Cigna®

THE SCHLUMBERGER INTERNATIONAL STAFF DEFERRED MEDICAL PLAN PARTICIPANT GUIDE (EURO)

Version date: January 2021

Schlumberger

SCHLUMBERGER INTERNATIONAL STAFF DEFERRED MEDICAL PLAN PARTICIPANT GUIDE

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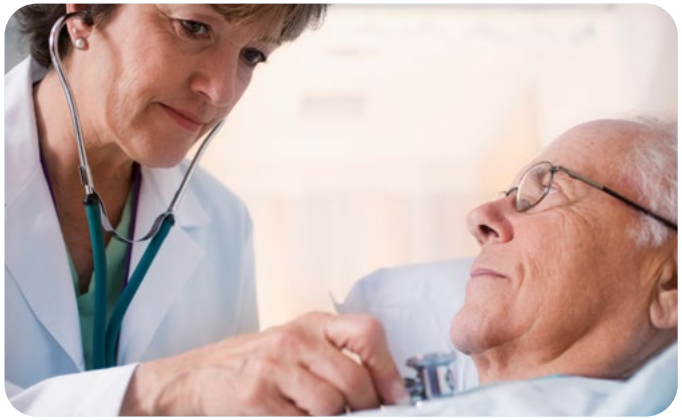
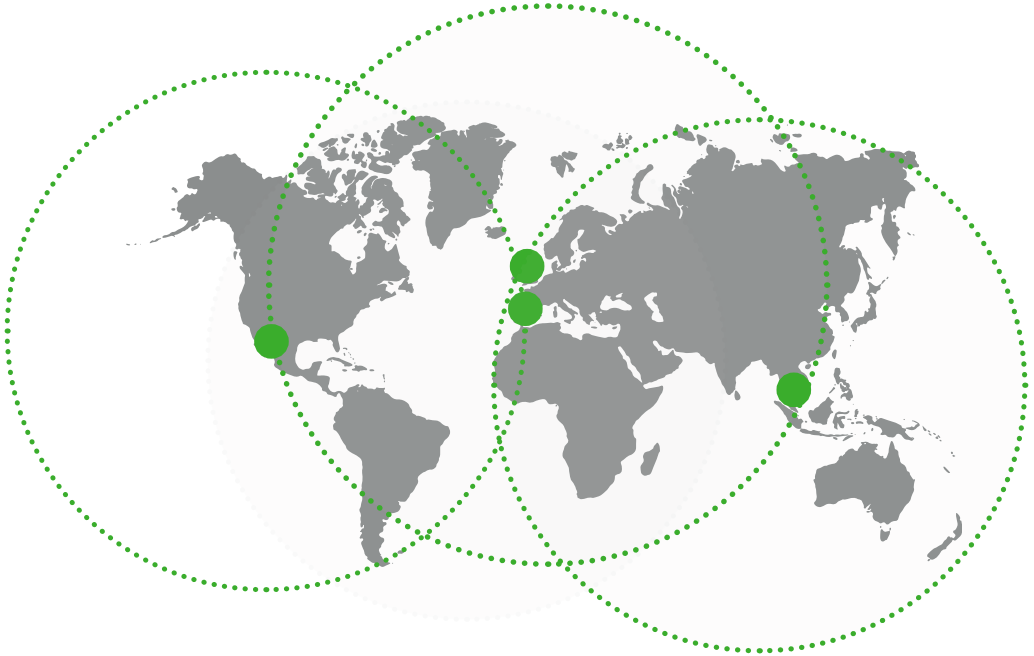


FULLY INTEGRATED SERVICE PLATFORM



Claims Submission
Online, scanned, email, hardcopy

Communication
Members contact Cigna via global contact number, email, online

One Dedicated Schlumberger Customer Services Team

4 core languages supported 24/7 (English, French, Spanish, Arabic)

31 languages supported in-house. 140+ languages supported through language line

Global Contact Numbers

+44-345-601-2239

Reverse charges or request a call back are available

+1-800-841-7764

Toll free when calling from within the US

(please see *section 1a* for further information)

Primary Schlumberger Operational Locations - Spain and UK
Supported by US (California) and Malaysia (Kuala Lumpur)

Dedicated policy administration team
Phone: +32 3 293 10 61
Email: DMPEnrolment@cigna.com

1. QUICK VIEW: PLAN CONTACTS AND SERVICES

Welcome to your Schlumberger International Staff Deferred Medical Plan which is managed in partnership with Cigna Global Health Benefits.

1a. Your Cigna Customer Service Team

As a plan member, you can enjoy a wide range of services, such as:

- You can contact your dedicated Schlumberger Customer Service team by calling +44-345-601-2239 or +1-800-841-7764 (toll free when calling from within the U.S.). Cigna will be happy to accept a reversed charge call to either number. You can also reach us at *DMPCustomerServices@cigna.com*
- When calling on either of the above telephone numbers you will be prompted to select from a list of languages. A complete list of these options can be found in *section 9c*
- Dedicated teams:
  - Multilingual 24/7 customer support with instant access to your policy, providing details of your benefit coverage, advice on where you can seek treatment, and updates on the status of your claim. This team from hereon will be referred to as "Customer Service team", and can be reached via +44-345-601-2239 or +1-800-841-7764 (toll free when calling from within the U.S.). Cigna will be happy to accept a reversed charge call to either number. You can also email *DMPCustomerServices@cigna.com*
  - A dedicated multilingual policy administration team to answer any question regarding your contract. This team will be able to advise you on any renewal questions, payment methods and frequency, and will answer all your queries regarding the voluntary coverage options (described in *section 10*). You can call + 32 3 293 10 61 or email *DMPEnrolment@cigna.com*
- Access to health care providers worldwide
- Access to health tools.

1b. Online Services

You can access information regarding your policy anytime through your personal Cigna web pages, Cigna Envoy (*www.CignaEnvoy.com*).

Cigna Envoy is also available while you're 'on the go' via our Mobile App.

From Cigna Envoy you can find:

- Pre-certification request
- Certificate of coverage
- Printable ID card (Electronic ID cards are available on the Mobile App)
- Policy documentation
- Claims submission features*
- Health resources
- Country guides
- Contact your Cigna Customer Service team*
- Claims tracking*
- Global provider search.*

Details of how to download the Mobile App can be found in *section 9g*.

1c. Pre-certification and UCR

These are important concepts for you to understand, and are explained fully in *sections 3b and 3c*.

Pre-certification means prior approval of treatment. To arrange prior approval of inpatient treatment and any other treatment above €1,200, you should notify Cigna ideally **ten days** in advance to enable them to arrange direct payment, where possible, and for you to be notified of any expenses which are above Usual, Customary and Reasonable (UCR). Make your pre-certification request by logging into *www.CignaEnvoy.com*, and select the '*Pre-certification Form*' from the '*My Account*' dropdown box. Alternatively you can contact your dedicated Schlumberger Customer Service team by calling +44-345-601-2239 or +1-800-841-7764 (toll free when calling from within the U.S.). Cigna will be happy to accept a reversed charge call to either number. You can also reach us at *DMPCustomerServices@cigna.com*.

* Also available on the Mobile App

1d. Find a Doctor/Hospital

Cigna recognises that you may be unfamiliar with local medical providers in your country of residence. To assist you in making a selection, Cigna has created a provider directory of pre-screened full service hospitals, clinics and outpatient centres worldwide, which is available at *www.CignaEnvoy.com* and on the Cigna Mobile App, which provides GPS functionality to locate the provider nearest to you. The network listing will also confirm whether the provider you select can offer direct settlement and/or preferential rates as well as details of languages spoken. If you require any assistance, want to visit an out of network provider, or do not find your preferred provider in the directory, your Cigna Customer Service team will happily assist you.

1e. Where to find further information related to the plan

The master copy of this Participant Guide, where all future updates will be made, is posted on the Schlumberger External Portal at: *https://myaskhr.slb.com*.

You will find answers to many common questions asked by plan participants in *section 9 (Plan Administration)*. In addition, a detailed FAQ is available at the above link. If you cannot find the answer to your question in the FAQ, contact your Cigna Customer Service team for any medical issues or questions related to plan benefits or services. If your question is not related to medical services forward it to *IBIS@slb.com*.

Your personal Cigna web pages, Cigna Envoy, also provide invaluable information related to your plan.

To complete registration, *click here* (or access *www.CignaEnvoy.com*). Enter your Cigna ID number as it appears on your Cigna welcome email and answer a few security questions. Click '*Register*' and a temporary PIN will be displayed on the screen. Change the temporary PIN to a password of your choice. Registration is now complete.

Once you have registered you can access Cigna Envoy through *www.CignaEnvoy.com*, then select '*I have an existing login*' and use the password you have created at registration.

2. PLAN OVERVIEW

This Participant Guide provides you, and your eligible family members who are covered under the plan, with an understanding of the important concepts, key features and details of treatment covered. Additionally, by reading through the content you will understand what Prefunded Cover (previously known as Free Cover) and After Prefunded Cover (previously known as After Free Cover) mean and the optional plans that are available to you, you will understand what conditions are excluded from cover, you will know how to make a claim for reimbursement, which types of treatment require pre-certification, how you can benefit from the health and wellbeing resources, and what services are provided by Cigna.

Eligible participants are responsible for ensuring they understand how the plan works and for sharing this Participant Guide with eligible family members. This will avoid you making claims for items which are not covered by the plan or finding out after treatment is taken that reimbursement will be reduced as the necessary procedures were not followed.

The Schlumberger International Staff Deferred Medical Plan, from hereon will be referred to as DMP.

