

2018

# SUMMARY PLAN DESCRIPTION

## Dental/Vision/Flexible Spending Accounts

your health.  
your life.  
your future.



**Occidental Petroleum Corporation**

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## Your Dental, Vision and FSA Plan Options

A brief description of the eligibility provisions for the Dental, Vision and FSA Plans are shown in the chart below. To see specific Plan summaries, see the following sections:

- [Dental Plan at a Glance](#)
- [Vision Plan at a Glance](#)
- [FSAs at a Glance](#)

<b>Who's Eligible</b>	<ul style="list-style-type: none"> <li>• All regular, full-time, non-represented employees regularly scheduled to work at least 30 hours per week.</li> <li>• Effective March 1, 2018, part-time, non-represented employees approved for the Phased Retirement Program.</li> <li>• Represented employees are eligible if provided for in the collective bargaining agreement.</li> </ul>
<b>Eligible Dependents for Dental and Vision Plans</b>	<p>Generally, your eligible dependents under the Dental and Vision Plans are your:</p> <ul style="list-style-type: none"> <li>• Legal spouse* (unless legally separated); and</li> <li>• Children under age 26. Eligible dependent children, regardless of the child's student, employment or marital status or residence, include: <ul style="list-style-type: none"> <li>–Your natural children</li> <li>–Children legally adopted or placed for adoption with you</li> <li>–Stepchildren and foster children</li> <li>–Other children whom you claim as dependents on your federal income tax return, for whom you and/or your spouse have primary legal custody, who live with you in a regular parent-child relationship, and for whom you can provide required documentation</li> </ul> </li> </ul>
<b><a href="#">Dental Plan</a></b>	<p>The Dental Plan, administered by Aetna Life Insurance Company, covers preventive dental care and services essential to the proper care of your teeth. The Dental Plan offers significant cost savings when you use <a href="#">network providers</a>. If you use a non-network <a href="#">dentist</a>, the Plan pays the same percentage of covered expenses, but only up to the Plan's "usual and customary" limits—you pay the rest.</p>
<b><a href="#">Vision Plan</a></b>	<p>The Vision Plan, provided through VSP Vision Care, has a large nationwide network of vision care providers, including doctors and eyewear suppliers. Benefits include exams and glasses (frames and lenses) or contact lenses.</p>
<b><a href="#">Flexible Spending Accounts (FSAs)</a></b>	<p>An FSA lets you pay for certain health care and dependent care expenses with pretax dollars. The FSAs are administered by PayFlex. Regardless of your health care plan elections, you may enroll in a Health Care FSA and/or a Dependent Care FSA during <a href="#">Open Enrollment</a>. You must re-enroll in the FSA each year. You may also be eligible to enroll or change your benefit elections during the year if you experience a qualified family Status Change.</p>

\* All legal marriages will be recognized for purposes of benefit eligibility, regardless of the state in which you reside. Domestic partners may be eligible for the regional medical plans per state law.



### **About This SPD**

This Summary Plan Description (SPD) summarizes your Occidental Petroleum Corporation Welfare Plan (Dental, Vision and FSA component), also known as the Plan or respectively as the Dental Plan, Vision Plan or FSA Plan. The Plan's complete provisions are contained in the Plan documents that legally govern the Plan's operation. The Plan documents include the official Plan text and other documents and reports that are maintained by the Plan. **If there is ever a conflict or difference between this SPD and the Plan document and contracts, the official Plan document and contracts will govern.**

This SPD reflects the Plan document provisions in effect on January 1, 2018. These provisions may not apply to you if your employment ended before this date. Please refer to future Summary of Material Modifications (SMMs) for any material changes to the Plan made after the date of this document.

## Managing Your Benefits

For Plan information and forms, go to My HR on [oxynet.oxy.com](http://oxynet.oxy.com). Your providers' customer service representatives can help answer your benefit questions. In addition, providers' websites offer access to information about your benefits and tools to help you manage your health and benefits. All you need to do is complete a simple registration process.

### BENEFIT CONTACTS

<p><b>OxyLink Online</b></p>	<p>Log on to <a href="#">OxyLink Online</a> with your network ID (or employee ID if you've left employment) and your password to access the Employee Self Service portal to:</p> <ul style="list-style-type: none"> <li>• Access your personal and payroll information</li> <li>• View your current Benefit Summary</li> <li>• Make new hire or Open Enrollment elections</li> <li>• Make a family Status Change benefit election</li> </ul>
<p><b>OxyLink Employee Service Center</b> 4500 South 129<sup>th</sup> East Avenue Tulsa, OK 74134-5801</p>	<p>For questions about your Oxy health and welfare benefit plans:</p> <ul style="list-style-type: none"> <li>• Call <b>800-699-6903</b>. Outside the U.S.: <b>918-610-1990</b> Monday through Friday (except holidays) 8:00 a.m. to 4:30 p.m. CT</li> </ul>
<p><b>Aetna</b> P.O. Box 14586 Lexington, KY 40512-4586</p>	<p>For questions about the Dental Plan:</p> <ul style="list-style-type: none"> <li>• Aetna: <b>800-334-0299</b>. Outside the U.S: <b>817-417-2000</b>, ext. 4154016; or</li> <li>• <a href="#">Aetna.com</a>. Through Aetna Navigator, you can: <ul style="list-style-type: none"> <li>– Print an ID card (not required to obtain services)</li> <li>– View benefits, check status of claims and print claim forms</li> <li>– Find a dentist</li> <li>– Use personal health record to monitor and manage your health</li> </ul> </li> </ul>
<p><b>VSP Vision Care</b> P.O. Box 385018 Birmingham, AL 35238-5018</p>	<p>For questions about the Vision Plan:</p> <ul style="list-style-type: none"> <li>• VSP: <b>800-877-7195</b>; or</li> <li>• <a href="#">Vsp.com</a>. Through the VSP website, you can: <ul style="list-style-type: none"> <li>– Get benefits and claim information</li> <li>– Print an ID card (not required to obtain services)</li> <li>– Print a claim form and file non-network claims</li> <li>– Find a network doctor or eyewear supplier</li> <li>– Get special discounts</li> <li>– View information about eye health</li> <li>– Contact customer service</li> </ul> </li> </ul>

## BENEFIT CONTACTS

### PayFlex

P.O. Box 4000  
Richmond, KY  
40476-4000

For questions about the FSAs:

- PayFlex: **844-PAYFLEX (844-729-3539)**. Outside the U.S.: **402-345-0666** Monday through Friday, 7 a.m. – 7 p.m. CT, and Saturday, 9 a.m. – 2 p.m. CT; or
- [Payflex.com](http://Payflex.com) or the PayFlex Mobile® app available through your iPhone or Android device's app store. Use the website or mobile app to:
  - View account balance, activity, payments and deposits
  - Print claim forms and submit claims
  - Pay providers directly or initiate a withdrawal from your account
  - View account alerts and notifications
  - View a list of common eligible expense items

### Provider ID Cards

In general, ID cards for the Dental and Vision Plans are not required to obtain services; however, if you wish to have an ID card, you can print separate dental and vision ID cards for each of the benefits in which you are enrolled. The cards include phone numbers you may need to contact the provider's Member Services.



# Eligibility and Enrollment

## Your Eligibility

You are eligible to participate in the Dental Plan, Vision Plan and Flexible Spending Accounts if you are a regular, full-time hourly or salaried non-represented employee of Occidental Petroleum Corporation ([OPC](#)) or an [affiliated](#) company ([Oxy](#)). You are considered full-time if you are regularly scheduled to work at least 30 hours per week. Effective March 1, 2018, part-time, non-represented employees approved for the Phased Retirement Program are eligible to participate.

Generally, you are eligible to participate if:

- You are on a U.S. dollar payroll;
- You are designated as eligible to participate by your employer; and
- You do not participate in a similar type of company-sponsored plan.

You are not eligible to participate in the Plan if:

- Your employment with Oxy is covered by a collective bargaining agreement, unless the agreement provides for your participation in the Plan;
- You are a temporary employee; or
- You are an intern.

You may not be covered as both an employee and a dependent.



### Part-Time Work and the Retiree Dental Plan

If you lose eligibility under the Dental Plan as a result of a reduction in work hours (i.e., you are regularly scheduled to work fewer than 30 hours per week) and you meet the eligibility requirements for retiree coverage (generally age 55 with 10 or more years of service), you may enroll in retiree dental and pay active employee rates through pretax payroll deductions while you remain employed.

## Dependent Eligibility

Generally your legal spouse (unless legally separated) and your children under age 26 are considered eligible dependents under the Dental and Vision Plans.

If both you and your spouse work for Oxy, only one of you may cover your child or children as dependents.

## Your Spouse

Your eligible spouse is your spouse to whom you are legally married. All legal marriages will be recognized for purposes of benefit eligibility, regardless of the state in which you reside. This includes a spouse through common law marriage in applicable states. This does not include a spouse from whom you are legally separated.

## Your Children

Your eligible children may include:

- Natural children;
- Children legally adopted or placed for adoption with you;
- Stepchildren;
- Foster children; and
- Other children who you claim as dependents on your federal income tax return (e.g., grandchildren), for whom you and/or your spouse have primary legal custody and who live with you in a regular parent/child relationship.

Unless otherwise noted in a specific coverage section, your children must be under the age of 26 to be eligible for coverage under the Plan regardless of their marital, student, financial or residency status. However, an unmarried child who has reached the upper age limit (age 26) and who is mentally or physically incapable of self-sustaining employment may continue to be eligible (see [Disabled Dependent Children](#) for more details).

### Qualified Medical Child Support Order

If, because of a divorce or legal separation, your children are not eligible for Plan coverage, it may be possible to obtain coverage through a Qualified Medical Child Support Order (QMCSO). A QMCSO is any judgment, decree or order issued by a court of competent jurisdiction, or other court or administrative order, requiring you to provide health care benefits for a child. You will be notified if any of your children are affected by a QMCSO. If so, the [plan administrator](#) will provide information to the child, custodial parent or legal guardian on how to obtain benefits and submit claims. The claims administrator will pay eligible claims to the child or the child's custodial parent or legal guardian, except to the extent paid directly to a service provider on behalf of the child.

You may ask the OxyLink Employee Service Center for a free copy of the procedures governing QMCSOs.

### Disabled Dependent Children

If you have a disabled child, the child's coverage may be continued past the Plan's limiting age for dependents. Your child is considered to be disabled if he or she:

- Is unable to earn a living because of a mental or physical disability that starts before the Plan's age limit; and
- Depends mainly on you for support and maintenance.

You must provide proof of your child's disability to the claims administrator no later than 31 days after your child reaches the dependent age limit. The claims administrator may continue to ask you for proof that the child continues to meet these conditions of incapacity and dependency.

The child's coverage will end on the first to occur of the following:

- Your child is no longer disabled;
- You fail to provide proof that the disability continues;
- You fail to have any required exam performed; or
- Your child's coverage ends for a reason other than reaching the age limit.

## Enrollment

You enroll for coverage on [OxyLink Online](#). You may enroll for Dental Plan, Vision Plan, Health Care FSA or Dependent Care FSA within 31 days of your date of hire or eligibility for the Plan. If you enroll within the first 31 days, your coverage will start as of the date of your initial eligibility.

## For the Dental and Vision Plans

When you enroll for dental and vision coverage, you will elect one of the following coverage levels for you and your eligible dependents:

DENTAL PLAN COVERAGE LEVEL	VISION PLAN COVERAGE LEVEL
<ul style="list-style-type: none"> <li>Employee Only</li> <li>Employee + One Dependent</li> <li>Family (employee plus two or more dependents)</li> </ul>	<ul style="list-style-type: none"> <li>Employee Only</li> <li>Employee + One Dependent</li> <li>Employee + Children</li> <li>Family (employee plus two or more dependents)</li> </ul>

If you have any questions or need additional information, contact the OxyLink Employee Service Center.

## For the Health Care and Dependent Care FSAs

Regardless of whether you participate in an Oxy Medical Plan or Dental Plan, you may enroll in the Flexible Spending Accounts (FSA). FSAs operate on a calendar year basis. In your first calendar year, eligible expenses are limited to those you incur after your date of hire or eligibility. Elections and any unused balance do not carry over from one year to the next. **You must reenroll each year to participate in an FSA for the next year.**

Your Health Care FSA must be treated as a Limited Purpose FSA if you:

- Are enrolled in a high deductible health plan (such as the Aetna HealthFund option); and
- Contribute to a Health Savings Account (HSA).

See [Limited Purpose FSA](#) for more details.

## Changing Your Elections

Under IRS rules, you can only change your elections at specific times.

### Open Enrollment Period

Each year Oxy designates a period of time during which you may change your elections for the next plan year (January 1 through December 31). The Open Enrollment period will be communicated to employees each year.

### Changes During the Year

Once you make your enrollment decisions, your elections remain in effect for the entire plan year. However, you may be able to change your elections before the next Open Enrollment if you have:

- A qualified [Status Change](#) and your election change is consistent with the change as allowed by IRS regulations;
- Another IRS-recognized event (e.g., QMCSO, enrollment in a marketplace plan during the marketplaces' annual enrollment or other allowed periods); or
- A loss of coverage under your spouse's employer-sponsored group medical plan or another group medical plan. Reasons for loss of coverage may be termination of employment, a reduction in work hours, death, plan termination or expiration of a COBRA period.

New dependents, including newborns, are not automatically covered by the Plan—you must enroll them for coverage. If you do not enroll them within 31 days, they are not eligible for coverage until the next Open Enrollment, unless you experience another family Status Change later in the year.

Also, dependents who are no longer eligible for coverage are not automatically dropped from coverage. You must remove them from the Plan. If you don't advise the Plan that a dependent is no longer eligible for coverage, the Plan may stop the dependent's coverage retroactive to the date the dependent became ineligible and you will **not** be refunded any premiums you paid for the ineligible dependent. You are required to repay the total cost of claims paid by the Plan for the ineligible dependent dating back to the original enrollment and/or termination of coverage date. The dependent is not eligible for COBRA coverage if his or her eligibility ends due to lack of (or insufficient) documentation for proof of eligibility.

If you change your benefit elections during the year, the change generally is effective on the date of the event as long as you make an election within 31 days after the event. If you delay enrolling for coverage or adding a dependent more than 31 days after the event, you or your dependents are considered late enrollees and must wait until the next Open Enrollment to elect coverage, unless you experience another Status Change later in the year.

## Status Change

Generally, you experience a change in status when you or a dependent gains or loses eligibility under the Plan. Status Changes include:

- Marriage, divorce or legal separation
- Change in number of dependents
- Employment status change
- Change in dependent coverage eligibility
- Change in eligibility under Medicaid or the Child Health Insurance Program (CHIP)
- Change of work or residence that impacts eligibility
- Loss or change in coverage under another employer plan
- Work schedule change (for Dependent Care FSA only)

If you have a new dependent because of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents if you request enrollment within 31 days after the event.

A change in dependent care provider is not considered to be a Status Change Event.

Any benefits change you elect must be consistent with the Status Change. Below are some examples:

- If you have a newborn or adopt a child, you can add the child and any other eligible dependents to the Plan coverage (and you may change options), but you cannot drop coverage for your spouse.
- If your child reaches the age limit for coverage under the Plan, you could drop coverage for that child, but you could not add or drop coverage for your spouse or another child.
- If you marry you may add your spouse and any other eligible dependents to your coverage, but you may not drop coverage for yourself unless you are added to your new spouse's plan coverage.

To change your election for marriage, divorce or adding a new child, log on to [OxyLink Online](#). To change your election for any other reasons, contact the OxyLink Employee Service Center. You must submit any required paperwork within 31 days of the Status Change, or within 60 days of a Medicaid or CHIP event. A change in FSA contribution amounts will be effective for future contributions only and start on the first available payroll period.

If you decline enrollment for yourself or your dependents because of other health insurance coverage, in the future you may be able to enroll yourself or your dependents in the Plan. If you lose coverage under your spouse's employer-sponsored group medical plan or another group medical plan because of termination of employment, a reduction in work hours, death, plan termination or expiration of a COBRA period, you must request enrollment within 31 days after your other coverage ends.

