any claim or fault on the part of any beneficiary of yours, whether under comparative negligence or otherwise.

Plan's Right to Subrogation

This section applies if another party is, or may be considered, liable for your injury, sickness, or other condition (including insurance carriers who are so financially liable).

The Plan will not cover either the reasonable value of the services to treat such an injury, sickness, or other condition or the treatment of such an injury, sickness, or other condition. These benefits are specifically excluded.

The Plan may, however, advance moneys or provide benefits for such an injury, sickness, or other condition, and, if so, the Plan is subrogated to all of your rights against any party liable for your injury, sickness, or other condition, or who is or may be liable for the payment for the medical treatment of such injury, sickness, or other condition (including any insurance carrier), in the amount of moneys or value of other benefits advanced or provided by the Plan to you. The Plan may assert this right independently of you. This right includes, but is not limited to, your rights under uninsured and underinsured motorist coverage, any no-fault insurance, medical payment coverage (auto, homeowners, or otherwise), workers' compensation coverage, or other insurance. The Plan is not obligated in any way to pursue this right independently or on your behalf, but may choose to pursue its rights to reimbursement under the Plan, at its sole discretion.

You are obligated to cooperate with the Plan and its agents to protect the Plan's subrogation rights. Your obligations include, but are not limited to, providing the Plan or its agents with any relevant information requested by them, signing and delivering such documents as the Plan or its agents reasonably request to enforce the Plan's subrogation right, and obtaining the consent of the Plan or its agents before releasing any party from liability for payment of medical expenses.

If you enter into litigation or settlement negotiations relating to your injury, sickness or other condition, you must not prejudice, in any way, the subrogation rights of the Plan under this section. If you fail to cooperate as provided in this section, including executing any documents required in this section, the Plan may, in addition to remedies provided elsewhere in the Plan and/or under the law, set off from any future benefits otherwise payable under the Plan the money and value of other benefits advanced under this section to the extent not recovered by the Plan.

The costs of legal representation of the Plan in matters related to subrogation shall be borne solely by the Plan. The costs of your legal representation shall be borne solely by you.

Equitable Lien

By accepting any benefits advanced by the Plan under this section, you acknowledge that any proceeds of settlement or judgment, including your claim to such proceeds held by another person or held by you, are being held for the benefit of the Plan under these provisions. If the Plan advances moneys or provides benefits for an injury, sickness, or other conditions, and you recover moneys or benefits from a third party in the amount of the moneys or benefits advanced, the Plan

has an equitable lien in connection with any such payments. Failure to hold such received funds in trust, and in a separate, identifiable account, will be deemed a breach of your fiduciary duty to the Plan.

Notice

You specifically agree to notify the Plan in writing whenever benefits are paid under the Plan that arise out of any injury, sickness, or other condition that provides or may provide the Plan subrogation or reimbursement rights. Furthermore, you specifically agree to notify the Plan: (1) within 30 days of the date any notice is given by any party, including an attorney, of its intent to pursue or investigate a claim to recover damages or obtain compensation due to an injury, sickness, or other condition; or (2) within 30 days of the date any party, including an attorney, undertakes, pursues, or investigates a claim to recover damages or obtain compensation due to an injury, sickness, other condition.

Waiver

The Plan Administrator in its sole and absolute discretion may waive or modify any or all provisions of this rule.

LEGAL INFORMATION ABOUT THE PLAN

This section provides important legal and administrative information regarding the Hess Corporation Employees' Health and Welfare Plan and your legal rights with respect to the Plan. It is important that you understand your rights as a Member in the Plan, so please review these provisions carefully.

Plan Name

Hess Corporation Employees' Health and Welfare Plan

Plan Number

501

Plan Year

Calendar year, January 1 – December 31

Plan Sponsor/Plan Employer*

Hess Corporation

1185 Avenue of the Americas

New York, NY 10036

Telephone: 212-997-8500

* **Note:** Other employers which are subsidiaries or affiliates of the Company may also participate in the ERISA-covered plans listed in this Section.