- DMP Main Medical Plan is administered and insured by Cigna
- DMP Supplementary Medical Plans are administered and insured by Cigna
- DMP Accidental Death and Disability Insurance is administered by Cigna and insured by AXA France Vie
- DMP is designed to provide continued comprehensive inpatient, outpatient, dental and vision coverage to eligible former Schlumberger International Staff Employees and their eligible dependents, after they have left the company during the period they are either looking for a new job (unemployed) or settling into permanent retirement (immediately withdrawing Schlumberger International Staff Pension Plan).

The DMP Main Medical Plan provides the following important features:

- No waiting periods
- No exclusions for pre-existing conditions
- No age limit for joining or maintaining coverage
- Coverage for spouse and dependent children
- No restrictions in the choice of doctors, laboratories, clinics/hospitals as long as they are appropriately licensed and registered doctors/institutions and the related cost is considered Usual, Customary and Reasonable (UCR).

DMP has been designed to:

- Act as Complementary Coverage when other Private or Government Medical, Dental or Vision schemes are available. You are expected to first make a claim from your primary plan and claim only the supplemental part from DMP. The plan is not intended to be a source of profit
- Act as Main Coverage when no other coverage is available to a member or his/her dependents
- Provide coverage only for Medical, Dental and Vision treatment, therefore all expenses such as, travel, transportation and accommodation that are directly or indirectly related to your receipt of medical treatment are not covered by the DMP
- Cover treatments or diagnoses that fall under conventional or mainstream medicine classifications. Therefore, experimental treatment and many alternative or complementary treatments are not covered under the plan unless detailed in the Table of Benefits.

For more details on DMP exclusions please refer to the exclusions under each of the Tables in s*ection 8: Benefits Covered by the Plan.*

You can obtain further information related to the plan by calling your Cigna Customer Service team, details of which you will find in *section 9: Plan Administration.*

3. IMPORTANT CONCEPTS YOU SHOULD UNDERSTAND

Continuing to be able to offer a comprehensive level of medical care to its DMP members and their families is a high priority for Schlumberger. However, with the increasing cost of medical treatment it is essential to ensure that all participants in the plan are responsible consumers and make good decisions about the necessity of treatment, the location in which they take the treatment, the frequency with which they use the plan, and the type of facility they use.

Below are some of the important measures which are established within the plan to help in this respect and you are encouraged to understand them to avoid disappointment if your claim is affected by one of them.

3a. Cigna's Global Network

Cigna has established a substantial global network of hospitals and clinics. Each provider relationship is independently contracted and negotiated by Cigna's in-house provider partnership team. You have a free choice regarding which provider you use for treatment and this is not restricted.

However, the advantage of using a medical facility from Cigna's network listing is that this, in most cases, provides you access to direct settlement for inpatient treatment and for outpatient treatment above €1,200. In addition, due to the preferential rates that Cigna has negotiated with many of their network providers, you should experience lower out of pocket costs.

3b. Usual, Customary and Reasonable (UCR) Criteria

What is UCR?

Usual, Customary and Reasonable (UCR) limit refers to maximum amount eligible for reimbursement under the DMP, for the benefits covered under the DMP.

How is UCR determined?

These UCR reimbursement limits have been determined based on a review of the current charges made by peer doctors for the same type of medical service within a specific country or geographical area. Some healthcare providers charge above the UCR limits, however the plan will reimburse only up to the UCR considered for that specific treatment.

When the participation guide states 80% of UCR charges, this means a contribution of 20%, this is the so-called co-insurance applicable for you as member.

Cigna will determine whether treatment costs are Usual, Customary and Reasonable with reference to medical, dental and vision expenses commonly charged in the specific country or area where the treatment is provided, for the US this is called Maximum Reimbursable Charge. When receiving care from an Out-of-Network provider in the US, the provider may bill you the difference between the payment they receive from Cigna and their usual fees.

How will I know when doctors, laboratories, clinics/hospitals are UCR or not?

Inpatient treatment: All costs under this category should be approved in advance via the pre-certification procedure, therefore costs are known in advance by Cigna. One of the advantages of pre-certification for participants in the plan is that if the costs for treatment are not UCR then you will be notified upfront what charges will be covered by the plan and what charges you will have to pay from your own pocket. In most cases you should have the option to change to a UCR facility before the treatment is taken.
Outpatient treatment: As this category of treatment is reimbursed after treatment is taken, you will only know about UCR at the time of reimbursement. Cigna would recommend that you check with them **before** taking extensive outpatient treatment, particularly if the facility appears more expensive than other facilities in your location.

What happens if the costs of doctors, laboratories, clinics/hospitals are above UCR?

DMP allows you complete freedom in choosing your medical providers. However, if the provider you have chosen charges above UCR for that location, and you have validated that with Cigna, you can either:

- Decide to remain with your initial choice of provider, and accept to pay the difference in charges between the UCR and the actual costs for that procedure with the chosen provider, or
- Ask Cigna to help you find an alternative provider whose pricing is within the UCR criteria.

What could the cost be to me if I choose a facility above UCR?

As an example, the UCR cost of a hospital room in France is €229 vs the cost of a hospital room at The American Hospital in Paris which could be €1,018. Therefore, the plan will pay on the basis of €229 (including cost sharing) and the patient will pay the remaining amount.

3c. Pre-certification Procedure

What is the Pre-certification Procedure?

Pre-certification, also referred to as pre-authorisation, is the process of informing Cigna, in advance of your medical or dental treatment when it meets certain criteria (see below *When is it necessary to pre-certify for treatment?*).

When is treatment considered medically necessary?

Medically necessary covered services and supplies are those determined by the Medical Team to be: - required to diagnose or treat an illness, injury, disease or its symptoms;

- Orthodox, and in accordance with generally accepted standards of medical practice;
- Clinically appropriate in terms of type, frequency, extent, site and duration;
- Not primarily for the convenience of the patient, physician or other health care provider and;
- Rendered in the least intensive setting that is appropriate for the delivery of the services and supplies.

Where applicable, the Medical Team may compare the cost-effectiveness of alternative services, settings or supplies when determining least intensive setting.

It is strongly recommended that you do not disclose the level of your benefits to any providers (doctors, dentists, ophthalmologists), as they may be tempted to apply an unreasonable surcharge to the estimate of their fees or even use your benefit limit as a 'budget'.

3. IMPORTANT CONCEPTS YOU SHOULD UNDERSTAND

Check status of your Annual limit
Please make sure to check the status of your annual limit before taking extensive treatment. You may be liable for costs over and above the annual limit agreed upon as per the renewal date.

Why should I follow the Pre-certification Procedure?
By following this process you ensure that:

- **Inpatient treatment:** Cigna can organise direct payment to your medical service provider avoiding you having to first make payment, which in some cases can be very significant, and then make a claim for reimbursement. Also Cigna can notify you of any UCR that may apply, giving you the opportunity to change provider if its charges are unreasonable. If planned treatment is known in advance, then Cigna can negotiate a pricing reduction through their Preferred Provider Network. Additionally, if surgery is recommended, Cigna doctors may request a second opinion to determine whether there is an alternative treatment which is non-invasive.
- **Outpatient treatment:** when a series of treatment is taken i.e. several physiotherapy sessions, or expensive dental work, then Cigna, when notified, can assess whether the costs charged by the medical facility or doctor are UCR. If they are above UCR you are notified in advance and can make a decision whether to remain with that provider or change to another who charges within UCR. Additionally, Cigna can organise direct payment of your treatment whenever possible.

When is it necessary to pre-certify for treatment?

- **Inpatient treatment:** In all cases, including maternity
- **Outpatient/Dental treatment:** In all cases over €1,200
- **Emergency treatment:** The Pre-certification Procedure cannot be followed as emergency treatment cannot be planned, however, you are required to inform Cigna within 72 hours of admission as they may be able to negotiate the treatment charges and arrange direct billing on your behalf.

What happens if you do not follow the Pre-certification Procedure?
In the event the Pre-certification Procedure is not followed, the direct payment or reimbursement will be systematically reduced to the Usual, Customary and Reasonable charge for that country or geographical area, where applicable. You should note that it is not uncommon for some medical facilities to require the patient to guarantee part of the treatment on a credit card, even though Cigna have already arranged pre-certification. Whilst Cigna tries to minimise this occurrence, it is normal practice in some private hospitals and clinics and cannot be avoided.

3d. Second Medical Opinion

In some countries health care is a 'business' and doctors may recommend invasive procedures even if the patient does not necessarily require them or if the medical condition can be treated by a non-invasive medical procedure. In some cases the reason for a diagnosis could be simply due to the fact that the patient has a comprehensive medical insurance which covers such treatment.

If you have concerns regarding the treatment being recommended by your doctor, you are entitled to request a second medical opinion. The plan will reimburse this second opinion as it may affect the treatment being taken and the charges to the plan. A second opinion will assist you in making an informed choice on the nature of treatment to be carried out and to help you to weigh up the benefits and any potential risks of surgical procedures. For some conditions there are medically sound alternatives which may be more suitable to your circumstances.

Second Medical Opinion via Advance Medical
Doctors can provide a second opinion face to face.

Alternatively, Cigna can provide a second opinion service offering a truly independent, objective and evidence based second analysis.

It's important plan members feel confident about their diagnosis and the proposed treatments or surgery. Our Treatment Decision Support Programme is an evidence-based, predictive model used by independent medical experts that will help plan members **make informed decisions** about correct diagnoses and the available treatment options.

We advise members seeking 2nd medical opinion support to contact Cigna Customer Services requesting for a case management file to be opened to obtain remote, independent support.
Third opinions need to be authorised by Cigna in advance and are only covered by DMP in exceptional circumstances. Please contact your dedicated Schlumberger Customer Service team by calling +44-345-601-2239 or +1-800-841-7764 (toll free when calling from within the U.S.). Cigna will be happy to accept a reversed charge call to either number. You can also reach us at *DMPCustomerServices@cigna.com*.