## Paying for Coverage

You pay for coverages as follows:

PLAN	CONTRIBUTIONS
<b>Dental</b> <b>Vision</b>	<ul style="list-style-type: none"> <li>• Both you and the company contribute to the cost of your dental coverage.</li> <li>• You pay the full cost of your vision coverage.</li> <li>• Your contribution amount depends on the coverage level you select.</li> <li>• Current monthly contributions are available on My HR on <a href="http://oxy.net/oxy.com">oxy.net.oxy.com</a>.</li> </ul>
<b>Health Care FSA</b> <b>Dependent Care FSA</b>	<ul style="list-style-type: none"> <li>• You contribute the entire amount for the FSAs.</li> <li>• Your per-pay-period portion of the monthly contribution amount will be deducted from each paycheck on a pretax basis.</li> <li>• Current monthly FSA minimum rates and maximum contribution amounts are available on My HR on <a href="http://oxy.net/oxy.com">oxy.net.oxy.com</a>.</li> </ul>

Pretax contributions are deducted from your pay before federal income and Social Security taxes are calculated and withheld. If you live in a state that recognizes the federal tax treatment of pretax contributions, your state income tax also will be withheld after your contributions are deducted. Contributions made by Long-Term Disability beneficiaries who become disabled on or after October 1, 1995 are made on an after-tax basis.

Under current federal law, you may not claim your pretax contributions as an itemized deduction on your federal income tax return.

Certain states may provide assistance under their state Medicaid plan or child health assistance under their state child health plan. Such state assistance may come in the form of premium assistance for the purchase of group health plan coverage. For additional information, see Notice Regarding Child Health Insurance Plan (CHIP Notice) available on My HR on [oxy.net.oxy.com](http://oxy.net/oxy.com).

### Pretax Contributions

Pretax contributions reduce the amount of your earnings that are reported for Social Security purposes. So, if you earn less than the Social Security Wage Base (SSWB) or if pretax contributions reduce your earnings below the SSWB, your Social Security withholding will be reduced. This reduced withholding could slightly decrease any Social Security benefits you may receive because Social Security benefits are based on your career earnings history.

In some states, certain other statutory benefits for which you may become eligible (such as unemployment insurance, workers' compensation and state disability insurance) are based on taxable earnings. Therefore, any benefit payments from these sources could be slightly reduced.

Your pay for purposes of determining pay-related Oxy benefits, such as Oxy's retirement, savings, disability and life insurance plans, will continue to be based on your base pay before pretax contributions are deducted.

## Dental Plan

The Dental Plan promotes and encourages preventive dental care and provides benefits for services that are essential to the proper care of your teeth.

How much you pay for your care out of your own pocket depends on whether the expense is covered by the Plan and whether you choose a network provider or a [non-network provider](#).

### Dental Plan at a Glance

For updates to this information, go to My HR on [oxynet.oxy.com](http://oxynet.oxy.com).

<b>Annual Deductible</b>	\$50 individual/\$150 family
<b>Annual Maximum</b> Applies to preventive and diagnostic, basic and major services	\$2,000 per person per calendar year
<b>Lifetime Maximum</b> Does not include orthodontia	Unlimited
<b>Orthodontia Lifetime Maximum</b>	\$2,500 per covered person
<b>COVERED SERVICES</b>	<b>YOU PAY (NETWORK OR NON-NETWORK)</b>
<b>Preventive and Diagnostic Services</b> <ul style="list-style-type: none"> <li>• Routine oral exams—2 per year</li> <li>• Cleaning and scaling of teeth—3 per year</li> <li>• Bitewing and diagnostic x-rays</li> <li>• Fluoride application (dependents under age 16)</li> <li>• Sealants for permanent molars (dependents under age 16)</li> <li>• Space maintainers</li> <li>• Problem-based exams</li> </ul>	Covered by Plan at 100% no deductible
<b>Basic Restorative Services</b> <ul style="list-style-type: none"> <li>• Simple extractions</li> <li>• Oral surgery</li> <li>• Fillings, except gold</li> <li>• Repair or recementing of crowns, inlays, bridgework and dentures</li> <li>• Relining of dentures</li> <li>• Treatment of diseases of the gums and tissues of the mouth (periodontics)</li> <li>• Endodontic treatments such as root canals</li> <li>• General anesthesia, if <a href="#">medically necessary</a></li> </ul>	20% after deductible
<b>Major Restorative Services</b> <ul style="list-style-type: none"> <li>• Crowns, inlays or gold fillings</li> <li>• Dentures</li> <li>• Fixed bridgework (including inlays and crowns as abutments)</li> </ul>	50% after deductible
<b>Orthodontic Services</b> <ul style="list-style-type: none"> <li>• Braces and other orthodontic treatment</li> </ul>	50%, not subject to deductible, up to lifetime maximum



## Dental Providers

### Using Network and Non-Network Dental Providers

Under the Dental Plan, you have the freedom to choose any licensed [dental provider](#) when you need dental care. You can select a dentist that belongs to the Aetna network (a network provider) or one that does not (a non-network provider).

When you use **network** providers:

- Your out-of-pocket expenses may be lower because network providers have agreed to provide covered services and supplies at a [negotiated charge](#).
- You will not pay any amounts above the negotiated charge for a covered service or supply.
- Aetna's negotiated fees do not apply to care that is not covered under the Plan.
- You will not have to submit dental claims for treatment received. Your network provider takes care of filing claims for you.
- You receive notification of what the Plan paid toward your covered expenses. (You are responsible for the deductible and your coinsurance amount shown on the explanation of benefits "EOB" form.)

If you receive care from a **non-network** provider:

- Your benefits are limited to the [recognized charge](#) (as defined by Aetna), and your expenses will generally be higher.
- If the charge is more than the [recognized charge](#), you pay the difference. This excess amount **will not** apply toward your deductible.
- You must file a claim to receive reimbursement from the Plan.

### Aetna Provider Network

To participate in Aetna's network, a dentist must meet certain standards through a process called credentialing—which looks at factors such as education and licensing. To find a network dentist in your area:

- **Use *Find a Doctor* at [aetna.com](#).**
  - If you log in to Aetna Navigator, your network is automatically selected.
  - To search for a network dentist without logging in, select the type of search you want (e.g., dentist) and enter your zip code. When asked to select a plan, choose Dental PPO/PDN with PPO II Network.
  - You can search the online directory for a specific dentist or all dentists in a given zip code. You can also get information about a dentist's practice, such as address, phone numbers and access for the disabled.
- **Contact Aetna Member Services.**
  - A representative can also help you find a network dentist in your area. The Aetna Member Services toll-free number is shown on your ID card.
  - You also may email Aetna Member Services from Aetna's secure member website, Aetna Navigator. Just go to [aetna.com](#) and select *Member Log In*.

## Your Share of Dental Service Costs

You can find information about current deductibles and maximum benefits on My HR on [oxynet.oxynet.com](http://oxynet.oxynet.com).

### Deductible

When you receive dental care, you pay a calendar year deductible for certain services. There are two types of deductible: individual and family.

The individual calendar year deductible is the part of covered expenses you and each covered dependent pays each year (January 1 to December 31) before the Plan starts to pay benefits.

If the covered dental expenses of all family members reach the family deductible (for example, if you have four covered family members and three family members meet their individual deductibles), no other deductible is required for the rest of the calendar year.



#### Important

The deductible does not apply to diagnostic and preventive services.

### Coinsurance

After you meet the deductible, the Plan pays a percentage of the covered dental expenses and you pay the rest. The portion of covered expenses you pay is called your coinsurance.

### Annual and Lifetime Maximums

The Plan will pay a set amount for diagnostic and preventive, basic and major services in a calendar year—the annual maximum. There is no separate lifetime maximum for these services; however, there is a separate lifetime maximum benefit for orthodontia expenses.

## Dental Treatment Estimate

If your dentist recommends a [course of treatment](#) expected to cost \$350 or more, an Advance Claim Review (pre-treatment estimate) is recommended.

Ask your dentist to provide a full description of the treatment you need, using a Dental Benefits Request form available on [OxyLink Online](#) and My HR on [oxynet.oxynet.com](http://oxynet.oxynet.com). Your dentist should send the form to Aetna before treatment begins. Aetna may ask for supporting x-rays and other diagnostic records. In determining the amount of benefits payable, Aetna will take into account alternate procedures, services or courses of treatment needed to accomplish the appropriate result.

After review of the treatment plan, Aetna will provide you and your dentist with a statement of the benefits payable by the Plan. You can use this information to decide how to proceed.

Advance Claim Review is a service that gives you information that you and your dentist can consider when deciding on a course of treatment. It is not necessary for emergency treatment or routine care such as cleanings or check-ups.

If an Advance Claim Review is not completed, Aetna will base its benefit decision on the amount of covered dental expenses that can be verified.

## Covered Dental Plan Expenses

The Plan covers medically necessary dental care expenses incurred while your coverage under the Plan is in effect. An expense is incurred on the day you receive a dental service or supply. Also, the Plan covers only expenses related to a [non-occupational injury](#) or a [non-occupational illness](#). Aetna will pay for the least expensive service or supply that treats the condition (see [Alternate Treatment](#)).

### Alternate Treatment

Sometimes there are several ways to treat a dental problem, all of which provide acceptable results. When alternate services or supplies can be used, the Plan's coverage will be limited to the cost of the least expensive service or supply that is:

- Customarily used nationwide for treatment; and
- Viewed by the dental profession as appropriate for treatment of the condition. The service or supply must meet broadly accepted standards of dental practice, taking into account your current oral condition.

You should review the differences in the cost of alternate treatment with your dental provider. Of course, you can still choose the more costly treatment method, but you are responsible for any charges in excess of what the Plan covers.

### Diagnostic and Preventive Services

Diagnostic and preventive services include:

- Routine oral exams—twice per calendar year
- Cleaning and scaling of teeth—three times per calendar year
- Problem-focused exams
- Topical application of fluoride—one per calendar year for dependents under age 16
- Diagnostic and other x-rays—one full mouth or panoramic series every three years
- Bitewing x-rays:
  - Two sets in a calendar year for dependents under age 14
  - One set in a calendar year for individuals age 14 and older
- Sealants only for permanent molars—once every three rolling years, for dependents under age 16
- Emergency treatment to relieve pain
- Space maintainers for premature loss of primary teeth only

### Basic Restorative Services

Basic restorative services include:

- Simple extractions
- Oral surgery:
  - For non-impacted wisdom teeth extractions
  - If the procedure is not covered under your medical plan (including extraction of impacted teeth)
- Fillings, except gold
- General anesthetics, if medically necessary
- Treatment of diseased periodontal structures
- Endodontic treatment, such as pulp capping and root canals
- Repair or recementing of crowns, inlays, bridgework or dentures
- Addition of teeth to an existing partial removable denture or existing fixed bridgework (see [Replacement Rule](#))
- Relining/rebasing of dentures

## Major Restorative Services

Major restorative services include:

- Inlays, gold fillings or crowns, including precision attachments for dentures
- First installation of removable dentures and partial dentures to replace one or more natural teeth, including adjustments for the six-month period after they were installed
- First installation of fixed bridgework to replace one or more natural teeth, including inlays and crowns as abutments
- Occlusal adjustment for temporomandibular joint disease (TMJ). Covered services include night guards for grinding the teeth or equilibration, capping the teeth, and fixed or partial bridgework
- Dental implants and related services
- Replacement of an existing removable denture or fixed bridgework with a new denture or fixed bridgework (see [Replacement Rule](#))

### Replacement Rule

Certain replacements of veneers, complete dentures, removable partial dentures, fixed partial dentures (bridges) and other prosthetic services are covered only when you give proof to Aetna that:

- You had a tooth (or teeth) extracted after the existing denture or bridge was installed. As a result, you need to replace or add teeth to your denture or bridge.
- The present veneer, complete denture, removable partial denture, fixed partial denture (bridge) or other prosthetic service was installed at least five years before its replacement and cannot be made serviceable.
- Your present denture is an immediate temporary one that replaces an extracted tooth (or teeth). A permanent denture is needed, and the temporary denture cannot be used as a permanent denture. Replacement must occur within 12 months from the date that the temporary denture was installed.

### Dental Work Completed After Coverage Ends

Your dental coverage may end while you or your covered dependent is in the middle of treatment. The Plan does not cover dental services that are given after your coverage ends. However, the Plan will cover the following services if they are **ordered** while you were covered by the Plan, and installed within 60 days after your coverage ends:

- Inlays
- Onlays
- Crowns
- Removable bridges
- Cast or processed restorations
- Dentures
- Fixed partial dentures (bridges)
- Root canals

**Ordered** means:

- For a denture: the impressions from which the denture will be made were taken.
- For a root canal: the pulp chamber was opened.
- For any other item: the teeth that will serve as retainers or supports, or the teeth that are being restored:
  - Have been fully prepared to receive the item; and
  - Impressions have been taken from which the item will be prepared.

## Orthodontic Treatment

The Plan covers [orthodontic treatment](#) for you and your covered dependents (including your legal spouse). However, the Plan does not cover the following orthodontic services and supplies:

- Replacement of broken appliances
- Retreatment of orthodontic cases
- Changes in treatment necessitated by an accident
- Maxillofacial surgery
- Myofunctional therapy
- Treatment of cleft palate
- Treatment of micrognathia
- Treatment of macroglossia
- Treatment of primary dentition
- Treatment of transitional dentition
- Lingually placed direct bonded appliances and arch wires (i.e., invisible braces) (see [Alternate Treatment](#))
- Removable acrylic aligners (i.e., invisible aligners) (see [Alternate Treatment](#))

## What the Dental Plan Does Not Cover

Not every dental care service or supply is covered by the Plan, even if prescribed, recommended or approved by your [physician](#) or dentist. The Plan covers only those services and supplies that are medically necessary. Some services are specifically limited or excluded. Charges made for the following are not covered except to the extent listed under [Covered Dental Plan Expenses](#).

- Any instruction for diet, plaque control and oral hygiene.
- Cosmetic services and supplies, including plastic, reconstructive and cosmetic surgery; personalization or characterization of dentures; other services and supplies that improve, alter or enhance appearance, augmentation and vestibuloplasty; and other substances to protect, clean, whiten, bleach or alter the appearance of teeth; whether or not for psychological or emotional reasons, except to the extent listed under [Covered Dental Plan Expenses](#).
- Crown, inlays and onlays, and veneers unless:
  - Treatment is for decay or traumatic injury and teeth cannot be restored with a filling material; or
  - The tooth is an abutment to a covered partial denture or fixed bridge.
- Dental services and supplies that are covered in whole or in part under any other:
  - Part of this plan; or
  - Plan of group benefits provided by the contract holder.
- Dentures, crowns, inlays, onlays, bridges, or other appliances or services used to splint; alter vertical dimension; restore occlusion; or correct attrition, abrasion or erosion
- Treatment of any [jaw joint disorder](#) and treatments to alter bite or the alignment or operation of the jaw, including TMJ treatment, orthognathic surgery, and treatment of malocclusion or devices to alter bite or alignment, except to the extent listed under [Covered Dental Plan Expenses](#)
- General anesthesia and intravenous sedation, unless specifically covered and only when done in connection with another necessary covered service or supply
- Pontics, crowns, cast or processed restorations made with high noble metals (gold or titanium)
- Prescribed drugs, pre-medication or analgesia
- Replacement of a device or appliance that is lost, missing or stolen; replacement of appliances that have been damaged due to abuse, misuse or neglect; and for an extra set of dentures

