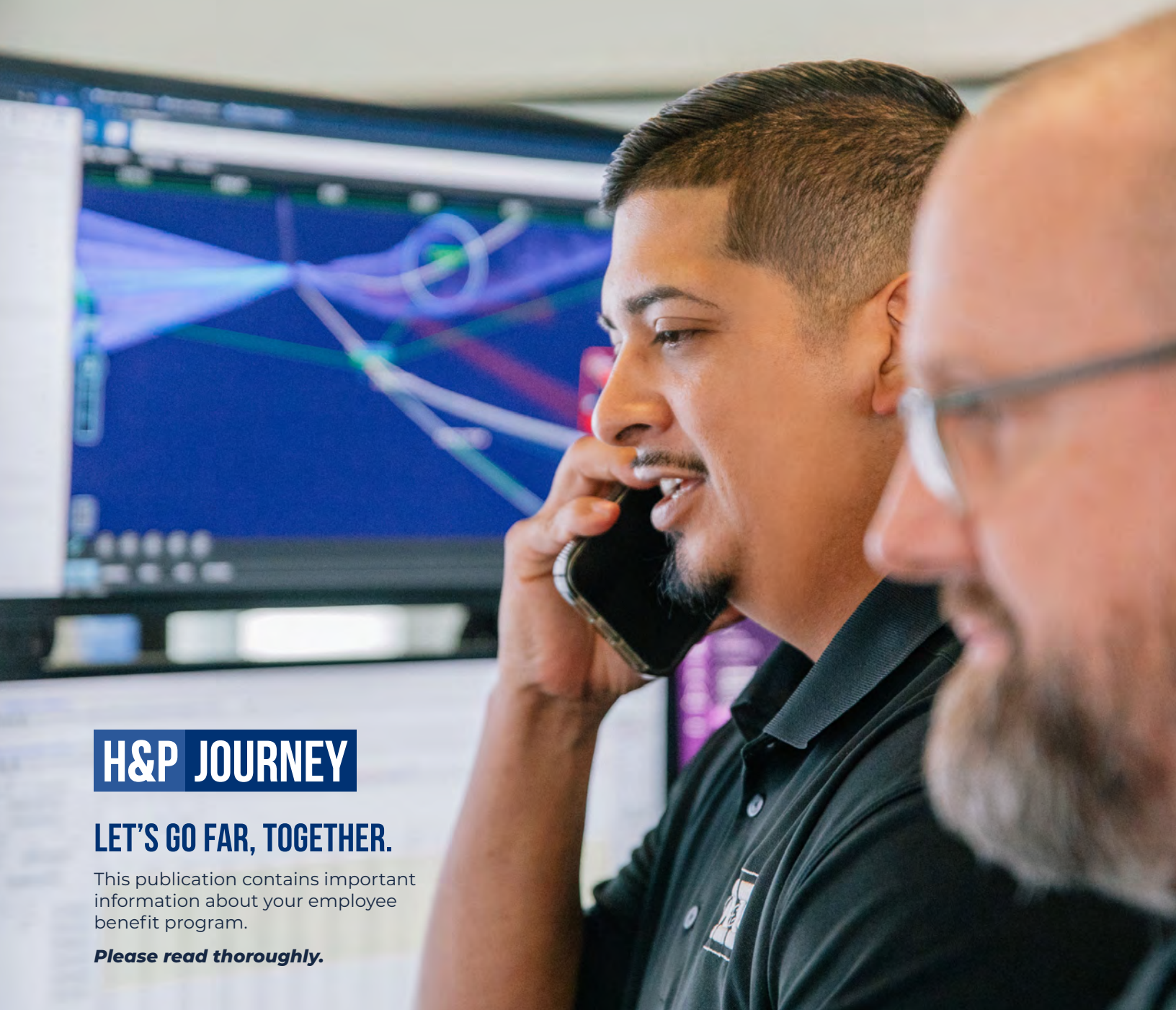
BENEFITS

2025 Enrollment Guide



H&P JOURNEY

LET'S GO FAR, TOGETHER.

This publication contains important information about your employee benefit program.

Please read thoroughly.

Table of Contents

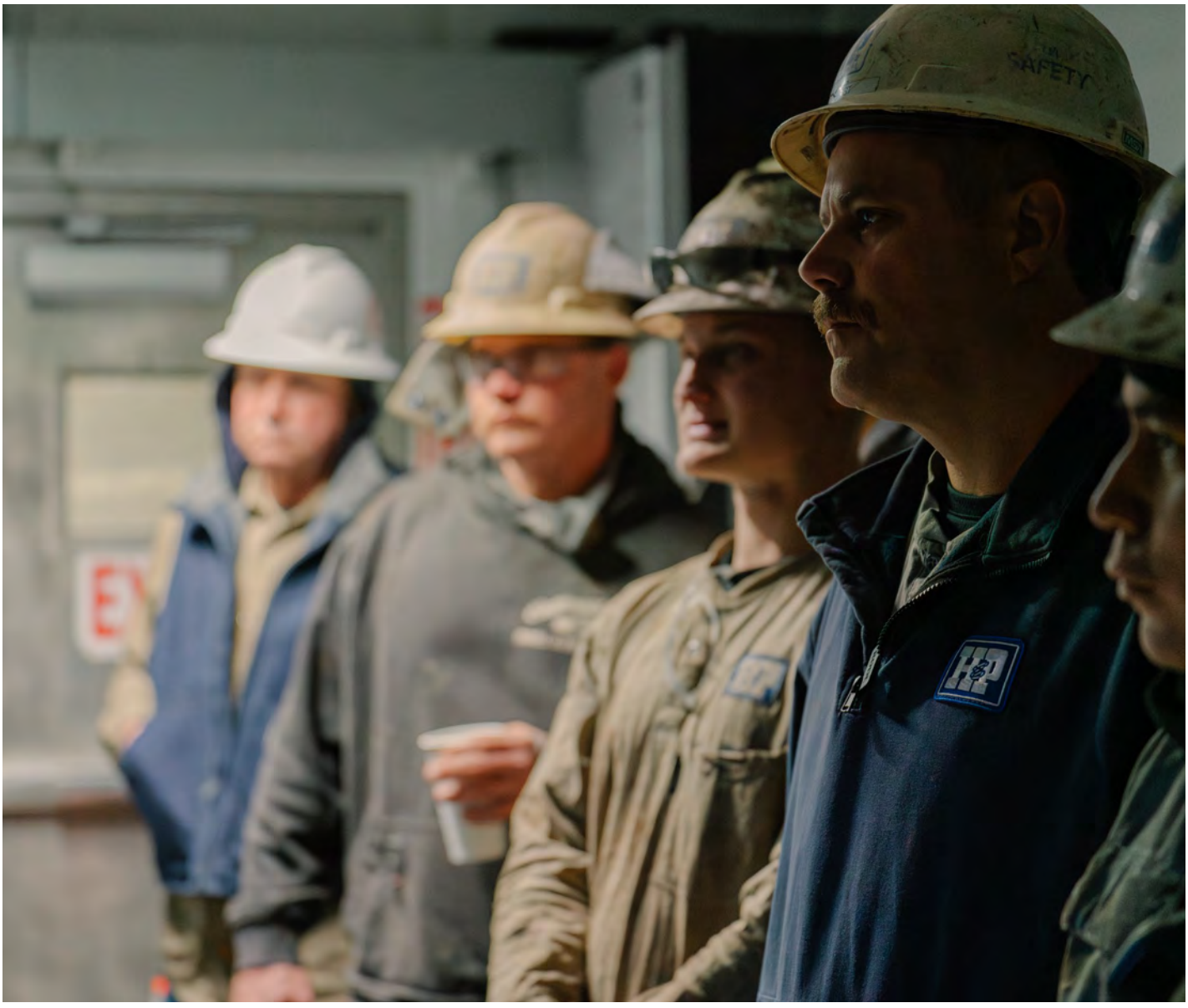
Page 27 includes your annual required Medicare Part D notice. Please see the end of the guide for this and other notices.

H&P Benefits

As an employee of H&P, you are the backbone of our company, and we are dedicated to helping you take control of your physical, mental, and financial health. We are proud to provide you with an affordable, comprehensive benefits plan.

The benefits program is an important piece of your total rewards package and a tool for your H&P Journey. Please review the benefits selections in light of you and your family's needs for 2025 and take advantage!

Need help? The HR Support Center is ready to answer your questions. Call us at **918.588.2247** (x22HR) or email us at **HR.Support@hpinc.com**.



Medical Insurance

H&P is committed to providing our employees with affordable comprehensive coverage that meets the needs of you and your family. For 2025, both medical and prescription insurance are provided by BCBS of Oklahoma. You use your BCBS ID card for both medical and prescription benefits.

Review the premium information on this page and the plan design information on the next page to better understand our benefit plan options.

Medical Premium Rates

	Bi-Weekly Medical Premiums (non-tobacco)		
	PPO Copay	PPO Deductible	High Deductible (HSA)
Employee	$57.53	$46.76	$43.39
Employee + Spouse	$152.71	$127.19	$120.12
Employee + Child(ren)	$127.75	$105.40	$98.88
Family	$227.73	$189.65	$179.12

$30 Biweekly Tobacco Surcharge

If you are a tobacco user, you will be subject to a $30 per bi-weekly paycheck tobacco surcharge. This applies to the medical plan premiums only.

A tobacco user is defined as an individual who has used tobacco products, including but not limited to pipes, cigarettes, cigars, chewing tobacco, snuff, or any other form of smoking or smokeless tobacco, on more than three occasions within the past six months.