Employer Identification Number

13-4921002

Plan Administrator/Named Fiduciary

Employee Benefits Plan Committee

Hess Corporation

1501 McKinney St.

Houston, TX 77010

Telephone: 713-496-4000

Agent for Service of Legal Process

Corporate Secretary

Hess Corporation

1501 McKinney St.

Houston, TX 77010

Legal process may also be served on the Plan Administrator.

Administration & Funding

Self-funded benefits are administered by the claims administrators listed under “Benefits & Claims Administrators.”

Insured benefits are administered by the insurers listed at under “Benefits & Claims Administrators.” Fully insured benefits will be paid out of the insurance policies listed under “Benefits & Claims Administrators.”

Source of Contributions

Contributions will be paid out of the Company's general assets and through contributions paid by Eligible Employees, in the amounts determined by the Company in its discretion.

BENEFITS & CLAIMS ADMINISTRATORS

Benefit Type and Provider	Group or Policy Information	Plan Financing	Funding the Plan	Claims Administrator
Anthem BCBS HDP	Group #270009	Self-insured	Member & employer contributions	Anthem BCBS 1-800-854-1834 www.anthem.com
Express Scripts	Group HESSCRP	Self-insured	Member & employer contributions	Express Scripts 1-800-858-1678 www.express-scripts.com
Anthem Mental Health & Substance Abuse	Group #270009	Self-insured	Member & employer contributions	Anthem Behavioral Health 1-800-854-1834 www.anthem.com
Anthem Vision	Group #270009	Self-insured	Member & employer contributions	Blue View Vision 1-866-723-0515 www.anthem.com
Delta Dental	05467	Self-insured	Member & employer contributions	Delta Dental 1-800-932-0783 www.deltadentalins.com
Health Advocate EAP	Hess Corp	Fee based	Employer funded	Health Advocate 1-877-583-8787
International Employee Assistance Program			Employer funded	International Employee Assistance Program 1-888-851-7032 or 1-877-857-2952

Benefit Type and Provider	Group or Policy Information	Plan Financing	Funding the Plan	Claims Administrator
Cigna International Medical Plan **(Medical, prescription drug, dental, and vision)**	06800A001/002	Fully Insured	Employer paid premiums	Cigna International Medical Plan P.O. Box 15050 Wilmington, DE 19850 1-800-441-2668 or 1-302-797-3100 www.CignaEnvoy.com
Short-term Disability	CW2275091	Self-insured	Employer funded	Matrix Skyline Dr., Suite 275 Hawthorne, NY 10532 1-877-315-9838
Reliance Standard Long-term Disability Insurance	149247-1-G	Fully insured	Employer paid premiums	Reliance Standard Life Insurance Company 7 Skyline Dr., Suite 275 Hawthorne, NY 10532 1-877-315-9838
MetLife Basic, Supplemental, & Dependent Life Insurance	149247-1-G	Fully insured	Member & employer paid premiums	Metropolitan Life Insurance Company 200 Park Avenue New York, NY 10166
Family Accident Insurance	PAI 0009059953-A	Fully insured	Member paid premiums	National Union Fire Insurance Company of Pittsburgh 175 Water Street, 15th Floor New York, NY 10038

Benefit Type and Provider	Group or Policy Information	Plan Financing	Funding the Plan	Claims Administrator
Business Travel Accident Insurance	GTP 9128973A	Fully insured	Employer paid premiums	National Union Fire Insurance Company of Pittsburgh 175 Water Street, 15th Floor New York, NY 10038

Plan Administration

The Plan Administrator has the sole and absolute discretionary authority to interpret the terms and provisions of the Plan, and its judgments will be final and binding on all parties. The Administrator may delegate such authority to another person or persons, including a Third Party Administrator or Insurer.

Fraud or Misrepresentation

If you, your Enrolled Dependents, or any other person claiming benefits under the Plan, perform an act or practice constituting fraud, make an intentional misrepresentation of material fact, or make a false statement that is material to your or the person's claim for benefits, the Plan Administrator, Insurer, or a Third Party Administrator may adjust the benefits payable to you or the person, or require that you or the person return the payments to the Plan or take any other action as deemed reasonable against you or the person committing fraud or making a misrepresentation.