- Services and supplies where there is no evidence of pathology, dysfunction or disease other than covered preventive services
- Services and supplies for your personal comfort or convenience, or the convenience of any other person, including a provider
- Services and supplies in connection with treatment or care that is not covered under the Plan
- Space maintainers except when needed to preserve space resulting from the premature loss of deciduous teeth
- Surgical removal of impacted wisdom teeth only for orthodontic reasons
- Treatment by other than a dentist. The Plan will cover the following services provided by a licensed dental hygienist under the supervision and guidance of a dentist:
  - Scaling of teeth
  - Cleaning of teeth
  - Topical application of fluoride
- Acupuncture, acupressure and acupuncture therapy, except as provided in the [Covered Dental Plan Expenses](#) section
- Any charges in excess of the benefit, dollar, day, visit or supply limits stated in this SPD
- Charges submitted for services by an unlicensed [hospital](#), physician or other provider or not within the scope of the provider's license
- Charges submitted for services that are not rendered, or not rendered to a person not eligible for coverage under the Plan
- Court ordered services, including those required as a condition of parole or release
- Any dental exams:
  - Required by a third party, including exams and treatments to obtain or maintain employment, or which an employer is required to provide under a labor agreement
  - Required by any law of a government, securing insurance or school admissions, or professional or other licenses
  - Required to travel, attend a school, camp or sporting event, or participate in a sport or other recreational activity
- Any special medical reports not directly related to treatment except when provided as part of a covered service
- Experimental or investigational drugs, devices, treatments or procedures, except to the extent listed under [Covered Dental Plan Expenses](#). A drug, device, procedure or treatment will be considered experimental or investigational if:
  - There are insufficient outcomes data available from controlled clinical trials published in the peer-reviewed literature to substantiate its safety and effectiveness for the illness or injury involved;
  - Approval required by the FDA has not been granted for marketing;
  - A recognized national medical or dental society or regulatory agency has determined, in writing, that it is experimental or investigational, or for research purposes;
  - It is a type of drug, device or treatment that is the subject of a Phase I or Phase II clinical trial or the experimental or research arm of a Phase III clinical trial, using the definition of "phases" indicated in regulations and other official actions and publications of the FDA and Department of Health and Human Services; or
  - The written protocol or protocols used by the treating facility, or the protocol or protocols of any other facility studying substantially the same drug, device, procedure or treatment, or the written informed consent used by the treating facility or by another facility studying the same drug, device, procedure or treatment states that it is experimental or investigational, or for research purposes.
- Payment for that portion of the charge for which Medicare or another party is the primary payer



- Miscellaneous charges for services or supplies, including:
  - Cancelled or missed appointment charges;
  - Charges to complete claim forms;
  - Charges the recipient has no legal obligation to pay; or
  - Charges that would not be made if the recipient did not have coverage (to the extent exclusion is permitted by law), including care:
    - In charitable institutions;
    - For conditions related to current or previous military service; or
    - While in the custody of a governmental authority.
- Non-medically necessary services including, but not limited to, those treatments, services, prescription drugs and supplies that are not medically necessary, as determined by Aetna, for the diagnosis and treatment of illness, injury, restoration of physiological functions, or covered preventive services. This applies even if they are prescribed, recommended or approved by your physician or dentist.
- Routine dental exams and other preventive services and supplies, except to the extent listed under [Covered Dental Plan Expenses](#).
- Services rendered before the effective date or after coverage ends, unless coverage is continued under the [Continuation of Coverage](#) section of this SPD.
- Work related: Any illness or injury related to employment or self-employment including any injuries that arise out of (or in the course of) any work for pay or profit, unless no other source of coverage or reimbursement is available to you for the services or supplies. Sources of coverage or reimbursement may include your employer, workers' compensation, or an occupational illness or similar program under local, state or federal law. A source of coverage or reimbursement will be considered available to you even if you waived your right to payment from that source. If you are also covered under a workers' compensation law or similar law, and submit proof that you are not covered for a particular illness or injury under such law, that illness or injury will be considered "non-occupational" regardless of cause.

## Requesting Dental Benefits

In general, if you use a network provider, the provider will submit the claim for you. You must submit the claim if you use a non-network provider within 90 days after the date you incur a covered expense. If, through no fault of your own, you are unable to meet this deadline, your claim will still be accepted if you file as soon as possible. However, if a claim is filed more than two years after the 90-day deadline, it will not be covered unless you are legally incapacitated.

## Filing Dental Claims

Claim forms are available on:

- [OxyLink Online](#)
- My HR on [oxynet.oxy.com](http://oxynet.oxy.com)
- [Aetna.com](http://Aetna.com) or by calling Aetna Member Services at **800-334-0299**

The claim form contains instructions on how and when to file a claim, as well as the address to which you should send your completed form. When filing a claim for benefits, you must provide:

- Names and addresses of dentists;
- The dates on which expenses are incurred; and
- Copies of all bills and receipts.

Claims should be submitted to:

Aetna  
P.O. Box 14094  
Lexington, KY 40512-4094  
Fax: 859-455-8650

You should always submit claims to the primary plan first. When filing a claim for [coordination of benefits](#), you must submit the explanation of benefits (EOB) statement received from the primary plan and all associated bills to the secondary plan.

You can file claims for benefits and appeal adverse claim decisions yourself or through an authorized representative—a person you authorize, in writing, to act on your behalf. The Plan will also recognize a court order giving a person authority to submit claims on your behalf. In the case of a claim involving urgent care, a health care professional with knowledge of your condition may always act as your authorized representative.



#### **Important**

If your claim is denied in whole or in part, you will receive a written notice of the denial from Aetna. The notice will explain the reason for the denial and the review procedures. See [When You Disagree with a Claim Decision](#) for more information about appeals.

### **Payment of Dental Benefits**

Generally, benefits will be paid after services are rendered and as soon as Aetna receives the necessary proof to support the claim. Aetna will pay any benefits directly to you unless you or the provider tells Aetna to make benefits payable to the provider when the claim is filed.

## Vision Plan

The Vision Plan provides benefits for annual eye exams, lenses, frames or contact lenses. The Plan is provided through VSP Vision Care.

How much you pay for your care out of your own pocket depends on whether the expense is covered by the Plan and whether you choose a VSP preferred provider, [affiliate provider](#) or an open access (non-network) provider.

### Vision Plan at a Glance

For updates to this information, go to My HR on [oxynet.oxy.com](http://oxynet.oxy.com).

	NETWORK AND AFFILIATE PROVIDERS	OPEN ACCESS PROVIDERS (NON-NETWORK)
<b>Network Provider</b>	<b>Network:</b> VSP Choice Network	NA
<b>WellVision Exam</b> Every calendar year	\$10 copay	\$10 copay; then reimbursed up to \$50*
<b>Prescription Glasses</b>	\$20 copay	\$20 copay
<b>Frames</b> Every other calendar year	Included in prescription glasses <ul style="list-style-type: none"> <li>• \$200 allowance for wide selection of frames</li> <li>• 20% savings on the amount over your allowance for VSP network providers</li> <li>• \$110 Costco (affiliate provider) allowance</li> </ul>	Included in prescription glasses  Reimbursed up to \$70*
<b>Lenses</b> Every calendar year <ul style="list-style-type: none"> <li>• Single vision</li> <li>• Lined bifocal</li> <li>• Lined trifocal</li> <li>• Lenticular</li> </ul>	Included in prescription glasses; includes polycarbonate lenses for dependent children up to age 26  <b>Affiliate Providers:</b> No coverage for Lenticular	<ul style="list-style-type: none"> <li>• Reimbursed up to \$48*</li> <li>• Reimbursed up to \$68*</li> <li>• Reimbursed up to \$83*</li> <li>• Reimbursed up to \$100*</li> </ul>
<b>Lens Enhancements</b> Every calendar year <ul style="list-style-type: none"> <li>• Progressive lenses</li> <li>• Other lens enhancements</li> </ul>	<ul style="list-style-type: none"> <li>• \$50</li> <li>• Average savings of 20-25%</li> </ul>	<ul style="list-style-type: none"> <li>• Reimbursed up to \$50*</li> <li>• Reimbursed up to \$50*</li> </ul>
<b>Elective Contacts</b> Every calendar year instead of glasses	<ul style="list-style-type: none"> <li>• \$150 allowance for contacts</li> <li>• 15% savings on a contact lens exam (evaluation and fitting) with network provider, up to \$40 copay</li> </ul>	Reimbursed up to \$105; applies to fitting within 90 days and evaluation fees and materials

	NETWORK AND AFFILIATE PROVIDERS	OPEN ACCESS PROVIDERS (NON-NETWORK)
<p><b>Medically Necessary Contacts</b></p> <p>Every calendar year instead of glasses</p>	<ul style="list-style-type: none"> <li>• <b>Network provider:</b> Covered in full after copay</li> <li>• <b>Affiliate provider:</b> \$20 copay; then reimbursed up to \$210*</li> </ul>	<ul style="list-style-type: none"> <li>• \$20 copay; then reimbursed up to \$210*</li> </ul>
<p><b>Low Vision</b></p> <ul style="list-style-type: none"> <li>• Supplemental testing</li> <li>• Supplemental aids</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Network provider:</b> Covered in full;</li> <li>• <b>Affiliate provider:</b> Reimbursed up to \$125*</li> <li>• 75% of VSP preferred provider's fee, up to \$1,000*</li> </ul>	<ul style="list-style-type: none"> <li>• Reimbursed up to \$125</li> <li>• 75% of VSP preferred provider's fee, up to \$1,000*</li> </ul>
<p>The maximum benefit for all low vision services and materials is \$1,000 every two years and a maximum of two supplemental tests within a two-year period.</p>		
<p><b>Diabetic Eyecare Plus (DEP) Program</b></p> <p>As needed (see <a href="#">Diabetic Eyecare Plus Program</a>)</p>	<p>Only covered with network providers:</p> <ul style="list-style-type: none"> <li>• <b>Exam:</b> \$20 copay</li> <li>• <b>Special ophthalmological services:</b> 80% of Medicare-allowed amount for each service, up to the provider's billed amount</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Exam:</b> Reimbursed up to \$100 after \$20 copay</li> <li>• <b>Special ophthalmological services:</b> Reimbursed up to \$120 per service</li> </ul>
<p>Limits and coordination with medical coverage may apply; ask your doctor for details.</p>		

**NETWORK PROVIDERS**

<p><b>Extra Savings</b></p>	<p><b>Glasses and sunglasses:</b></p> <ul style="list-style-type: none"> <li>• Extra \$20 to spend on featured frame brands; go to <a href="http://vsp.com/specialoffers">vsp.com/specialoffers</a> for details</li> <li>• 20% savings on additional glasses and sunglasses, including lens enhancements, from any VSP provider within 12 months of your last WellVision exam</li> </ul> <p><b>Retinal screening:</b></p> <ul style="list-style-type: none"> <li>• No more than a \$39 copay on routine retinal screening as an enhancement to a WellVision exam</li> </ul> <p><b>Laser vision correction:</b></p> <ul style="list-style-type: none"> <li>• Average 15% off the regular price or 5% off the promotional price; discounts only available from contracted facilities</li> </ul>
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\* Minus applicable copay, if any.

Coverage with a participating retail chain may be different. Visit [vsp.com](http://vsp.com) for coverage details once your benefit is effective.

**Vision Care Providers**

You may choose to receive vision care and materials from any vision service provider you wish. How much you pay for your care out of your own pocket depends on whether the expense is covered by the Plan and whether you choose a VSP Choice network, affiliate or non-network (open access) provider for your services and eyewear.

## VSP Choice Network (VSP Preferred Providers)

**VSP preferred providers** have agreed to participate in the VSP Choice Network. Network providers include highly skilled and professional optometrists, therapeutic optometrists or ophthalmologists qualified to practice vision care and/or provide vision care materials. Optometrists are Therapeutic Pharmaceutical Agent (TPA) certified and the ophthalmologists are American Board of Ophthalmology (ABO) certified. They are chosen carefully based on their professional licensing, work history, education, malpractice history, professional liability and ethics. The VSP Choice Network is nationwide and offers the greatest choice and convenience with a diverse network that includes approximately 37,000 providers.

To find a VSP Choice Network provider in your area:

- Go to [vsp.com](http://vsp.com) and select *Find a VSP Doctor*, or
- Contact VSP Member Services at **800-877-7195**.

When you use a **VSP Choice Network provider (VSP preferred provider)**:

- Your out-of-pocket expenses may be lower because network providers have agreed to provide covered services and supplies at a negotiated charge.
- You don't have to worry about being charged more than your copay (unless you select materials over the maximum allowable expense covered by the Vision Plan).
- You will not have to submit vision claims for treatment received; your network provider takes care of it.
- You only pay for your portion of the covered expense.

Note, however, VSP's negotiated fees do not apply to care that is not covered under the Plan.

## Affiliate Providers

Affiliate providers are providers of covered services and materials who are not contracted as VSP preferred providers but who have agreed to bill VSP directly for Plan benefits. Some affiliate providers may not be able to provide all Plan services (e.g., such as Diabetic Eyecare Plus [DEP] Program services). You should discuss requested services with your provider or contact VSP Customer Care for details. A benefit authorization is required for affiliate providers.

Services from an affiliate provider are in lieu of services from a VSP preferred provider or an **open access provider**. There is no guarantee that the amount reimbursed will be sufficient to pay the cost of services or materials in full. VSP is unable to require affiliate providers to adhere to VSP's quality standards.

Be aware, where affiliate providers are located in membership retail environments, you may be required to purchase a membership as a condition of obtaining Plan benefits (e.g., purchase a Costco membership to use the Costco affiliate providers).

When you use an **affiliate provider**:

- Non-network benefits typically result in higher out-of-pocket expenses for you and/or your covered dependents; however, many of the services are covered at the network level. You will still pay the full costs for expenses above the network coverage level.
- You will not have to submit vision claims for treatment received. The affiliate provider will file your claim with VSP.
- You only pay for your portion of the covered services expense.

## Open Access Providers

Services from an open access (non-network) provider are in lieu of services from a VSP network or affiliate provider. There is no guarantee that the amount reimbursed will be sufficient to pay the cost of services or materials in full. VSP is unable to require open access providers to adhere to VSP's quality standards.

If you receive care from an **open access** provider:

- They have not contracted with VSP to provide vision care services and/or material to participants, so these benefits typically result in higher out-of-pocket expenses for you and/or your covered dependents.
- You may have to pay the full cost for services and then file a claim to receive reimbursement from the Plan.

## Scheduling an Appointment

When you schedule an appointment with a VSP preferred provider, you must indicate you (and/or your covered dependents) are a VSP member. This will ensure you receive the VSP network plan benefits. If you do not identify yourself as a VSP member, you won't receive the network benefits.

The VSP preferred provider will obtain a benefit authorization from VSP, which expires after 30 days. If you don't use the services within 30 days, the VSP preferred provider will need to call for a new benefit authorization before you or your covered dependents can receive Plan benefits.

After you receive services, the VSP preferred provider will bill VSP directly. You are responsible for any applicable copays, non-covered services or materials, or amounts that exceed Plan allowances and annual maximum benefits. A benefit authorization is not required for open access providers; however, it is required for affiliate providers.

## Covered Vision Services

The Vision Plan covers:

- **WellVision exam:** A comprehensive exam of visual functions and prescription of corrective eyewear. The provider will prescribe and order lenses, verify the accuracy of finished lenses, and assist you with frame selection and adjustment.
- **Eyeglasses (lenses and frames):** Lenses that are mounted in eyeglass frames and worn on the face to correct visual acuity limitations. Single, lined bifocal, lined trifocal and lenticular lenses are covered. (Lenticular lenses are not covered through affiliate providers.)
- **Other eyeglass lens enhancements:** Including but not limited to, tinted lenses, polycarbonate lenses (for adults), transition lenses, high-index lenses, progressive lenses, ultraviolet coating, scratch-resistant coating, edge coating and photo chromatic coating.
- **Contact lenses:** Lenses worn on the surface of the eye, in place of prescription eyeglasses, to correct visual acuity limitations.
- **Medically necessary contact lenses:** For a medical condition, injury or impairment that makes it medically necessary for contact lenses to be worn in lieu of eyeglasses. Must meet specific benefit criteria prescribed by the provider.
- **Low vision service:** Professional services for severe visual problems not correctable with regular lenses. Supplemental testing includes evaluation, diagnosis and prescription of vision aids where indicated. Must meet specific benefit criteria prescribed by the provider.

Some limits and exclusions of coverage may apply to particular services and supplies, as outlined in this SPD and the [Vision Plan at a Glance](#). See [What the Vision Plan Does Not Cover](#) for expenses that are not covered under the Vision Plan.



## Diabetic Eyecare Plus Program

The Diabetic Eyecare Plus (DEP) Program is an additional vision benefit that is available if you or a covered dependent:

- Is enrolled in the Vision Plan;
- Uses a VSP network provider; and
- Has been diagnosed with type 1 or type 2 [diabetes](#) plus specific ophthalmological conditions.

The DEP Program provides coverage for limited, vision-related medical services. If you think you are eligible, contact VSP for a current list of these procedures. The frequency at which these services may be provided depends on the specific service and the associated diagnosis. The DEP Program is intended to be a supplement to your group medical plan. You should refer to your group medical plan SPD to determine how to obtain medical plan benefits.