Tobacco Cessation Program

Tobacco users may access the program at **www.bcbsok.com** through the Well on Target Portal or call BCBS for details at **888.780.7875**. As an added incentive, you can remove the $30 biweekly tobacco use surcharge once you complete the program by contacting the HR Support Center (HRSC) with proof of completion. They can be reached at **918.588.2247** or by email at **hr.support@hpinc.com**

Medical Plan Design

	PPO Copay		PPO Deductible		High Deductible (HSA)	
	In-Network	Non-Network	In-Network	Non-Network	In-Network	Non-Network
Calendar Year Deductible						
Single	$1,000	$2,000	$1,000	$2,000	$1,650	$3,300
Family	$3,000	$6,000	$3,000	$6,000	$3,300	$6,600
Coinsurance (you pay)	10%	30%	20%	40%	20%	40%
Out-of-Pocket Max						
Single	$3,000	$6,000	$3,000	$6,000	$4,000	$8,000
Family	$9,000	$18,000	$9,000	$18,000	$8,000	$16,000
Annual Employer HSA Contribution						
	N/A		N/A		$500	
Other Services						
Office Visit (PCP)	$30	30%*	20%*	40%*	20%*	40%*
Specialist Visit	$50	30%*	20%*	40%*	20%*	40%*
Preventive Care	$0	30%*	$0	40%*	$0	40%*
Emergency Services	$350		20%*		20%*	
Urgent Care	$75	30%*	20%*	40%*	20%*	40%*
Inpatient Services	10%*	30%*	20%*	40%*	20%*	40%*
Outpatient Services	10%*	30%*	20%*	40%*	20%*	40%*
Prescription Drugs (30-Day Supply)						
Generic	$15		20%*		20%*	
Formulary	$45					
Non-Formulary	$70					

* The member's coinsurance amount that is applied after the deductible has been met.

- **PPO Copay**
  - Services that charge a copay are covered before you meet your deductible. Any copay amount for both medical and prescription costs do not apply towards the deductible, but they will apply to the out-of-pocket maximum. Any other member paid amount will apply to both the deductible/out-of-pocket maximum. Coinsurance will apply once a family member meets the individual deductible, and then once they reach the individual out-of-pocket maximum, all covered services will be covered at 100%.
  - This plan is set-up as embedded for both the deductible and out-of-pocket maximum. Each family member has their own deductible and out of pocket maximum that contributes to the overall family deductible and out-of-pocket maximum.
- **PPO Deductible**
  - Any member paid amount (for both medical and prescription costs) will apply to both the deductible and out-of-pocket maximum. Coinsurance will apply once a family member meets the individual deductible, and then once they reach the individual out of pocket maximum, all covered services will be covered at 100%.
  - This plan is set up as embedded for both the deductible and out-of-pocket maximum. Each family member has their own deductible and out-of-pocket maximum that contributes to the overall family deductible and out-of-pocket maximum.
- **High Deductible (HSA)**
  - Any member paid amount (for both medical and prescription costs) will apply to both the deductible and out-of-pocket maximum. Coinsurance will apply once you meet your deductible and then once you reach your out-of-pocket maximum, all covered services will be covered at 100%.
  - This plan is set up as non-embedded for both the deductible and out-of-pocket maximum. This means that if you have other family members in this plan, the overall family deductible and out-of-pocket maximum must be met before coinsurance will apply. The single deductible and single out-of-pocket maximum does not apply when you have one or more dependents on the plan.

Blue Cross Blue Shield Global® Core

Healthcare Coverage When You are Abroad

As a Blue Cross and Blue Shield member, you take your healthcare benefits with you when you are abroad. Through the Blue Cross Blue Shield Global Core program, you have access to doctors and hospitals around the world.

To Take Advantage of the Program

- Always carry your current member ID card.
- Before you travel, contact your Blue Cross and Blue Shield (BCBS) company for coverage details. Coverage outside the United States may be different.
- If you need to locate a doctor or hospital, call the Service Center for Blue Cross Blue Shield Global Core (see number below). An assistance coordinator, in conjunction with a medical professional, will arrange a physician appointment or hospitalization if necessary.
- If you need inpatient care, call the Service Center (see number below) to arrange direct billing. In most cases, you should not need to pay upfront for inpatient care except for the out-of-pocket expenses (noncovered services, deductible, copayment, and coinsurance) you normally pay. The hospital should submit the claim on your behalf.
- In addition to contacting the Service Center, call your BCBS company for precertification or preauthorization. Refer to the phone number on the back of your member ID card. **Note: This number is different from the phone number listed below.**
- For outpatient and doctor care or inpatient care not arranged through the Service Center, you may need to pay upfront. Complete a Blue Cross Blue Shield Global Core International claim form and send it with the bill(s) to the Service Center (the address is on the form). You can also submit your claim online or through the Blue Cross Blue Shield Global Core mobile app. The claim form is available from your BCBS company or online at **www.bcbsglobalcore.com**.

IN AN EMERGENCY, GO DIRECTLY TO THE NEAREST HOSPITAL.

TO LEARN MORE ABOUT BLUE CROSS BLUE SHIELD GLOBAL CORE:

- Visit **www.bcbsglobalcore.com**.
- Use the Blue Cross Blue Shield Global Core app for Android, iPhone, and iPod touch (rates from your wireless provider may apply).
- Call your BCBS company to inform them of your pending travel plans.
- Call the Service Center at **800.810.2583** or collect at **804.673.1177**, 24 hours a day, seven days a week.

The Blue Cross Blue Shield Global Core program was formerly known as BlueCard Worldwide®.

Blue Cross, Blue Shield, the Blue Cross and Blue Shield symbols, BlueCard, BlueCard Worldwide, and Blue Cross Blue Shield Global are trademarks of the Blue Cross Blue Shield Association, an association of independent Blue Cross and Blue Shield companies. Android is a trademark of Google Inc. Apple, the Apple logo, iPod touch, and iTunes are trademarks of Apple Inc., registered in the U.S. and other countries. iPhone is a trademark of Apple Inc. App Store is a service mark of Apple Inc.

BCBS Wellness Programs

Remember to take advantage of the programs that are available to you through BCBSOK.

24/7 Nurseline

Sometimes it's hard to know what to do about certain illnesses or injuries, especially at night or on the weekends. The 24/7 Nurseline is staffed by registered nurses who are available 24 hours a day, 7 days a week. In a matter of minutes, they can help you identify some options. Plus, you can learn more about 1,000+ health topics via an audio library system when you call.

Note: For medical emergencies, call 911 or your local emergency services first.

- Utilize the **24/7 Nurseline** to communicate with a nurse at any time you need. Please call **800.581.0407** to speak with a nurse.

MDLive—Telemedicine

- MDLive is Helmerich & Payne's virtual health partner for those enrolled in a medical plan with BCBSOK.
- This online resource offers you virtual visits with certified doctors and therapists, available 24 hours a day, 7 days a week. You have the option to speak with a doctor immediately or to schedule an appointment for another time.
- Receive access to care for non-emergency medical issues, including behavioral health and pediatric care, from wherever you are, whether you are at home or traveling.
- To activate your account: call **888.970.4081**, go to **MDLIVE.com/bcbsok**, text BCBSOK to **635-483**, or download the MDLIVE mobile app.

Well onTarget Program

We want all of our employees to live their healthiest life, so we encourage you to engage your health through the tools available via the BCBSOK wellness program, called Well onTarget.

To learn more about Well onTarget, please visit **bcbsok.com**, and go to the wellness tab.

- Self-directed courses: Learn about nutrition, fitness, weight loss, quitting smoking, and managing stress
- Health and wellness content: The health library teaches and empowers through evidence based, reader-friendly articles
- Health assessment: Answer some questions to learn more about your health and receive a personal wellness report

Tivity Health Fitness Program

The Fitness Program offers flexible options to get in shape and stay active. Choose from a network of gyms offering tiered pricing that fits your budget and lifestyle. This program includes pay-as-you-go classes. Additionally, you can use the mobile app to access thousands of digital fitness videos, live classes, and fitness programs.

Log into BAM **https://mybam.bcbsok.com/** and search for Fitness Program under Wellness.

Virtual Annual Check-up with Catapult

This virtual checkup platform will allow you to receive a comprehensive preventive care examination from the comfort of your home, inclusive of:

- Assessment and review—diagnostic blood tests and measurements, family health history, depression and anxiety screenings, and prescription reviews
- Consultation and action—video consults with a Nurse Practitioner, referrals to other BCBS programs, and outreach/ follow-ups with a PCP

For more information/to order a Catapult kit, please visit **www.VirtualCheckup.com/HPInc**. Once ordered, you will receive a home kit with the materials needed for a checkup.

Digital Mental Health with Learn to Live

Online programs through Learn to Live at no added cost for:

- Stress, anxiety, and worry
- Depression
- Social anxiety
- Insomnia
- Substance abuse

Get started with a mental health assessment by logging into Blue Access for Members and selecting Digital Mental Health under the Wellness tab. Available to employees and family members age 13 and older.

Digital Therapy with Hinge Health

This program provides digital therapy options for chronic musculoskeletal conditions such as back pain, neck pain, and osteoarthritis. Hinge Health combines expert clinical care and advanced technology to go beyond traditional physical therapy and can be completed in your own home at your convenience.

- The Hinge Health App includes exercises, coaching, and education, with unlimited one-on-one support at no cost to you.
- The Hinge Health app is available for free on the App store!