3e. Participant Responsibility

It is the individual responsibility of every adult participant covered by the DMP to make careful decisions about their health. In many cases, the treatment being provided under the health care plan is a direct result of lifestyle choices, some of which could be prevented by following a healthy lifestyle thus reducing your chances of developing chronic diseases, such as diabetes, cancer and heart disease.

You are encouraged to:

- Eat healthy foods. Avoid junk food. Reduce the amount of sodium in your diet. Choose water to drink and eat healthy snacks
- Get plenty of exercise. Reduce screen time
- Stop Smoking
- If you drink alcohol, consume in moderation
- Drive safely
- Get sufficient sleep
- Go for periodic health check-ups (particularly important for persons over 40 years of age)
- Have a blood pressure test at least every 2 years (above age 40) or 3 years (below age 40)
- Practice safe sex avoiding STDs.

3f. Report unprofessional or unethical behaviour of providers to Cigna

If you are uncomfortable with the conduct of a provider, the way they are charging or the advice they are providing, you have a responsibility to report that situation to Cigna. Do not continue using services of an unprofessional provider, Cigna can help you find an alternative.

4. 'PREFUNDED COVER' PERIOD AND 'AFTER PREFUNDED COVER' PERIOD

The medical coverage provided by DMP is divided into 2 periods of coverage: 'Prefunded Cover' (previously known as Free Cover) Period and 'After Prefunded Cover' (previously known as After Free Cover) Period.

Departure Date

'Prefunded Cover' Period
(Commences the day following the last day of employment with Schlumberger)
3–24 Month Period

'After Prefunded Cover' Period
(Following end of 'Prefunded Cover' Period)
Renewal subject to eligibility

USEFUL TIP

You are covered by the plan effective the day following your last day of employment and the duration of 'Prefunded Cover' is reported in your PEF (earned through active participate in the plan during employment). The 'Prefunded Cover' period cannot be postponed to start at a later date.

What is 'Prefunded' Period?
'Prefunded' is a period of medical coverage which was funded by DMP contributions made during active employment and provided to individuals who have met the eligibility criteria.

Former employees, who are eligible to participate in the 'Prefunded Cover' period, are given a **one-time decision to join** DMP 'Prefunded Cover' Period or take their DMP Contributions plus earnings. Should a former employee choose to receive a refund of DMP Contributions plus earnings, **he/she will not be permitted to join DMP ('Prefunded Cover' or 'After Prefunded Cover' Periods) at a later date**, even at his/her own cost.

What is 'After Prefunded Cover' Period?
Following the 'Prefunded Cover' Period, DMP participants who meet the required 'After Prefunded Cover' eligibility criteria, can choose to continue to be covered by opting for the 'After Prefunded Cover' by paying premiums directly to Cigna.

Former employees who at the time of termination chose to receive a refund of contributions plus earnings instead of 'Prefunded Cover', **will not be permitted to join DMP 'After Prefunded Cover' Period**, even at their own cost. It is mandatory for a former employee to be covered first under the 'Prefunded Cover' Period in order to qualify for the 'After Prefunded Cover' Period.

5. ELIGIBILITY FOR COVERAGE

5a. Participant Eligibility and Length of Coverage

A former employee will be eligible to participate in the 'Prefunded Cover' (previously known as Free Cover) Period provided:

- He/she has met the minimum required number of contributions

Minimum required number of contributions

AND

- He/she is terminated by the company 'other than for cause' and unemployed at the time of leaving **OR**
- He/she is retiring and immediately drawing his/her International Staff Pension Plan, has reached age 60 if in ISDC or age 65 (or have 85 points) if in US Abroad Pension **AND if** DMP contributions commenced after July 1st, 2015, he/she has a minimum of 10 years Schlumberger seniority at the time of retirement **OR**
- He/she has left the company due to illness and is receiving payment under the IS Short Term Disability plan.

The number of months of contribution are dependent on the members' status at the time of leaving as follows:

- If he/she leaves directly from International Staff Status or as an Active Participant in the plan he/she requires a minimum of 12 months contribution to be eligible
- If he/she leaves from another employment status and is not actively contributing to the plan he/she requires a minimum of 60 months contribution to be eligible.

Employees who leave the company and do not meet the above criteria will receive a refund of their own contributions plus investment income. For instance, if you have accrued less than 60 months of contribution whilst active on IS payroll then returned to home country status and are terminated from HC payroll you will not have accrued the necessary 60 months of contributions to be eligible to participate in the plan. Therefore, as you are leaving as 'nonactive' you will receive a refund of your contributions plus earnings.

The length of coverage provided during the 'Prefunded Cover' Period is directly related to the number of months of DMP participation during active employment, as follows:

		Reason for Departure	
		Termination at Company initiative	**Retiring and immediately drawing international pension**
Conditions to be eligible to DMP Prefunded Cover	**Minimum contribution** to the plan whilst active	12 months	
	Minimum SLB Seniority	None	10 years
Access to After Prefunded Cover (Paying annual premiums)		Yes, limited to 12 months	Yes, for life

Months of contribution	Months of 'Prefunded Cover'
12 - 59	3
60 - 119	6
120+	12
>= 180 AND active with an International contract effective prior to July 1st, 1996	24

Note: Employees who are already participating to DMP at 1 July 2015 will not require 10 years minimum SLB seniority if retiring and immediately drawing their international pension.

5. ELIGIBILITY FOR COVERAGE

5b. Eligible Family Members

The following family members are eligible for coverage under DMP (the family eligibility criteria applied during 'Prefunded Cover' and 'After Prefunded Cover' Period are the same):

- Legal Spouse
- Dependent Child until they reach their 19th birthday
- Dependent Child aged above 18 years and under 25 years provided he/she:
  - Remains unmarried AND
  - Is a full-time student AND
  - Is 100% financially dependent on the former employee
- Dependent Child who is physically or mentally incapacitated following the child's 19th birthday provided:
  - The child remains unmarried AND
  - The child cannot live independently AND
  - The child is 100% financially dependent on the employee AND
  - Proof of the disability is submitted to Cigna prior to the child's 19th birthday and regularly thereafter at Cigna's request.

Grandchildren and wards of court are excluded even if they are dependent on former employees' sole financial support.

5c. Compliance with local Healthcare Regulations

Please note that the Schlumberger Deferred Medical Program is a unique plan design and is not designed to be compliant with any local government mandated healthcare requirements. If you are required to comply with minimum healthcare provision guidelines in your country of residence, such as in the US, Australia, Turkey, Saudi Arabia, Abu Dhabi, Dubai and some European countries (e.g. Ireland) this is your personal responsibility.

You may be subject to a fine or tax implications if you decide to stay on the DMP plan without having a local plan.

In order to prove that a child is a full-time student, a 'Certificate of Attendance' issued by the relevant school/university must be presented to Cigna on an annual basis. You can upload your certificate directly to Cigna Envoy by selecting '*My Account*' then '*Evidence of Eligibility*'. Coverage under DMP will be provided only for the period stated in the 'Certificate of Attendance' but may be further extended to cover vacation periods in the case of known extended periods of study, after which a new certificate will have to be submitted for the new educational year. For further information please refer to the FAQ document held under *'My Plans'* then *'My Documents and Forms'* on Cigna Envoy.

6. 'AFTER PREFUNDED COVER' PERIOD: PREMIUM STRUCTURE AND PAYMENT

6a. Premium Structure

At the end of the 'Prefunded Cover' (previously known as Free Cover) period, a participant who is eligible to renew for the 'After Prefunded Cover' (previously known as After Free Cover) Period (see *section 5*) will be contacted by Cigna requesting payment of the premium for the DMP Main Plan. The premium amount is determined based on the following factors:

- Country of residence
- Family status
- Age.

In addition to the DMP Main Plan, participants can also subscribe to one of the Supplementary Medical options and/or the Accidental Death and Disability Insurance options detailed in *section 10*.

6b. Zones of Coverage

Most participants choose the premium rate based on their country of residence i.e. where they will receive the majority of their medical care. In the event that the participant typically seeks medical treatment elsewhere, he/she can select the premium rate based on this preferred treatment country at the time of registration, providing that the preferred treatment country is more expensive than the country of residence. Claims may be denied where treatment is persistently being taken in countries outside of the zone of coverage for which a premium is being paid. Members are advised to discuss with the plan administrator if this is likely to occur.

Premiums are based on 5 geographic zones:

1. France*: Premiums are in Euros. Within the zone there are two options:

a. France with French Social Security: For participants registered with **French Social Security**, with DMP coverage complementary to FSS. The premiums are based on the fact that the majority of treatment will be received from FSS.

b. France without French Social Security: For residents in France who are not eligible for French Social Security.

Main country of treatment is France, however, treatment will be reimbursed on a worldwide basis with the exception of treatment in the USA which will only be reimbursed in the event of an emergency and claims must have accompanying evidence from the treating physician and related travel documentation.

2. United Kingdom with NHS*: Premiums are in Euros. DMP coverage is complementary to **NHS** (National Health Service). The premiums are based on the fact that the majority of treatment will be received under the NHS. Medical expenses received in the private sector and submitted to Cigna will need to be supported by evidence as to why such treatment was taken in the private sector (for instance letter of Referral to private sector by an NHS doctor or evidence of a long waiting list).

Main country of treatment is the UK, however, treatment will be reimbursed on a worldwide basis with the exception of treatment in the USA which will only be reimbursed in the event of an emergency and claims must have accompanying evidence from the treating physician and related travel documentation.

