HESS CORPORATION RETIREES' MEDICAL PLAN

SUMMARY PLAN DESCRIPTION

FOR HESS RETIREES

2018

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INTRODUCTION

This book serves as the summary plan description ("SPD") for the Hess Corporation ("Company") Retirees' Medical Plan ("Plan"). The governing plan documents for the Plan are the Hess Corporation Retirees' Medical Plan Wrap Document ("Wrap Document"), this SPD, and the Anthem Medical Benefit Booklet prepared by the claims administrator for self-insured medical benefits offered under the Plan.

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 benefits.

The Claims Administrator makes medical claim determinations based on the Plan's guidelines and processes the claims. The Claims Administrator 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, 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:

- Medical program through Anthem
- Prescription Drugs program through Express Scripts
- COBRA Dental program through Delta Dental

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, for any reason, without notice. If the Plan is amended or modified, the ability of Retirees 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 Retiree 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 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.

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.

You can request a copy of the Wrap Document or the SPD and/or any applicable benefit booklets or brochures 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 the Express Scripts 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 terminate employment from the Company for any reason on or after age 55, have at least 10 years of vesting service under the Hess Corporation Employees' Pension Plan (the "Pension Plan"), and are not eligible for Medicare. For more information about how vesting service is credited, please see the Pension Plan's Summary Plan Description.

You are also eligible for benefits under the Plan if you are receiving disability retirement benefits under the Pension Plan. You are eligible for disability retirement benefits under the Pension Plan if you become disabled while working for the Company and have been credited with at least 10 years of vesting service (but you are not required to be age 55). You will be considered disabled under the Pension Plan if you are receiving disability benefits under the Social Security Act, as evidenced by a valid award letter from the Social Security Administration. Once you have received Social Security disability benefits for a period of 24 months, you become eligible for Medicare and therefore ineligible for Retiree Medical under the Plan.

If you are eligible for benefits under the Plan and terminate employment from the Company after Medicare eligibility (age 65 or disabled, your eligible dependents can remain covered under the Plan.

If you are eligible for benefits under the Plan and die in service or die while still eligible for benefits under the Plan, your eligible dependents can remain covered under the Plan.

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 at the time of your termination of employment from the Company who is not eligible for Medicare due to disability or age;
- Your eligible same sex or opposite sex Domestic Partner at the time of your termination of employment from the Company who is not eligible for Medicare due to disability or age;
- Your Eligible Children through the end of the calendar year in which they attain age twenty-six (26);
- Your Disabled Children.

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.

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 discussed below.

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 Retiree 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 in the Plan, you must complete an online affidavit/questionnaire verifying that the child is disabled.
- If you and your Spouse are both Eligible Retirees, 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.

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.

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 which: (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 Retiree 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 Retiree to provide coverage for his or her dependent children, the Company will accept the enrollment of the Retiree 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 a Retiree 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.

INITIAL ENROLLMENT

- If you were enrolled in the Hess Corporation Employees' Health and Welfare Plan (the "Active Plan"), you will be automatically enrolled in the Plan at the same level of coverage you had as an active employee.
- If you were not enrolled in the Active Plan, you must enroll within 30 days [of becoming eligible for coverage] if you want to have coverage in the Plan.
- To enroll, you may complete the medical information section online at: empyrean.hess.com or by calling the Benefits Center at 1-877-511-4377 and speaking with a customer service professional.

Completion of enrollment serves as your authorization to the Company to set up a direct bill arrangement with the direct bill administrator for purposes of collecting your contribution to coverage. You will receive an invoice each month that you must pay in a timely manner to maintain your coverage under the Plan. Once elections are received, the Effective Date of coverage will be your first day of retirement or termination from the Company. Benefits will not be provided for health services that you receive before the Effective Date of coverage.

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OPEN ENROLLMENT

If you do not enroll yourself and/or Dependents when you first become eligible to participate in the Plan, you can enroll later only if you experience the loss of other coverage, such as coverage through your Spouse's employer or coverage you had as an employee with another company after leaving Hess.

IMPORTANT NOTICES

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 the Plan 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 Plan is, on average for all 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.

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

If you decide to join a Medicare drug plan, your current coverage will not be affected. For those individuals who elect Part D coverage, coverage under the 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 will 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.

NOTE: You will get this notice each year.

You will also get it before the next period you can join a Medicare Drug Plan and if the coverage through Hess Corporation changes. You may also 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.

For more information about Medicare prescription drug coverage:

- 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).

For more information about this notice or your current prescription coverage:

You can access the Benefits Center 24 hours a day, seven days a week by visiting the Benefits Center at empyrean.hess.com.

You can also speak with a Benefits Specialist at 1-877-511-4377, Option 1, Monday through Friday, 7:30 a.m. to 5:30 p.m., Central Time, except on holidays. For TDD communication services for hearing impaired, call toll-free 1-877-526-5517.