Pre-Pregnancy through Menopause Support with Ovia Health

Ovia Health apps can help you track your cycle and provide you with pregnancy, parenting, and menopause support. The apps are available in English and Spanish, and provide videos, tips, coaching, and more.

Additionally, if your pregnancy is high-risk, BCBSOK will provide support from maternity specialists to help you care for yourself and your baby.

- Just search for Ovia Health in your App store!

Blue365

Blue365 is a program available to members that offers health and wellness discounts on a number of goods & services.

Members can also access Blue365 for discounts on health-related products and programs.

Explore more details at **bcbsok.com**

BCBS Discount Program

Blue365 is just one more advantage you have by being a BlueCross and BlueShield of Oklahoma (BCBSOK) member. With this program, you may save money on health and wellness products and services from top retailers that are not covered by insurance. There are no claims to file and no referrals or pre-authorizations.

Once you sign up for Blue365 at **blue365deals.com/bcbsok**, weekly "Featured Deals" will be emailed to you. These deals offer special savings for a short period of time.

Below are some of the ongoing deals offered through Blue365.

EyeMed | Davis Vision

You can save on eye exams, eyeglasses, contact lenses and accessories. You have access to national and regional retail stores and local eye doctors. You may also get possible savings on laser vision correction.

TruHearing® | Beltone™ | American Hearing Benefits

You could get savings on hearing tests, evaluations and hearing aids. Discounts may also be available for your immediate family members.

Dental | Solutions℠

You could get dental savings with Dental Solutions. You may receive a dental discount card that provides access to discounts of up to 50 percent at more than 70,000 dentists and more than 254,000 locations.

Jenny Craig® | Sun Basket | Nutrisystem®

Help reach your weight loss goals with savings from leading programs. You may save on healthy meals, membership fees (where applicable), nutritional products, and services.

See all the Blue365 deals and learn more at **blue365deals.com/bcbsok**.

Spending Account Comparison

Health Savings Account (HSA)*	Flexible Spending Account (FSA)	Healthcare FSA Limited Purpose	Dependent Care FSA
Definitions/Eligibility			
Pre-tax benefit account that is used to pay for eligible out-of-pocket medical, prescription, dental, and vision expenses. Please note: HSA is only available to employees enrolled in the High Deductible Plan.	Pre-Tax benefit account that is used to pay for eligible medical, prescription, dental, and vision expenses that aren't covered by your insurance plans. Eligibility: Must be enrolled in the PPO Deductible or the PPO Copay plan.	Pre-tax benefit account that is compatible with the health savings account. This account allows you to maximize this savings of the HSA by using this account to pay for eligible dental and vision expenses.	Pre-Tax benefits account used to pay for dependent care (daycare) services while you or your spouse are at work. All benefit-eligible employees are eligible to open an account.
Advantages			
■ H&P will contribute $500 annually to your HSA ($19.23 bi-weekly). ■ Contributions are tax deductible. ■ Account grows tax free. ■ Tax free withdrawals for eligible healthcare expenses. ■ The account is yours to keep.	■ Contributions are tax deductible. ■ Tax-free distributions for qualified medical, dental and vision expenses. ■ Employee can draw on the account for medical, dental, and vision expenses before funds are placed in the account.	■ Contributions are tax deductible. ■ Helps save out of pocket dental and vision expenses while saving long-term funds in HSA account. ■ Employees can draw on the account before funds are placed in it	■ Contributions are tax deductible. ■ Tax-free distributions for qualified dependent care expenses.
Eligible Expenses			
Expenses specified by the plan that generally qualify for the medical, dental, and vision expenses.	Expenses specified by the plan that generally qualify for the medical, dental, and vision expenses. For a comprehensive list of eligible expenses, contact WEX at **866.451.3399**.	Dental and Vision expenses. For a comprehensive list of eligible expenses, contact WEX at **866.451.3399**.	Daycare expenses for childcare/eldercare. For a comprehensive list of eligible expenses, contact WEX at **866.451.3399**.
Contribution Limit			
For 2025, the limit on all contributions is **$4,300** for employee only is **$8,550** for family. This limit includes the **$500** that H&P will contribute to your HSA. For employees age 55 and older, the catch-up contribution limit is $1,000.	For 2025, employees can contribute up to **$3,200.**	For 2025, employees can contribute up to **$3,200.**	For 2025, individuals or married employees filing taxes jointly can contribute **$5,000**. For employees who are married and file their taxes separately, can contribute **$2,500**.
Carryover/Rollover			
Employees can carryover the HSA year to year and is portable between employers.	■ For 2025, Employees can carry over a maximum of **$640** into 2026. This can be used towards expenses incurred in 2026. ■ For 2025, Employees have until 3/31/2026 to submit expenses for claims incurred in 2025.	■ For 2025, Employees can carry over a maximum of **$640** into 2026. This can be used towards expenses incurred in 2026. ■ For 2025, Employees have until 3/31/2026 to submit expenses for claims incurred in 2025.	■ Dependent care is not available to carry over. ■ For 2025, Employees have until 3/31/2026 to submit expenses for claims incurred in 2025.

* You are not eligible for an HSA if you are enrolled in Medicare, TRICARE, receiving Social Security benefits, claimed as a dependent on someone else's tax return and if your spouse is enrolled in an FSA that is not "limited" purpose. You cannot be enrolled in the Flexible Spending Account as well.

Be sure to designate your beneficiary for your HSA account by contacting WEX or visiting the WEX website.

Dental Insurance

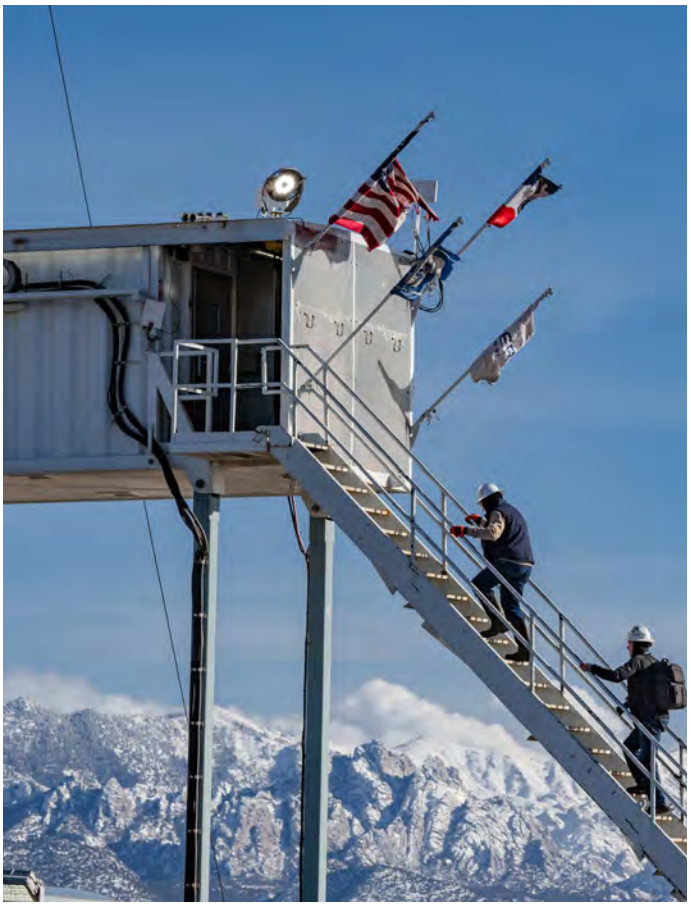
H&P offers a competitive, comprehensive dental plan through Delta Dental of Oklahoma. Below outlines premiums for this plan and coverage details.

Premium

Bi-Weekly Dental Premiums	
Employee	$10.94
Employee +1	$23.23
Family	$41.00

Deductible

- $50 deductible applies to Class II and Class III services per person
- The maximum family deductible per benefit year is $150
- Deductibles do not apply to Class I or Class IV services



Annual Maximum

- $1,500 annual maximum benefit per person. Applies to the combined expenses for Classes I, II and III.

Covered Services

Class I Services (Preventative Services)—100%
Oral examinations, emergency palliative treatment, x-rays, fluoride, and sealants for minors.

Class II Services—80%
Fillings, crowns for dependent children, oral surgical procedures, tooth extractions, root canals, and periodontics services.

Class III Services—50%
Major restorative services for treatments of decay/cavity that cannot be restored with another filling material, partials, dentures, implants, maintenance, and repair of implants.

Class IV Services—50%
Orthodontic services for dependents children under the age of 26; orthodontic lifetime limit is $1,500.

Vision Plan

H&P offers vision care through Vision Service (VSP). VSP does not provide insurance cards. Let your provider know you are enrolled in VSP to confirm service.

	Bi-Weekly Vision Premiums	
	PPO Plan	Premier Plan
Employee	$2.88	$3.57
Family	$6.49	$8.08

	Vision PPO	Vision Premier
Copayments	Copayment of $25 per person for exams and glasses.	Copayment of $25 per person for exams and glasses.
Eye Exams	Available once every 12 months. Covered in full after copay.	Available once every 12 months. Covered in full after copay.
Frames*	$170 allowance for wide selection of frames. $190 allowance for featured frame brands. Available once every 24 months.	$170 allowance for wide selection of frames. $190 allowance for featured frame brands. Available once every 12 months.
Lens	Copayment is combined with exam.	Copayment is combined with exam.
Lens Enhancements	■ Standard progressive lenses—$0 ■ Polycarbonate lenses—$0 ■ Scratch-resistant coating—$0 ■ UV protection—$0 ■ Premium progressive lenses—$95-$105 ■ Custom progressive lenses—$150-$175	■ Standard progressive lenses—$0 ■ Polycarbonate lenses—$0 ■ Scratch-resistant coating—$0 ■ UV protection—$0 ■ Premium progressive lenses—$95-$105 ■ Custom progressive lenses—$150-$175
Contacts	$170 allowance for contacts and contact lens exam. No copayment.	$170 allowance for contacts and contact lens exam. No copayment.
Diabetic Eye Care Plus Program	■ Services related to diabetic eye disease. ■ Glaucoma and age-related degeneration. ■ Retinal screening for eligible members with diabetes. ■ $20 copayment. **Ask VSP doctor for details**	■ Services related to diabetic eye disease. ■ Glaucoma and age-related degeneration. ■ Retinal screening for eligible members with diabetes. ■ $20 copayment. **Ask VSP doctor for details**

* Frame allowance may be applied towards non-prescription sunglasses for post PRK, LASIK, or Custom LASIK patients.

