OXY Benefits

Summary Plan Description

MEDICAL PLAN
OXY MEDICARE ADVANTAGE PPO

Aetna's National Medicare Advantage Network

2019

your health.
your life.
your future.

Oxy Benefits
Medicare Advantage PPO Plan
Summary Plan Description

Effective January 1, 2019

CONTENTS

Your Retiree Medical Plans

The Oxy Retiree Medical Program is comprised of two separate plans:

Oxy Non-Medicare-Eligible Plan *(includes retirees who are NOT eligible for the Oxy Medicare Advantage PPO Plan)* Described in a separate SPD	The medical option available is the Occidental Petroleum Corporation Retiree Medical Plan (i.e., Oxy Retiree Medical Plan, and, in some areas, regional HMO options). You are eligible for coverage under this plan if you and your covered dependents: • Are NOT eligible for Medicare (or have been deemed not eligible for the Oxy Medicare Advantage PPO Plan) and • Meet the eligibility requirements outlined in the SPD for this plan. If you are eligible for Medicare, but an eligible dependent is not Medicare-eligible, the dependent who is not Medicare-eligible may be covered under this plan.
Oxy Medicare-Eligible Plan Described in this SPD	The medical option available under this Plan is the Oxy Medicare Advantage PPO Plan—also known as the Aetna Medicare℠ Plan (PPO) with extended service area (ESA). The Plan also includes Medicare Part D expanded prescription drug coverage. You are eligible for coverage under this Plan if, due to age or disability, you or any of your covered dependents: • Are eligible for Medicare, and • Meet the eligibility requirements outlined in this SPD.

The **Oxy Medicare-Eligible Plan** is described in this Summary Plan Description (SPD).

Oxy reserves the right, at any time or for any reason, to suspend, withdraw, amend, modify or terminate the Oxy Retiree Medical Plan and/or the Oxy Medicare Advantage PPO Plan (including the amount you must pay for any benefit), in whole or in part.

Medical Plan Eligibility

For updates to this information, go to OxyLink at **oxylink.oxy.com**

Who's Eligible	Medicare-eligible retirees and Medicare-eligible covered dependents who are eligible for retiree medical coverage through Oxy and the Oxy Medicare Advantage PPO Plan (also referred to as the Medicare Advantage PPO Plan).
Integration with Medicare	If you are eligible to participate in the Medicare Advantage PPO Plan, you are covered by Medicare, but your benefits are provided under the Medicare Advantage PPO Plan.
Summary of Benefits	The Summary of Benefits and Schedule of Cost Sharing provided by Aetna, along with the Evidence of Coverage (EOC), provide information about what benefits are covered under the Medicare Advantage PPO Plan and what costs you share.
Additional Information	Additional contact information for assistance with claims, billing or member card services is provided in Chapter 2 of the EOC or you can call the Aetna Medicare Service Center at **866-539-6750.**

About This SPD

This booklet describes benefits for retirees and their covered dependents who are eligible for coverage under the Medicare Advantage PPO Plan as defined in the *Eligibility and Enrollment* section. This information along with the 2019 Evidence of Coverage (EOC), Summary of Benefits and Schedule of Cost Sharing provided by Aetna Life Insurance Company (Aetna) serves as your Summary Plan Description (SPD). This Medicare Advantage PPO Plan is administered and insured by Aetna, and the benefits described in this booklet are paid solely by Aetna or its affiliates. **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, 2019. Refer to future Summary of Material Modifications (SMMs) for any material changes to the Plan made after the date of this document.

Benefits at a Glance—Oxy Medicare Advantage PPO Plan

The chart below shows the copays, coinsurance and out-of-pocket maximums you pay under the Oxy Medicare Advantage PPO Plan, based on the option for which you are eligible, as shown below. In general, benefits are based on the Medicare-approved amount, which is the amount Medicare sets for a service or supply. More coverage details for specific services and supplies are included in Evidence of Coverage (EOC) documents for the three options. Not all PPO plans are available in all areas.