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 January 31, 2018. Contact your State for more information on eligibility –

ALABAMA – Medicaid	FLORIDA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: http://flmedicaidtplrecovery.com/hipp/ Phone: 1-877-357-3268
ALASKA – Medicaid	**GEORGIA – Medicaid**
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	Website: http://dch.georgia.gov/medicaid - Click on Health Insurance Premium Payment (HIPP) Phone: 404-656-4507
ARKANSAS – Medicaid	**INDIANA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: http://www.indianamedicaid.com Phone 1-800-403-0864
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**IOWA – Medicaid**
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: Colorado.gov/HCPF/Child-Health-Plan-Plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711	Website: http://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp Phone: 1-888-346-9562

KANSAS – Medicaid	NEW HAMPSHIRE – Medicaid
Website: http://www.kdheks.gov/hcf/ Phone: 1-785-296-3512	Website: https://www.dhhs.nh.gov/ombp/nhhpp/ Phone: 603-271-5218 Hotline: NH Medicaid Service Center at 1-888-901-4999
KENTUCKY – Medicaid	**NEW JERSEY – Medicaid and CHIP**

Website: http://chfs.ky.gov/dms/default.htm Phone: 1-800-635-2570	Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
LOUISIANA – Medicaid	**NEW YORK – Medicaid**
Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331 Phone: 1-888-695-2447	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
MAINE – Medicaid	**NORTH CAROLINA – Medicaid**
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-442-6003 TTY: Maine relay 711	Website: https://dma.ncdhhs.gov/ Phone: 919-855-4100
MASSACHUSETTS – Medicaid and CHIP	**NORTH DAKOTA – Medicaid**
Website: http://www.mass.gov/eohhs/gov/departments/masshealth/ Phone: 1-800-862-4840	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
MINNESOTA – Medicaid	**OKLAHOMA – Medicaid and CHIP**
Website: http://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/medical-assistance.jsp Phone: 1-800-657-3739	Website: http://www.insureoklahoma.org Phone: 1-888-365-3742
MISSOURI – Medicaid	**OREGON – Medicaid**
Website: https://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075
MONTANA – Medicaid	**PENNSYLVANIA – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084	Website: http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm Phone: 1-800-692-7462
NEBRASKA – Medicaid	**RHODE ISLAND – Medicaid**
Website: http://www.ACCESSNebraska.ne.gov Phone: (855) 632-7633 Lincoln: (402) 473-7000	Website: http://www.eohhs.ri.gov/ Phone: 855-697-4347

Omaha: (402) 595-1178	
NEVADA – Medicaid	**SOUTH CAROLINA – Medicaid**
Medicaid Website: https://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.scdhhs.gov Phone: 1-888-549-0820

SOUTH DAKOTA - Medicaid	**WASHINGTON – Medicaid**
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/premium-payment-program Phone: 1-800-562-3022 ext. 15473
TEXAS – Medicaid	**WEST VIRGINIA – Medicaid**
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Website: http://mywvhipp.com/ Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
UTAH – Medicaid and CHIP	**WISCONSIN – Medicaid and CHIP**
Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669	Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf Phone: 1-800-362-3002
VERMONT– Medicaid	**WYOMING – Medicaid**
Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427	Website: https://wyequalitycare.acs-inc.com/ Phone: 307-777-7531
VIRGINIA – Medicaid and CHIP	
Medicaid Website: http://www.coverva.org/programs_premium_assistance.cfm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm CHIP Phone: 1-855-242-8282	

To see if any other states have added a premium assistance program since January 31, 2018, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov

1-866-444-EBSA (3272) 1-877-267-2323, Menu Option 4, Ext. 61565

HEALTH CARE PROGRAMS

MEDICAL

The Plan's medical Benefit Option is a high deductible plan (HDP) administered by the Claims Administrator, with a health savings account (HSA) administered by Fidelity.

Health Savings Account

The HSA is administered by Fidelity, the custodian and trustee for the HSA. Enrollees in the Anthem HDP must open an HSA with Fidelity. Debit cards and claims are managed at Fidelity through netbenefits.com.

Terms and Conditions

The terms and conditions of the Anthem HDP, including the description of covered benefits, including mental health and substance abuse 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 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 Hess Medical 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	$1,350	$2,700
Employee + One	$2,700	$5,400
Employee + Family	$2,700	$5,400
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	$375	
Employee + One	$750	
Employee + Family	$750	
Medical Benefits		
Preventive Care	100%	Up to $500 annual allowance, then 65% after deductible
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 Health Savings Account is a lump sum deposit in January.

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

Additionally, all medical and prescription drug claims are aggregated together toward meeting either the in network or the out of network deductible.

The out of pocket maximums noted in the chart above apply separately to in network and out of network services. This means that you are not required to meet both out of pocket maximums before benefits can begin. All in network claims are aggregated together toward meeting the out of pocket maximum and all out of network claims are aggregated together toward meeting the out of pocket maximum.

Additionally, the out of pocket maximums cross apply between medical and prescription drug claims. This means that all medical and prescription drug claims are aggregated together toward meeting the out of pocket maximum.

HEALTH SAVINGS ACCOUNT (HSA)

Eligibility Requirements

In order to be eligible to make or receive Health Savings Account (HSA) contributions for any given month, you must ***be enrolled*** in a qualified High Deductible Health Plan (HDP), like the 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

Opening Your Account

A Health Savings Account ("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.