Basic Life Insurance/AD&D

Life/AD&D

H&P cares about you and your family. In the event of your passing, your company-provided life insurance will be there to help.

Eligibility

All active, benefit eligible employees are enrolled into the basic life/AD&D insurance policy 100% paid by H&P.

Employees will become eligible for basic life/AD&D insurance on the first day they are eligible for benefit coverage.

Basic Life/AD&D Benefit

Employees are guaranteed 2× their Annual Compensation rounded to the next higher $1,000.

Maximum Benefit

The lesser of 2× Annual Compensation or $300,000.

Why Should I Review my Beneficiary Designation?

It's important to make sure H&P has your most up-to-date beneficiary on file. In the tragic event of one's passing, H&P is legally required to pay the beneficiary on record.

HOW DO I UPDATE MY LIFE INSURANCE/AD&D BENEFICIARIES?

Log on to Workday to update both your basic and supplemental life insurance/AD&D beneficiaries. This is a part of the enrollment process that you will have in your Workday inbox, but you can change your beneficiaries at any time.

If you are enrolled in spouse or child life insurance, you are the beneficiary; therefore, no designation is necessary.

For any questions, you can call the HR Support Center (HRSC) at 918.588.2247 or send an email to **HR.Support@hpinc.com**.

View the MetLife certificates for more information by visiting **HelmerichPayne.com/USBenefits**. Password: HPBenefits.

Supplemental Coverage

Employees have the opportunity to purchase supplemental life/AD&D insurance for themselves, their eligible spouse, and/or their eligible dependent child(ren). Log in to Workday to see premium rates.

Supplemental Employee Life/ AD&D Insurance

You are able to elect 5× your annual salary up to $1,000,000. As a new hire or newly eligible employee, you can elect 3× your annual salary up to $500,000 without evidence of insurability (EOI).

Supplemental Child Life Insurance

Employees can cover their dependent child(ren) on life insurance up to the age of 19 years old under Supplemental Child Life Insurance. Each dependent child benefit is Guaranteed Issue in the amount of $10,000.

Supplemental Spouse Life/ AD&D Insurance

If you elect Supplemental Life/AD&D coverage for yourself, you can also elect Supplemental Spouse Life/AD&D coverage for your spouse. MetLife allows several incremental options based on your annual compensation outlined in the table below. The maximum of the Supplemental Spouse Life/ AD&D benefit is 50% of your basic life/AD&D and Supplemental Life/AD&D amount, up to $275,000.

As a new hire or newly eligible employee, you can elect up to $20,000 without evidence of insurability (EOI) for Spouse Life/AD&D.

Employees must provide a copy of a marriage certificate or common law affidavit to cover their spouse on life insurance.

Options	
Option 1	0.5× the Employee's annual compensation
Option 2	1.0× the Employee's annual compensation
Option 3	1.5× the Employee's annual compensation
Option 4	2.0× the Employee's annual compensation

Increases in benefit due to an increase in the Employee's Annual Compensation are not subject to evidence of insurability. The Supplemental Life also provides a Terminal Illness Benefit of a maximum of 80% of your Basic and/or Supplemental Life/AD&D Insurance benefits up to a certain maximum depending on plan.

Additional Accident Benefits

Seatbelt and Airbag Benefit

H&P has worked with MetLife to provide an additional benefit to the beneficiaries of any active covered employee whose death was a result of an automobile accident where it can be shown that the employee was wearing their seatbelt. In addition, an Airbag Benefit would be paid if the automobile was equipped with an Airbag. These benefits apply to both employees and dependents.

Benefits	
Seatbelt Benefit	15% of the principal sum subject to a maximum benefit of $15,000
Airbag Benefit	15% of the principal sum subject to a maximum benefit of $15,000

- **MINIMUM BENEFIT:** $1,000

Helmet Benefit

The Helmet Benefit is applicable for covered, active employees whose death is a result of an accident while wearing a helmet while riding a two-wheeled or three-wheeled motorized vehicle. This benefit applies to both employees and dependents.

- **Benefit Amount:** $10,000

Education and Child Care Benefit

If a covered, active employee or their spouse's death is a result of an accident, the employee's family may qualify for the below benefits.

Benefits	
Spouse Education Benefit	Amount equal to tuition charges for up to 1 academic year, subject to a maximum benefit of the lesser of $5,000 or 5% of the full employee AD&D benefit
Child Education Benefit	Amount equal to tuition charges for up to 4 consecutive academic years beyond 12th grade, subject to a maximum benefit of the lesser of $10,000 per academic year or 20% of the full employee AD&D benefit
Child Care Benefit	Amount equal to child care center charges for up to 4 consecutive years, subject to a maximum benefit of $5,000 annually or 12% of the full employee AD&D benefit

Long Term Disability

Long-term disability insurance (LTD) ensures an employee (if approved by the vendor) will receive a percentage (up to 60%) of their income in the event that they are unable to work due to illness, injury, or accident for more than 180 days.

Eligibility

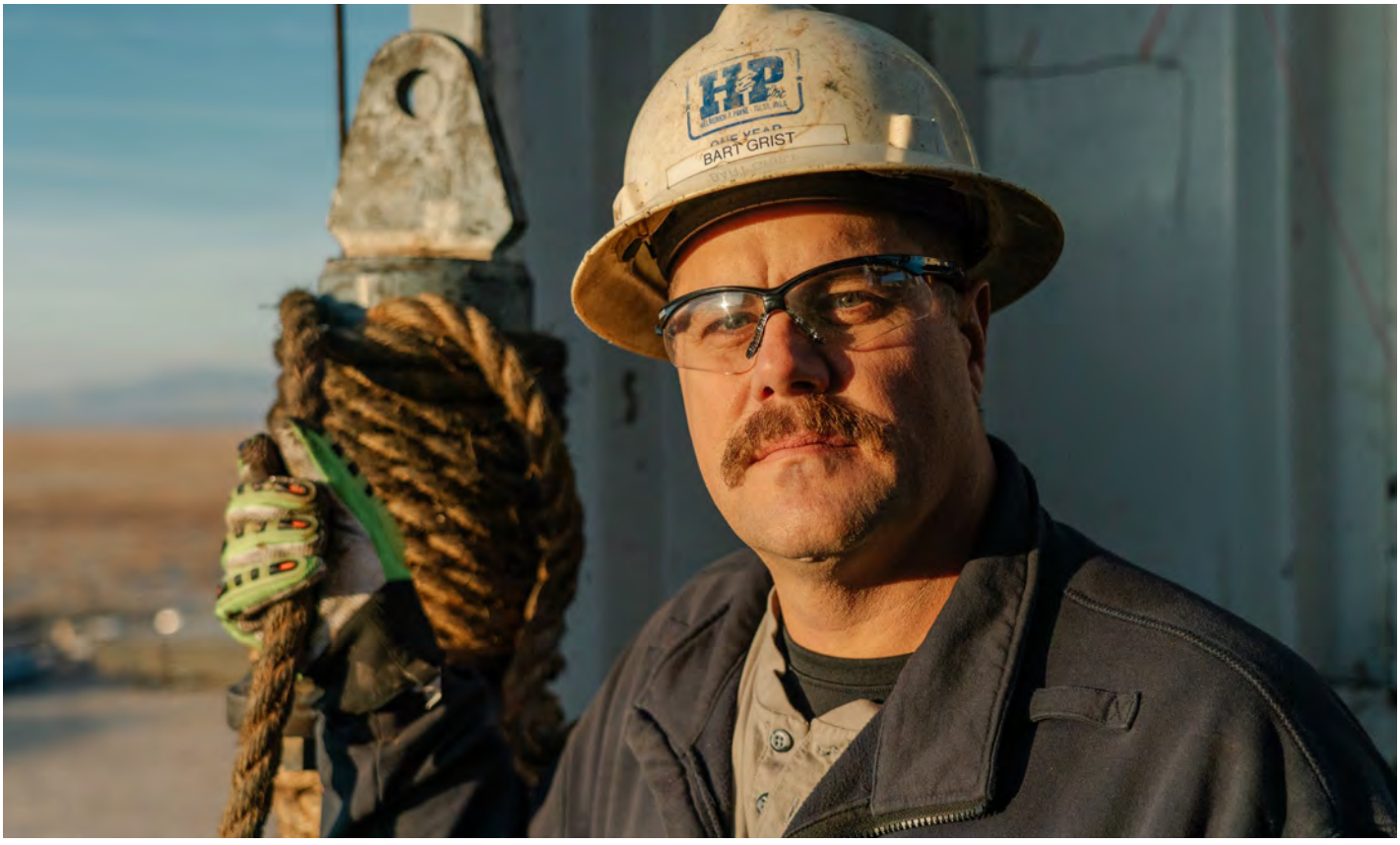
Full-time employees working at least 20 hours per week are eligible. Employees must elect long-term disability during their new hire benefit elections or open enrollment elections.