Plan Amendment and Termination

The Company reserves the right to amend or terminate at any time, and to any extent, the Plan, including the benefits offered under the Plan as described in this summary plan description.

Neither the Plans nor the benefits described in this summary plan description can be orally amended. All oral statements and representations shall be without force or effect even if such statements and representations are made by the Plan Administrator, by an employee of the Company, or by any member of the applicable committees of the Plan. Only written statements by the applicable committee of the Plan shall bind the Plan.

YOUR RIGHTS

YOUR RIGHTS UNDER ERISA

As a Member in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 ("ERISA"). ERISA provides that all plan participants shall be entitled to:

Receive Information about Your Plan and Benefits

You have the right to:

- Examine, without charge, at the Plan Administrator's Office, and at other specified locations, such as regional offices, all documents governing the Plan, including insurance contracts 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 Plan, including insurance contracts, copies of the latest annual report (Form 5500 Series), and an updated SPD. The Plan Administrator may make a reasonable charge for copies not required by law to be furnished free of charge.
- Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each Member with a copy of this summary annual report.

Continue Group Health Plan Coverage

You have the right to continue health care coverage for yourself, your spouse, or your dependents if there is a loss of coverage under the Plan as a result of a Qualifying Event. You or your dependents may have to pay for such coverage. Review this SPD and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the 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 Members and beneficiaries. No one, including your employer, 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.

Enforcing 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 make a written request for a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.
- If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or federal court. Generally, you must complete the appeals process before filing a lawsuit against the Plan. However, you should consult with your own legal counsel in determining when it is proper to file a lawsuit against the Plan.
- If you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court.
- If it should happen that Plan Fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor or you may file suit in Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U .S. Department of Labor, 200 Constitution Avenue N.W., Washington DC 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the Employee Benefits Security Administration publications hotline at (866) 444-3272 or by logging on to the Internet at www.dol.gov/ebsa.

YOUR RIGHTS UNDER COBRA

General Notice Of COBRA Continuation Coverage Rights

Continuation Coverage Rights Under COBRA

Introduction

You're getting this notice because you recently gained coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it. When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

You may have other options available to you when you lose group health coverage.

For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

COBRA Continuation Coverage

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect Hess Corporation, and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary. The retired employee's spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

COBRA Availability

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the employee;
- Commencement of a proceeding in bankruptcy with respect to the employer;; or

- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse, or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to: The Benefits Center at 1-877-511-4377 or online at empyrean.hess.com.

Providing COBRA Coverage

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability Extension

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage.

Second Qualifying Event

If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both);

gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Other Coverage Options

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicare, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

Ability to Enroll in Medicare Instead of COBRA Continuation Coverage after the End of Group Health Plan Coverage

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period to sign up for Medicare Part A or B, beginning on the earlier of

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information visit https://www.medicare.gov/medicare-and-you.

Contact for Questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.HealthCare.gov.

Address Changes

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

COBRA Administrator

Hess Corporation Employees' Health and Welfare Plan

To report a Qualifying Event, contact the Benefits Center at 1-877-511-4377, option 1 or online at empyrean.hess.com.

To report a second Qualifying Event, or to inquire about your COBRA election, payments, duration of coverage, or general questions, contact the Benefits Center at 1-877-511-4377, option 1.

YOUR RIGHTS UNDER HIPAA

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

THIS NOTICE ALSO APPLIES TO YOUR SPOUSE AND OTHER DEPENDENTS. PLEASE SHARE IT WITH THEM. IF YOU ARE COVERED BY AN INSURED HEALTH COVERAGE OPTION UNDER THE PLAN, YOU WILL RECEIVE A SEPARATE NOTICE FROM THE INSURER OR HMO.

Introduction

As group health plans, the Hess Corporation Employees' Health & Welfare Plan, the Hess Corporation Retirees' Medical Plan, and the Hess Corporation Cafeteria Plan (the "Plan" or "Plans") are covered entities within the meaning of the Health Insurance Portability and Accountability Act of 1996, commonly known as "HIPAA". Under HIPAA, the Plans are legally required to provide you, the participant, with notice of the Plans' legal duties and privacy practices with respect to Protected Health Information ("PHI"). PHI includes any individually identifiable information that relates to your physical or mental health, the health care that you have received or payment for your health care, including name, address, date of birth and Social Security number.