3. Euro Zone*: (Germany, Austria, Belgium, Spain, Finland, Greece, Ireland, Italy, Luxembourg, Netherlands, Portugal, Slovenia, Cyprus, Malta, Slovakia, United Kingdom (for those not eligible to receive treatment under the NHS), Norway, Sweden, Switzerland or Denmark): Premiums are in Euros.

Main country of treatment is in the Euro Zone, however, treatment will be reimbursed on a worldwide basis with the exception of treatment in the USA which will only be reimbursed in the event of an emergency and claims must have accompanying evidence from the treating physician and related travel documentation.

4. USA:

a. USA where main member or their spouse is a US citizen, Green Card holder or receiving Medicare

This zone of coverage is restricted to Main Participants (or their spouse) having US citizenship, being Green Card holders (below age 65) or being recipients of Medicare (for members aged over 65). Members will be required to provide Cigna with a copy of US passport, Green Card or proof of Medicare coverage in order to participate.

b. USA where main member or their spouse is not a US citizen, Green Card holder or receiving Medicare

This zone of coverage is available to members who have no formal link to the US and are not receiving subsidized benefits from the US government.

Main country of treatment is USA, however, treatment will be reimbursed on a worldwide basis.

c. The plan can provide US coverage for dependent children of non-US DMP participants who are studying in US, in order for this to be arranged a school certificate will need to be provided.

5. Worldwide*: Premiums are in USD. For those residing outside France, the Euro Zone countries listed to the left, the UK and USA.

Treatment will be reimbursed on a worldwide basis with the exception of treatment in the USA which will only be reimbursed in the event of an emergency and claims must have accompanying evidence from the treating physician and related travel documentation.

Please refer to the '*Frequently Asked Questions*' available on *https://myaskhr.slb.com*, and on *www.CignaEnvoy.com* under '*My Account*' then '*My Documents*' to help you select the Zone of Coverage that best fits your needs and Family conditions.

6c. Payment of Premiums for the 'After Prefunded cover' Period

The participant's share of the cost is payable in advance, either annually or quarterly depending on your status. Premiums are payable in the currency corresponding to your zone of coverage as detailed in *section 6b* (USD or Euros).

Premiums can be paid by:

- credit/debit card online
- bank transfer
- direct debit within SEPA zone (Single European Payment Area - for payments in Euros only)
- by cheque.

Please contact Cigna for more details.

You are encouraged to use the online payment option as it is both the quickest and most reliable method. Although Cigna will send payment reminders, it is the participant's responsibility to make sure that payment is timely. If Cigna has not received the premium and supporting documents when applicable by the renewal deadline, Cigna reserves the right to refuse ongoing participation in the plan and decline reimbursement for subsequent claims.

** Individuals or families where the Main Participant and/or the spouse is not a US citizen or US Green Card holder: covered on a worldwide basis excluding the USA (treatment in the US will only be reimbursed in the event of a life threatening emergency that requires immediate attention to prevent loss of life, sight or limb). Evidence will be needed to substantiate such a claim and to demonstrate that treatment was not intentionally being sought in the US.*

7. SCOPE OF COVERAGE

7a. Plan Limit

The Plan Limit provided by the **DMP Main Plan** ('Prefunded Cover' and 'After Prefunded Cover' Period) is:
Plan Limit: €100,000 annual limit per insured
Currency of the Plan: €.

Additionally, DMP Participants can upgrade this plan limit by opting to be covered under **DMP Supplementary Plans** details of which you will find in *section 10: Optional Plans*.

7b. Geographical Scope

During 'Prefunded Cover', the DMP geographical scope is defined as follows:

- Individuals or families where the Main Participant and/or the spouse is a US citizen or US Green Card holder: covered on a worldwide basis (including the USA).
- Individuals or families where the Main Participant and/or the spouse is not a US citizen or US Green Card holder: covered on a worldwide basis excluding the USA (treatment in the US will only be reimbursed in the event of a life threatening emergency that requires immediate attention to prevent loss of life, sight or limb). Evidence will be needed to substantiate such a claim and to demonstrate that treatment was not intentionally being sought in the US.
- The plan can provide US coverage for dependent children of non-US DMP participants who are studying in US, in order for this to be arranged a school certificate will need to be provided.

During 'After Prefunded Cover', the zone of coverage should reflect the country of residence of the Main DMP participant or the country in which the participant typically seeks medical treatment. The USA Zone A is restricted to Main DMP participants (or his/her spouse) having US citizenship or being Green Card Holders. In addition, plan members older than 65 need to have Medicare cover. You will be requested to submit proof to Cigna that you meet these conditions (copy passport/valid Green Card/Medicare cover).

If the Main DMP participant and his dependents are resident in countries that fall under different zones of coverage then premiums for zone with the highest premium apply.

	Participant Cost Sharing	DMP Coverage
Inpatient Treatment	20% of UCR charges up to an OoP maximum of €1,000 per individual	80% of UCR charges up to an OoP maximum of €1,000 per individual then 100% of UCR charges up to subcategory limit
Outpatient Treatment, Dental Treatment and Vision Treatment	From 20% of UCR charges	Up to 80% of UCR charges

Treatment in the USA is excluded for all participants who are not enrolled in the USA zone.
It is possible to change your main country of residence in the course of the policy year to a zone with wider geographical spread (i.e. upgrade zone of coverage). Participants that are physically moving to the USA will be requested to provide documentary evidence of the new residency details, and where applicable any supporting material such as valid Green Card/ proof of Medicare cover.

Premium changes following a change in zone of coverage to a more limited geographical spread (i.e. downgrade zone of coverage) or changing within the existing zone to a zone of coverage with Social Security (for zone France) or NHS (in the UK) will only come into effect as from the next renewal date.

7c. Participant Cost Sharing

Routine treatment, like many other health care plans is reimbursed with an element of cost sharing which is designed to encourage responsible use of medical treatment in terms of the nature, the frequency and the quantity of consumption.

Cost sharing is represented as a % of reimbursement cost which is capped at an Out of Pocket (OoP) maximum.

You will see from the table above that major, often unexpected and expensive treatment such as Inpatient is reimbursed at 100%, once the OoP maximum of €1,000 per individual has been reached for the year.

The OoP maximum applies to each plan year, running 1st January to 31st December.
The example below demonstrates how the cost sharing and Out of Pocket mechanisms work for inpatient treatment:
A participant pays €4,000 for a hospitalization; the plan will reimburse 80% of that cost of treatment i.e. €3,200 and the participant will pay €800 out of his/her pocket. All subsequent treatments in the inpatient category during that plan year will be reimbursed on the same basis until the Out of Pocket, the accumulation of the participant's 20% cost-sharing, has reached €1,000 which is when total individual claims reach €5,000. The plan will then reimburse 100% of the cost of eligible inpatient treatment.

REMEMBER
Participants covered under USA Zone A and aged over 65 years old can only use DMP as coverage to complement Medicare or other primary insurance plan.

Participants covered under France with FSS or UK with NHS can only use DMP as coverage to complement French Social Security (France) or National Health Service (UK).

Please note that your reimbursement through French Social Security and DMP combined will not exceed the DMP coverage limit of covering 80% of UCR for Outpatient.

This plan is complementary to the French Social Security system. The benefit limits include the part reimbursed by the French Social Security system.

Three practicle examples are:
Billed 100 eur FSS covers 50. Cigna covers 30;
Billed 100 eur. FSS covers 20, Cigna covers 60;
Billed 100 eur. FSS covers 80 EUR or more, Cigna covers 0

8. BENEFITS COVERED BY THE PLAN (AND THOSE WHICH ARE NOT)

In all the following benefit tables the sub category limits are applied on a calendar year basis, 1st January to 31st December each year. Note that under each sub category there are some exclusions, however, you must also read the General Exclusions in *section 8f.*

Reminder: Main plan annual limit: €100,000 per person per year.

8a. INPATIENT TREATMENT

- Inpatient treatment is defined as treatment received in hospital which includes an overnight stay
- Pre-certification is required for all Inpatient treatment and Day Care Surgery and should ideally be made 10 days before treatment commences
- See *section 9d* for detail of documentation required in order to pre-certify

Type of Service	Plan Reimbursement	Notes
Semi-private room and board	80% of the first €5,000 of annual covered expenses (up to UCR), 100% thereafter—up to the annual maximum	Private room and board will be reimbursed up to a hospital's average rate for a semi-private room unless a private room is all that is available
Intensive Care and Coronary Care Facilities		
Day Care Surgery (requiring general anaesthetic and admission to the facility for investigation/operation/recovery)		
Operating, delivery, recovery rooms and equipment		
General nursing provided by the hospital		
Surgeons', anesthetists', physicians' fees		
Inpatient X-rays, diagnostic tests and procedures		
Prescribed medicines and drugs for use in the hospital		
Hospital outpatient services for emergency treatment furnished for an injury on the day of or the day after the injury		
Hospital outpatient services furnished on the day of and in connection with surgical procedures involving cutting or the reduction of a dislocation or fracture		
Ground ambulance transportation (locally)		
Psychiatric inpatient treatment		Lifetime maximum of €10,000 per person
Extended care facility expenses	Up to 120 days for recovery from an accident or illness if confined to such facility within 7 days of hospital stay of 3 days or longer	Other than for alcoholism, mental disorder, senility or drug addiction

EXCLUSIONS FOR INPATIENT TREATMENT

- Ancillary inpatient services e.g. TV, phone, internet, extra bed, guest meals etc
- Any service or item provided in a medical facility during inpatient stay, when it is part of outpatient exclusions i.e: Nutritionist consultation incurred during a hospital stay
- Stays in a cure centre, SPA centre, health resort and recovery centre
- Cosmetic Surgery
- Expenses for the acquisition of an organ including, but not limited to, donor search, typing, harvesting, transport and administration costs
- Domestic services following surgery, such as home help