Examples of symptoms and conditions under the DEP Program include:

SYMPTOMS	CONDITIONS
<ul style="list-style-type: none"> <li>• Blurry vision</li> <li>• Transient loss of vision</li> <li>• Trouble focusing</li> <li>• Floating spots</li> </ul>	<ul style="list-style-type: none"> <li>• <a href="#">Diabetic retinopathy</a></li> <li>• <a href="#">Diabetic macular edema</a></li> <li>• <a href="#">Rubeosis</a></li> </ul>

### Obtaining DEP Program Services

**If you are covered under a group medical plan:** Your vision provider should first submit a claim to your group medical insurance plan. Any amounts not paid by the medical plan are then considered for payment by VSP. See [Coordination of Benefits \(COB\)](#) for more information on benefits if you have two or more plans covering the same service.

**If you are not covered by a group medical plan:** When you are not covered by a group medical plan, you pay the applicable copay and any amounts for additional services provided that are not covered by the Plan at the time of each DEP Program visit.

### Referrals for DEP Program Services

If your VSP provider cannot provide covered services, your provider will refer you to another VSP provider or physician who offers the necessary services. If you require services beyond the scope of the DEP Program, the VSP provider will refer you to a physician.

Referrals are intended to ensure you receive the appropriate level of care for your presenting condition. You do not need a referral from a network provider to receive Plan benefits.

## What the Vision Plan Does Not Cover

The Plan is designed to cover visual needs rather than cosmetic materials. Some vision care services and/or materials are not covered under the Plan and other limits may apply.

The Plan does not cover the following services:

- Services and/or materials not specifically included in this SPD as covered Plan benefits
- Plano lenses (lenses with refractive correction of less than ± .50 diopter)
- Two pairs of glasses instead of bifocals

- Replacement of lenses, frames and/or contact lenses furnished under the Plan that are lost or damaged, except at the normal intervals when Plan benefits are otherwise available
- Orthoptics or vision training and any associated supplemental testing
- Medical or surgical treatment of the eyes
- Refitting of contact lenses after the initial (90-day) fitting period
- Contact lens modification, polishing or cleaning
- Local, state and/or federal taxes, except where VSP is required by law to pay

In addition, the DEP Program does not cover:

- Frames, spectacle lenses, contact lenses or any other ophthalmic materials
- Surgery of any type, and any pre- or post-operative services and/or supplies
- Treatment for any pathological conditions
- An eye exam required as a condition of employment
- Insulin or any medications or supplies of any type

These lists of expenses not covered are not all inclusive. Other specific expenses may be determined to be not covered under the Vision Plan by VSP or the plan administrator. If you have questions on a specific expense, you should contact VSP.

Some brands of eyeglass frames may be unavailable for purchase as Plan benefits, or may be subject to additional limitations. You may obtain details regarding frame brand availability from the VSP provider or by calling VSP's Customer Care Division at **800-877-7195**.

## Requesting Vision Benefits

All claims must be submitted to VSP within 365 calendar days from the date services are rendered and/or materials provided. Claims received by VSP after 365 days will be denied unless prohibited by applicable state or federal law.

## Filing Vision Claims

If you use a VSP preferred provider or an affiliate provider, the provider will file directly with VSP on your behalf.

If you use an open access provider, you may be responsible for paying for all services and/or materials in full and submitting a claim to VSP for reimbursement. You will be required to complete a VSP claim form and submit it along with any receipts to VSP for reimbursement. Member Reimbursement Claim Forms are available:

- On VSP's website at [vsp.com](http://vsp.com); or
- By calling VSP Member Services at **800-877-7195**.

If an open access provider agrees to submit a claim to VSP on your or your covered dependents' behalf, VSP will reimburse the provider directly if the claim includes a valid assignment of benefits. All reimbursement will be in accordance with the open access provider fee schedule, less any applicable copay.

Claims should be submitted to:

VSP Vision Care  
P.O. Box 385018  
Birmingham, AL 35238-0518

You should always submit claims to the primary plan first. When filing a claim for [coordination of benefits](#), you must submit the explanation of benefits (EOB) statement received from the primary plan and all associated bills to the secondary plan.

You can file claims for benefits and appeal adverse claim decisions yourself or through an authorized representative—a person you authorize, in writing, to act on your behalf. The Plan will also recognize a court order giving a person authority to submit claims on your behalf, except in the case of a claim involving urgent care, a health care professional with knowledge of your condition may always act as your authorized representative.

**Important**

If your claim is denied in whole or in part, you will receive a written notice of the denial from VSP. The notice will explain the reason for the denial and the review procedures. See [When You Disagree with a Claim Decision](#) for more information about appeals.

**Payment of Vision Benefits**

Generally, benefits will be paid after services are rendered and as soon as VSP receives the necessary proof to support the claim. VSP will pay VSP preferred providers and affiliate providers directly. If you submit an open access provider claim for payment, reimbursement will be paid directly to you unless you sign an assignment of benefits with the provider authorizing VSP to make payment directly to the provider.

## Flexible Spending Accounts (FSAs)

The Flexible Spending Accounts (FSAs) allow you to save on a pretax basis for eligible health care and/or dependent care expenses. Oxy offers both a Health Care Flexible Spending Account and a Dependent Care Flexible Spending Account.

### FSAs at a Glance

For updates to this information, go to My HR on [oxy.net.oxy.com](http://oxy.net.oxy.com).

FEATURE	HEALTH CARE FSA	DEPENDENT CARE FSA
<b>Your Annual Contributions</b>	<ul style="list-style-type: none"> <li>• \$100 minimum; \$2,600 maximum</li> <li>• If you are in a high deductible health plan (e.g., Aetna HealthFund) and an HSA, you may only enroll in a Limited Purpose Health Care FSA:               <ul style="list-style-type: none"> <li>– <i>Before you meet your medical deductible</i>, use the FSA for eligible dental, vision and certain preventive drug expenses.</li> <li>– <i>Once you've met your medical deductible</i>, use your FSA for eligible medical and prescription drug expense as well.</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>• \$100 minimum</li> <li>• Maximum:               <ul style="list-style-type: none"> <li>– Single or married filing a joint tax return: \$5,000 (if married, this is your and your spouse's combined contribution limit)</li> <li>– Married filing a separate tax return: \$2,500</li> <li>– Your annual contribution may not exceed the lesser of your or your spouse's earned income. If your spouse has no income and is a full-time student or disabled, the IRS assumes your spouse's annual income is \$3,000 if you claim expenses for one dependent, and \$6,000 if you claim expenses for two or more dependents.</li> </ul> </li> </ul>
<b>Tax Savings</b>	Contributions are pretax for federal income, Social Security and, in some cases, state income taxes. Qualified reimbursements are tax-free.	
<b>Eligible Expenses</b>	<ul style="list-style-type: none"> <li>• Medical, dental and vision deductibles and copays</li> <li>• Coinsurance and other out-of-pocket expenses not covered by your medical, dental or vision plans</li> </ul> <p>Note: Over-the-counter medications must have a prescription.</p>	Expenses related to care of eligible dependents, including: <ul style="list-style-type: none"> <li>• Day care</li> <li>• Before- and after-school programs</li> <li>• Summer day camp</li> <li>• Adult day care</li> </ul>
	For a list of eligible expenses or if you have questions about the PayFlex claim filing process, call PayFlex at <b>844-PAYFLEX</b> (844-729-3539) or go to the PayFlex website.	
<b>Reimbursement</b>	You choose whether to have your reimbursement paid to you or paid directly to your provider. For the Health Care FSA, you may set up auto pay for reimbursement of your Aetna medical and Express Scripts prescription drug eligible expenses. Auto pay must be elected each plan year. To make your election, log on to <a href="http://payflex.com">payflex.com</a> . Select <i>Health Plan Claims</i> , then <i>View Health Plan Activity Options</i> .	
<b>Forfeiture of Funds</b>	Each year you have until March 31 to submit claims for eligible expenses incurred during the previous calendar year. Otherwise you will forfeit any unused money in your FSA.	
<b>Portability</b> (if you leave Oxy)	You may use your Health Care FSA for eligible expenses <b>incurred</b> through your last day of Oxy service, unless you elect <a href="#">COBRA coverage</a> for a Health Care FSA.	You may use your Dependent Care FSA for eligible expenses incurred through your last day of Oxy service.

## Health Care FSA

### Eligible Health Care Expenses

Eligible health care expenses are those that generally:

- Are incurred during the plan year by:
  - You or your spouse;
  - A child for whom you provide at least half of the financial support (if you are a divorced or separated parent, both you and your former spouse may be entitled to deduct expenses incurred for your child's health care); or
  - Any other person whom you claim as a dependent on your federal income tax return;
- Qualify as health care expense deductions for federal income tax purposes—considered medical care under the Internal Revenue Code ([Code](#)) section 213(d);
- Are not claimed as itemized health care expenses on your federal income tax return; and
- Are not reimbursed to you or paid to your health care providers from any other source (such as your health care plans).

If you have questions or want additional information about eligible expenses:

- See IRS Publication 502, *Medical and Dental Expenses*, available on the IRS website at [irs.gov](https://www.irs.gov) or call **800-TAX-FORM** (800-829-3676); or
- Contact PayFlex at **844-PAYFLEX** (844-729-3539) or log on to [payflex.com](https://www.payflex.com).

Note that certain expenses that are deductible as medical care are not eligible for reimbursement under the FSA Plan.

## Health Care FSA Expense Examples

Listed below are some examples of eligible and ineligible expenses:

ELIGIBLE EXPENSES	INELIGIBLE EXPENSES
<ul style="list-style-type: none"> <li>• Acupuncture</li> <li>• Auto equipment to assist the physically disabled</li> <li>• Birth control pills and other contraceptive devices</li> <li>• Braille books and magazines</li> <li>• Crutches</li> <li>• Deductibles, coinsurance or copays for a health care plan or HMO</li> <li>• Dental expenses not covered by a dental plan</li> <li>• Expenses that exceed limits imposed by a health care plan</li> <li>• Eye exams, prescription glasses and contact lenses, and most corrective vision surgeries such as LASIK</li> <li>• Household visual alert system for the hearing impaired</li> <li>• Hearing exams and aids</li> <li>• Infertility treatment</li> <li>• In-home elevators for the disabled</li> <li>• Invalid chairs and wheelchairs</li> <li>• Organ donor expenses</li> <li>• Orthodontia expenses not covered by a dental plan</li> <li>• Physical exams and school or camp physicals for children</li> <li>• Prescription drug expenses not covered by a prescription drug plan</li> <li>• Seeing-eye or guide dog or other animal and its maintenance for the visually or hearing impaired or a person with other physical disabilities</li> <li>• Smoking cessation programs, patches and gum</li> <li>• Special devices, such as a tape recorder or typewriter for the visually impaired</li> <li>• Specialized equipment for the disabled</li> <li>• Speech therapy</li> <li>• Sterilization surgery</li> <li>• Transportation expenses if primarily for and essential to medical care</li> <li>• Weight-loss programs undertaken at a physician's direction to treat an existing disease such as obesity or heart disease</li> <li>• Wig advised by a doctor as essential for a person who has lost all hair from disease</li> </ul>	<ul style="list-style-type: none"> <li>• Expenses for which you've already been reimbursed by other health care plans (including Medicare, Medicaid, and Oxy's or any other medical, dental and vision care plans)</li> <li>• Expenses incurred by anyone other than you or your qualified dependents</li> <li>• Expenses that are not considered medical care under Code section 213(d)</li> <li>• Babysitting, child care and nursing services for a normal, healthy baby, including the cost of a licensed practical nurse (L.P.N.) to care for a normal and healthy newborn</li> <li>• Cosmetic dental work and cosmetic surgery</li> <li>• Custodial care in an institution</li> <li>• Electrolysis</li> <li>• Funeral and burial expenses</li> <li>• Health care plan contributions</li> <li>• Health club dues</li> <li>• Household help, even if such help is recommended by a physician</li> <li>• Long-term care premiums</li> <li>• Meals while away from home for medical treatment</li> <li>• Medicare premiums</li> <li>• Over-the-counter health aids that do not treat a specific medical condition, including those recommended by your physician</li> <li>• Over-the-counter drugs that may be beneficial to health, but are not for medical care (e.g., vitamins, weight-loss aids)</li> <li>• Nutritional supplements, unless obtained with a physician's prescription</li> <li>• Personal use items, unless the item is used primarily to prevent or alleviate a physical or mental defect or illness</li> <li>• Prescription drugs for cosmetic purposes</li> <li>• Weight-loss programs not prescribed by a doctor</li> <li>• Vitamins or minerals taken for general health purposes</li> </ul>



**Important**

Expenses for longer term treatment, other than orthodontia, may be reimbursed only for services actually performed in a given tax year, regardless of the payment schedule you have established with your provider. Orthodontic expenses will be reimbursed based on the year in which the expenses are paid.

**Over-the-Counter (OTC) Expense Examples**

The IRS has determined that certain over-the-counter (OTC) items qualify as medical care and can be reimbursed through an FSA. You must provide documentation that validates the expense, including the date and amount of purchase, on a separate Over-the-Counter Flexible Spending Account reimbursement claim form. In addition, *OTC medications, other than insulin, may only be reimbursed through an FSA if they are accompanied by a bona fide prescription.*

Listed below are examples of eligible OTC expenses:

ELIGIBLE OTC EXPENSES (MEDICATIONS REQUIRE A PRESCRIPTION)	INELIGIBLE OTC EXPENSES
<ul style="list-style-type: none"> <li>• Acne treatment products</li> <li>• Antacids, digestive, urinary pain relief, laxative and motion sickness medications</li> <li>• Analgesics for fever and pain relief</li> <li>• Antibiotic, hydrocortisone, pain, itch relief, and anti-fungal creams and ointments</li> <li>• Eye care products, including contacts, saline solution and eye lubricant drops</li> <li>• Family planning products such as pregnancy tests, contraceptive creams and condoms</li> <li>• First aid products such as bandages, dressings, heat wraps and compresses</li> <li>• Humidifiers and vaporizers</li> <li>• Joint support bandages and hosiery</li> <li>• Medical monitoring and testing equipment for diabetes, blood pressure and cholesterol</li> <li>• Shampoo treatments for psoriasis and lice</li> <li>• Vaginal infection and incontinence products</li> </ul>	<ul style="list-style-type: none"> <li>• Vitamins, nutritional and dietary supplements such as homeopathic medicines, unless prescribed in writing by a physician</li> <li>• Sleep aid products, unless prescribed in writing by a physician</li> <li>• Cosmetics, including make-up, cotton swabs, cotton balls and lotions</li> <li>• Skin care products such as sun block, sun tan products, moisturizers and lip balm</li> <li>• Hair care products such as shampoo, conditioner and hair loss treatments</li> <li>• Personal grooming products such as combs, brushes, clippers, facial steamers, etc.</li> <li>• Dental care products such as toothpaste, floss, mouthwash, fluoride and plaque rinses, whitening/breath strips, denture cleaners and adhesives</li> <li>• Baby care products such as formula, baby food, diapers, creams, lotions and powders</li> </ul>



## Limited Purpose FSA

The IRS requires the use of a Limited Purpose FSA if you are also contributing to a Health Savings Account (HSA).

*Before you meet your combined medical/prescription drug deductible, the only expenses reimbursable from your Limited Purpose FSA are:*

- Dental care;
- Vision care; and
- [Preventive drugs and services](#).

*After you meet your deductible and supply proof to PayFlex, you may use your Limited Purpose FSA as you would a regular FSA for all qualified health care expenses, including OTC products and IRS-approved medical expenses that may not be covered under your medical plan.*

The annual contribution limits are the same for a regular and Limited Purpose FSA. As with a regular FSA, any unused funds in a Limited Purpose FSA are forfeited at the end of the year. Because of the forfeitures and restrictions on reimbursement until you meet your deductible, if you enroll in an HSA option, take extra care in deciding how much money to place in a Limited Purpose FSA.