All amounts shown are what **you pay** for network and non-network providers, unless otherwise noted.

	OXY PPO WITH RX	OXY PRE-84 PPO WITH RX	INDSPEC PPO WITH RX
Eligible Group For further details, refer to the *Eligibility and Enrollment* Section	Certain hourly and salaried, bargained and non-bargained, retirees who retired on or after January 1, 1984	Certain hourly and salaried retirees who retired prior to January 1, 1984	Certain non-bargained INDSPEC retirees previously enrolled in Security Blue and bargained INDSPEC retirees
ANNUAL DEDUCTIBLE			
	None		
OUT-OF-POCKET (OOP) MAXIMUM			
Individual	$2,000	$2,000	$3,400
	When your share of covered expenses reaches the OOP maximum, covered expenses for the remainder of the calendar year are paid at 100%, except for hearing aids, vision care and Medicare prescription drug expenses.		
PREVENTIVE CARE			
Wellness exams, certain routine physical examinations, and Medicare-covered immunizations *Refer to the Evidence of Coverage (EOC) for details on covered preventive services*	$0 copay	$0 copay	$0 copay
OFFICE VISITS			
Primary Care Physician	$30 copay	$10 copay	$10 copay
Specialist	$40 copay	$15 copay	$15 copay
DIAGNOSTIC PROCEDURES			
Outpatient Diagnostic X-rays, Lab and Testing	$40 copay	$15 copay	$0 copay
Outpatient Complex Imaging	$150 copay	$100 copay	$0 copay

	OXY PPO WITH RX	OXY PRE-84 PPO WITH RX	INDSPEC PPO WITH RX
EMERGENCY CARE			
Emergency Care Worldwide, waived if admitted	$100 copay	$75 copay	$50 copay
Urgent Care Worldwide	$50 copay	$35 copay	$40 copay
Ambulance	$40 copay	$10 copay	$25 copay
Observation Care	Your cost share for Observation Care is based on the services you receive.		
HOSPITAL/SURGICAL CENTER			
Inpatient	$120 copay per stay	$120 copay per stay	$0 copay
Outpatient Surgery	$100 copay	$100 copay	$0 copay
Blood	All components of blood are covered beginning with the first pint.		
MENTAL HEALTH AND SUBSTANCE ABUSE TREATMENT			
Inpatient	$120 copay per stay	$120 copay per stay	$0 copay
Outpatient	$40 copay	$15 copay	$15 copay
OTHER SERVICES			
Skilled Nursing Facility Up to 100 days per Medicare benefit period*	• Days 1 – 20: $0 copay per day • Days 21 – 100: $50 copay per day	• Days 1 – 20: $0 copay per day • Days 21 – 100: $75 copay per day	$0 copay
Home Health Agency Care	$0 copay	$0 copay	$0 copay
Hospice Care	Covered by original Medicare at a Medicare-certified hospital.		
Outpatient Rehabilitation Physical, Occupational and Speech therapy	$40 copay	$15 copay	$15 copay
Cardiac Rehabilitation	$40 copay	$15 copay	$0 copay
Pulmonary Rehabilitation	$30 copay	$15 copay	$0 copay
Radiation Therapy	$40 copay	$15 copay	$0 copay
Chiropractic Care Limited to original Medicare covered services for manipulation of the spine	$20 copay	$10 copay	$15 copay
Durable Medical Equipment and Prosthetic Devices	20% coinsurance	20% coinsurance	15% coinsurance

* A benefit period begins the day you go into a hospital or skilled nursing facility. The benefit period ends when you haven't received any inpatient hospital care or skilled care in a skilled nursing facility for 60 days in a row. If you go into a hospital or skilled nursing facility after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods.