8. BENEFITS COVERED BY THE PLAN (AND THOSE WHICH ARE NOT)

8b. OUTPATIENT TREATMENT

- Pre-certification is required for all treatment in excess of €1,200 and should ideally be made 10 days before treatment commences
- See *section 9d* for detail of documentation required in order to pre-certify

Type of Service	Plan Reimbursement	Notes
Physician's non-surgical fees	80% of UCR charges	
Hospital outpatient charges		
Outpatient Surgeon's, Anesthesiologist's, Pathologist's and Radiologist's fees for surgical procedures		
Day Care Surgery for non-surgical/minor-surgical procedures, requiring local anaesthetic and short recovery time (<3 hours)/no admission required		
Prescription drugs		Medicines, including vitamins & minerals, must be prescribed
X-ray examinations, prescribed laboratory tests, radium and radioactive isotope therapy		
Physical Therapy Requirements, treatment that is established as being medically necessary to treat an illness, injury, disease or its symptoms.		Cigna Medical team to advise on number of sessions, which is subject to condition
Artificial limbs and eyes		
Braces, supports and crutches		If prescribed
Rental of durable medical or surgical equipment		
Hearing aids (purchase or repair)	80% of UCR charges up to €750 per ear	Reimbursed every 4 years
Occupational therapy, speech therapy where linked to a diagnosed physical impairment	80% of UCR charges up to OoP* maximum for Occupational, Vision & Speech therapies. 50% of UCR charges up to OoP* maximum for ABA therapy.	Speech therapy for Adults is covered in relation to an acute medical condition with a reasonable likelihood of restoring skills.
Fees charged by registered nurses, home health aide services or home health care agencies in accordance with a home health care plan after eligible inpatient treatment are covered by the plan, when provided by a qualified nurse	80% of UCR charges up to 120 visits per year	If prescribed
Chiropractors' and Osteopathic fees	80% of UCR charges	If prescribed. Number of sessions to be agreed by the Cigna Medical Team subject to condition
Outpatient hospital emergency room services		
Professional ambulance service from place where injured or stricken by a disease to the first hospital where treatment is given (not related to a hospitalization)		
Psychiatric Treatment	Consultations conducted by a psychiatrist: 80% of UCR charges. Pharmacy: 50% of UCR charges. Up to €2,500 per year	
Health check-up	80% of UCR charges for maximum one check-up per year	Blood Pressure test recommended every 2–3 years for adults
Inoculations and vaccinations	80% of UCR charges	If prescribed. For the list of covered vaccinations as approved by Schlumberger HSE, see here
Smoking prevention		If prescribed
Cancer detection (screening when required for treatment) and treatment, including Chemotherapy & Radiotherapy	80% of UCR charges up to the OoP maximum for Inpatient Treatment, 100% of UCR charges thereafter	
Emergency Dental Treatment	Please refer to the Dental section (8d) of this booklet for information on the benefits that apply should you require emergency dental treatment	This benefit will be payable for treatment received during the emergency visit immediately after accidental damage to natural teeth

EXCLUSIONS FOR OUTPATIENT TREATMENT

- Over the counter medicines, purchased without prescription, to treat minor short term conditions lasting less than 5 days; such as medication for headaches, fever and pain, sore throat lozenges, mouthwash, ear, nose drops and tear replacements are not reimbursed
- Nutritional or dietary consultations and supplements, including but not limited to special infant formula and cosmetic products, even if medically recommended or prescribed or acknowledged as having therapeutic effects
- Parapharmaceutical items such as thermometers, sunblock creams, disinfectants, soap, moisturizing cream, shampoo, mosquito or insect repellent, diapers, feminine care products, shaving cream, after shave
- Massage therapy
- Services of a registered nurse who is a family member or who lives in the participant's home
- Anti-aging treatment
- Vaccination for travel
- Home nursing services: home help such as washing, dressing, feeding when not provided by a registered nurse

**OoP- Out of Pocket: see section 7c.*

8. BENEFITS COVERED BY THE PLAN (AND THOSE WHICH ARE NOT)

8c. MATERNITY TREATMENT

- **Pre-certification for delivery is required** at least two months before due date in order to allow Cigna to arrange direct payment to hospital/clinic/doctor. Upon notifying Cigna, the Cigna Customer Services team can provide you with the Maternity flyer, this document contains very important information regarding pregnancy and delivery.
- In some clinics delivery costs are not Usual, Customary and Reasonable. Therefore, you are encouraged to notify Cigna as soon as you are aware of your pregnancy so you are clear about which charges the plan will accept.
- See *section 9d* for detail of documentation required in order to pre-certify

Type of Service	Plan Reimbursement	Notes
Pregnancy and child birth	Prenatal outpatient care: 80% of UCR charges	
	Childbirth inpatient care (normal delivery or C-section): 80% of the first €5,000 of annual covered Inpatient expenses (up to UCR), 100% thereafter—up to the annual maximum	Expenses relating to any form or contraception are excluded.

EXCLUSIONS FOR MATERNITY TREATMENT

- Infertility and fertility treatment

8d. DENTAL TREATMENT

- **Pre-certification is required** for all treatment exceeding €1,200 and should be made 10 days before treatment commences
- See *section 9d* for detail of documentation required in order to pre-certify

Type of Service	Plan Reimbursement	Notes
Basic Dental Care: Regular oral examinations, teeth cleaning, treatment of immediate relief of dental pain, accidental damage to natural teeth and restoration of natural teeth, including X-rays, fillings, extractions, root-canal treatment, gum treatment, basic dental surgery, wisdom tooth extractions, Tempo Mandibular Joint, periodontology	80% of UCR charges	
Major Dental Care: Dental crowns, bridges, dentures, implants and implant related surgery	50% of UCR charges up to €2,000 per person per year	

EXCLUSIONS FOR DENTAL TREATMENT

- Aesthetic treatment, bleaching, experimental methods, and dentistry for cosmetic purposes
- Orthodontic treatment

8e. VISION TREATMENT

Type of Service	Plan Reimbursement	Notes
Ophthalmologist's fees	80% of UCR charges	Eye tests do not contribute towards the single annual vision limit
Eyeglasses Lenses	80% of UCR charges up to the overall limit of EUR 375 per year per person. The single annual limit applies to Eyeglasses Lenses (**one pair)** and Laser Surgery.	If prescribed
Laser Surgery for vision correction	80% of UCR charges up to the overall limit of EUR 375 per year per person. The single annual limit applies to Eyeglasses Lenses (**one pair**) and Laser Surgery.	

EXCLUSIONS FOR VISION TREATMENT

- Eyeglasses Frames
- Sun glasses
- Insurance for glasses (frames and lenses)
- Contact Lenses

8. BENEFITS COVERED BY THE PLAN (AND THOSE WHICH ARE NOT)

8f. GENERAL EXCLUSIONS	
Type of Service	**Notes**
All items already detailed throughout *section 8*	Refer to 'Exclusions' tables under each sub-category
Charges for medical expenses incurred under the DMP before the start date or after the end dates	See *section 5*: Eligibility for Coverage
Expenses covered by a government program such as a Social Security, a local primary insurance, or any other insurance plan	
Care provided in a government hospital or medical facility for which an individual would not be charged in the absence of the plan	
Treatment carried out by a Plastic Surgeon whether or not for medical/psychological purposes and any cosmetic or aesthetic treatment to enhance appearance, even when medically prescribed	Except reconstructive surgery necessary to restore function or appearance after a disfiguring accident, or as a result of surgery for cancer, if the accident or surgery occurs during your membership of the scheme. Treatment must be pre-approved
Orthopedic shoes or soles	
Foot care or other foot treatment not resulting from an illness or injury	
Care or treatment for intentionally caused diseases or self inflicted injuries	
Treatment for obesity (except when the Body Mass Index is over 35) or treatment for weight loss	
Infertility and Fertility Procedures, including but not limited to, contraception products and devices, tubal ligation, vasectomy, sterilisation, IVF, sexual dysfunction. Expenses relating to any form or contraception are excluded.	
Termination of pregnancy, except where it is a therapeutic abortion due to underlying conditions related to maternal health or fetal disease, whether based on medical advice, or in an emergency situation. 100% of UCR charges will be reimbursed under these circumstances.	
Circumcision	Unless for medical reasons. Medical report will be requested and treatment needs to be pre-approved
Sex change operations and reversals, or any treatment needed to prepare for or recover from these operations e.g. psychological counselling (including complications arising out of such treatment)	
Expenses incurred as a result of an altercation in which the member or dependent is judged to be the aggressor	
Treatment related to the delayed development of children such as speech therapy, or treatments such as conduct disorder, oppositional defiant disorder, antisocial behaviour, attachment disorders, adjustment disorder, and treatments that encourage positive social-emotional relationships such as communication therapies, floor time and family therapy	Speech therapy is only eligible for reimbursement in the context of a diagnosed physical impairment such as nasal obstruction, neurogenic impairment or articulation disorders involving the oral structure e.g. cleft palate; or if a medical report shows there is a medical condition, it can be covered up to the age of 6. Speech therapy for Adults is covered if Treatment is for or in connection with speech and occupational therapy, if and insofar recommended by a Specialist with the intention to restore skills which previously existed and have been lost as a result of an acute medical condition, or has a reasonable likelihood of being restored