The Plans are legally required to maintain the privacy of your PHI. The primary purpose of this notice is to describe the legally permitted uses and disclosures of PHI, some of which may not apply to the Plans in practice. This notice also describes your right to access and control your PHI.

The Plans are required to abide by the terms of this Notice of Privacy Practices ("Notice"). However, the Plans reserve the right to change the terms of this or any subsequent Notice at any time. If the Plans elect to make a change, the revised Notice will be effective for all PHI that the Plans maintain at that time. Within 60 days of any material revision of their privacy practices, the Plans will distribute a new Notice.

Additionally, you can obtain a copy of the most recent Notice by visiting The Benefits Center at empyrean.hess.com. You may also request one from a Benefits Specialist by calling The Benefits Center at 1877-511-4377, option 1, Monday through Friday, 8:30 a.m. to 6:30 p.m., Eastern Time, except on holidays. For TDD communication services for the hearing impaired, call toll-free 1-877-526-5517.

This Notice is effective April 14, 2003 and updated as of September 23, 2013.

Permitted Uses and Disclosures

Uses and Disclosures for Treatment, Payment and Health Care Operations

The Plans and Business Associates, third parties that perform various activities (e.g. hospital preauthorization or case management) for the Plans, may use and disclose your PHI without your consent or authorization in connection with your receiving treatment, payment for such treatment and for health care operations. Generally, the Plans and Business Associates will make every reasonable effort to disclose only the minimum necessary amount of PHI to achieve the purpose of the use or disclosure.

Treatment means the provision, coordination or management of your health care. As health plans, while the Plans do not provide treatment, the Plans may use or disclose your PHI to support the provision, coordination or management of your care. For example, the Plans may disclose the fact that you are eligible for benefits to a provider who contacts them to verify your eligibility.

Payment means activities in connection with processing claims for your health care (including billing, claims management, subrogation, reviews for medical necessity and appropriateness of care and utilization review and pre-authorizations). For example, the Medical Benefit Plan or a Business Associate may disclose your PHI to physicians engaged by the Plan for their medical expertise in order to help determine medical necessity and eligibility for coverage. In addition, the Plans may disclose your PHI, including your eligibility for health benefits and specific claim information, to other health plans in order to coordinate benefits between this Plan and other plans under which you may have coverage. The Plans may also disclose your PHI to Business Associates. In such circumstances, the Plans will have a written contract with the Business Associate, which requires the Business Associate to protect the privacy of your PHI.

The Plans or Business Associates may also disclose your PHI and your dependents' PHI on explanations of benefit forms ("EOBs") and other payment-related correspondence, such as pre-certifications, which are sent to you. In addition, if you appeal a benefit determination on behalf of a dependent, or if a family member appeals a benefit determination on behalf of you or one of your dependent, the Plans or a Business Associate may disclose PHI related to that appeal to you or that close family member. If you appeal a benefit determination and you designate an authorized representative to act on your behalf, the Plans or a Business Associate will disclose PHI related to that appeal to that designated representative.

Health Care Operations generally mean Plan administration functions. For example, the Plans or a Business Associate may use or disclose your PHI for quality assessment and improvement,

vendor review and underwriting activities. However, the Genetic Information Nondiscrimination Act ("GINA") prohibits a health plan from using PHI that is genetic information for underwriting purposes.

Disclosures to the Plan Sponsor and to Your Representatives

DISCLOSURES TO HESS CORPORATION

The Plans or a Business Associate may disclose your PHI to the Plans' Sponsor (Hess Corporation) so that the Sponsor can perform plan administration function on behalf of the Plans. In addition, if you are covered under an insured plan, the insurer may disclose your PHI to Hess Corporation in connection with plan administration functions. In accordance with the Plans documents, Hess Corporation has agreed not to use or disclose PHI other than as permitted in this Notice or as required by law, and has agreed not to use or disclose PHI with respect to any employment-related actions or decisions.