	OXY PPO WITH RX	OXY PRE-84 PPO WITH RX	INDSPEC PPO WITH RX
OTHER SERVICES (CONTINUED)			
Podiatry Services Limited to original Medicare covered benefits only	$40 copay	$10 copay	$15 copay
Diabetic Supplies Medicare-covered supplies including supplies to monitor blood glucose	$0 copay	$0 copay	$0 copay
Diabetic Eye Exams	$0 copay	$0 copay	$0 copay
Outpatient Dialysis Treatments	$30 copay	$15 copay	$0 copay
Medicare Part B Prescription Drugs	$50 copay	$50 copay	$25 copay
Medicare-Covered Dental Non-routine care covered by Medicare	$40 copay	$15 copay	$15 copay
ADDITIONAL NON-MEDICARE COVERED SERVICES			
Vision Eyewear Reimbursement	NA	NA	Up to $100 reimbursed every 12 months
Meals	Covers up to 14 meals following an inpatient stay.		
Hearing Aid Reimbursement	Reimburse up to $2,500 once every three years	Reimburse up to $2,500 once every three years	Reimburse up to $1,000 once every 36 months
Fitness Benefit	Silver Sneakers		
Resources for Living	Covers service that provides help locating resources for everyday needs		
Teladoc	Telehealth or Telemedicine – Primary Care Physician copay for each virtual visit		
Transportation Non-emergency	24 one-way trips with 60 miles allowed per trip		
Acupuncture	$40 copay	$15 copay	$15 copay
Enhanced Chiropractic Services Provided by a licensed chiropractor	$40 copay	$15 copay	NA
Non-Medicare Covered Foot Orthotics	$40 copay	$15 copay	NA
Routine Podiatry	$40 copay	$10 copay	NA
Private Duty Nursing	$0 copay	$0 copay	NA

PRESCRIPTION DRUG BENEFITS			
Prescription Drug Network and Formulary	• Network: Your Medicare Part D plan is associated with pharmacies in the P1 network. – *Standard retail pharmacy* is a network pharmacy that has a contract with Aetna to provide your covered prescription drugs. – *Preferred retail pharmacy* is also a network pharmacy contracted with Aetna to provide lower cost sharing for some prescription drugs. – To find a network pharmacy, visit **Oxy.aetnamedicare.com** • Formulary: Open 2 Plus prescription drug list You must use network pharmacies to receive Plan benefits except in limited, non-routine circumstances as defined in the Evidence of Coverage (EOC). In these situations, you are limited to a 30-day supply. Quantity limits and restrictions may apply.		
Annual Deductible	None		
	OXY PPO WITH RX	**OXY PRE-84 PPO WITH RX**	**INDSPEC PPO WITH RX**
Out-of-Pocket (OOP) Drug Limit	$1,500 per person You pay $0 once you reach the OOP maximum or $5,100 in true out-of-pocket costs, whichever is reached first.	$1,500 per person	No limit
Initial Coverage Limit (ICL) and Coverage Gap	$3,820 per person	$3,820 per person	$3,820 per person
	You enter the coverage gap after reaching the ICL until you reach $5,100 in true out-of-pocket prescription drug expenses. Oxy provides additional coverage during the coverage gap stage for covered drugs. In general, this means you continue to pay the same amount for covered drugs throughout the coverage gap of the Plan as you paid in the initial coverage stage.		
Catastrophic Coverage After you reach $5,100 in true out-of-pocket costs	$0 copay	$0 copay	Greater of: • 5% of drug cost, or • $3.40 for a generic or drug treated like a generic, or • $8.50 for all other drugs