Elimination Period

Employees must be disabled for 180 days before receiving disability payments. Disability payments must first be approved by MetLife or the state.

Premiums

50% of this benefit is paid by H&P, and it protects 60% of your annual salary, up to a monthly maximum of $12,500. The employee premium is $0.425 per $100 of covered earnings.



Retirement Plans

H&P cares about your future and providing ways you can save for retirement. H&P contributes **dollar for dollar** up to 5% each year to help you achieve your retirement goals.

401(k) Summary

Enrollment

- New employees are auto-enrolled at 3%
- Default investment is the age appropriate Target Retirement Fund
- Annual automatic 1% increase

Employee Contribution Options

- Pre-tax/Traditional
- Post-tax/Roth
- Combination of Traditional and Roth

Employee Contribution Amounts

- 0 to 75% of eligible pay

IMPORTANT NOTE: H&P no longer maintains beneficiary designations and those forms are null and void. If you previously filled out an H&P form, you must designate a beneficiary directly with Vanguard. You can do this by going to vanguard.com/retirementplans or calling Vanguard Participant Services at 800.523.1188.

Company Match

- Dollar for dollar up to 5%

Rollovers

- Contact Vanguard to rollover 401(k) from previous employer

Vesting for Company Match

Vesting schedule	
After Year 1	0%
After Year 2	50%
After Year 3	100%

401(k) Beneficiary Designation

Contact Vanguard to select beneficiary for 401(k) account:

- Phone: **800.523.1188**
  - Hours: Monday through Friday, 8:30 a.m. to 9 p.m., Eastern time.
- Website: **www.vanguard.com/retirementplans**
  - You'll need the last four digits of your beneficiary's Social Security number, or their birth date and mailing address.
- Download Vanguard App to manage retirement account

Employee Assistance Program

The Employee Assistance Program (EAP) offered through Magellan provides free services for you and your household members. Please see the key features/resources below that are included in the program.

Key Features

- Automatically enrolled
- Provided at no cost to you and your household members
- Includes up to 5 counseling sessions
- Completely confidential service provided by a third party

BetterHelp Virtual Therapy

Through this program, you have access to confidential virtual therapy, provided by BetterHelp, at no cost to you. Counseling is available for the entire family—individuals, couples, and teens (with parental consent and in accordance with applicable law and clinical appropriateness). This is available by text message, live chat, phone, or video conference. To register, please visit **BetterHelp.com/Magellan** and click on "Get Started" or call the Magellan number listed below.

Work-Life Services

Save time and money on life's most important needs. Specialists provide expert guidance and personalized referrals to service providers including childcare, adult care, education, home improvement, and more. The website includes webinars, live talks, and articles focused on key life events and day-to-day challenges.

Lifestyle Coaching

Define and reach your goals with the support of a coach. Coaches can help with personal improvement, healthy eating, weight loss, and more. Coaches are available by phone or video.

Financial Wellness, Legal Services, and Identity Theft Resolution

Meet with experts that can help you take control of your finances, resolve legal issues such as estate planning and family law, restore credit, research specific topics and/or print your own state-specific legal forms.

Digital Emotional Wellness Tools

Take advantage of proven programs to help manage anxiety, stress, depression, pain, sleep, substance misuse or recovery, and more. Personalized and interactive with self-directed activities, uplifting stories, videos, and daily inspiration help you live your best life.

Additionally, download the free NeuroFlow app for mental health and anxiety management tips specifically designed for children and teens.

- Just search for NeuroFlow in your App store!

Call your Employee Assistance Program at **800.424.4105** (TTY 711) to be connected with the right resource or professional or visit **Member.MagellanHealthcare.com** to browse all of the services available.

Frequently Asked Questions

I missed my enrollment window. How can I enroll now?

You may enroll during our next open enrollment period. If you experience a qualifying life event, you will have 45 days from the date of the event to update your enrollments through Workday.

I had a baby, got married, or gained/lost other insurance coverage and want to change my enrollment. How do I do that?

Visit **HelmerichPayne.com/usbenefits** (Password: HPBenefits) to find step-by-step instructions on how to change your benefits. You will have a 45-day window starting on the date of the event. Don't wait for official birth certificates, but send us a document from the hospital showing your baby's birth date and name.

How can I send a document (birth certificate, marriage license, etc.) to the Benefits group?

You can upload the document on Workday OR you can email or text a photo to **HR.Support@hpinc.com** or fax us at **918.588.5480**.

I applied for a Principal Residence Loan. Who should I contact for information on what documents I need to provide?

Please contact Vanguard at **800.523.1188** or visit **www.vanguard.com**.

I've moved, how do I change my address?

Log into Workday > Personal Information > Change Contact Information > Click the pencil to make updates > Submit.

How do I review and update my beneficiary assignments?

- Life Insurance/AD&D: Update through the Workday online benefits portal.
- 401(k) at Vanguard: Log in to **vanguard.com** to update.
- HSA at WEX: Visit **wex.com** to update.

How do I complete a tobacco cessation program?

BCBS offers a tobacco cessation program. To learn more, contact BCBS at **888.780.7875** or visit **bcbsok.com**. Please submit certification of completion to the HR Support Center to remove the tobacco surcharge at **hr.support@hpinc.com**.

I need prescription safety glasses. Can I get reimbursed?

You can get reimbursed for a portion of the cost of prescription safety glasses. Contact your HSE Rep for the form and information.

How long can my dependent child be covered under H&P's plan?

Dependent child(ren) are eligible for medical, dental and vision insurance until age 26. They will automatically be removed from coverage on the 1st of the month following their 26th birthday. Dependent child(ren) are eligible for the supplemental child life insurance up to age 19.

How do I enroll in my 401(k)? And how much does H&P match?

As a new hire you will automatically be enrolled at 3% contribution in the Traditional 401(k) Thrift Plan. If you want to change the amount or enroll in the Roth plan, you will need to contact Vanguard directly. Our Group number is **090830**. H&P will match up to 5%. Employees seeking to maximize the H&P Match can login to their Vanguard account, click on Manage My Money, and choose the Maximize my contributions link.

How do I enroll in 401(k) Catch-Up Contributions?

If you are turning 50 or 50+ in the plan year, your 401(k) deferral contributions will continue until you reach the IRS Catch-Up Contribution maximum for the year. If you do not wish to continue deferring up to the catch-up maximum, simply log into Vanguard and change or remove your deferral. To restart your deferrals for the next plan year, you will need to update your deferral election at Vanguard.

Enroll on Your Computer or Phone

Turn your phone sideways. Works better in landscape mode

- Go to **www.myhpway.com**
- Click on the Workday icon
- Check your Workday inbox
- Click on **"Open Enrollment Change"** modification
- Review your benefits options, click **"Elect"** on the benefits you want and **"Waive"** on the benefits you don't want
- Review dependent information and add or remove appropriate dependents
- Review/update your beneficiaries, address, and emergency contacts
- Review your benefit elections and click "Submit"

H&P BENEFITS WEBSITE:

Visit **HelmerichPayne.com/USBenefits**
Password: HPBenefits

- Make changes for the new year
- Get plan information
- Review your benefits guide
- Find vendor contacts
- View recorded webinars

NEW! UPWISE DECISION SUPPORT

The Upwise decision support tool can offer you a personalized and comprehensive benefits recommendation, whether you are already comfortable with your plan or looking for guidance in your elections. To utilize the tool, follow these steps:

- Take an interactive survey at the start of enrollment that explores your health, wellness, finances, and future plans.
- Based on your survey insights, Upwise provides a tailored recommendation including all the benefits your employer provides.
- Upwise becomes your digital benefits consultant throughout the year, offering timely reminders on how to use your benefits. This tool can be accessed during open enrollment through My H&P Way.

You can access the decision support tool by going to My H&P Way, selecting OKTA, and clicking on the Upwise tile. This is a secure connection and can only be accessed through OKTA. All information captured by Upwise is secure and confidential.

Update Your Benefits

Once you make your enrollment selections, you may not change your benefits during the year unless you experience a "change of status" or life event. Please review the list of events that can take place during the course of the year that would qualify for a "change of status" and allow you to make changes to your benefit elections. **Please note, that even if you have family coverage, you still need to make changes in Workday and provide documentation within 45 days of the "change of status" event.**

Simply log on to www.myhpway.com > Your H&P Journey > Benefits then follow the instructions on the link for the type of event that fits your situation. There is also a link on the page that takes you into Workday to begin the change. As always be sure you are on a desktop or laptop computer.

- You can upload documents through Workday.
- You can fax documents to **918.588.5485**.
- You can email or text photos of documents to **HR.Support@hpinc.com**.

Change In Status Event Type	Documentation Required
Birth	Something from the hospital with your baby's name and date of birth on it. A crib card, verification of birth facts, application for birth certificate, etc. Do not wait for the official birth certificate.
Adoption/ Guardianship	Court document showing placement for adoption/sole legal guardianship has been granted.
Marriage	Marriage certificate
Legal Separation	Legal separation agreement
Divorce	Full copy of the finalized divorce decree
Loss of Other Coverage	Letter or document from your former insurance company or HR Department stating the names of all who have lost insurance, what type of insurance ended, and what date it ends.
Gain of Other Coverage	Letter or document from your new insurance company or HR Department stating the names of all who have gained insurance, what type of insurance is being added, and what date it begins.