DISCLOSURES TO FAMILY MEMBERS, OTHER RELATIVES AND CLOSE PERSONAL FRIENDS

The Plans or a Business Associate may disclose to your family member, other relative or close personal friend PHI that is directly relevant to the person's involvement with your care or payment for your care, provided that you have either agreed to the disclosure or have been given an opportunity to object to the disclosure and have not objected. The Plans and Business Associates may also disclose your PHI to any authorized public or private entities assisting in disaster relief efforts. You have the right to stop or limit these disclosures by contacting us at the address shown at the end of this Notice.

DISCLOSURES TO YOUR PERSONAL REPRESENTATIVES PURSUANT TO YOUR AUTHORIZATION

You may authorize a personal representative to receive your PHI and to act on your behalf. Contact the Plans or appropriate Business Associate (see last page of this notice for a listing) to obtain the appropriate form to designate the people who are authorized to receive your PHI.

Other Permitted Uses and Disclosures

The Plans and Business Associates may also use or disclose your PHI without your consent or authorization under the following circumstances. Some of these events rarely happen; however, the Plans want to inform you of the specific circumstances under which your PHI can be disclosed according to HIPAA.

1) **Reminders:** The Plans or a Business Associate may use your PHI to provide you with reminders. For example, the Plans or a Business Associate may use your child's date of

birth to remind you that you may elect COBRA continuation coverage for your child who would otherwise lose coverage under the plan.

2) **Treatment Alternatives, and Health-Related Benefits and Services:** The Plans or a Business Associate may use your PHI to inform you about treatment alternatives. In addition, the Plans or a Business Associate may use or disclose your PHI to inform you about other health-related benefits and services that may be of interest to you.
3) **Required by Law:** The Plans or a Business Associate may use or disclose your PHI to the extent that the Plans are required to do so by federal, state or local law and the use or disclosure complies with and is limited to the relevant requirements of such law. You will be notified, if required by law, of any such uses or disclosures.
4) **Public Health:** The Plans or a Business Associate may disclose your PHI to a public health authority that is permitted by law to collect or receive the information or for public health and safety purposes. Your PHI may also be used or disclosed for the purpose of preventing or controlling disease (including communicable diseases), injury or disability. If directed by the public health authority, the Plans and Business Associates may also disclose your PHI to a foreign government agency that is collaborating with the public health authority.
5) **Health Oversight:** The Plans or a Business Associate may disclose your PHI to a health oversight agency for activities authorized by law, such as audits, investigations, inspections and legal actions. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.
6) **Abuse or Neglect:** The Plans or a Business Associate may disclose your PHI to any public health authority authorized by law to receive information about abuse, neglect or domestic violence if the Plans or a Business Associate reasonably believes that you have been a victim of abuse, neglect or domestic violence. In such a case, the Plans or a Business Associate will inform you that such a disclosure has been or will be made unless that notice would cause a risk of serious harm.
7) **Legal Proceedings:** The Plans or a Business Associate may disclose your PHI in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal. In addition, the Plans and Business Associates may disclose your PHI under certain conditions in response to a subpoena, discovery request or other lawful process.
8) **Law Enforcement:** The Plans or a Business Associate may disclose your PHI when required for certain law enforcement purposes.