## Preventive Drugs and Services

You may be able to use your Limited Purpose FSA before meeting your deductible for certain preventive drugs and services. Preventive drugs are generally used for the conditions listed in the *Preventive Category* below:

PREVENTIVE CATEGORY	DRUG CLASSES
Hypertension and prevention of various conditions related to hypertension	<ul style="list-style-type: none"> <li>• Beta blockers</li> <li>• Calcium channel blockers</li> <li>• Antihypertensives</li> <li>• Diuretics</li> <li>• Ace inhibitors</li> <li>• Angiotensin receptor blockers</li> </ul>
Hyperlipidemia and prevention of heart disease, etc.	Antihyperlipidemics (i.e., cholesterol-lowering drugs)
Diabetes and prevention of various diabetic complications	Antidiabetics
Asthma and prevention of asthmatic episodes	Antiasthmatic agents (long acting only)
Osteoporosis and prevention of conditions stemming from osteoporosis	Antiosteoporosis medications
Prevention of stroke	Blood thinning agents
Prevention of a variety of pediatric conditions	Pediatric vitamins with fluoride
Prevention of maternal and fetal problems	Prenatal multivitamin with iron and folic acid

Services that may be considered preventive care by the IRS are:

- Periodic health evaluations, including tests and diagnostic procedures ordered in connection with routine exams, such as annual physicals
- Routine prenatal and well-child care
- Child and adult immunizations
- Tobacco cessation programs
- Obesity weight-loss programs
- Screening services

## Health Care FSA or Itemized Deductions

If you have eligible health care expenses, you can save on taxes by using a Health Care FSA *or* by itemizing deductions when you file your income tax return, but you can't use both for the same expense.

If you decide to itemize eligible medical expenses on your income tax return, you can deduct only out-of-pocket, unreimbursed health care expenses that exceed 10% of your annual adjusted gross income. If you expect to have substantial out-of-pocket health care expenses exceeding 10% of your adjusted gross income, you may want to consider the itemized deduction. If your expenses do not exceed 10% of your adjusted gross income, the Health Care FSA may be the better alternative. Consult your personal tax advisor if you have questions about which method is best for you.

## Dependent Care FSA

### Eligible Dependent Care Expenses

Eligible dependent care expenses are those that are incurred by you for a:

- Qualifying child under age 13 who can be claimed as a dependent on your federal income tax return; and/or
- Qualifying relative (e.g., child, sibling, parent, grandparent) who is physically or mentally incapable of self-care, and with whom you share your principal residence for more than half of the taxable year.

The expenses must be for:

- Day care received in your home, as long as:
  - You cannot claim your care provider as a dependent for federal income tax purposes; and
  - The provider is not one of your children under age 19 at the end of the year; or
- Day care received outside of your home. However, any care facility that cares for more than six people at a time must be properly licensed and comply with all applicable state and local laws.

As a rule, eligible dependent care expenses are incurred so you can work. If you are married, both you and your spouse must be working or looking for work, or your spouse must be a full-time student.

If you have questions or want additional information about a qualifying child, qualifying relative or eligible expenses:

- See IRS Publication 503, *Child and Dependent Care Expenses*, available on the IRS website at [irs.gov](https://www.irs.gov) or call **800-TAX-FORM** (800-829-3676); or
- Contact PayFlex at **844-PAYFLEX** (844-729-3539) or log on to [payflex.com](https://payflex.com).

Listed below are some examples of eligible expenses and ineligible expenses under a Dependent Care FSA:

ELIGIBLE EXPENSES	INELIGIBLE EXPENSES
<ul style="list-style-type: none"> <li>• At-home day care providers</li> <li>• Properly licensed day care centers</li> <li>• Day camps</li> <li>• Preschools</li> <li>• Nursery schools</li> <li>• Services of a housekeeper or domestic as long as they also provide significant day care services</li> </ul>	<ul style="list-style-type: none"> <li>• Babysitting so you can attend a social event</li> <li>• Generally, food and education expenses for a child at kindergarten level or above</li> <li>• Overnight camps</li> <li>• Payment for dependent health care expenses</li> <li>• Transportation expenses for your day care provider</li> <li>• Dependent day care services necessary because you are home from work due to illness</li> </ul>

### Dependent Care FSA or Federal Tax Credit

In addition to the Dependent Care FSA, the IRS offers another tax savings alternative when you file your federal income tax return—a tax credit. You may not use the tax credit for the same expenses reimbursed through your FSA. It is possible, however, to divide your eligible expenses between a Dependent Care FSA and the tax credit.

In most cases, you will have higher tax savings from a Dependent Care FSA or a combination of a Dependent Care FSA and the tax credit. However, depending on your income, your individual tax situation will determine which method results in the greater tax savings. To determine the best method for you, consult your tax advisor.

### Requesting Health Care and Dependent Care FSA Benefits

All eligible health care and dependent care expenses must be incurred (services provided) during the plan year, January 1 through December 31. You must file claims with PayFlex by **March 31 of the following plan year**. Claims received after this deadline will not be processed or reimbursed, and you will forfeit any remaining balance in your accounts.

HEALTH CARE FSA REIMBURSEMENT	DEPENDENT CARE FSA REIMBURSEMENT
<ul style="list-style-type: none"> <li>• Eligible health care expenses will be reimbursed up to the total amount you elect to contribute to your Health Care FSA for the plan year.</li> </ul>	<ul style="list-style-type: none"> <li>• You can only be reimbursed up to the amount that is available in your account at the time you request reimbursement.</li> </ul>

### Filing FSA Claims

The Plan offers three ways to submit FSA claims for reimbursement:

- Use the *File A Spending Account Claim* feature at [payflex.com](http://payflex.com)
- Use the *File Claim* feature on the PayFlex Mobile® app
- Fill out a paper claim form and fax it to PayFlex at **888-238-3539** or mail it to:

PayFlex Systems USA, Inc.  
P.O. Box 4000  
Richmond, KY 40476-4000

When you submit a claim, you'll need to include supporting documentation:

HEALTH CARE FSA DOCUMENTATION	DEPENDENT CARE FSA DOCUMENTATION
<p>If your expense was submitted to a health care plan, you can send your EOB from your insurance carrier. Otherwise send an itemized statement or detailed receipt*. The documentation needs to include the following:</p> <ul style="list-style-type: none"> <li>• Merchant or service provider name</li> <li>• Patient name (if applicable)</li> <li>• Date of service</li> <li>• Amount of service or purchase</li> <li>• Description of item or service</li> </ul>	<p>You can send a detailed receipt or statement with your claim or your day care provider can sign the paper claim form.</p>

\* PayFlex can't accept documentation that shows an estimated or pending amount filed with insurance, or for services not yet provided.

If you have questions, visit [payflex.com](http://payflex.com) and select *Contact Us*. PayFlex is available Monday – Friday, 7 a.m. through 7 p.m. CT and Saturday, 9 a.m. through 2 p.m. CT.



### Important

If your claim is denied in whole or in part, you will receive a written notice of the denial from PayFlex. The notice will explain the reason for the denial and the review procedures. See [When You Disagree with a Claim Decision](#) for more information about appeals.

## Payment of FSA Benefits

**For both the Dependent Care and Health Care FSAs**, you may elect to have your reimbursement checks directly deposited into the checking or savings account that you designate on [payflex.com](http://payflex.com). Once you've enrolled in the FSA, log on to PayFlex. Under *Account Actions*, select *Link a Bank Account*, then provide your direct deposit banking information. You may change or stop direct deposit at any time.

**For the Health Care FSA**, you have the following *additional* options:

- **Auto Pay.** You may elect to have your Aetna medical and dental claims and your Express Scripts copays or coinsurance automatically forwarded to your Health Care FSA for reimbursement. This also includes your Express Scripts prescriptions under the Anthem Medical Plan. However, Anthem medical claims and VSP vision claims are not eligible for Auto Pay.

To set up, log on to [payflex.com](http://payflex.com). Under the *Health Plan Claims* tab, select *View Health Plan Activity Options*. Review and update your automatic reimbursement settings and select *Save* before leaving the page. **Important:** You must re-elect Auto Pay each year. Do *not* elect Auto Pay if you coordinate medical or dental claims with another health plan. Additionally, Auto Pay is not available if you enroll in a Health Savings Account (HSA).

- **Direct payment to you or your provider.** You can have PayFlex pay you or your provider directly. For example, after you receive your explanation of benefits (EOB) from a provider visit or for prescription drug expenses, log on to PayFlex at [payflex.com](https://payflex.com). Under *Account Actions*, select *File a Claim*. Then, select *Pay Me* to pay yourself back or *Pay Them* to pay the provider directly (follow the instructions to submit a copy of your receipt, invoice or other documentation). If PayFlex processes and approves your claim, the payment is sent to you or to your provider as applicable, and the amount is automatically taken out of your FSA.

## Restrictions on Spending Accounts

- **Forfeitures:** The IRS requires that any money remaining in your spending accounts at the close of the plan year—for which you have not incurred eligible expenses or claimed reimbursement—must be forfeited. Forfeitures cannot be deducted on your income tax return. You cannot carry forward any unspent balance in your accounts into the next plan year.

Remember, claims for eligible expenses incurred during the plan year must be received by PayFlex no later than March 31 of the following plan year. When you enroll in the Plan, it is important that you estimate carefully the amount of money you set aside in your spending accounts and remember to submit your claims before the deadline.

- **Non-discrimination testing:** The IRS requires that FSAs pass certain non-discrimination tests. This may result in a portion of the contributions of some highly compensated employees being taxable. If this occurs, affected employees will be notified.
- **Separation of accounts:** You cannot transfer dollars set aside in your Health Care FSA to your Dependent Care FSA, or vice versa. The accounts are separate, and the money you allocate for one account cannot be used for the other.



### Important

IRS regulations governing FSAs have changed in the past and may change again in the future.

## Coordination of Benefits (COB)

When you and your eligible dependents are covered by more than one health plan (e.g., medical, dental, vision), your benefits are coordinated with benefits from your other coverage to prevent duplicate payments for the same services. **COB does not apply to Flexible Spending Accounts.**

The Plan coordinates coverage with any of the following plans:

- Group insurance;
- Other prepaid coverage under service plan contracts, or under group or individual practice;
- No-fault auto insurance required by law and provided on other than a group basis;
- Medicare or other governmental benefits; and
- Any other type of coverage for groups, including plans that are insured and those that are not.

If the plan includes medical, prescription drug, dental, vision and hearing coverage, those coverages will be considered separate plans. For example, medical coverage will be coordinated with other medical plans, and dental coverage will be coordinated with other dental plans.

### How COB Works for Dental and Vision Plans

When you have a claim for expenses that is covered by two or more plans, one plan—known as the primary plan—pays benefits first. The other plan, the secondary plan, adjusts payments so the total benefit paid does not exceed 100% of the total [allowable expense](#).

When the Oxy Plan is **primary**, it pays the allowable amount for the treatment you received.

When the Oxy Plan is **secondary**, it pays the amount necessary so the total amount you receive from the Oxy Plan and the other plans combined is not greater than the amount you would have received under the Oxy Plan alone (100% of the total allowable expense under the Oxy Plan). In determining that amount, the Plan calculates the benefits it would have paid in the absence of other coverage. Then the Plan applies that amount to any allowable expense under the Plan that was unpaid by the primary plan. The amount will be reduced so that when combined, the total benefits paid by all plans for the claim do not exceed 100% of the total allowable expense. In addition, as the secondary plan, the Plan will credit to its deductible any amounts that would have been credited in the absence of other coverage.

### Order of Benefit Determination

#### For the Dental Plan

In general, the rules used to determine which plan pays benefits first for the Dental Plan are:

- The plan with no coordination provision is primary. (Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits may provide that the supplementary coverage is excess to any other parts of the plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan hospital and surgical benefits, and insurance-type coverages that are written in connection with a closed panel plan to provide out-of-network benefits.)
- The plan that covers the person other than as a dependent pays before the plan that covers that person as a dependent. (If the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the plan covering the person as a dependent and primary to the plan covering the person as other than a dependent [e.g., a retired employee], then the order of benefits between the two plans is reversed so that the plan covering the person as an employee, member, subscriber or retiree is secondary and the other plan is primary.)

- For a dependent child who has coverage under both parents' plans (when the parents are married or living together), the plan that covers the parent with the earlier birth date (month and day) in the year is primary (no matter what the year). If the month and day of birth of both parents is the same, then the plan that has covered the parent for a longer time pays first. If the other plan has a rule based on gender of the parent, the rule in the other plan determines order of payment.
- For dependent children whose parents are legally separated or divorced, plan payments are determined in this order:
  - If there is a court decree that states that the parents shall share joint custody of a dependent child, without stating that one of the parents is responsible for the health care expense of the child, the order of benefit determination rules specified in the bullet above will apply (earlier birth date rule);
  - If there is a court decree (Qualified Medical Child Support Order, or QMCSO) for the child, the plan that covers the child as a dependent of the parent who is responsible pays before any other plan that covers the child as a dependent child. If the parent with responsibility has no health coverage but his or her spouse does, the plan of that parent's spouse is the primary plan;
  - If there is no QMCSO:
    - The plan of the custodial parent (the parent awarded custody by a court decree or, if there is no court decree, the parent with whom the child resides more than one half of the calendar year without regard to any temporary visitation);
    - The plan (if any) of the spouse of the custodial parent;
    - The plan of the parent not having custody; and then
    - The spouse's plan of the parent not having custody.
- For a dependent child covered under more than one plan of individuals who are not the parents of the child, the order of benefits is determined as outlined above as if the individuals were the parents.
- The plan that covers a person as an employee who is neither laid-off nor retired (or as that employee's dependent) pays before the plan that covers that person as a laid-off or retired employee (or as that employee's dependent). If the other plan does not have this rule, then this rule is ignored.
- If a person whose coverage is provided under a right of continuation provided by federal or state law also is covered under another plan, the plan covering the person as an employee, member, subscriber or retiree (or as that person's dependent) is primary, and the continuation coverage is secondary. If the other plan does not have this rule, then this rule is ignored.
- The plan that has covered the person as an employee, member or subscriber for a longer time pays before the plan that has covered the person a shorter time.
- When the rules above do not apply, the allowable expenses are shared equally between the plans. In addition, the Plan will not pay more than it would have paid had it been primary.

### For the Vision Plan

In general, the rules used to determine which plan pays benefits first for the Vision Plan are:

- When coordinating benefits, it must be determined which plan is billed first.
- The plan that covers the patient as an employee is **primary**.
- The plan that covers the patient as a dependent is **secondary**.

If the patient is a dependent child and is covered under both parents' plans, typically the parent whose birth date falls first in the calendar year has the primary plan. If the parents are separated or divorced, the parent with custody is primary, unless otherwise ordered by the court.

The primary plan must pay or provide benefits as if the secondary plan does not exist.



When VSP administers the secondary plan, the patient will receive a specified allowance for each service (exam, lenses, frame or contacts) that will be used to pay up to, but not more than, the billed amount. Only services received on the primary benefit may be used for coordinating like services on the secondary benefit.

Secondary allowances are applied first to the same service of the primary plan. Any remaining amount may be used to cover additional expenses on other services.

VSP will reimburse the patient according to each benefit's non-network schedule of allowances, not to exceed the actual exam fee and the cost of corrective eyewear.

**Note:** Coordination of benefits does not guarantee that all out-of-pocket expenses will be covered in full. The member is responsible for any remaining expenses.

## Right to Receive and Release Necessary Information

The claims administrators may receive or release, from any other organization or person, any information necessary to decide whether coordination applies and to determine benefits payable under the Plan. This may be done without your consent. Any person claiming benefits under the Plan is required to give information necessary to coordinate benefits.

## Facility of Payment

Any payment made under another plan may include an amount that should have been paid under the Plan. If it does, the claims administrator may pay that amount to the organization that made that payment. That amount is then to be treated as though it were paid under the Oxy Plan. The claims administrator will not have to pay that amount again. The term *payment made* means reasonable cash value of the benefits provided in the form of services.

## Right of Recovery

If the claims administrator pays more than it should have paid under this COB provision, it may recover the excess from one or more of the persons it has paid or for whom it has paid, or any other person or organization that may be responsible for the benefits or services provided for the covered person. The amount of the payments made includes the reasonable cash value of any benefits provided in the form of services.

## Claims and Appeals Procedures

This section explains the rules and provisions that affect claim denial and appeals of benefits.

The plan administrator is responsible for claims and appeals procedures. However, the plan administrator has delegated authority to handle claims and appeals to the claims administrators. See [Administrative Information](#) for contact information.

### Filing an Initial Claim

The claims administrator has the right to adopt reasonable policies, procedures, rules and interpretations of the Plan to promote orderly and efficient administration. The claims administrator may not abuse its discretionary authority by acting arbitrarily and capriciously.

When you file a claim, the claims administrator reviews the claim and makes a decision to either approve or deny the claim. The claims administrator has the full discretionary authority to:

- Interpret the provisions of the Plan—such interpretation will be final and conclusive on all persons;
- Determine eligibility for benefits;
- Provide employees with a reasonable notification of their benefits available under the Plan; and
- Approve reimbursement requests and authorize the payment of benefits.