	OXY PPO WITH RX	OXY PRE-84 PPO WITH RX	INDSPEC PPO WITH RX
PRESCRIPTION DRUG BENEFITS			
Tier 1 – Generic Drugs			
• Standard retail up to 30-day supply	$10 copay	$10 copay	$10 copay
• Preferred retail up to 30-day supply	$9 copay	$9 copay	$9 copay
• Standard retail/mail order up to 90-day supply	$30 copay	$30 copay	$30 copay
• Preferred retail up to 90-day supply	$27 copay	$27 copay	$27 copay
• Preferred mail order up to a 90-day supply	$20 copay	$20 copay	$25 copay
Tier 2 – Preferred Brand Drugs			
• Standard retail up to 30-day supply	25% ($10 min, $50 max)	25% ($10 min, $50 max)	$10 copay
• Preferred retail up to 30-day supply	25% ($10 min, $50 max)	25% ($10 min, $50 max)	$10 copay
• Standard retail/mail order up to 90-day supply	25% ($30 min, $150 max)	25% ($30 min, $150 max)	$30 copay
• Preferred retail up to 90-day supply	25% ($30 min, $150 max)	25% ($30 min, $150 max)	$30 copay
• Preferred mail order up to a 90-day supply	25% ($20 min, $100 max)	25% ($20 min, $100 max)	$25 copay
Tier 3 – Non-Preferred Brand Drugs			
• Standard retail up to 30-day supply	25% ($25 min, $100 max)	25% ($25 min, $100 max)	$40 copay
• Preferred retail up to 30-day supply	25% ($25 min, $100 max)	25% ($25 min, $100 max)	$40 copay
• Standard retail/mail order up to 90-day supply	25% ($75 min, $300 max)	25% ($75 min, $300 max)	$120 copay
• Preferred retail up to 90-day supply	25% ($75 min, $300 max)	25% ($75 min, $300 max)	$120 copay
• Preferred mail order up to a 90-day supply	25% ($50 min, $200 max)	25% ($50 min, $200 max)	$100 copay
Tier 4 – Specialty Drugs Includes high-cost, unique generic and brand drugs			
• Standard retail up to 30-day supply	25% ($25 min, $100 max)	25% ($25 min, $100 max)	$40 copay
• Preferred retail up to 30-day supply	25% ($25 min, $100 max)	25% ($25 min, $100 max)	$40 copay
• Standard retail/mail order up to 90-day supply	25% ($75 min, $300 max)	25% ($75 min, $300 max)	Limited to one-month supply
• Preferred retail up to 90-day supply	25% ($75 min, $300 max)	25% ($75 min, $300 max)	Limited to one-month supply
• Preferred mail order up to a 90-day supply	25% ($50 min, $200 max)	25% ($50 min, $200 max)	Limited to one-month supply

	OXY PPO WITH RX	OXY PRE-84 PPO WITH RX	INDSPEC PPO WITH RX
PRESCRIPTION DRUG BENEFITS			
Additional Features • Precertification • Step-therapy • Non-Medicare Part D drugs	Precertification and step-therapy rules apply. Additional non-Medicare Part D drugs may be covered, such as for anorexia, weight loss, weight gain and treatment for sexual or erectile dysfunction. However, the cost of these drugs does not count toward qualifying for catastrophic coverage or **Extra Help** from Medicare to pay for prescriptions. See *For Oxy PPO and Pre-1984 Plans: Your Plan Includes Supplemental Coverage (Non-Part D Drug Rider)* for more information.		Precertification and step-therapy rules apply. Non-Medicare Part D drugs are **not** covered.

You must continue to pay your Part B premium.

The formulary, pharmacy network and/or provider network may change at any time. You will receive notice when necessary.

If you reside in a long-term care facility, your cost share is the same as at a retail pharmacy and you may receive up to a 31-day supply.

Members who get **Extra Help** do not need to fill prescriptions at preferred network pharmacies to get Low Income Subsidy (LIS) copays.