9) **Coroners, Funeral Directors, and Organ Donation:** The Plans or a Business Associate may disclose your PHI to a coroner or medical examiner for identification purposes, or other duties authorized by law. The Plans and Business Associates may also disclose your PHI to a funeral director, as authorized by law, in order to permit the funeral director to carry out his/her duties. PHI may also be used and disclosed for cadaveric organ, eye or tissue donation and transplantation purposes.
10) **Research:** The Plans or a Business Associate are permitted to disclose your PHI to researchers when their research has been approved by an institutional review board or a privacy board.
11) **Avert a Serious Threat to Health or Safety**: Consistent with applicable federal and state laws, the Plans and Business Associates may disclose your PHI if the Plans or a Business Associate believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public and the disclosure is made to a person reasonably able to prevent or lessen the threat.
12) **Military Activity and National Security:** When the appropriate conditions apply, the Plans and Business Associates may use or disclose PHI of individuals who are Armed Forces personnel. The Plans and a Business Associate may also disclose your PHI to authorized federal officials conducting national security and intelligence activities.
13) **Workers' Compensation:** The Plans or a Business Associate may disclose your PHI to comply with workers' compensation laws and other similar programs established by law.
14) **Inmates:** If you are an inmate of a correctional institution or under the custody of a law enforcement official, the Plans and Business Associates may disclose your PHI to the institution or official if the PHI is necessary for the institution to provide you with health care; to protect the health and safety of you or others; or for the security of the correctional institution.
15) **Required Uses and Disclosures:** The Plans or a Business Associate must make disclosures to you and to the Secretary of the U.S. Department of Health and Human Services to investigate or determine our compliance with the federal regulations regarding privacy.
16) **Marketing/Sale of PHI / Psychotherapy Notes:** The Plans will obtain your written authorization to use or disclose PHI for marketing purposes where the Plans receive financial remuneration, for the sale of PHI or with respect to psychotherapy notes, except for limited health care operations purposes.

Other uses and disclosures of your PHI will be made only with your written authorization, unless otherwise permitted by law as described above. If you authorize the Plans or a Business

Associate to use or disclose your PHI for purposes other than those set forth in this Notice, you may revoke that authorization in writing at any time, except to the extent that the Plans or a Business Associate have already taken action based upon the authorization. Thereafter, the Plans or a Business Associate will no longer use or disclose your PHI for the reasons covered by your written authorization.

Breach of PHI

The Plans are required to notify you if there is a breach of your unsecured PHI.

Know Your Rights

Right to Inspect and Copy

As long as the Plans and Business Associates maintain your PHI, you may inspect and obtain a copy of your PHI that is contained in a "Designated Record Set" in the electronic form or format requested. A "Designated Record Set" is a group of records that comprise the enrollment, payment, claims adjudication, case or medical management record systems maintained by or for the Plans. Under federal law, however, you may not inspect or copy psychotherapy notes or information compiled in reasonable anticipation of, or for use in, a civil, criminal, or administrative action or proceeding.

The Plans may decide to deny you access to your PHI. Depending on the circumstances, the decision to deny access may be reviewable by a licensed health professional who was not involved in the initial denial of access and who has been designated by the Plans to act as a reviewing official. If your request is denied, you or your personal representative will be provided with a written denial setting forth the basis for the denial, a description of how you may exercise your review rights and a description of how you may complain to the Plans and the U.S. Department of Health and Human Services.

To request access to inspect and/or obtain a copy of any of your PHI, you must submit your request in writing to the Plan or appropriate Business Associate (refer to the last page of this notice for the address) indicating the specific information requested. If you request a copy, please indicate the form in which you want to receive it *(i.e.,* paper or electronic). The Plans or a Business Associate may impose a fee to cover the costs of supplies, labor, copying and postage.

Right to Request Restrictions on the Use and Disclosure of Your PHI

You may ask us to restrict the uses and disclosures of your PHI to carry out treatment, payment and health care operations. You may also request that the Plans or a Business Associate restrict uses and disclosures to family members, relatives, friends, or other persons identified by you

who are involved in your care. However, the Plans generally are not required to agree to a restriction that you request unless you have paid out-of-pocket in full for the covered services at issue. If the Plans or a Business Associate agree to the request, the Plans or the Business Associate will not use or disclose your PHI in violation of that restriction unless it is needed to provide emergency treatment or the Plans or the Business Associate terminates the restriction with or without your agreement. If you do not agree to the termination, the restriction will continue to apply to PHI created or received prior to the notice to you of the termination of the restriction. To request a restriction, you must write to the Plan or appropriate Business Associate (refer to the last page of this notice for the address) indicating what information you want to restrict, whether you want to restrict use, disclosure or both, and to whom you want the restriction to apply.