If your benefit claim is denied, in whole or in part, you will receive notification by mail or electronically from the claims administrator within the time frames noted in the following table. The notice provides important information to assist you in making an appeal of the denied claim (or adverse benefit determination), if you wish to do so. Refer to [When You Disagree with a Claim Decision](#) for more information about appeals.

You can file claims for benefits and appeal adverse claim decisions yourself or through an authorized representative (that is, a person you authorize in writing to act on your behalf, including your provider). The Plan will also recognize as your authorized representative:

- A court order giving a person authority to submit claims on your behalf; and
- In the case of a claim involving urgent care, a health care professional with knowledge of your condition.



#### Adverse Benefit Determination

An adverse benefit determination is a denial, reduction, termination of or failure to provide or make payment (in whole or in part) for a service, supply or benefit. It may be based on:

- Your eligibility for coverage;
- Plan limits or exclusions;
- The results of any utilization review activities;
- A determination that the service or supply is experimental or investigational; or
- A determination that the service or supply is not medically necessary.

## Time Frames for Claim Processing

TYPE OF CLAIM	CLAIMS ADMINISTRATOR RESPONSE TIME	EXTENSION
<p><b>Urgent care claim</b> (including urgent care that is concurrent care involving the extension of a course of treatment or number of treatments): a claim for medical care or treatment where delay could:</p> <ul style="list-style-type: none"> <li>• Seriously jeopardize your life or health, or your ability to regain maximum function;</li> <li>• Subject you to severe pain that cannot be adequately managed without the requested care or treatment; or</li> <li>• In the case of a pregnant woman, cause serious jeopardy to the health of the fetus.</li> </ul>	<p>As soon as possible, taking into account the medical demands, but no later than 72 hours (24 hours for concurrent care if the claim is at least 24 hours before the expiration of the prescribed course of treatment or number of treatments) after the Plan receives your claim.</p> <p>If you fail to provide sufficient information with the claim to determine whether, or to what extent, benefits are payable from the Plan, you are notified no later than 24 hours after the Plan receives your claim about the specific information you need to submit. You will have at least 48 hours to provide this information. You will be notified of the claim decision as soon as possible, but no later than 48 hours after the earlier of the Plan's receipt of the specified information or the end of the period during which you may provide the specified information.</p>	NA
<p><b>Concurrent care claim reduction or termination:</b> a decision to reduce or terminate a course of treatment that was previously approved.</p>	With enough advance notice to allow you to appeal.	NA
<p><b>Concurrent care claim extension</b> (that is not urgent care): a request to extend a previously approved course of treatment.</p>	Within a reasonable time, but no later than 15 days after the Plan receives your claim.	Initial notification may be extended up to 15 days if an extension is necessary due to matters beyond the Plan's control. You will be notified before the end of the initial 15-day or 30-day period why the extension is necessary and when the Plan expects to make a decision. If you failed to submit necessary information, the notice will specify what information is necessary, and you will have 45 days to provide it.
<p><b>Pre-service claim:</b> a claim for a benefit that requires approval of the benefit in advance of receiving care (<a href="#">precertification</a>).</p>	Within a reasonable time, but no later than 15 days after the Plan receives your claim.	While the Plan is waiting for your response, the determination period is suspended.
<p><b>Vision Plan, Health Care FSA and post-service claims:</b> a claim for care or treatment that has been rendered.</p>	Within a reasonable time, but no later than 30 days after the Plan receives your claim.	

TYPE OF CLAIM	CLAIMS ADMINISTRATOR RESPONSE TIME	EXTENSION
<b>Dependent Care FSA claim</b>	Within a reasonable time, but no later than 90 days after the Plan receives your claim.	If special circumstances require an extension, the period may be extended for an additional 90 days. You will be notified before the end of the 90-day period why the extension is necessary and when the Plan expects to make a decision.

## Claim Denial

If your claim is denied, in whole or in part, you will receive a notice by mail or electronically that contains all of the following:

- A reference to the specific reasons for the denial;
- The specific Plan provisions on which the denial is based;
- In the case of a group health plan claim, if an internal rule, guideline, protocol or other similar criterion was relied on to determine a claim, you will receive either a copy of the actual rule, guideline, protocol or other criterion, or a statement that the rule, guideline, protocol or other criterion was used and how you can request a copy free of charge. If the denial is based on medical necessity, experimental treatment or a similar exclusion or limit, you will receive either an explanation of the scientific or clinical judgment for the determination based on the Plan terms and your medical circumstances, or a statement that you can receive the explanation free of charge upon request;
- A description of any additional material or information needed to perfect the claim and an explanation of why it's necessary;
- An explanation of the Plan's claim review procedures, applicable time limits and, except with regard to claims under the Dependent Care FSA, your rights to bring a civil action under ERISA section 502(a) following any denial on review; and
- An explanation of the expedited claim review procedure for an urgent care claim. In the case of an urgent care claim, the Plan may notify you by phone or fax and follow up with a notice by mail or electronically no later than three days after the notification.

## When You Disagree with a Claim Decision

### Appeal Process

Requests for appeal may be submitted verbally or in writing within 180 days from the receipt of the notice of an adverse benefit determination to the [claims administrator](#) (60 days for Dependent Care FSA claims). However, appeals of adverse benefit determinations involving urgent care for dental care may be made to Aetna Member Services at **800-334-0299**.

Your appeal should include:

- Your name;
- Your employer's name;
- A copy of the notice of an adverse benefit determination;
- Your reasons for making the appeal; and
- Any other information you would like to have considered.

Written requests for claim appeals may be sent to:

CLAIMS ADMINISTRATOR	APPEALS ADDRESS
<b>Aetna:</b> <ul style="list-style-type: none"> <li>Dental Plan</li> </ul>	Aetna Attn: National Account CRT P.O. Box 14463 Lexington, KY 40512
<b>VSP:</b> <ul style="list-style-type: none"> <li>Vision Plan</li> </ul>	VSP Vision Care 3333 Quality Drive Rancho Cordova, CA 95670-7985
<b>PayFlex:</b> <ul style="list-style-type: none"> <li>FSA Plan</li> </ul>	PayFlex Systems USA, Inc. P.O. Box 4000 Richmond, KY 40476-4000

The Plan provides either one or two levels of appeal depending on the type of coverage. If you have two levels of appeal and you are dissatisfied with the outcome of your level one appeal, you can request a level two appeal, to be filed no later than 60 days following receipt of the level one notice of adverse benefit determination. Appeals are reviewed by personnel not involved in making the adverse benefit determination (except for concurrent care claim reduction or termination and Dependent Care FSA). The following chart summarizes how appeals are handled for different types of claims.

TYPE OF APPEAL	LEVEL ONE APPEAL RESPONSE	LEVEL TWO APPEAL RESPONSE
<b>Urgent care medical and dental claims</b> (including urgent care that is concurrent care)	36 hours	36 hours
<b>Concurrent care claim reduction or termination</b>	With enough advance notice to allow you to appeal	NA
<b>Concurrent care claim extension</b> (that is not urgent care)	Treated like an urgent care claim or a pre-service claim depending on the circumstances	Treated like an urgent care claim or a pre-service claim depending on the circumstances
<b>Pre-service claim</b>	15 calendar days	15 calendar days
<b>Vision Plan and post-service claims</b>	30 calendar days	30 calendar days
<b>Health Care FSA claims</b>	30 calendar days; may be extended on notice to you	NA
<b>Dependent Care FSA claims</b>	Within a reasonable time, but no later than 60 days after the Plan receives your claim; may be extended on notice to you	NA

## Aetna Complaints for Dental

If you are dissatisfied with the service you receive from the Plan or want to complain about a provider, you must write Aetna Customer Service within 30 calendar days of the incident. You must include a detailed description of the matter and include copies of any records or documents you think are relevant. Aetna will review the information and provide you with a written response within 30 calendar days of the receipt of the complaint, unless additional information is needed and it cannot be obtained within this period.

## VSP Complaints for Vision

You have the right to expect quality care from VSP preferred providers. More information is available under *Patient's Rights and Responsibilities* at [vsp.com](http://vsp.com). Complaints and grievances are disagreements regarding access to care, quality of care, treatment or service and may be submitted to VSP in writing, by telephone, online or through VSP Preferred Providers. You may call VSP's Customer Care Division at **800-877-7195**, or you may submit any complaints and/or grievances, including appeals, in writing to:

VSP Vision Care  
3333 Quality Drive  
Rancho Cordova, CA 95670-7985

VSP will resolve your complaint within 30 calendar days after receipt, unless special circumstances require an extension of time. In that case, VSP will resolve your complaint as soon as possible, but not later than 120 calendar days after VSP receives the complaint. If VSP determines they cannot resolve your complaint within 30 days, VSP will notify you of the expected resolution date. Upon final resolution, VSP will notify you of the outcome in writing.

## Other Remedies

When you have completed the appeals process described above, additional voluntary alternative dispute resolution options may be available, including mediation or arbitration. Additional information is available from the U.S. Department of Labor or the insurance regulatory agency for your state of residency. Additionally, under the provisions of ERISA (Section 502(a) (1) (B) [29 U.S.C. 1132(a) (1) (B)]], you have the right to bring a civil action when all available levels of reviews, including the appeal process, have been completed. ERISA remedies may apply in those instances where the claims were not approved in whole or in part as the result of appeals under the Plan and you disagree with the outcome of such appeals.

## Out-of-Network Charges

If you or your dependents receive services from a non-network provider and that provider does not bill you or your dependents or does not collect the applicable deductible, copay or coinsurance amounts, the non-network charge will be the allowable amount determined by the claims administrator.

## Assignment of Coverage

Your benefit under the Plan belongs to you and generally may not be sold, assigned, transferred, pledged or garnished under most circumstances. The plan administrator may accept elections or make payments to someone who is legally authorized to conduct your affairs. This may be a relative, a court-appointed guardian or some other person.

Dental and vision benefits provided under the Plan may not be assigned, transferred or in any way made over to another party by you or your dependents. Nothing in the Plan will be construed to make the Plan or Oxy liable to any third party to whom you or your dependents may be liable for dental or vision care, treatment or services. For the Vision Plan, neither the vision policy nor any of the rights or obligations of VSP or the company may be assigned or transferred without the prior written consent of both VSP and the company, except as expressly authorized in the vision policy.

In addition, the Plan is required to comply with federal laws, such as IRS tax levies and court-issued Qualified Domestic Relations Orders (QDROs). The plan administrator will hold or pay your benefit as it finds appropriate in case of your bankruptcy or other assignment of your benefits under the Plan whether voluntary or involuntary.

However, the Plan may make dental and vision payments to physicians and other health care professionals or institutions who provide health care services or supplies to participants in the normal course of administration of the Plan. Payments to a state providing Medicaid benefits in accordance with ERISA Section 609 are allowed. Similarly, Oxy's subrogation and reimbursement rights are not limited by this provision.

## Recovery of Overpayment

If the claims administrator makes a benefit payment over the amount that you are entitled to under the Plan, the claims administrator has the right to:

- Require that the overpayment be returned on request; or
- Reduce any future benefit payment by the amount of the overpayment.

These rights do not affect any other right of overpayment recovery the claims administrator may have.

The Plan will have an equitable lien on the amount of any overpayment made to a provider on your behalf and such provider must hold any amounts in trust on behalf of the Plan to cover any other benefits payable to such provider or to reimburse the Plan. The Plan may enforce its equitable lien and constructive right to reimbursement under any remedy permitted by law.

## Incorrect Information, Fraud, Concealment or Error

The Plan has the right to seek repayment by whatever means permitted by law if due to an error (whether human or systems) or incorrect information (whether provided by fraud, misrepresentation or concealment):

- You or your dependents are provided coverage under the Plan;
- Continuation coverage is provided;
- Claims are paid;
- Liability for failure to enroll, provide continuation coverage, pay benefits or terminating coverage arises; or
- An overpayment or erroneous payment is made.

Likewise, a human or systems error will not deprive you or your dependents of coverage or impact the payment of benefits under the Plan to which you or your dependents are otherwise entitled.

Except as otherwise required by law, if you or your dependents fail to provide requested information, make a false statement, or furnish fraudulent or incorrect information, the Plan reserves the right to terminate your and your dependents' coverage under the Plan either retroactively or prospectively, seek repayment for any payments made on your or your dependents' behalf, and refuse to offer continuation coverage.

## Legal Action

You must exhaust all appeal levels and procedures before you initiate any litigation, arbitration or administrative proceeding regarding an alleged breach of the contract terms by the claims administrator or any matter within the scope of the appeals procedure.

If your claim for benefits is not approved in whole or in part, and you disagree with the outcome, you have the right to bring a civil action when **all available levels of reviews, including all appeal processes, have been completed** and for the Vision Plan, after the expiration of 60 days after the claim and any applicable documentation has been filed with VSP.



In addition, no legal action may be started after the later of:

- 180 days after receiving a written response to the last level of appeal; or
- Two years after the earliest date you sought services or benefits.

**For the Vision Plan**, you cannot bring legal action before exhausting your rights under the Vision Plan and/or before the expiration of 60 calendar days after the claim and any applicable documentation has been filed with VSP. You cannot bring such action after the expiration of any applicable statute of limitations, in accordance with the terms of the Vision Plan.

## Unclaimed Funds

In the event any reimbursement check issued under a program funded using Oxy's general assets remains uncashed after a period of time determined by the plan administrator, the check will be voided, and the funds returned applied to payment of current benefits under the applicable program. If you or your dependent subsequently request repayment, the plan administrator will make payment pursuant to the terms and conditions of the program in effect at the time the original claim was presented.

## Subrogation and Reimbursement for Third Party Claims

If you or your dependents are entitled to benefits under the Plan for a condition caused or possibly caused by a third party or for which a third party may be liable, as a condition to receiving such benefits, you and your dependents agree to reimburse the Plan in full and first priority from any amounts recovered from the third party. The Plan may require you or your dependents to sign a reimbursement agreement, and the Plan will be subrogated to all rights, however arising, of you and your dependents against the third party.

The Plan is subrogated to any payment from the third party without regard to whether such payment is characterized as recovery for pain and suffering, mental anguish, punitive damages or any other basis of recovery other than for medical or other welfare benefits provided by the Plan and regardless of whether the liability is reduced as a result of legal proceedings, arbitration, compromise settlement or otherwise.

The Plan's subrogation rights shall be a first priority claim against all third parties and the amount due to the Plan will be paid to the Plan before any amounts are paid to you or your dependents. If such amount is not payable immediately, such amount will be segregated and held in constructive trust for the Plan. The Plan may also recover its reasonable costs and attorneys' fees from any third party recovery.

The amount to which the Plan is subrogated will not be limited or reduced because a third party is liable only in part, the third party's resources are limited, due to application of the make whole or common fund doctrine, or for any other reason. To the extent the amount to which the Plan is subrogated or entitled to reimbursement is limited or reduced under state law, then the Plan will have the right to reimbursement from you or your dependents for the amount by which such rights are limited.

The Plan's right of subrogation will not exceed the amount of benefits paid, payable or likely to become payable under the Plan plus reasonable costs and attorneys' fees or the total amount of recovery from the third party. The plan administrator may enforce the Plan's subrogation rights in any manner it deems appropriate. You or your dependents may be required to execute a reimbursement agreement, assignment or other documents as requested by the plan administrator, must hold any amounts received in trust for the Plan and must notify the plan administrator if a third party may be liable for any condition treated under the Plan.

If a benefit program document contains subrogation provisions, those provisions will control to the extent such provisions are in compliance with the law and are drafted to permit the maximum allowable recovery. If the benefit program document does not address or those provisions are ambiguous with respect to an issue, then these provisions will apply and control to the extent necessary to resolve the issue or ambiguity.

## When Coverage Ends

This section explains how and why your coverage can be terminated, and how you may be able to continue coverage after it ends.

### When Employee Coverage Ends

Your coverage under the Plan ends on the first to occur of the following events:

- The Plan is discontinued;
- You voluntarily stop your coverage;
- Termination of your employment, except for dental coverage while you are receiving benefits under Oxy's Long-Term Disability Plan;
- The coverage, or coverage while on LTD, described in this SPD is terminated under the group contract;
- You are no longer eligible, as defined in [Your Eligibility](#) or [Eligibility While on LTD](#);
- If you continued coverage while on LTD, you stop being eligible for benefits under the LTD Plan; or
- You fail to make any required contribution.