You can find an updated pharmacy directory at **oxy.aetna.medicare.com** under *Prescription Drugs—Find a Pharmacy*. To find a network retail pharmacy close to you:

1. Select *Find a Network Pharmacy*
2. Click on *Search by Location.*
3. For Type, select *Retail Pharmacy Locations.*

You may also search by zip code or by city; then *Select a Plan (*Medicare Group Part D 2019 P1 Network). Click on *Preferred* or *Standard* to view the list of available pharmacies. Using a Preferred pharmacy may save you money on some drugs; however, you can go to any of the pharmacies on either list. You may also call the Aetna Medicare Service Center at 866-539-6750 for help in finding a network pharmacy.

Specialty pharmacies fill high-cost specialty drugs that require special handling. Although specialty pharmacies may deliver covered medicines through the mail, they are not considered mail-order pharmacies. As a result, most specialty drugs are not available at the mail-order cost share.

For mail-order, you can get prescription drugs shipped to your home through the network mail order delivery program. Typically, mail-order drugs arrive within 7-10 days. You can call 1-888-792-3862, (For TTY/TDD assistance, call 711) 24 hours a day, seven days a week, if you do not receive your mail-order drugs within this timeframe. Members may have the option to sign-up for automated mail-order delivery.

Aetna's retiree pharmacy coverage under this Plan is an enhanced Part D Employer Group Waiver Plan that is offered as a single integrated product. The enhanced Part D plan consists of two components: basic Medicare Part D benefits and supplemental benefits. Basic Medicare Part D benefits are offered by Aetna based on the contract Aetna has with CMS. Aetna receives monthly payments from CMS to pay for basic Part D benefits. Supplemental benefits are non-Medicare benefits that provide enhanced coverage beyond basic Part D. Supplemental benefits are paid for by plan sponsors or members and may include benefits for non-Part D drugs.

Aetna reports claim information to CMS according to the source of applicable payment (Medicare Part D, plan sponsor or member).

Drugs Not Covered by Medicare

There are three general rules about drugs that Medicare drug plans will not cover under Part D. This Plan cannot:

- Cover a drug that would be covered under Medicare Part A or Part B.
- Cover a drug purchased outside the United States and its territories.
- Generally, cover drugs prescribed for "off label" use, (any use of the drug other than indicated on a drug's label as approved by the Food and Drug Administration) unless supported by criteria included in certain reference books like the American Hospital Formulary Service Drug Information, the DRUGDEX Information System and the USPDI or its successor.

Additionally, by law, the following categories of drugs are not normally covered by a Medicare prescription drug plan unless the Plan offers enhanced drug coverage for which an additional premium may be charged. These drugs are not considered Part D drugs and may be referred to as "exclusions" or "non-Part D drugs." These drugs include:

- Drugs used for the treatment of weight loss, weight gain or anorexia
- Drugs used for cosmetic purposes or to promote hair growth
- Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations
- Outpatient drugs that the manufacturer seeks to require that associated tests or monitoring services be purchased exclusively from the manufacturer as a condition of sale
- Drugs used to promote fertility
- Drugs used to relieve the symptoms of cough and colds
- Non-prescription drugs, also called over-the-counter (OTC) drugs
- Drugs when used for the treatment of sexual or erectile dysfunction

For Oxy PPO and Pre-1984 Plans: Your Plan Includes Supplemental Coverage (Non-Part D Drug Rider)

Your Plan includes a Supplemental Benefit Prescription Drug Rider. Certain types of drugs or categories of drugs are not normally covered by Medicare prescription drug plans. These drugs are not considered Part D drugs and may be referred to as "exclusions" or "non-Part D drugs."

This Plan offers additional coverage for some prescription drugs not normally covered. The amount paid when filling a prescription for these drugs does not count towards qualifying for catastrophic coverage. For those receiving **Extra Help** from Medicare to pay for prescriptions, the **Extra Help** will not pay for these drugs.