RIGHT TO REQUEST TO RECEIVE COMMUNICATIONS BY ALTERNATIVE MEANS OR AT AN ALTERNATIVE LOCATION

The Plans and Business Associates will accommodate your reasonable request to receive communications of PHI by alternative means or at alternative locations if your request includes a statement that disclosure could endanger you. For example, you can ask that the Plans or a Business Associate only contact you at work or by mail or at an address other than your home address. Any such requests must be in writing and directed to the Plans or appropriate Business Associate (refer to the last page of this notice for the address).

RIGHT TO AMEND YOUR PHI

You have the right to request that the Plans or Business Associates amend your PHI. Your request must be made in writing and must be submitted to the Plans or appropriate Business Associate (refer to the last page of this notice for the address). In addition, you must provide a reason that supports your request. If the Plan or Business Associate denies your request for an amendment to your PHI, you have the right to file a written statement of disagreement, and you may request that the Plan or Business Associate include your statement with any future disclosures of that PHI.

RIGHT TO AN ACCOUNTING OF DISCLOSURES

You have the right to request an "accounting" *(i.e.,* a list) of certain disclosures of your PHI made by the Plans or Business Associates. In general, the Plans or Business Associates are required to comply with your request, subject to certain exceptions, such as disclosures made in connection with treatment, payment and health care operations, and disclosures made for national security or intelligence purposes.

In order to request an accounting of disclosures, you must submit your request in writing to the appropriate Plans or Business Associate (refer to the last page of this notice for the address). You have the right to receive an accounting of disclosures of PHI made within six years (or less) of the date on which the accounting is requested, but not prior to April 14, 2003. Your request should indicate the form in which you want the list *(e.g.,* paper or electronic). The first request within a 12- month period will be free of charge. For additional requests within the 12-month period, the Plans or Business Associate may charge you for the costs of providing the accounting. The Plans or Business Associate will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any cost is incurred.

RIGHT TO RECEIVE A PAPER COPY OF THIS NOTICE

You may request a paper copy of this Notice at any time, even if you have previously agreed to accept this Notice electronically. Requests should be made to:

The Hess Benefits Center at Empyrean

PO Box 1268

Bellaire, TX 77402

Complaints

If you believe that your privacy rights have been violated, you may complain in writing to Internal Audit, Hess Corporation, 1501 McKinney St. Houston, TX 77010, by email at internalaudit@hess.com, by phone at (800)353-2790 or to the Secretary of the U.S. Department of Health and Human Services, Hubert H. Humphrey Building, 200 Independence Avenue S.W., Washington, D.C. 20201. You will not be retaliated against for filing a complaint.

Questions and Requests

If you have any questions regarding this Notice or the subjects addressed in it, or would like to submit a written request to the Plan as described above, please contact:

Privacy Officer c/o Hess Corporation Corporate Benefits Department, 1501 McKinney St., Houston, TX 77010, Phone: 713-496-4000.

The use and disclosure of PHI by the Plans is regulated by the federal Health Insurance Portability and Accountability Act, known as HIPAA. You may find these rules at 45 *Code of Federal Regulations* Parts 160 and 164. This Notice attempts to summarize the regulations. The regulations will supersede this Notice if there is a discrepancy between the information in this Notice and the regulations.

GLOSSARY

Active Full-Time Employee — An Employee who works for the Company on a regular basis in the Company's usual course of business. To be considered an Active Full-Time Employee, an Employee must work at least 30 hours per week

Actively at Work — An Employee will be considered to be Actively at Work with the Company on a day which is one of the Company's scheduled work days if he is performing, in the usual way, all of the regular duties of his job on a Full-time basis on that day. He is deemed to be actively at work on the preceding scheduled work day.

Benefit Program — Any employee benefit offered by the Company and attached hereto or incorporated by reference.

COBRA — The Consolidated Omnibus Budget Reconciliation Act

Covered Dependent — Any Dependent in an Employee's family who meets all the requirements of the Eligibility section of this SPD, has enrolled in the Plan, and is subject to Premium requirements set forth by the Plan.

Dependent — A dependent of an Employee who is eligible to receive coverage under a Benefit Program, as determined by the Plan Administrator in accordance with the governing plan documents.

Disabled Child/Children — A child is disabled if he or she is permanently and totally physically or mentally handicapped, regardless of age, provided that disability began before the child reached age twenty-six (26).