When a "change of status" event occurs, you must request benefit coverage changes through Workday, **(not the insurance carrier) within 45 days** of the date the "change of status" event occurs.

Find the Answers You Need

MEDICAL AND PRESCRIPTION

BlueCross BlueShield of Oklahoma
888.780.7875
bcbsok.com

DENTAL

Delta Dental of Oklahoma
800.522.0188
deltadentalok.org

VISION

Vision Service Plan (VSP)
800.877.7195
vsp.com

TELEMEDICINE

Virtual Health
888.970.4081
MDLIVE.com/bcbsok

WELLNESS

Well onTarget
wellontarget.com

EMPLOYEE ASSISTANCE PROGRAM

Magellan
24/7 Support—**800.424.4105**
Member.MagellanHealthcare.com

LIFE INSURANCE/ AD&D AND LONG TERM DISABILITY

MetLife
800.438.6388
mybenefits.metlife.com

FLEXIBLE SPENDING AND HEALTH SAVINGS ACCOUNTS

WEX
866.451.3399
benefitslogin.wexhealth.com

RETIREMENT

Vanguard
800.523.1188
vanguard.com

QUESTIONS/ ENROLLMENT/CHANGES TO BENEFITS

HR Support: **918.588.2247**
Email: **HR.Support@hpinc.com**
myhpway.com

HINGE HEALTH, 24/7 NURSELINE, AND CATAPULT

Hinge Health
855.902.2777
hinge.health/helmerichpayne-oe

24/7 Nurseline
800.581.0407

Catapult
www.VirtualCheckup.com/HPInc

H&P BENEFITS WEBSITE:

Visit **HelmerichPayne.com/USBenefits**
Password: HPBenefits

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Glossary

General Benefits Terms

- **Base Salary—**Salary calculated before overtime or bonuses.
- **Beneficiary—**The person(s) or trust who will receive the money from either your life insurance/AD&D, HSA, and/or 401(k) account should you die. There are two levels of beneficiary. The first person, group or trust who receives the benefit is the "primary" beneficiary. If more than one person is named, the benefit is split between the remaining primary beneficiaries. If no beneficiary is named, the benefit will go to the estate of the employee. Please note there is an additional cost to the family to set up an estate.
- **Dependent—**Those individuals you can enroll in your policies. These include your current spouse, children, step-children, adopted children, and children for whom you are the Sole Legal Guardian. Children are eligible for medical, dental, and vision insurance up to age 26 and for Child Life insurance until age 19.
- **Effective Date—**The date your benefits start. For new hires, please check your personalized letter for your effective date as it is determined by your hire date. If you are enrolling due to a change of status, your effective date is determined by when the changes in Workday are made and proof of the change were submitted and completed.
- **Eligibility—**All full-time regular employees and part-time employees working a minimum of 20 hours per week are eligible.
- **Leave Of Absence (LOA)—**This may be due to injury, illness or taking care of a spouse due to the birth of a child, etc. If you stop receiving H&P paychecks during this time, you will need to pay for your benefits out-of-pocket to keep them active until you return.
- **Open Enrollment—**A specific period each fall when you can make any changes you want to your enrollment for the following year. Typically this starts in mid/late October.

Insurance Terms

- **AD&D—**Employee and spouse life insurance policies have an additional Accidental Death & Dismemberment policy.
- **Basic Life / Supplemental Life—**Each active employee is enrolled in Basic Life Insurance for free. Supplemental life insurance is optional and paid for by the employee.
- **COBRA—**Health insurance that is paid entirely by the employee after employment ends. The employee must enroll in COBRA insurance through WEX.
- **Deductible—**The amount out-of-pocket paid due to office visits, prescriptions, lab work, etc. before your insurance plan begins to pay at a higher rate. In the case of our medical plans without copays, you will pay the corresponding coinsurance percentage of a bill until you've paid your deductible, then insurance will begin to pay that percentage for in-network services. Please refer to the plan descriptions for details.

- **Long-Term Disability (LTD)—** Administered by MetLife, this is a wage replacement program that the employee can elect. Enrolled employees who have been on LOA for 6 months due to injury or illness, and who are going to be out longer, can file a claim with MetLife to receive up to 60% of your base salary per month.
- **Out-Of-Pocket Limit—**The most you will pay during the plan year. If you reach the out-of-pocket limit during the plan year, the plan will pay 100% of charges after that point for the year. This will also be impacted by in-network or out-of-network services. Please refer to the plan descriptions for details.
- **Premiums—**The amount per month that you pay for your coverage through your paychecks.
- **Supplemental Spouse Life and AD&D/ Child Life—**If the employee is enrolled in supplemental life insurance, the spouse can also be enrolled in supplemental spouse life and AD&D insurance for up to 50% of the employee's supplemental life insurance up to $275,000.
  - Supplemental Child Life is available through MetLife as well.
  - For more information on these plans, please refer to page 11 or reach out to MetLife.

Retirement Terms

- **401(k) Thrift—**The traditional 401(k) plan that you are automatically enrolled in at a 3% contribution rate as a new hire. Taxes are paid at the time of distribution.
- **401(k) Roth—**A post-tax 401(k) plan where taxes are taken out now rather than later.
- **401(k) Catch-Up Contributions—** Employees age 50+ can defer an additional amount in catch-up contributions. There is no need to complete a form—Your current deferrals will continue until you reach the catch-up contribution maximum determined annually by the IRS. Be sure to review your current deferral election to ensure it is the amount you wish defer. If you wish to make any changes, please log into Vanguard and change or remove your deferral.

IMPORTANT NOTICE
This packet of notices related to our health care plan includes a notice regarding how the plan's prescription drug coverage compares to Medicare Part D. If you or a covered family member is also enrolled in Medicare Parts A or B, but not Part D, you should read the Medicare Part D notice carefully. It is titled, "Important Notice From Helmerich & Payne Management, LLC About Your Prescription Drug Coverage and Medicare."

IMPORTANT NOTICE FROM HELMERICH & PAYNE MANAGEMENT, LLC 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 Helmerich & Payne Management, LLC and about your options under Medicare's prescription drug coverage. This information can help you decide whether you want to join a Medicare drug plan. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

If neither you nor any of your covered dependents are eligible for or have Medicare, this notice does not apply to you or your dependents, as the case may be. However, you should still keep a copy of this notice in the event you or a dependent should qualify for coverage under Medicare in the future. Please note, however, that later notices might supersede this notice.

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. Helmerich & Payne Management, LLC has determined that the prescription drug coverage offered by the Helmerich & Payne Management, LLC Employee Health Care Plan ("Plan") is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is considered "creditable" prescription drug coverage. This is important for the reasons described below.

Because your existing coverage is, on average, at least as good as standard Medicare prescription drug coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to enroll in a Medicare drug plan, as long as you later enroll within specific time periods.

Enrolling in Medicare—General Rules

As some background, you can join a Medicare drug plan when you first become eligible for Medicare. If you qualify for Medicare due to age, you may enroll in a Medicare drug plan during a seven-month initial enrollment period. That period begins three months prior to your 65th birthday, includes the month you turn 65, and continues for the ensuing three months. If you qualify for Medicare due to disability or end-stage renal disease, your initial Medicare Part D enrollment period depends on the date your disability or treatment began. For more information you should contact Medicare at the telephone number or web address listed below.

Late Enrollment and the Late Enrollment Penalty

If you decide to *wait* to enroll in a Medicare drug plan you may enroll later, during Medicare Part D's annual enrollment period, which runs each year from October 15 through December 7. But as a general rule, if you delay your enrollment in Medicare Part D, after first becoming eligible to enroll, you may have to pay a higher premium (a penalty).

If after your initial Medicare Part D enrollment period you go **63 continuous days or longer without "creditable" prescription drug coverage** (that is, prescription drug coverage that's at least as good as Medicare's prescription drug coverage), your monthly Part D premium may go up by at least 1 percent of the premium you would have paid had you enrolled timely, for every month that you did not have creditable coverage.

For example, if after your Medicare Part D initial enrollment period you go 19 months without coverage, your premium may be at least 19% higher than the premium you otherwise would have paid. You may have to pay this higher premium for as long as you have Medicare prescription drug coverage. *However, there are some important exceptions to the late enrollment penalty.*

Special Enrollment Period Exceptions to the Late Enrollment Penalty

There are "special enrollment periods" that allow you to add Medicare Part D coverage months or even years after you first became eligible to do so, without a penalty. For example, if after your Medicare Part D initial enrollment period you lose or decide to leave employer-sponsored or union-sponsored health coverage that includes "creditable" prescription drug coverage, you will be eligible to join a Medicare drug plan at that time.

In addition, if you otherwise lose other creditable prescription drug coverage (such as under an individual policy) through no fault of your own, you will be able to join a Medicare drug plan, again without penalty. These special enrollment periods end two months after the month in which your other coverage ends.

Compare Coverage

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. See the Helmerich & Payne Management, LLC Plan's summary plan description for a summary of the Plan's prescription drug coverage. If you don't have a copy, you can get one by contacting us at the telephone number or address listed below.

Coordinating Other Coverage With Medicare Part D

Generally speaking, if you decide to join a Medicare drug plan while covered under the Helmerich & Payne Management, LLC Plan due to your employment (or someone else's employment, such as a spouse or parent), your coverage under the Helmerich & Payne Management, LLC Plan will not be affected. For most persons covered under the Plan, the Plan will pay prescription drug benefits first, and Medicare will determine its payments second. For more information about this issue of what program pays first and what program pays second, see the Plan's summary plan description or contact Medicare at the telephone number or web address listed below.