8. BENEFITS COVERED BY THE PLAN (AND THOSE WHICH ARE NOT)

8f. GENERAL EXCLUSIONS	
Type of Service	**Notes**
Psychotherapy, psychoanalysis as well as any form of counselling not carried out by a psychiatrist are not covered	
Treatment for any illnesses, diseases or injuries resulting from active participation in war, riots, civil disturbances, terrorism, criminal acts or acts against any foreign hostility	
Travel and accomodation costs related to medical care	
Care in a nursing home, custodial care or home for the elderly	Custodial care means services and supplies including room and board which are provided to an individual, whether disabled or not, primarily to assist in the activities of daily living
Any form of treatment or products which are considered experimental or unproven, based on generally accepted medical practice	
Alternative or Complementary treatment, with the exception of those listed in the benefit table	Chinese medicine and Ayurvedic medicine are excluded from cover
Anything not ordered by a doctor or not medically necessary, as well as medical or dental services that are considered not meeting professional standards	(i) anything which is not ordered by a doctor or is not medically necessary; such as Treatment not provided by an appropriate qualified and licensed practitioner (ii) any medical or dental services which are not considered orthodox
Charges for missed appointments or interest on late fees	
Any treatment or amount which is not a Usual Customary and Reasonable expense	
Genetic testing is excluded, these are tests for identification of hereditary diseases for members.	Sequencing-Based Non-Invasive Prenatal Testing (NIPT) is included where recommended by a treating physician i.e. in the event of a high-risk pregnancy or for women aged 35 or over. Only if pre-approval has been sought and the medical team has deemed the treatment medically necessary, genetic testing can be accepted, and only when they provide more clarity with determining diagnosis and treatment of cancer. Germline testing/ pre-dispositions to cancer should be reviewed on a case by case basis, only when having a material impact on the management of the case/ if there is strong evidence this would be beneficial.
Cigna will not offer cover or pay benefit when it is illegal to do so under applicable laws. Examples include but are not limited to, exchange controls, local licensing, regulations, trade embargo and anti-corruption	
Costs or fees for filling in a claim form or other administration charges	
Treatment directly related to surrogacy. Cigna will not pay maternity benefits to: (i) an eligible female who acts as a surrogate (ii) anyone else acting as a surrogate for an eligible female	

The DMP plan is not intended to be a source of profit. The combined reimbursement should not exceed the actual costs of the medical, dental and vision care received by you or your covered dependents.

9. PLAN ADMINISTRATION

The Schlumberger DMP medical plans are insured and administered by Cigna.

Multilingual customer service advisors are available to assist you and your family members to better understand the benefits provided under the DMP, to handle pre-certification requests, to issue insurance certificates (e.g. required for visa purposes), to help you find medical providers, to manage the claims reimbursement process, and to answer any related questions you may have.

Cigna is committed to protecting your privacy and complies with the highest standards of data confidentiality and security. Cigna only shares your medical or personal information as set out in the Privacy Notice, available on *www.CignaEnvoy.com*.

In the event of sensitive diagnosis, your medical or personal information may be shared between the Cigna Medical Team and the Schlumberger Medical Advisers. Also, at Schlumberger's instruction, Cigna may disclose your medical or personal information to the Schlumberger Medical Advisers from time to time for purposes of case management.

9a. Enrolment in the plan: 'Prefunded Cover'

Why is the enrolment process necessary?

The enrolment process is necessary in order for Schlumberger to inform Cigna who is eligible for coverage and for Cigna to create a new record for you in their system, recording any eligible dependents where applicable. Even though you may have been covered under the International Health Care Plan during employment it is not automatic that all employees are eligible to participate in DMP.

What is the enrolment process?

Schlumberger BACO department sends a report to Cigna providing details of former International Staff eligible for DMP 'Prefunded Cover' Period Coverage.

This monthly report indicates:

- Former employee name, eligible dependent name and contact details (including email address as provided to BACO department)
- Length of DMP 'Prefunded Cover' provided based on number of months contributed
- Date DMP Cover should start (day following last day in Schlumberger payroll).

Once notified by BACO, Cigna will contact you to confirm your enrolment in the plan, normally within a week. You will be sent a welcome email detailing your Cigna personal ID number. It will also explain how to connect to your personal Cigna web pages, Cigna Envoy (*www.CignaEnvoy.com*). You will be asked to log into the website and complete/verify personal details, e.g. address, telephone number, language preference, bank details for reimbursement of medical claims.

Please note BACO department can only report your eligibility for DMP 'Prefunded Cover' to Cigna once your complete Termination Package has been processed.

DMP members who are retiring or separating under the IS Life and Disability Plan, you will receive a physical ID card for yourself and all eligible dependents. These will be posted to the address Cigna has on file for you. All other members will be issued with electronic ID cards unless you specifically request for physical ID cards to be sent by post. Electronic ID cards are available through the Cigna Envoy Mobile App (see section 9g).

Note: all members can download a printable ID card from your Cigna personal website.

USEFUL TIP

Even if you were covered under the International Health Care Plan (IHCP) administered by Cigna at the time of leaving the company, you will receive new login details as the two plans are completely different. You should also verify that your registration details and dependent coverage are as expected.

9. PLAN ADMINISTRATION

REMEMBER

- DMP offers Single Coverage or Family Coverage. You should verify if the registration by Cigna is in line with your expectations
- Any change from Single Coverage to Family Coverage must be substantiated by providing Cigna with the necessary supporting documentation i.e. birth or marriage certificate
- After a change from Family Coverage to Single Coverage it is not permitted to change back to Family Coverage unless there is a change in circumstance i.e. marriage or birth of a child, and supporting documentation will be required by Cigna.

9b. Renewal of the plan: 'After Prefunded Cover'

Why is the renewal process necessary?

The renewal process is necessary for Cigna to validate your continued eligibility and revise your record in their administration system.

What is the process?

One month before your DMP 'Prefunded Cover' period ends, Cigna will send you a DMP Renewal Package detailing information required to renew the DMP 'After Prefunded Cover'. Subject to your status, the content and terms will be different:

- For retirees, there are two possible scenarios:
  - 'Prefunded Cover' ends December 31st. Cigna will send you renewal terms for 12 months
  - 'Prefunded Cover' ends on a different date. Coverage is renewed only until the end of the calendar year and then, subsequently once premiums for the next year are set
- Former employees that were terminated by the company 'other than for cause' and remain unemployed at the end of the 'Prefunded Cover' period: Cigna will send you renewal terms for a one-off extension of 12 months (payable in advance).

What is the DMP Renewal Package?

It is an email sent by Cigna to DMP Participants including:

- Renewal conditions and requirements if you are not a retiree drawing ISPP
- Premium Schedule
- Explanation of how premiums are calculated taking into account: Elected Zone, Age and Family Status so DMP members can make an informed decision when transitioning to 'After Prefunded Cover' Period.

9c. How to contact Cigna

You can contact your Cigna Customer Services team by telephone, email or through Cigna Envoy.

+44-345-601-2239 or +1-800-841-7764 (toll free when calling from within the U.S.). Cigna will be happy to accept a reversed charge call to either number

DMPCustomerServices@cigna.com

www.CignaEnvoy.com

When calling your Cigna Customer Services team you will be given the following options:

- For English, press 2
- For Arabic, press 3
- For Spanish, press 4
- For French, press 5

Cigna will be happy to accept a reversed charge call or arrange a call back if required.

Cigna's office addresses are as follows:

- Cigna Global Health Benefits Europe, Parque Empresarial La Finca, Paseo del Club Deportivo 1, Edificio 14 Planta 1, 28223 Pozuelo de Alarcón, Madrid, Spain
- Cigna Global Health Benefits Europe, 1 Knowe Road, Greenock PA15 4RJ, Scotland
- Cigna Global Health Benefits, PO Box 15050, Wilmington, DE 19850-5050 USA
- Cigna, Suite 3B-15-3A Level 15 Block B, Plaza Sentral, Jalan Stesen Sentral 5, 50470 Kuala Lumpur, Malaysia

9. PLAN ADMINISTRATION

9d. HOW TO GET FAST REIMBURSEMENT

The table below shows some Tips & Tricks to help you to be reimbursed as quickly as possible and with no inconveniences along the way. By using these you can avoid us having to contact you for clarification before Cigna can process your claims, and as a result reimburse you faster. The aim is to process claims within 5 business days of receipt, having the data mentioned below will ensure no additional delays occur.

	Tips & Tricks
✓	Input the reason for the medical claim in the Diagnosis/symptoms field so that your claim can be assessed. Examples of the information to be provided by you should be detailed such as 'blood tests due to fatigue', 'severe and ongoing headache', 'routine dental checkup' instead of a generic comment such as 'doctors visit' or 'dentist appointment'
✓	Ensure you have confirmed your preferred payment currency, payment method and complete bank account details
✓	Please include readable official invoices. These should clearly state: the name of the patient, the treatment date, the breakdown of costs per type of treatment. Always keep copies of invoices for your own records. Also include any other documents you may have justifying the medical expense (e.g. medical report, or prescription, breakdown of treatment (i.e. x-rays, scan, laboratory test, physiotherapy) discharge summary for inpatient cases (hospital stays) as this may speed up the reimbursement process. In the event of having paid upfront (pay and claim reimbursement) please provide proof of payments/ payment receipts. The table on the next page provides a detailed overview of further supporting documentation that is required in function of the type of claim you submit.
✓	Claims for different family members should be submitted under the name of each individual family member
✓	Claims for each type of treatment (medical, dental, vision) should be submitted separately
✓	Claims for major dental treatment should include the tooth number(s)
✓	When you send your claims via email, the total attachment size should not exceed 3MB

9. PLAN ADMINISTRATION

9e. WHAT DOCUMENTATION DO I NEED TO PROVIDE TO PRE-CERTIFY/MAKE A CLAIM?