Non-Part D drugs covered under the Supplemental Benefit Prescription Drug Rider are:

- Agents when used for anorexia, weight loss or weight gain
- Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations
- Agents when used for the treatment of sexual or erectile dysfunction (ED)
- Agents when used for the symptomatic relief of cough and colds
- Agents used to promote fertility
- Agents used for cosmetic purposes or hair growth

Below is a list of non-Part D drugs that are not covered under the Supplemental Benefit Prescription Drug Rider:

- Non-prescription drugs, also called over-the-counter (OTC) drugs
- Outpatient drugs for which the manufacturer requires associated tests or monitoring services be purchased only from the manufacturer as a condition of sale

Non-Part D drugs covered under the rider can be purchased at the appropriate Plan copay. Copays and other costs for these prescription drugs will not apply toward the deductible, initial coverage limit or true out-of-pocket threshold. Some drugs may require prior authorization before they are covered under the Plan. The physician can call Aetna for prior authorization, toll free, at **800-414-2386**.

You can call Member Services at the number on the back of your Aetna Medicare member ID card if you have questions.

Managing Your Benefits

For Plan information and forms, go to **Oxy.aetnamedicare.com**. The Aetna Medicare Service Center's customer service representatives can help answer your benefit questions. In addition, the Aetna and the OxyLink website 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	
OxyLink Employee Service Center 4500 South 129th East Avenue Tulsa, OK 74134-5801	For questions about retiree medical eligibility or other Oxy Retiree Medical Plans: • Call **800-699-6903.** Outside the U.S.: **918-610-1990** Monday through Friday (except holidays) 8 a.m. to 4:30 p.m. CT • Email questions to **oxylink@oxy.com** • Visit the website: **oxylink.oxy.com**
Aetna P.O. Box 14088 Lexington, KY 40512-4088	For questions about the Oxy Medicare Advantage PPO Plan: • Call Aetna Medicare Service Center: **866-539-6750**; or • Go to **Oxy.aetnamedicare.com**

Eligibility and Enrollment

Eligibility

Generally, you and your covered dependents on record at the time of your Oxy retirement date are eligible to participate if you:

- Were a regular, full-time employee of Occidental Petroleum Corporation (OPC) or an affiliated company (Oxy) or, effective March 1, 2018, a part-time non-represented employee approved for the Phased Retirement Program, on a U.S. dollar payroll (temporary employees and interns are not eligible to participate) and:
  - Were designated as eligible to participate by your employer or through your collective bargaining agreement, and did not participate in a similar type of employer-sponsored plan.
  - Were at least age 55 with 10 or more years of regular, full-time Oxy service when you left Oxy employment (other rules may apply to collective bargaining groups, grandfathered groups or sold or closed locations).

  You were considered a full-time employee if you were regularly scheduled to work at least 30 hours per week. For this purpose, "affiliated company" means any company in which 80 percent or more of the equity interest is owned by Occidental Petroleum Corporation.
- Are not eligible for retiree coverage under another group medical plan as a result of credit for Oxy service.
- Were enrolled in an Oxy Medical Plan, including regionally available options, e.g., a Health Maintenance Organization (HMO) option, the day before your retirement, except as described below:
  - If you were covered under your spouse's medical plan or any other medical plan immediately before retirement from Oxy, you are eligible for coverage under this Medicare Advantage PPO Plan when you retire or later if you lose coverage under the other plan, as long as you elect coverage within 31 days of the event. Proof of prior medical coverage or loss of creditable coverage is required.

If you were part of a collective bargaining group, your eligibility to participate is generally described above.

Service credit for prior employer service following a merger, acquisition or joint venture may have been granted as part of the transaction. Credit while on Long-Term Disability may apply. Contact OxyLink Employee Service Center for more information.

In addition to being eligible for the Plan, each participant must meet the following criteria *to enroll* in the Plan:

- Be eligible for and enrolled in Medicare Parts A and Part B; and
- Not be independently enrolled in an individual Medicare Part C (i.e., Medicare Advantage), Medicare Part D or similar plan.