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

If you were enrolled in the Plan your HSA will automatically continue as an enrollee in this Plan.

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

Once your HSA is open, the Company and you can make contributions to the account. For Retirees who are eligible January 1 of a calendar year, the Company contributes the full annual amount of $375 for single coverage or $750 for family coverage. In addition to the Company contribution, you may also make voluntary contributions to your HSA on an after-tax basis, subject to the annual IRS maximum. The IRS sets an annual contribution limit, which is subject to adjustment annually. Contributions you make on an after-tax basis can be used as an adjustment to your income when you file taxes.

For 2018, the maximum annual contribution to your HSA, including Company contributions and your contributions, is:

- $3,450 for employee only coverage; or
- $6,900 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 cannot exceed the IRS limits or you will be subject to income tax and penalties.

All contributions to your HSA are yours to keep. 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, with a balance of more than $1,000 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 allowed to grow on a tax-advantaged basis over time 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.

PRESCRIPTION DRUG BENEFITS

Express Scripts, Inc. administers the prescription drug Benefit Program and provides clinical management services. 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 Acredo, 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

Acredo 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 Acredo. Using a specialty pharmacy ensures the lowest cost for you and the benefit plan.

Description of Benefits Coverage

The benefit 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 Benefit Program 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 Benefit Program 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 Benefit Program when accompanied by a prescription.

Under the prescription drug Benefit Program, a 30-day supply may be dispensed for the Coinsurance amount determined by Your 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 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 Acredo 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 Acredo 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). 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 file a claim for coverage of the brand-name drug.

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.
- 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 order and which 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 urgency 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 urgency, 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);

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.

COBRA 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	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
Prosthodontics	60%*; no deductible	60%*; after deductible

Dentures, Bridgework, Implants		
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	$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

COBRA Dental benefits are provided through Delta Dental ("Delta"). To enroll, you must complete the COBRA election form that will be mailed to you within 30 days after your coverage as an active employee terminates.

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 Plan Profile 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 Contract.

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 Delta Dental Summary 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 Delta Dental 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 which 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 Delta Dental Summary 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.

ADMINISTRATIVE INFORMATION

WHEN COVERAGE ENDS

Coverage under the Plan stops for you or your enrolled Dependent upon eligibility for Medicare. Eligibility for Medicare is based on age, disability, and end stage renal disease.

It you become eligible for Medicare before your enrolled Spouse, your coverage terminates, but coverage for your Spouse and any children you may have enrolled will continue. Once your Spouse becomes eligible for Medicare, your Spouse's coverage and coverage for any children you may have enrolled terminates. Children you may have enrolled can then continue coverage through COBRA for up to 36 months.

Death

Upon your death as a Retiree, 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 without premiums.

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 consent 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 Retirees' Medical Plan

Plan Number

503

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.”

Source of Contributions

Contributions will be paid out of the Company's general assets and through contributions paid by Eligible Retirees, 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 1-800-858-1678www.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
Delta Dental	05467	Self-insured	Member & employer contributions	Delta Dental 1-800-932-0783 www.deltadentalin

				s.com

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. The Company further reserves the right to increase Retiree contributions, reduce benefits or terminate the participation of Retirees at its discretion.

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 law suit against the Plan. However, you should consult with your own legal counsel in determining when it is proper to file a law suit 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 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 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-retiree dies;
- The parent-retiree 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:

- 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, 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.

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 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.

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 Benefits Center

PO Box 61865

Phoenix, AZ 85082-1865

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

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

COBRA — The Consolidated Omnibus Budget Reconciliation Act

Company – The Hess Corporation.

Covered Dependent — Any Dependent in a Retiree'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 a Retiree who is eligible to receive coverage under a Benefit Program, as determined by the Plan Administrator in accordance with the governing plan documents.

Disability Retirement – a type of retirement under the Hess Corporation Employees' Pension Plan that requires a participant of any age to have at least 10 years of pension vesting service and be awarded Social Security Disability Benefits.

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 the end of the calendar year in which attaining 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;
- Has been in a relationship with you continuously for the last six months.

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 a Retiree who is eligible to receive coverage under a Benefit Program, including:

- Stepchildren who live with the Employee;
- The Retiree's eligible disabled children;
- Children who are placed with the Retiree for adoption;
- Children for whom the Retiree has legal guardianship issued by a court;
- Children of the Retiree'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 defined below.

Eligible Retiree — With respect to a Benefit Program, a Retiree 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.

Employer — An employer who has allowed its Employees and Retirees 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 a Retiree 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 individual establishes with a custodian or trustee who has entered into an agreement with the Company to receive contributions directly from the Company.

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 — A Retiree 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 Retiree and each Dependent, as defined in this Summary booklet, while such person is covered by this Plan.

Retiree – A Former Employee of the Company who has met the eligibility requirements for early retirement (age 55 with 10 years of service), Disability Retirement.

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 lawfully married to a Retiree 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.