In order for Cigna to quickly and efficiently administer your claim you should ensure that you provide the necessary documentation. The table below details the supporting documentation or information required for the different types of treatment, as well as indicating whether Pre-certification is required:

Nature of treatment	Pre-certification required	Supporting documentation/information required for claim
Inpatient treatment or Day Surgery	Yes	■ Medical documentation indicating the diagnosis and explanation of type of surgery or treatment recommended ■ Name and contact details of treating doctor and facility in which treatment will take place ■ Date of service and type of room (if overnight stay included) ■ Cost estimate for the treatment or surgery
Maternity	Yes	■ Name and contact details of treating doctor and facility in which delivery will take place ■ Expected due date and type of room ■ Cost estimate for the delivery including breakdown of services (where possible: In the case of a 'maternity package' you should note that charges must be itemised and they will be paid at the end of the services, or at intervals. Cigna will not reimburse services before they are incurred)
Consultations	No	■ Invoice to include name of patient, date of service, name of treating doctor and medical facility ■ For specialist consultations the specialisation of the doctor should be shown on the invoice/letterhead, Note: there is no requirement for a doctor's referral
Diagnostic testing and medical imaging	Only if over €1,200	■ Invoice to include name of patient, date of service, name of treating doctor and medical facility, and type of test ■ For MRI, CAT scans etc over €1,200, medical documentation from the doctor explaining why required
Pharmacy	No	■ Invoice to include name of patient, date of issue, name of prescribing doctor and name of medication ■ Copy of the original prescription from a registered doctor must be provided
Physical therapies	Only if over 10 sessions	■ Invoice to include name of patient, date of service, name of therapist and medical facility, type of therapist, number of sessions ■ Medical referral is required. For ongoing/registered pre-existing medical cases and Alternative and Complementary Medicine, Cigna may require an up to date referral/prescription
Dental	Only if over €1,200	■ Detailed plan of treatment including how many teeth are being treated ■ Cost estimate (itemised for each service) ■ Name of dentist, practice name and contact details ■ In the case of major dental or treatment to single teeth, the tooth number is to be provided. Cigna may request an OPG (panoramic dental view of the mouth)
Vision	Only if over €1,200	**Lenses:** ■ Invoice to include name of patient, split of cost between frame/lenses and vision defect (alternatively prescription to be submitted) **Laser Surgery:** ■ Invoice to include name of patient and technique used

9. PLAN ADMINISTRATION

9f. Claims Processing How do I get reimbursed?

1

Online claims submission

Collect the required documents, please refer to section 8d for all of the documents needed for the claim submission.

When you are a registered user of www.CignaEnvoy.com you can submit claims through the secure web portal in an easy to follow process. Just click the '*Manage My Claims*' section.

2

Fast Track - Submit via Mobile App or Website

Scan or take a photo of all required documents as per 8d and submit via www.cignaenvoy.com or onto the Envoy mobille app.

Or send by email:

1. Complete a claims reimbursement form for each patient (available to download on www.cignaenvoy.com)
2. Scan the claims reimbursement form and the required documents
3. Email the scanned documents to Schlumberger@Cigna.com

3

Receive your reimbursement

You can view claims that have been submitted online (in the '*Manage My Claims*' section at www.CignaEnvoy.com or via the Mobile App) and track progress. Payment is usually made within five days. Once payment has been made a copy of your settlement letter will be added to the '*Manage My Claims*' section of Cigna Envoy.

Tips to speed up the claims process

- Ensure all documentation as described in *section 9d* is provided
- State how and where you want the reimbursement issued
- For electronic bank transfer, full details must be provided, including bank name and address, account name, account/IBAN number and sort/routing/BIC/SWIFT code. For cheque reimbursement please provide address details.

As the primary member of the policy, you will have administrative access to personal data held about you and your eligible family members covered under the plan. In the event of a claim, this will include some limited sensitive personal data.

USEFUL TIP

One of the common reasons reimbursement is reduced is due to the application of cost sharing. This is often confused with an exchange rate conversion. It is important you understand the items where cost sharing is applied before you contact Cigna to query your reimbursement. It is also important to note that the Out of Pocket does not include the following items: reduced reimbursement due to sub category limits i.e. major dental care cap per year, charges in excess of UCR and expenses not covered by the plan. Claim process does not apply to French Zone with FSS and Noemie.

If you are an international resident in a sanctioned country, Cigna is able to support your customer service needs including access to their online services through Cigna Envoy or via the Envoy App. Eligible treatment taken in an OFAC sanctioned country should be paid in advance by you and will be reimbursed by Cigna to your bank account outside the country of treatment. Sanctioned country nationals ordinarily resident in another sanctioned country or residing in another country which is not sanctioned can be covered for claims incurred in their country of origin or the sanctioned country they reside in, if they returned for a short visit for personal reasons (Cigna Customer Services will request details regarding the length and purpose of the visit to the home country; additional documentation covering the treatment may also be requested to determine whether it was urgent or emergent).Claims cannot be reimbursed into a bank account in the sanctioned country or directly to a provider in the said country, nor in the currency of the sanctioned country. Trailing dependants (i.e. dependants of a sanctioned country national remaining permanent residents of the sanctioned country) are not eligible for cover.

Cigna will communicate with their partners, including Schlumberger, in situations where there may be inpatient or expensive treatment required.

9. PLAN ADMINISTRATION

Below are some common questions you may have about the claims process:

What is the deadline for sending my expenses?
Please ensure you submit your claim as soon as reasonably practicable following the start of treatment, and no later than 12 months from the start of treatment. Prompt filing results in faster payment of your claims. Claims received more than 12 months after the start of treatment will not be paid.

What currency will my claim be reimbursed in?
Payment will be made to you in the currency of your choice. However, you will automatically be reimbursed in Euros, unless you specifically instruct Cigna that reimbursements should be made in another currency. If you wish to change your currency of payment you can do so by logging on to *www.CignaEnvoy.com*.

Who pays the bank charges as a result of the claim reimbursement?
Cigna bears the cost of bank to bank transfers but cannot be held responsible for bank fees applicable in your country or related to your type of account.

For security of payment and quicker reimbursements purposes it is recommended that you provide your bank details to Cigna and avoid requesting reimbursement by cheque.

If I send a claim based on a currency that is not the same as the currency of my bank account, what exchange rate is used?
The exchange rate used to determine your reimbursement is the Cigna agreed exchange rate (based on the daily rate provided by Citibank to Cigna). The exchange rate used will be shown on your settlement letter which you can find in the '*Manage My Claims*' section of Cigna Envoy.

I do not understand the reimbursement that I received/I disagree with the reimbursement. Who should I contact?
Go to *www.CignaEnvoy.com* and select option '*Contact Us*'. Alternatively you can contact your dedicated Schlumberger Customer Service team by calling +44-345-601-2239 or +1-800-841-7764 (toll free when calling from within the U.S.). Cigna will be happy to accept a reversed charge call to either number. You can also reach us at *DMPCustomerServices@cigna.com*.

My dependents benefit from coverage of another plan. What should I do?
If you, or your eligible dependents, are covered by a Government program or local social security plan or another group health care plan (e.g.your partner's employer's health care plan, divorced parent plan covering your dependent children, educational institution, professional association, etc.), the benefits of both plans will be coordinated so that the combined payments do not exceed the actual covered expenses.

The general rule is that one plan pays first and the second plan pays the remaining eligible expenses up to the limits in the second plan. Make your claim to the primary plan, then provide Cigna with supporting documents for the remaining eligible expenses.

If you have the possibility of using the benefits provided by your country's social security plan, you are encouraged to use this as your first source of cover (whenever possible and where treatment is of acceptable quality). This will help preserve the future of the DMP.

What do I do if I have expenses for which a third party may be liable?
You and your dependents must tell Cigna in writing as soon as possible about any claim or right of legal action against any other insurance, person or source, that arises from a claim under this plan. You must keep Cigna fully informed of any developments.

Providing your claim is eligible for cover within the terms and conditions and benefit limits of this policy, the recovery by Cigna of claims costs from a third party will not delay or prevent the payment of your claim by Cigna. Cigna will not pay for the proportion of any treatment which is over the benefit limits in the list of benefits.

9. PLAN ADMINISTRATION

9g. Online services available from Cigna's web portal

You can access your personal website at *www.CignaEnvoy.com*, selecting '*I have an existing login*' and using the password you have created at initial login.

See *section 1* for login procedure.

There is a wide range of information available to you on these web pages, including:

- Pre-certification request
- Certificate of coverage
- Printable ID card (Electronic ID cards are available on the Mobile App)
- Policy documentation: your benefits and exclusions, what you and your family members are covered for
- Claims submission features*
- Country guides allowing you to access practical travel information, such as cultural, health and safety, travel tips, visitor and currency information for over 190 countries
- Contact your Cigna Customer Service team*
- Claims tracking: you and your dependents' full claims history*
- Global provider search: allowing you to find an appropriate medical provider in your location*.

In addition to the above, you can also tap into **health care resources** including medical phrase translation, medical terms translation, managing a condition (e.g. asthma, diabetes and heart problems) and a health library with articles on various health conditions, medical tests, medications and more.

*Available on the Mobile App

Mobile App

Cigna Envoy is available while you're 'on the go' via our Mobile App which can be downloaded from the Apple App store, Google Play Store (not within mainland China), Amazon App Store or BlackBerry World (not within France). Just search for "*Cigna Envoy*". You will need to use your Cigna user name and password when using our Mobile App.

From the Mobile App you are able to:

- Download your electronic Cigna member (ID) card
- Contact your Cigna Customer Service team
- Submit a claim (available on iOS and Android) or check the status of a claim
- Search for a medical facility within the Cigna network, using GPS functionality.