If you do decide to join a Medicare drug plan and drop your Helmerich & Payne Management, LLC prescription drug coverage, be aware that you and your dependents may not be able to get this coverage back. To regain coverage you would have to re-enroll in the Plan, pursuant to the Plan's eligibility and enrollment rules. You should review the Plan's summary plan description to determine if and when you are allowed to add coverage. Special Enrollment Period Exceptions to the Late Enrollment Penalty.

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If you do decide to join a Medicare drug plan and drop your Helmerich & Payne Management, LLC prescription drug coverage, be aware that you and your dependents may not be able to get this coverage back. To regain coverage you would have to re-enroll in the Plan, pursuant to the Plan's eligibility and enrollment rules. You should review the Plan's summary plan description to determine if and when you are allowed to add coverage.

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

Contact the person listed below for further information, or call 918-588-2247. **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Helmerich & Payne Management, LLC changes. You also may request a copy.

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 whether or not you are required to pay a higher premium (a penalty).

Date:	October 21, 2024
Name of Entity/Sender:	Human Resources
Contact—Position/Office:	Human Resources
Address:	222 N. Detroit Ave. Tulsa, Oklahoma 74120
Phone Number:	918-588-2247

Nothing in this notice gives you or your dependents a right to coverage under the Plan. Your (or your dependents') right to coverage under the Plan is determined solely under the terms of the Plan.

HELMERICH & PAYNE MANAGEMENT, LLC
IMPORTANT NOTICE COMPREHENSIVE NOTICE OF PRIVACY POLICY AND PROCEDURES

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

This notice is provided to you on behalf of:

- **Helmerich & Payne Management, LLC Medical Plan**
- **Helmerich & Payne Management, LLC Dental Care Plan**
- **Helmerich & Payne Management, LLC Vision Plan**
- **Helmerich & Payne Management, LLC Flexible Benefits Plan**

* This notice pertains only to healthcare coverage provided under the plan.

For the remainder of this notice, Helmerich & Payne Management, LLC is referred to as Company.

1. Introduction: This Notice is being provided to all covered participants in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and is intended to apprise you of the legal duties and privacy practices of the Company's self-insured group health plans. If you are a participant in any fully insured group health plan of the Company, then the insurance carriers with respect to those plans is required to provide you with a separate privacy notice regarding its practices.

2. General Rule: A group health plan is required by HIPAA to maintain the privacy of protected health information, to provide individuals with notices of the plan's legal duties and privacy practices with respect to protected health information, and to notify affected individuals follow a breach of unsecured protected health information. In general, a group health plan may only disclose protected health information (i) for the purpose of carrying out treatment, payment and health care operations of the plan, (ii) pursuant to your written authorization; or (iii) for any other permitted purpose under the HIPAA regulations.

3. Protected Health Information: The term "protected health information" includes all individually identifiable health information transmitted or maintained by a group health plan, regardless of whether or not that information is maintained in an oral, written or electronic format. Protected health information does not include employment records or health information that has been stripped of all individually identifiable information and with respect to which there is no reasonable basis to believe that the health information can be used to identify any particular individual.

4. Use and Disclosure for Treatment, Payment and Health Care Operations: A group health plan may use protected health information without your authorization to carry out treatment, payment and health care operations of the group health plan.

- An example of a "treatment" activity includes consultation between the plan and your health care provider regarding your coverage under the plan.
- Examples of "payment" activities include billing, claims management, and medical necessity reviews.
- Examples of "health care operations" include disease management and case management activities.

The group health plan may also disclose protected health information to a designated group of employees of the Company, known as the HIPAA privacy team, for the purpose of carrying out plan administrative functions, including treatment, payment and health care operations.

If protected health information is properly disclosed under the HIPAA Privacy Practices, such information may be subject to redisclosure by the recipient and no longer protected under the HIPAA Privacy Practices.

5. Disclosure for Underwriting Purposes. A group health plan is generally prohibited from using or disclosing protected health information that is genetic information of an individual for purposes of underwriting.

6. Uses and Disclosures Requiring Written Authorization: Subject to certain exceptions described elsewhere in this Notice or set forth in regulations of the Department of Health and Human Services, a group health plan may not disclose protected health information for reasons unrelated to treatment, payment or health care operations without your authorization. Specifically, a group health plan may not use your protected health information for marketing purposes or sell your protected health information. Any use or disclosure not disclosed in this Notice will be made only with your written authorization. If you authorize a disclosure of protected health information, it will be disclosed solely for the purpose of your authorization and may be revoked at any time. Authorization forms are available from the Privacy Official identified in section 23.

7. Special Rule for Mental Health Information: Your written authorization generally will be obtained before a group health plan will use or disclose psychotherapy notes (if any) about you.

8. Uses and Disclosures for which Authorization or Opportunity to Object is not Required: A group health plan may use and disclose your protected health information without your authorization under the following circumstances:

- When required by law;
- When permitted for purposes of public health activities;
- When authorized by law to report information about abuse, neglect or domestic violence to public authorities;
- When authorized by law to a public health oversight agency for oversight activities (subject to certain limitation described in paragraph 20 below);
- When required for judicial or administrative proceedings (subject to certain limitation described in paragraph 20 below);
- When required for law enforcement purposes (subject to certain limitation described in paragraph 20 below);
- When required to be given to a coroner or medical examiner or funeral director (subject to certain limitation described in paragraph 20 below);
- When disclosed to an organ procurement organization;
- When used for research, subject to certain conditions;
- When 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 to a person reasonably able to prevent or lessen the threat; and
- When authorized by and to the extent necessary to comply with workers' compensation or other similar programs established by law.

9. Minimum Necessary Standard: When using or disclosing protected health information or when requesting protected health information from another covered entity, a group health plan must make reasonable efforts not to use, disclose or request more than the minimum amount of protected health information necessary to accomplish the intended purpose of the use, disclosure or request. The minimum necessary standard will not apply to: disclosures to or requests by a health care provider for treatment; uses or disclosures made to the individual about his or her own protected health information, as permitted or required by HIPAA; disclosures made to the Department of Health and Human Services; or uses or disclosures that are required by law.

10. Disclosures of Summary Health Information: A group health plan may use or disclose summary health information to the Company for the purpose of obtaining premium bids or modifying, amending or terminating the group health plan. Summary health information summarizes the participant claims history and other information without identifying information specific to any one individual.

11. Disclosures of Enrollment Information: A group health plan may disclose to the Company information on whether an individual is enrolled in or has disenrolled in the plan.

12. Disclosure to the Department of Health and Human Services: A group health plan may use and disclose your protected health information to the Department of Health and Human Services to investigate or determine the group health plan's compliance with the privacy regulations.

13. Disclosures to Family Members, other Relations and Close Personal Friends: A group health plan may disclose protected health information to your family members, other relatives, close personal friends and anyone else you choose, if: (i) the information is directly relevant to the person's involvement with your care or payment for that care, and (ii) either you have agreed to the disclosure, you have been given an opportunity to object and have not objected, or it is reasonably inferred from the circumstances, based on the plan's common practice, that you would not object to the disclosure.

For example, if you are married, the plan will share your protected health information with your spouse if he or she reasonably demonstrates to the plan and its

representatives that he or she is acting on your behalf and with your consent. Your spouse might to do so by providing the plan with your claim number or social security number. Similarly, the plan will normally share protected health information about a dependent child (whether or not emancipated) with the child's parents. The plan might also disclose your protected health information to your family members, other relatives, and close personal friends if you are unable to make health care decisions about yourself due to incapacity or an emergency.

14. Appointment of a Personal Representative: You may exercise your rights through a personal representative upon appropriate proof of authority (including, for example, a notarized power of attorney). The group health plan retains discretion to deny access to your protected health information to a personal representative.

15. Individual Right to Request Restrictions on Use or Disclosure of Protected Health Information: You may request the group health plan to restrict (1) uses and disclosures of your protected health information to carry out treatment, payment or health care operations, or (2) uses and disclosures to family members, relatives, friends or other persons identified by you who are involved in your care or payment for your care. However, the group health plan is not required to and normally will not agree to your request in the absence of special circumstances. A covered entity (other than a group health plan) must agree to the request of an individual to restrict disclosure of protected health information about the individual to the group health plan, if (a) the disclosure is for the purpose of carrying out payment or health care operations and is not otherwise required by law, and (b) the protected health information pertains solely to a health care item or service for which the individual (or person other the health plan on behalf of the individual) has paid the covered entity in full.

16. Individual Right to Request Alternative Communications: The group health plan will accommodate reasonable written requests to receive communications of protected health information by alternative means or at alternative locations (such as an alternative telephone number or mailing address) if you represent that disclosure otherwise could endanger you. The plan will not normally accommodate a request to receive communications of protected health information by alternative means or at alternative locations for reasons other than your endangerment unless special circumstances warrant an exception.

17. Individual Right to Inspect and Copy Protected Health Information: You have a right to inspect and obtain a copy of your protected health information contained in a "designated record set," for as long as the group health plan maintains the protected health information. A "designated record set" includes the medical records and billing records about individuals maintained by or for a covered health care provider; enrollment, payment, billing, claims adjudication and case or medical management record systems maintained by or for a health plan; or other information used in whole or in part by or for the group health to make decisions about individuals.

The requested information will be provided within 30 days if the information is maintained on site or within 60 days if the information is maintained offsite. A single 30-day extension is allowed if the group health plan is unable to comply with the deadline. If access 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 those review rights and a description of how you may contact the Secretary of the U.S. Department of Health and Human Services.