The Plan coverage stops on the last day of the month in which you lose eligibility for the Dental and Vision Plans. FSA coverage ends on your termination date. You may have a right to continue your coverage as described in [Continuation of Coverage](#). You may not convert your coverage to an individual policy when you leave Oxy.

### FSA's

You **may not** be reimbursed for any health care or dependent care FSA expenses incurred **after** the date your participation ends. However, you may have a right to continue contributing to your Health Care FSA as described in [Continuation of Coverage](#).

You can continue to submit claims and be reimbursed for expenses incurred before you left Oxy. You can submit eligible *dependent care expenses* up to the **current balance** in your account. You may submit eligible *health care expenses* up to the **amount you elected to contribute for the plan year** as long as they were incurred before the end of your participation. All claims for reimbursement must be received no later than March 31 of the following plan year.

### When Dependent Coverage Ends

Your dependent's eligibility for coverage will end on the earliest of the following events:

- Dependent coverage is terminated under the Plan;
- A dependent becomes covered as an employee;
- A dependent no longer meets the Plan's definition of a dependent; or
- Your coverage terminates.

The Plan coverage stops on the last day of the month in which your dependent loses eligibility. You must notify the OxyLink Employee Service Center within 31 days of your dependent's change in eligibility status. Any applicable contribution change will take effect on the next available pay cycle. There will be no refund of contributions unless it is due to an Oxy administration error.

Your dependents may have a right to continue their coverage. See [Continuation of Coverage](#) or contact the OxyLink Employee Service Center for more information.

## Retirement

Generally, you and your dependents covered under the Plan may be eligible for retiree dental coverage if you are age 55 or older with at least 10 years of Oxy service. The special provisions described in [Continuation of Coverage](#) may apply if your employee coverage ends as the result of a reduction in work hours. Contact the OxyLink Employee Service Center for more information.

Retired employees and their dependents are not eligible for coverage under the Vision Plan. The Vision Plan coverage for you and your dependents stops on the last day of the month in which you retire. You and your dependents may have a right to continue your coverage as described in [Continuation of Coverage](#).

## Death

If you die in active employment, are not eligible for retiree coverage, and are covered under the Dental or Vision Plan, or you are an LTD Plan beneficiary covered under the Dental Plan, coverage for your dependents will continue until the end of the second month following the month in which you die. For example, if you die on March 20, coverage will continue through the following May 31. However, your surviving dependents may have a right to further continue their coverage under COBRA as described in [Continuation of Coverage](#). There is no conversion policy available for your surviving dependents.

If you die as an active employee but are eligible for retiree coverage under the Dental Plan, your spouse and your covered dependents are eligible to continue their coverage under the retiree dental plan as of the first of the third month following your date of death, as if you had retired on that date. If retiree dental coverage is elected, your spouse must pay the applicable retiree contribution. If dependent coverage (including spouse) is elected, coverage will continue for your dependents until the earliest occurrence of one of the following events:

- Dependent's coverage ends under the Plan;
- Your surviving spouse remarries;
- Eligibility for coverage under another group plan;
- Failure to meet the requirements for dependent coverage;
- Failure to pay any required contributions; or
- Your surviving spouse's death.

In addition, if you die as an active employee, retiree dental coverage can also be determined under the retiree medical and dental provision of the Notice and Severance Pay Plan. Retiree dental coverage is available to your surviving spouse and dependents as early as when you would otherwise have turned age 55 if you:

- Had at least 30 years of eligible service; or
- Were at least age 50 with five or more years of eligible service, with combined age and eligible service of 65 years or more at the time of death.

Contact the OxyLink Employee Service Center for more information.

## Continuation of Coverage

Your elected Plan coverage continues as long as you remain eligible and contributions are paid. In addition, coverage continues if your absence is **approved** by the company for:

- Short-term disability;
- Long-term disability;
- Leave of absence;
- Family and Medical Leave Act (FMLA); or
- Military leave.

### Short-Term Disability (STD)

If you are an Oxy employee enrolled in the Plan and you are absent from work because of [illness](#) or [injury](#), Plan coverage continues if you:

- Remain disabled;
- Receive payment under Oxy's Short-Term Disability (STD) Plan or similar company-sponsored plan; and
- Pay your required contribution.

If you do not return to active employment at the end of your benefits under STD, your eligibility for continued coverage under the Plan will end. See [When Coverage Ends](#).

### Long-Term Disability (LTD)

Eligibility and enrollment guidelines may differ for individuals who are receiving benefits under Oxy's Long-Term Disability Plan (LTD Plan beneficiaries) and their dependents. Receipt of LTD Plan benefits affects eligibility for coverage under the Dental Plan.

#### Eligibility While on LTD

You and your covered dependents, on the date you become an LTD Plan beneficiary, are eligible for coverage under the Dental Plan if you meet the requirements listed under [Your Eligibility](#).

Your covered dependents are described in [Dependent Eligibility](#).

#### Enrollment While on LTD

If you are covered by the Dental Plan when you become eligible for LTD Plan benefits, your coverage will automatically be continued as long as you are eligible to receive LTD benefits and you continue to make any required contributions on an after-tax basis.

You may waive coverage, but if you do, you may not reenroll under the Plan unless:

- You are enrolling during an Open Enrollment period; or
- You or your spouse has other coverage and loses eligibility for that coverage. As a result, you or your spouse may reenroll within 31 days of losing coverage. Proof of coverage loss is required.

You may elect not to cover your spouse if he or she is covered under another group plan. You may not be covered as both an LTD Plan beneficiary and a dependent spouse under Oxy's Plan. If your spouse has dependents as an Oxy employee and later leaves Oxy for any reason, you may enroll yourself and your dependents within 31 days of the loss of coverage.

## Contributions While on LTD

Generally, you will continue to be eligible for the Dental Plan if you receive benefits under the LTD Plan and make any required contributions. The Plan option and coverage level you select determines the amount of your contribution. If you became disabled on or after October 1, 1995, you make the same contributions as active employees, but on an after-tax basis.

Monthly billing for your coverage and payment processing will be administered by My Benefits Service Center on behalf of Oxy following approval for LTD.

## Approved Leaves of Absence and FMLA

If you are on an approved leave of absence, including an FMLA leave or leave under applicable state law, you may elect, for up to a maximum of six months, to:

- Continue coverage and contributions, if you are on a paid leave;
- Pay contributions on an after-tax basis, if you are on an unpaid leave;
- For the FSAs only, request to continue contributions on an after-tax basis or postpone your contributions until you return to work; or
- Discontinue your participation in the Plan on the day your leave begins. When you return:
  - **For dental and vision coverage:**
    - If you are on an FMLA or similar state law leave, automatic reinstatement of coverage is allowed; or
    - If you are on any other type of leave, you cannot reenroll until the next Open Enrollment period.
  - **For the FSAs**, the payroll system will automatically calculate the remaining annual election amount, the number of pay periods left in the year and adjust the per pay period deduction amount. If you *do not* wish to resume contributions or bring your account up-to-date, you must contact Payroll or your Human Resources representative upon your return.

If you do not continue contributions during your leave, claims may only be submitted for eligible expenses incurred through the date your leave starts.

For additional information regarding an FMLA leave of absence, refer to the [FMLA](#) policy and/or contact your Human Resources representative.

## During Military Leave

During a military leave under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), coverage under the Plan may continue as specified under law (USERRA rules). In the absence of any USERRA rules on length of coverage, coverage may not be continued beyond six months from your date of leave. You must make any required contributions. However, coverage is excluded for service-connected illnesses or injuries. Reenrollment will be permitted if you return to work and request reinstatement through the OxyLink Employee Service Center within 31 days (even if you elected to discontinue your coverage during your USERRA military leave).

You may contact your Human Resources representative or the OxyLink Employee Service Center with any questions regarding continued coverage under USERRA.

More information about the types of military service, the maximum length of military service, your deadline for returning to work, and other requirements for reemployment rights under USERRA is available online at [dol.gov/vets](http://dol.gov/vets).

## Under COBRA

Under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), you and your dependents have the right to continue group health plan coverage if it ends for the reasons under [Qualifying Events](#). If you pay the required premiums, you may continue participation in the Plan option in which you are enrolled at the time of your qualifying event.

### Special Rule for Health Care FSA

If your Health Care FSA eligibility ends because of a COBRA-qualifying event, COBRA coverage is available through the end of the plan year in which the qualifying event occurred. On the date of the qualifying event, you must have an unused balance in your Health Care FSA. The maximum reimbursement amount available for the remainder of the plan year is calculated by taking the annual contribution amount you elected minus the claims that were reimbursed before the date of the qualifying event. Log on to [payflex.com](http://payflex.com) to review your account and submit claims.

If you elect COBRA continuation, you may continue to incur eligible expenses as long as they are before the end of your participation under COBRA. Your participation under COBRA will end at the earlier of the following:

- You reach the end of your COBRA continuation period (end of plan year); or
- You fail to make the monthly required COBRA premium payment.

### Other Coverage Options

Instead of enrolling in COBRA coverage, there may be other coverage options for you and your family through:

- The Health Insurance Marketplace;
- Medicaid; or
- Other group health plan coverage options (such as a spouse's plan). You must enroll through a special enrollment period, generally within 30 days of losing coverage.

Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at [healthcare.gov](http://healthcare.gov).



#### Qualified Beneficiary

A qualified beneficiary includes you, your covered spouse and your covered dependent children at the time a coverage-ending event occurs. If you or your spouse gives birth to or adopts a child after the qualifying COBRA event, the child is also a qualified beneficiary. If you marry while continuing coverage under COBRA, your new spouse and any other dependents you add to your family are also considered qualified beneficiaries. New beneficiaries must be enrolled in the Plan within 31 days of the event.

## Qualifying Events

You and your qualified beneficiaries have a right to choose COBRA coverage if coverage is lost because of any of these qualifying events:

COVERAGE IS LOST BECAUSE...	CAN CONTINUE COVERAGE FOR...	FOR UP TO...	TAKE ACTION
<ul style="list-style-type: none"> <li>Your hours are reduced</li> <li>You go on certain leaves of absence</li> <li>You terminate employment for reasons other than gross misconduct</li> </ul>	<ul style="list-style-type: none"> <li>You</li> <li>Your spouse</li> <li>Your dependent children</li> </ul>	18 months	<p>You and your qualified beneficiaries are notified of the right to continue coverage. To continue coverage, enroll within 60 days of the later of the COBRA notification date or the date regular benefits end.</p>
<ul style="list-style-type: none"> <li>You die</li> <li>You become entitled to benefits under Medicare</li> </ul>	<ul style="list-style-type: none"> <li>Your spouse</li> <li>Your dependent children</li> </ul>	36 months	
<ul style="list-style-type: none"> <li>You divorce, legally separate or your marriage is annulled</li> </ul>	<ul style="list-style-type: none"> <li>Your ex-spouse</li> <li>Your dependent children</li> </ul>	36 months	<p>You or your qualified beneficiaries must notify OxyLink Employee Service Center within 60 days of the event by the approved method, or your dependents lose their right to COBRA coverage.</p>
<ul style="list-style-type: none"> <li>Your dependent child is no longer eligible for coverage under the Plan (for example, your child reaches the age limit)</li> </ul>	<ul style="list-style-type: none"> <li>Your dependent child</li> </ul>	36 months	<p>After receiving notice of the qualifying event from you, your qualified beneficiaries are notified of their right to continue coverage. To continue coverage, enroll within 60 days of the later of the COBRA notification date or the date regular benefits end.</p>

## Disability Extension

An 11-month extension of coverage may be available for all qualified beneficiaries if one of the qualified beneficiaries is determined by the Social Security Administration (SSA) to be disabled. The disability must start before the 60th day of COBRA coverage and last until the end of the 18-month period of COBRA coverage. To qualify for this disability extension, you must notify the COBRA administrator (PayFlex) and provide a copy of the SSA determination within 60 days after the date of the SSA disability determination and before the end of the original 18-month COBRA period. Notify the COBRA administrator within 30 days after the SSA's determination that the qualified beneficiary is no longer disabled.

## Second Qualifying Event

An extension of coverage is available to spouses and dependent children if a second qualifying event occurs during the first 18- or 29-month continuation period. You must notify the COBRA administrator (PayFlex) in writing within 60 days after a secondary qualifying event if you want to extend your COBRA coverage. COBRA coverage will not last beyond 36 months from the date of the original qualifying event.



## Enrolling in COBRA Coverage

COBRA coverage is provided on the same terms as active employees' coverage. When active employees' coverage changes, it also changes for COBRA coverage.

Each qualified beneficiary has an independent right to elect COBRA coverage. You can elect coverage for your spouse. You or your spouse can elect coverage for your children. You elect coverage by enrolling within 60 days from the date of the qualifying event—or the date you receive the form, if later.

You must pay your premiums for the first month of continuation coverage within 45 days of the date you elect COBRA. Make all future payments on the first day of each month (subject to a 30-day grace period) while coverage continues.

If you do not pay your premium within the initial 45-day period (30 days of the due date for future payments), your coverage will end retroactive to the last day for which timely payment was made. You will lose all continuation rights under the Plan.

## Cost of COBRA Coverage

Your cost for COBRA coverage is the full cost of coverage to the Plan—that is, the amount you pay for coverage plus the company's contribution to the cost—with a 2% administrative fee added. You pay 150% of the full premium cost for the additional 11 months of disability coverage.

Your cost will change if the cost of group coverage for the company's active employees' changes. Unlike active employees, you pay the cost of COBRA coverage with after-tax dollars. With after-tax contributions, you may lose some tax advantages of paying your benefits or eligible expenses through the Plan.

## When COBRA Coverage Ends

Continued coverage ends on the first of the following events:

- The end of the maximum COBRA continuation period;
- Failure to pay required premiums;
- Coverage under another group plan that does not restrict coverage for pre-existing conditions;
- Oxy no longer offers a group health plan;
- A qualified beneficiary is on extended coverage for up to 29 months due to disability and a final determination is made that the beneficiary is no longer disabled; or
- You or your dependents die.

When you or a family member on COBRA becomes enrolled in Medicare, continued Plan coverage is secondary to Medicare.

## Contact and Address Information

To protect your family's rights, you should keep the Plan informed in writing of any changes in your address and any changes in your marital status. You should also keep a copy, for your records, of any notices you provide. You may provide such notices to the OxyLink Employee Service Center via electronic mail to [oxylink@oxy.com](mailto:oxylink@oxy.com) or mail to:

4500 South 129<sup>th</sup> East Avenue  
Tulsa, Oklahoma 74134-5801

Plan materials are available on My HR on [oxy.net.oxy.com](http://oxy.net.oxy.com), on [OxyLink Online](#) or from the OxyLink Employee Service Center at **800-699-6903**.

If you have questions about COBRA, contact the OxyLink Employee Service Center. For more information about your rights under [ERISA](#), including COBRA, HIPAA and other laws affecting group health plans, contact the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) website at <https://www.dol.gov/agencies/ebsa> or call their toll-free number at **866-444-3272**. For more information about health insurance options available through a Health Insurance Marketplace, visit [healthcare.gov](https://healthcare.gov).

## Additional Information

### Administrative Information

Outlined below is some additional information about the Plan and those who have assumed responsibility for its operation.

<b>Plan Name</b>	Occidental Petroleum Corporation Welfare Plan, also known as the Plan or: <ul style="list-style-type: none"> <li>• For dental coverage, the Dental Plan;</li> <li>• For vision coverage, the Vision Plan; and</li> <li>• For pretax contributions and flexible spending accounts, the FSA Plan.</li> </ul>
<b>Plan Sponsor's Employer Identification Number</b>	95-4035997
<b>Plan Number</b>	591
<b>Plan Year Ends</b>	December 31
<b>Plan Administrative Services</b>	Administrative services contracts with Aetna Life Insurance Company, Vision Service Plan (VSP) Insurance Company and PayFlex
<b>Plan Administrator</b>	Occidental Petroleum Corporation Employee Benefits Committee 5 Greenway Plaza, Suite 110 Houston, TX 77046 713-215-7000
<b>Claims Administrators</b>	<p><b>For Dental:</b></p> <p>Aetna Life Insurance Company 151 Farmington Avenue Hartford, CT 06156</p> <p><b>For Vision:</b></p> <p>Vision Service Plan (VSP) Insurance Company 3333 Quality Drive Rancho Cordova, CA 95670</p> <p><b>For FSA:</b></p> <p>PayFlex Systems USA, Inc. 10802 Farnam Drive #100 Omaha, NE 68154</p>
<b>Plan Sponsor</b>	Occidental Petroleum Corporation 5 Greenway Plaza, Suite 110 Houston, TX 77046 713-215-7000

<b>Named Fiduciary</b>	<ul style="list-style-type: none"> <li>• Aetna Life Insurance Company for dental claims</li> <li>• Vision Service Plan (VSP) for vision claims</li> <li>• PayFlex for FSA claims</li> </ul>
<b>Plan Type</b>	An ERISA welfare plan
<b>Address for Legal Process</b>	Service for legal process related to the Plan may be made upon the plan administrator or claims administrators at the addresses listed above.
<b>Funding</b>	The dental benefits are not insured with Aetna or any of its affiliates. They are paid from employee contributions and OPC's general assets. The vision benefits are fully insured with VSP and paid for from employee contributions. The FSAs are funded with employee contributions and administered by PayFlex.