9h. How to make a complaint

If you have any cause for complaint, or wish to highlight any concerns, please contact Cigna in the first instance:

In writing: Cigna Global Health Benefits Europe, 1 Knowe Road, Greenock PA15 4RJ, Scotland
By phone: +44-345-601-2239 or +1-800-841-7764 (toll free when calling from within the U.S.). Cigna will be happy to accept a reversed charge call to either number
By email: *Complaints.Schlumberger@cigna.com*

The dedicated complaints handling staff at Cigna will acknowledge receipt of complaints within 24 hours of their being received and aim to resolve all complaints fairly and consistently, within 5 working days. You can request to speak to a supervisor at any time if you are not satisfied with the service or answer you receive from your Cigna Customer Services Team.

Complaint resolution dispute

If you are unhappy with the final decision reached, or the investigation has not been completed within 8 weeks you may refer the matter to the Ombudsman des Assurances either email: *info@ombudsman.as* or telephone: + 32 2547 5871.

Their decision is binding on Cigna but you may reject it without affecting your legal rights.

10. OPTIONAL PLANS

The DMP Optional Plans are independent from the DMP Main Plan however eligibility is contingent upon participation in the DMP Main Plan.
A member of the DMP Main Plan can apply for the Supplemental Medical Plans either during enrolment in the 'Prefunded' or on renewal of the 'After Prefunded Cover' plan.

10a. Supplementary Medical

Insured and administered by Cigna.

Benefits Provided

You have the possibility to increase the €100,000 Annual Maximum that can be reimbursed under the plan by subscribing to one of the Supplementary options:

- **Supplementary 200 Option:** Maximum amount that will be reimbursed by the DMP is increased to €200,000 per person and per calendar year
- **Supplementary 500 Option:** Maximum amount that will be reimbursed by the DMP is increased to €500,000 per person and per calendar year.

Within the plan design, the benefits, level of coverage for each category of treatment and services, and procedures remain the same as under the DMP Main plan.

Requirements

In order to benefit from one of the Supplementary Options, participants and dependents will be requested to undergo a medical screening. Note that this requirement may be waived for former Schlumberger employees with more than ten years seniority at the time of application.

A completed "Confidential Medical Questionnaire" form should be sent to Cigna. Cigna's Medical Consultant reserves the right to refuse acceptance of cover for the Supplementary Options.

Commencement and Termination of Coverage

The Supplementary Option you have chosen can start:

- At the commencement of your 'Prefunded Cover'
- At the commencement of your 'After Prefunded cover' or at the following years' renewal.

No retroactive cover will be accepted.

The supplementary medical plans cannot subsist by themselves; termination from the DMP Main Plan implies termination of the optional plans.

Premiums

While on 'Prefunded Cover', premiums for any of the Supplementary Medical Options are payable annually in advance, aligned with the calendar years. In the 'After Prefunded cover' plan premiums are payable in line with the payment frequency selected for the DMP Main Plan.

The Cigna DMP Policy Administration team can answer any questions you have on payment and applicable premiums.

REMEMBER

There is a 24 months coverage period you need to respect for your current choice when selecting a Supplementary Medical Plan:

- If you upgrade from DMP Main Plan to any of the DMP Supplementary Options you cannot change back to DMP Main Plan within the next 24 months
- If you upgrade to Supplementary 500 you cannot downgrade coverage to Supplementary 200 option within the next 24 months
- Once you downgrade your coverage you cannot re-upgrade such coverage within the next 24 months
- Change of cover can only be made during 'Prefunded Cover' or at the time of renewal.

10b. Accidental Death and Disability Insurance

Administered by Cigna and insured by Axa France Vie.

The DMP main participant or spouse can apply for this Optional Insurance. The coverage provides a lump sum in the event of an accident in which the insured either loses his life or is impaired permanently. Coverage is worldwide, 24 hours out of 24, and is valid in both private life and professional activity.

Designed as a low-cost optional supplement to the medical program, the DMP Accidental Death and Disability insurance should not be seen as the sole source of life insurance income but more of a top up to another arrangement you have in place.

The use of life insurance for estate planning is a complex endeavor which each participant should consider taking into account his individual set of circumstances, and those of his family. The following benefits are provided:

Death

In the event of an accident in which the insured person loses his life either immediately or within the next twelve months as a direct consequence of the accident, the Insurer will pay the total sum insured.

Payment will be made to the beneficiary or beneficiaries elected by the insured person. The insured may change his beneficiary(ies) at any time by written notice to Cigna. If at the time of death, one or more beneficiaries have died, the whole benefit will be paid to the surviving beneficiaries in the same relative proportions as indicated in the beneficiary designations. The application form includes the possibility of using a standard formula which automatically applies if all of the most recently designated beneficiaries have died before the insured person:

STANDARD FORMULA:

I instruct the Insurer to pay the insured sum to my spouse in the event of my accidental death. If I am separated legally from my spouse* or my spouse* predeceases me or I have no spouse*, the benefit should be paid in equal shares to my children (born or to be born). If I am separated legally from my spouse* or have no spouse* or children, the benefit should be paid in equal shares to my parents or surviving parent. If I do not have any spouse*, children, or surviving parent or parents, the benefit should be paid to my estate.*

It is advisable to update the beneficiaries' nomination periodically, at least following events such as marriage, divorce or birth of a child.

Do not forget to make a copy of the application form and of any subsequent beneficiary nominations before you mail the documents to Cigna.

*legal spouse, common law spouse or domestic partner as described in the insurance policy.

10. OPTIONAL PLANS

Disability
In the event of an accident in which the insured becomes permanently disabled, the Insurer will pay a lump sum to the insured person.

The amount of the lump sum payment is calculated by multiplying the total sum insured by the permanent disability rate. The disability rate is determined on the basis of the permanent disability schedule in the insurance policy. For example, 100% of the insured sum will be paid if the accident results in permanent total paralysis, loss of both hands, loss of sight in both eyes, the amputation of an arm and a leg, etc. A reduced percentage of the insured sum will be paid if the accident leads to lesser permanent disabilities, for example, loss of one eye, loss of movement of a knee, amputation of a thumb and index finger, etc.

These examples are only indicative. A full description of how the disability scale is applied is included in the insurance policy. The disability scale is available on request.

The maximum disability benefit in respect of one or more accidents is 100% of the insured sum.

Requirements
- Applicants must be under 65 years old
- A specific Application Form for Accidental Death and Disability Insurance should be completed for each person who is to be insured.

Commencement and Termination of Coverage
Coverage begins from the date as confirmed to you by the Cigna DMP Policy Administration team, whom you can also contact if you require a certificate specifically for this Insurance. It should be noted accidental death and disability cover must be maintained for a minimum of 12 consecutive months, regardless your selected payment frequency. On each annual renewal date for the accidental death and disability coverage the sum insured for each person may be increased or decreased.

Provided that there is no interruption in the payment of the premium and provided that the insured continues to be covered by the DMP Main Plan, the accidental death and disability coverage will be maintained to December 31 of the year in which the insured's 70th birthday occurs. The cut-off date of 70 years old applies separately to each family member. This coverage will be automatically stopped in the next renewal period after 70th birthday.

Enrolment Process
Application forms are available on *www.CignaEnvoy.com* (click *'My Account'*, then click *'My Documents'*) or can be requested directly from the Cigna DMP Policy Administration team. They should be completed and returned to Cigna, who will submit them to the Insurer. Cigna will reach out with payment information as soon as your application has been processed.

Premiums
While on Prefunded Cover', AD&D policy premiums are payable annually in advance, aligned with the calendar years. Premium currency in Prefunded Cover is USD by default.

In the 'After Prefunded Cover' plan, AD&D policy premiums are payable in line with the payment frequency and method selected for payment of the DMP Main Plan premium.

The Cigna DMP policy administration team can answer your questions on payment and applicable premiums.

Exclusions
Accidental Death or Disability benefits do not cover the consequences of any of the following:
- Being in an airplane involved in tests, races, shows, attempts to break records, acrobatic stunts, or pulling gliders
- Self-inflicted injuries or an accident deliberately caused by the insured person
- Suicide or attempted suicide during the first two years of coverage under this option
- Rebellions, civil war, or foreign war
- Nuclear explosion
- Professional sports, races, or race-meetings involving motorized vehicles
- Brawls or fights, except when acting in self-defense
- The insured being wholly or partially under the influence of alcohol
- Cardiovascular events and cerebrovascular incidents.

REMEMBER
When Selecting AD&D Insurance:
- This decision can be taken either at the time of enrolling under DMP 'Prefunded Cover' Period or at the time of renewing for the DMP 'After Prefunded Cover' Period
- A minimum contract period of 12 consecutive months will apply, regardless the start date of your '(After) Prefunded Cover' Period.

Claims
When an accident occurs which results in the death of an insured person or the likelihood that a permanent disability may result from the accident, it is important that AXA France Vie, the insurer, is notified in writing as soon as possible. AXA France Vie will indicate the procedure which needs to be followed and the documents which will be necessary for the eventual claim to be settled properly and without delay.

Claims address
- AXA Group Life Insurance
  Email: *insuranceplan@axa.fr*
  (You will receive a response within a maximum delay of 48 hours)
- Tel. : +33-344-604-200
  (from 9h-17h Paris-France time. If you leave a message you will be called back within 48 hours)
- Address:
  AXA - Claims Department 2874
  TSA 20114
  69836 Saint Priest Cedex 9
  France

11. FUTURE OF THE PLAN

The nature and scope of benefits provided under the plan in the future will be highly dependent on the responsible usage of the plan by all participants. The benefits provided will evolve in line with market positioning and affordability with changes to benefit limits, treatment covered and member cost participation being reviewed on an annual basis.

Schlumberger

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