Domestic Partner — A Domestic Partner is defined as a person of the same or opposite sex who:

- Shares your permanent residence and has done so continuously for the last six months;
- Is in an exclusive, committed relationship with you and has done so continuously for the last six months;
- Is not married to anyone else under statutory or common law and is not in another domestic partner relationship;
- Is jointly responsible with you for financial obligations and each other's common welfare: and
- Is at least 18 years of age.

Effective Date — The date for which the Plan approves an individual application for coverage. For individuals who join this Plan after the first enrollment period, the Effective Date is the date the Plan approves each future Participant according to its normal procedures.

Eligible Children — The natural and adopted children, regardless of where they live, of an Employee who is eligible to receive coverage under a Benefit Program, including:

- Stepchildren who live with the Employee;
- The Employee's eligible disabled children;
- Children who are placed with the Employee for adoption;
- Children for whom the Employee has legal guardianship issued by a court;
- Children of the Employee's same sex or opposite sex Domestic Partner provided the domestic partner is covered under the Plan;
- A minor child who qualifies as a dependent under the Internal Revenue Code of 1986, as amended.
- Children who must be covered under a QMCSO, as discussed below.

Eligible Employee — With respect to a Benefit Program, an Employee who is eligible to receive coverage under such Program.

Employee — A person who is engaged in active employment with the Employer and is eligible for Plan coverage under the employment regulations of the Employer. An individual is not eligible for coverage under the Plan if he is (or may be) a self-employed individual or an independent contractor. The determination of an individual as self-employed or an independent contractor made in good faith by the Company shall not be subject to retroactive change for the purposes of the Plan if it subsequently is determined by the Internal Revenue Service, another federal agency, a state agency, or as the result of legal action that such individual should have been classified as an employee of the Company.

Employee Contributions — Any pre-tax or after-tax contributions required to be paid by a Member for coverage under any Benefit Program.

Employer — An Employer who has allowed its Employees to participate in the Plan by acting as the Plan Sponsor or adopting the Plan as a participating Employer by executing a formal document that so provides .

Enrolled Dependent — A Dependent of an Employee who is properly enrolled under the Plan.

ERISA — The Employee Retirement Income Security Act of 1974, and any amendments thereto.

Former Employee — A person formerly employed by the Company as an Employee.

Health Savings Account ("HSA") — An individually-owned health savings account as described in Code section 223 that an Eligible Employee establishes with a custodian or trustee who has entered into an agreement with the Company to receive salary reduction contributions directly from the Company's payroll.

HIPAA — The Health Insurance Portability and Accountability Act of 1996, as amended.

Medicare — Parts A, B, C and D of the insurance program established by Title XVIII, United States Social Security Act, as amended by 42 U.S .C. Sections 1394, et seq. and as later amended.

Member — An Employee who satisfies the requirements of Eligibility in the "Eligibility & Enrollment section", is covered under one or more of the Benefit Programs under the Plan, and whose participation has not otherwise been terminated.

Participant — The Employee and each Dependent, as defined in this Summary booklet, while such person is covered by this Plan.

Pre-Disability Earnings — Your Monthly Rate of Basic Earnings in effect on the day before you became disabled.

Qualified Medical Expenses — Qualified Medical Expenses are expenses for medical care, as generally defined in Code §213(d)(with certain exceptions, for example, special rules apply to health insurance premiums), for the HSA account holder and his or her spouse or tax dependents, to the extent that such amounts are not reimbursed by insurance or otherwise. Examples of qualifying medical expenses can be found in IRS publication 502 and publication 969 at www.irs.gov.

Spouse — For purposes of this Plan, a Spouse is defined as an individual who is an individual who is lawfully married to an Employee and not legally separated. An individual shall be considered lawfully married regardless of where the individual is domiciled if either of the following are true: (1) the individual was married in a state, possession, or territory of the U.S. and the individual is recognized as lawfully married by that state, possession, or territory of the U.S.; or (2) the individual was married in a foreign jurisdiction and the laws of at least one state, possession, or territory of the U.S. would recognize the individual as lawfully married.