## Plan Continuation

Oxy expects and intends to continue the Plan but does not guarantee any specific level of benefits or the continuation of any benefits during any periods of active employment, inactive employment, disability or retirement. Benefits are provided solely at Oxy's discretion. Oxy reserves the right, at any time or for any reason, through an action of the Executive Vice President of Human Resources of Occidental Petroleum Corporation or the successor to that position, to suspend, withdraw, amend, modify or terminate the Plan (including altering the amount you must pay for any benefit), in whole or in part. In the case of material changes in this description of the Plan, such action will be evidenced by a written announcement to affected individuals.

## Discretionary Authority

The plan sponsor has designated two named fiduciaries under the Plan, who together have complete authority to review all denied claims for benefits under the Plan. The plan administrator has discretionary authority to determine who is eligible for coverage under the Plan and the claims administrators have discretionary authority to determine eligibility for benefits under the Plan. In exercising its fiduciary responsibilities, each named fiduciary shall have discretionary authority to determine whether and to what extent covered Plan participants are eligible for benefits, and to construe disputed or doubtful Plan terms. A named fiduciary shall be deemed to have properly exercised such authority unless it has abused its discretion hereunder by acting arbitrarily and capriciously.

The plan administrator is responsible for making reports and disclosures required by applicable laws and regulations.

## Plan Documents

This benefit plan description summarizes the main features of the Plan, and is not intended to amend, modify or expand the Plan provisions. In all cases, the provisions of the Plan document and any applicable contracts control the administration and operation of the Plan. If a conflict exists between a statement in this summary and the provisions of the Plan document or any applicable contracts, the Plan document will govern. You may request a copy of all the Plan documents by writing to the plan administrator at the address shown in [Additional Information](#). Copies of requested documents will be furnished within 30 days at a reasonable charge.

## No Implied Promises

By adopting and maintaining the Occidental Petroleum Corporation Welfare Plan for certain eligible employees, Oxy has not entered into an employment contract with any employee. Nothing contained in the Plan documents or in this summary gives any employee the right to be employed by Oxy or to interfere with Oxy's right to discharge any employee at any time. Similarly, the Plan does not give Oxy the right to require any employee to remain employed by Oxy or to interfere with the employee's right to terminate employment with Oxy at any time.

**Oral representations or promises will not be binding on the Plan. Participants and beneficiaries should not** rely on any oral description of the Plan because the written terms of the Plan document will always govern.

## Multiple Employers and Misstatement of Fact

You cannot be covered under the Plan multiple times because you are connected with more than one employer or because you can be covered as both an employee and a dependent.

If there is a misstatement of fact that affects your coverage under the Plan, the true facts will be investigated to determine the coverage that applies.

## Outcome of Covered Services and Supplies

The claims administrators and Oxy are not responsible for, and they do not make any guarantees concerning, the outcome of the covered services and supplies you receive.

## Your ERISA Rights

As a participant in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA), as follows:

### Receive Information About Your Plan and Benefits

- Examine, without charge, at the plan administrator's office and at other specified locations, all documents governing the Plan, including insurance contracts and a copy of the latest annual report (Form 5500 Series) that is filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain, upon written request to the plan administrator, copies of all documents governing the operation of the Plan, including insurance contracts and the latest annual report (Form 5500 Series), and an updated Summary Plan Description. The plan administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.
- Receive a copy of the procedures used by the Plan for determining a Qualified Medical Child Support Order (QMCSO).

### Continue Group Health Plan Coverage

You have the right to continue dental and vision coverage for yourself, spouse or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You and your dependents may have to pay for such coverage. Review this Summary Plan Description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

### Prudent Action by Plan Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries.

No one, including your employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

### Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain documents relating to the decision without charge and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the plan administrator to provide the materials and pay up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the plan administrator.

If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the status of a domestic relations order or a medical child support order, you may file suit in a federal court.

If it should happen that Plan fiduciaries misuse the Plan's money or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

## Help with Your Questions

If you have any questions about your Plan, you should contact the plan administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance with obtaining documents from the plan administrator, you should contact:

- The nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory; or
- The Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.



## Glossary

Following are definitions of the terms and phrases used throughout this document.

**Affiliate**—Any business entity that is more than 80% owned, directly or indirectly by OPC, or is in an affiliated service group with OPC, as defined under the Code.

**Affiliate provider**—Any optometrist, optician, ophthalmologist, or other licensed and qualified vision care provider who is not contracted as a VSP preferred provider but who has agreed to bill VSP directly for Plan benefits as described in this SPD.

**Allowable expense for coordination of benefits (COB)**—A health care service or expense, including coinsurance and copays and without reduction of any applicable deductible, that is covered at least in part by any of the health plans covering the person. When a health plan provides benefits in the form of services (for example an HMO), the reasonable cash value of each service will be considered an allowable expense and a benefit paid. An expense or service that is not covered by any of the health plans is not an allowable expense. Any expense that a health care provider by law or in accordance with a contractual agreement is prohibited from charging a covered person is not an allowable expense. The following are examples of expenses and services that are not allowable expenses:

- If a covered person is confined in a private hospital room, the difference between the cost of a semi-private room in the hospital and the private room is not an allowable expense. This does not apply if one of the health plans provides coverage for a private room.
- If a person is covered by two or more health plans that compute their benefit payments on the basis of reasonable or recognized charges, any amount in excess of the highest of the reasonable or recognized charges for a specific benefit is not an allowable expense.
- If a person is covered by two or more health plans that provide benefits or services on the basis of negotiated charges, an amount in excess of the highest of the negotiated charges is not an allowable expense.
- The amount a benefit is reduced or not reimbursed by the primary health plan because a covered person does not comply with the health plan provisions is not an allowable expense. Examples of these provisions are second surgical opinions, precertification of admissions and preferred provider arrangements.
- If all health plans are high deductible health plans and the person intends to contribute to an HSA, the deductible for the primary high deductible health plan is not an allowable expense, except for any health expense not subject to the deductible per the Code.

If a person is covered by one health plan that computes its benefit payments on the basis of reasonable or recognized charges and another health plan that provides its benefits or services on the basis of negotiated charges, the primary plan's payment arrangements will be the allowable expense for all the health plans. However, if the secondary plan has a negotiated fee or payment amount different from the primary plan and if the provider contract permits, that negotiated fee will be the allowable expense used by the secondary plan to determine benefits.

When a plan provides benefits in the form of services, the reasonable cash value of each service rendered is considered an allowable expense and a benefit paid.

**Age-related macular degeneration (AMD)**—Age-related macular degeneration (AMD) is a disease that destroys the clear, straight ahead central vision necessary for reading, driving, identifying faces and performing other daily tasks.

**Code**—The Internal Revenue Code of 1986, as amended.

**Course of treatment**—A planned program of one or more services or supplies to treat a dental condition. The condition must be diagnosed by the attending dentist as a result of an oral exam, and treatment may be given by one or more dentists. The course of treatment starts on the date a dentist first gives a service to correct or treat the dental condition.

**Dental provider**—The following entities legally qualified to furnish dental services or supplies:

- Any dentist;
- Group;
- Organization;
- Dental facility; or
- Other institution or person.

**Dentist**—A legally qualified dentist, or a physician licensed to do the dental work he or she performs.

**Diabetes**—There are two types of diabetes:

- **Type 1:** A disease in which the pancreas stops making insulin.
- **Type 2:** A disease in which the pancreas either makes too little insulin or cannot properly use the insulin it makes to convert blood glucose to energy.

**Diabetic macular edema**—Swelling of the retina in diabetes mellitus due to leaking of fluid from blood vessels within the macula.

**Diabetic retinopathy**—A weakening in the small blood vessels at the back of the eye.

**ERISA**—The Employee Retirement Income Security Act of 1974.

**Glaucoma**—A disease in which damage to the optic nerve leads to progressive, irreversible vision loss.

**Hospital**—An institution that:

- Is primarily engaged in providing, on its premises, inpatient medical, surgical and diagnostic services;
- Is supervised by a staff of physicians;
- Provides 24-hour-a-day R.N. service;
- Charges patients for its services; and
- Is operating in accordance with the laws of the jurisdiction in which it is located; or
- Does not meet all of the requirements above, but does meet the requirements of the jurisdiction in which it operates for licensing as a hospital and is accredited as a hospital by the Joint Commission on the Accreditation of Healthcare Organizations.

In no event does hospital include a convalescent nursing home or any institution or part of one that is used principally as a convalescent facility, rest facility, nursing facility, facility for the aged, extended care facility, intermediate care facility, skilled nursing facility, hospice, rehabilitative hospital, or facility primarily for rehabilitative or custodial services.

**Illness**—A pathological condition of the body that presents a group of clinical signs and symptoms and laboratory findings peculiar to it and that sets the condition apart as an abnormal entity differing from other normal or pathological body states.

**Injury**—An accidental bodily injury that is the sole and direct result of:

- An unexpected or reasonably unforeseen occurrence or event; or
- The reasonable unforeseeable consequences of a voluntary act by the person.

Such occurrence, act or event must be definite as to time and place.

**Jaw joint disorder**—This is:

- A temporomandibular joint (TMJ) dysfunction or any similar disorder of the jaw joint;
- A myofascial pain dysfunction (MPD); or
- Any similar disorder in the relationship between the jaw joint and the related muscles and nerves.

**Medically necessary**—Health care, dental or vision services, and supplies or prescription drugs that a physician, other health care provider, dental provider or vision provider, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that provision of the service, supply or prescription drug is:

- In accordance with generally accepted standards of medical or dental practice;
- Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease;
- Not primarily for the convenience of the patient, physician, other health care or dental provider; and
- Not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.

For these purposes “generally accepted standards of medical or dental practice” means standards that are based on credible scientific evidence published in peer-reviewed literature generally recognized by the relevant medical or dental community, or otherwise consistent with physician or dental specialty society recommendations and the views of physicians, dentists or vision providers practicing in relevant clinical areas and any other relevant factors.

**Negotiated fee (charge or rate)**—The maximum charge a network provider has agreed to make for any service or supply for the purpose of benefits under the Plan.

**Network provider**—A health care provider who belongs to the claims administrator’s network and has contracted to furnish services or supplies for a negotiated charge.

**Network services or supplies**—Health care service or supply that is furnished by a network provider.

**Non-occupational illness**—An illness that does not arise out of (or in the course of) any work for pay or profit, and result in any way from an illness that does.

An illness will be considered non-occupational regardless of its cause if proof is provided that the person:

- Is covered under any type of workers’ compensation law; and
- Is not covered for that illness under such law.

**Non-occupational injury**—An accidental bodily injury that does not arise out of (or in the course of) any work for pay or profit, and result in any way from an injury that does.

**Non-network care (out-of-network care)**—A health care service or supply provided by a non-network provider (one who does not belong to the claims administrator’s network).

**Non-network provider**—A health care provider who does not belong to the claims administrator’s network and has not contracted with the claims administrator to furnish services or supplies at a negotiated fee.

**OPC**—Occidental Petroleum Corporation, a Delaware corporation.

**Open access provider (non-network provider)**—Any optometrist, optician, ophthalmologist or other licensed and qualified vision care provider who has not contracted with VSP to provide vision care services or materials for the VSP network.

**Open Enrollment**—The period of time during which you must make an election to participate for the next plan year.

**Orthodontic treatment**—Any medical or dental service or supply that is furnished to prevent or diagnose or correct a misalignment (whether or not for the purpose of relieving pain):

- Of the teeth;
- Of the bite; or
- Of the jaws or jaw joint relationship.

The following are not considered orthodontic treatment:

- The installation of a space maintainer; and
- A surgical procedure to correct malocclusion.

**Oxy**—Occidental Petroleum Corporation or an affiliated company.

**Plan administrator**—Occidental Petroleum Corporation Employee Benefits Committee.

**Physician**—A duly licensed member of a medical profession who:

- Has an M.D. or D.O. degree;
- Is properly licensed or certified to provide medical care under the laws of the jurisdiction where the individual practices; and
- Provides medical services that are within the scope of his or her license or certificate.

This also includes a health professional who:

- Is properly licensed or certified to provide medical care under the laws of the jurisdiction where he or she practices;
- Provides medical services that are within the scope of his or her license or certificate;
- Under applicable insurance law is considered a “physician” for purposes of this coverage;
- Has the medical training and clinical expertise suitable to treat your condition;
- Specializes in psychiatry, if your illness or injury is caused, to any extent, by alcohol abuse, substance abuse or a mental disorder; and
- Is not you or related to you.

**Plan**—The Occidental Petroleum Corporation Welfare Plan. Unless the context otherwise requires in this SPD, the Plan means:

- Dental benefits (also called the Dental Plan);
- Vision benefits (also called the Vision Plan); and
- Pretax contributions and flexible spending accounts (also called the FSA Plan).

**Precertification**—A review of inpatient admissions and other care to determine whether the requested care is covered under your Plan. This review should take place before the admission and before the care is provided.

**Recognized charge** (also referred to as reasonable and customary charge)—For the Dental Plan, the amount of a non-network provider’s charge that is eligible for coverage. You are responsible for all amounts above the recognized charge. The recognized charge may be less than the provider’s full charge.

Your Dental Plan's recognized charge applies to all non-network covered expenses. In all cases, the recognized charge is determined based on the geographic area where you receive the service or supply.

Except as otherwise specified below, the recognized charge for each service or supply is the lesser of what the provider bills and:

- For dental expenses, the recognized charge for a service or supply is the lesser of:
  - What the provider bills or submits for that service or supply; and
  - The 80th percentile of the prevailing charge rate.

Aetna has the right to apply Aetna reimbursement policies. Those policies may further reduce the recognized charge. These policies take into account factors such as:

- The duration and complexity of a service;
- When multiple procedures are billed at the same time, whether additional overhead is required;
- Whether an assistant surgeon is necessary for the service;
- If follow-up care is included;
- Whether other characteristics modify or make a particular service unique;
- When a charge includes more than one claim line, whether any services described by a claim line are part of or incidental to the primary service provided; and
- The educational level, licensure or length of training of the provider.

Aetna reimbursement policies are based on Aetna's review of:

- The Centers for Medicare and Medicaid Services' (CMS) National Correct Coding Initiative (NCCI) and other external materials that say what billing and coding practices are and are not appropriate;
- Generally accepted standards of medical and dental practice; and
- The views of physicians and dentists practicing in the relevant clinical areas.

Aetna uses commercial software to administer some of these policies. Some policies are different for professional services than for facility services.

For this definition, geographic area and prevailing charge rates are as follows:

- **Geographic area**—The area made up of the first three digits of the U.S. Postal Service zip code. If Aetna determines they need more data for a particular service or supply, Aetna may base rates on a wider geographic area such as an entire state.
- **Prevailing charge rates**—The percentile value reported in a database prepared by FAIR Health, a nonprofit company. FAIR Health changes these rates periodically. Aetna updates its systems with these changes within 180 days after receiving them from FAIR Health. If the FAIR Health database becomes unavailable, Aetna has the right to substitute an alternative database that Aetna believes is comparable.

**Rubeosis**—Abnormal blood vessel growth on the iris and the structures in the front of the eye.

**Special ophthalmological service**—Medical eye care procedure for the investigation and management of ocular disorders associated with diabetic eye disease, [glaucoma](#) and/or [AMD](#).

**VSP preferred provider**—An optometrist or ophthalmologist who:

- Is licensed and qualified to practice vision care and/or provide vision care materials; and
- Has contracted with VSP to provide benefits on behalf of VSP participants.