18. Individual Right to Amend Protected Health Information: You have the right to request the group health plan to amend your protected health information for as long as the protected health information is maintained in the designated record set. The group health plan has 60 days after the request is made to act on the request. A single 30-day extension is allowed if the group health plan is unable to comply with the deadline. If the request is denied in whole or part, the group health plan must provide you with a written denial that explains the basis for the denial. You may then submit a written statement disagreeing with the denial and have that statement included with any future disclosures of your protected health information.

19. Right to Receive an Accounting of Protected Health Information Disclosures: You have the right to request an accounting of all disclosures of your protected health information by the group health plan during the six years prior to the date of your request. However, such accounting need not include disclosures made: (1) to carry out treatment, payment or health care operations; (2) to individuals about their own protected health information; (3) prior to

the compliance date; or (4) pursuant to an individual's authorization.

If the accounting cannot be provided within 60 days, an additional 30 days is allowed if the individual is given a written statement of the reasons for the delay and the date by which the accounting will be provided. If you request more than one accounting within a 12-month period, the group health plan may charge a reasonable fee for each subsequent accounting.

20. Reproductive Health Care Privacy: Effective December 23, 2024, a group health plan may not disclose protected health information to: (i) conduct a criminal, civil, or administrative investigation into a person for the mere act of seeking, obtaining, providing, or facilitating reproductive health care; (ii) impose criminal, civil, or administrative liability on any person for the mere act of seeking, obtaining, providing, or facilitating reproductive health care; or (iii) identify any person for the purposes described in (i) and (ii).

Reproductive health care means care, services, or supplies related to the reproductive health of the individual.

This prohibition only applies if the reproductive health care is lawful under the law of the state in which the health care was provided and under the circumstances in which it was provided, or if the reproductive health care was protected, required, or authorized by Federal law, including the United States Constitution, regardless of the state in which it is provided. For example, if you receive reproductive health care in a state where such care is lawful even though it is not lawful in the state where you reside, the plan may not disclose this information to conduct an investigation.

A group health plan may not use or disclose protected health information potentially related to reproductive health care for the purposes of uses and disclosures of 1) public health oversight activities, 2) judicial and administrative proceedings, 3) law enforcement purposes, and 4) coroners and medical examiners without obtaining a valid attestation from the person requesting the use or disclosure of such information. A valid attestation under this section must include the following elements:

(i) A description of the information requested that identifies the information in a specific fashion, including one of the following: (A) the name of any individual(s) whose protected health information is sought, if practicable; and (B) if including the name(s) of any individual(s) whose protected health information is sought is not practicable, a description of the class of individuals whose protected health information is sought.

(ii) The name or other specific identification of the person(s), or class of persons, who are requested to make the use or disclosure.

(iii) The name or other specific identification of the person(s), or class of persons, to whom the covered entity is to make the requested use or disclosure.

(iv) A clear statement that the use or disclosure is not for a purpose prohibited by the reproductive health care regulation.

(v) A statement that a person may be subject to criminal penalties if that person knowingly and in violation of HIPAA obtains individually identifiable health information relating to an individual or discloses individually identifiable health information to another person.

(vi) Signature of the person requesting the protected health information, which may be an electronic signature, and date. If the attestation is signed by a representative of the person requesting the information, a description of such representative's authority to act for the person must also be provided.

For example, if you lawfully obtain an abortion and an investigation into the provider is conducted, law enforcement would need to submit an attestation in order to try and obtain the information. The plan would deny the request per HIPAA's prohibition on the disclosure of reproductive health care because such care was lawful.

21. The Right to Receive a Paper Copy of This Notice Upon Request: If you are receiving this Notice in an electronic format, then you have the right

to receive a written copy of this Notice free of charge by contacting the Privacy Official (see section 24).

22. Changes in the Privacy Practice. Each group health plan reserves the right to change its privacy practices from time to time by action of the Privacy Official. You will be provided with an advance notice of any material change in the plan's privacy practices.

23. Your Right to File a Complaint with the Group Health Plan or the Department of Health and Human Services: If you believe that your privacy rights have been violated, you may complain to the group health plan in care of the HIPAA Privacy Official (see section 24). You may also file a complaint with 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. The group health plan will not retaliate against you for filing a complaint.

24. Person to Contact at the Group Health Plan for More Information:

If you have any questions regarding this Notice or the subjects addressed in it, you may contact the Privacy Official.

Privacy Official

The Plan's Privacy Official, the person responsible for ensuring compliance with this notice, is:

Human Resources
918-588-2247

Effective Date

The effective date of this notice is: October 21, 2024.

NOTICE OF SPECIAL ENROLLMENT RIGHTS

HELMERICH & PAYNE MANAGEMENT, LLC EMPLOYEE HEALTH CARE PLAN

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to later enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage).

Loss of eligibility includes but is not limited to:

- Loss of eligibility for coverage as a result of ceasing to meet the plan's eligibility requirements (e.g., divorce, cessation of dependent status, death of an employee, termination of employment, reduction in the number of hours of employment);
- Loss of HMO coverage because the person no longer resides or works in the HMO service area and no other coverage option is available through the HMO plan sponsor;
- Elimination of the coverage option a person was enrolled in, and another option is not offered in its place;
- Failing to return from an FMLA leave of absence; and
- Loss of eligibility under Medicaid or the Children's Health Insurance Program (CHIP).

Unless the event giving rise to your special enrollment right is a loss of eligibility under Medicaid or CHIP, you must request enrollment within *60 days* after your or your dependent's(s') other coverage ends (or after the employer that sponsors that coverage stops contributing toward the coverage).

If the event giving rise to your special enrollment right is a loss of coverage under Medicaid or CHIP, you may request enrollment under this plan within ***60 days*** of the date you or your dependent(s) lose such coverage under Medicaid or CHIP. Similarly, if you or your dependent(s) become eligible for a state-granted premium subsidy toward this plan, you may request enrollment under this plan within ***60 days*** after the date Medicaid or CHIP determine that you or the dependent(s) qualify for the subsidy.

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within *60 days* after the marriage, birth, adoption, or placement for adoption.

To request special enrollment or obtain more information, contact:

Human Resources
918-588-2247

**** This notice is relevant for healthcare coverages subject to the HIPAA portability rules.***

GENERAL COBRA NOTICE

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.

What is COBRA continuation coverage?

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

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

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

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

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

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

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

When is COBRA continuation coverage available?

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

- The end of employment or reduction of hours of employment;
- Death of the employee;
- 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 in writing to the Plan Administrator. Any notice you provide must state the name of the plan or plans under which you lost or are losing coverage, the name and address of the employee covered under the plan, the name(s) and address(es) of the qualified beneficiary(ies), and the qualifying event and the date it happened. The Plan Administrator will direct you to provide the appropriate documentation to show proof of the event.

How is COBRA continuation coverage provided?
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 of 18-month period of COBRA continuation coverage
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. If you believe you are eligible for this extension, contact the Plan Administrator.

Second qualifying event extension of 18-month period of continuation coverage
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.

Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicare, Medicaid, Children's Health Insurance Program (CHIP), 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**.

Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period[1] to sign up for Medicare Part A or B, beginning on the earlier of

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

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

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

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

If you have 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**.

Keep your Plan informed of 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.

Plan contact information

For additional information regarding your COBRA continuation coverage rights, please contact the Plan Administrator below:

Human Resources
222 N. Detroit Ave.
Tulsa, Oklahoma 74120
918-588-2247

NOTICE OF RIGHT TO DESIGNATE PRIMARY CARE PROVIDER AND OF NO OBLIGATION FOR PRE-AUTHORIZATION FOR OB/GYN CARE

INSTRUCTIONS FOR

Helmerich & Payne Management, LLC Employee Health Care Plan generally allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the plan administrator at 918-588-2247.

For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from Helmerich & Payne Management, LLC Employee Health Care Plan or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the Helmerich & Payne Management, LLC Employee Health Care Plan at:

Human Resources
918-588-2247

WOMEN'S HEALTH AND CANCER RIGHTS NOTICE

Helmerich & Payne Management, LLC Employee Health Care Plan is required by law to provide you with the following notice:

The Women's Health and Cancer Rights Act of 1998 ("WHCRA") provides certain protections for individuals receiving mastectomy-related benefits. Coverage will be provided in a manner determined in consultation with the attending physician and the patient for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedemas.

The Helmerich & Payne Management, LLC Employee Health Care Plan provide(s) medical coverage for mastectomies and the related procedures listed above, subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. Therefore, the following deductibles and coinsurance apply:

PPO Copay	**In-Network**	**Out-of-Network**
Individual Deductible	$1,000	$2,000
Family Deductible	$3,000	$6,000
Member Coinsurance	10%	30%
PPO Deductible	**In-Network**	**Out-of-Network**
Individual Deductible	$1,000	$2,000
Family Deductible	$3,000	$6,000
Member Coinsurance	20%	40%
High Deductible (HSA)	**In-Network**	**Out-of-Network**
Individual Deductible	$1,650	$3,300
Family Deductible	$3,300	$6,600
Member Coinsurance	20%	40%

If you would like more information on WHCRA benefits, please refer to your Summary Plan Description or contact your Plan Administrator at:

Human Resources
918-588-2247

Notes

BENEFITS

2025 Enrollment Guide

This benefit guide is only intended to highlight some of the major benefit provisions of the company plan and should not be relied upon as a complete detailed representation of the plan. Please refer to the plan's summary plan descriptions for further detail. Should this guide differ from the summary plan descriptions, the summary plan descriptions prevail.

Actively C.A.R.E. / Innovative Spirit / Do The Right Thing / Teamwork / Service Attitude

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