Special retiree medical eligibility provisions will apply if you receive severance benefits under Option A of Oxy's **Notice and Severance Pay Plan**, or similar arrangement with Oxy that provides for such eligibility.

The following table provides a breakout of each group currently covered under the Oxy Medicare Advantage PPO Plan. The eligible groups are subject to change from time to time at Oxy's discretion.

GROUP	ELIGIBILITY DESCRIPTION	PLAN MAPPING
Beaumont - Bargaining	Certain Beaumont retirees covered under the non-bargaining salaried retiree plan, Oxy Retiree Medical Plan	Oxy PPO with Rx
Chicago – Bargaining	Chicago retirees	Oxy PPO with Rx
Cincinnati – Bargaining	Certain Cincinnati retirees covered under the non-bargaining salaried retiree plan, Oxy Retiree Medical Plan	Oxy PPO with Rx
IFPTE Niagara – Bargaining	IFPTE Niagara retirees	Oxy PPO with Rx
INDSPEC – Bargaining and Non-Bargaining	INDSPEC salaried retirees previously enrolled in Security Blue and eligible INDSPEC bargained retirees	INDSPEC PPO with Rx
Jersey City – Bargaining	Certain Jersey City retirees covered under the non-bargaining salaried retiree plan, Oxy Retiree Medical Plan	Oxy PPO with Rx
Louisville – Bargaining	Louisville retirees	Oxy PPO with Rx
Ludington – Bargaining	Ludington retirees	Oxy PPO with Rx
Niagara – Bargaining	Bargaining Niagara retirees retired on or after October 1, 2007	Oxy PPO with Rx
Salaried – Non-Bargaining	Salaried retirees who retired prior to January 1, 1984	Oxy Pre-84 PPO with Rx
	Salaried retirees who retired on or after January 1, 1984	Oxy PPO with Rx
THUMS Non-Bargaining	THUMS retirees who are covered under the non-bargaining salaried retiree plans	Oxy PPO with Rx

Special retiree medical eligibility provisions will apply if you:

- Receive severance benefits under Option A of Oxy's Notice and Severance Pay Plan, or similar arrangement with Oxy that provides for such eligibility. See **Special Provisions Under the Notice and Severance Pay Plan**; or
- Are a Medicare-eligible Long-Term Disability (LTD) participant.

To participate in the Oxy Medicare Advantage PPO Plan, each participant also must:

- Be Medicare-eligible;
- Have a U.S. physical address;
- Be enrolled under Medicare Parts A and B; and
- Provide OxyLink Employee Service Center with your Medicare Number found on your Medicare Health Insurance ID card.

Medicare-eligible disabled dependents are also eligible to participate in the Oxy Medicare Advantage PPO Plan. Contact OxyLink Employee Service Center if your dependent becomes eligible for Medicare due to disability prior to age 26. See Chapter 1, Section 2 of the EOC for additional eligibility information.

Special Provisions Under the Notice and Severance Pay Plan

Special eligibility provisions apply if you elect and receive benefits under Option A of Oxy's Notice and Severance Pay Plan or enter into a similar arrangement with Oxy that provides for such eligibility. If you were part of a collective bargaining group, this section only applies if your negotiated bargaining agreement specifically provided for your participation in the Notice and Severance Pay Plan.

Your eligibility for retiree medical coverage will be determined based on your age and years of service as if you continued to be an employee throughout your severance or the medical coverage period specified in a similar arrangement with Oxy (each referred to as "Medical Coverage Period"). Retiree medical coverage will be provided under the Medicare Advantage PPO Plan or applicable Oxy Retiree Medical Plan in effect at the time your retiree medical election takes effect, if on the last day of your Medical Coverage Period, you:

- Have at least 30 years of eligible service,
- Are at least age 50 and have at least 5 years of eligible service with combined age and service of 65 years or more, or
- Otherwise satisfy the eligibility requirements under the medical plan.

To determine your eligibility under these special provisions, calculate your combined age and service by adding your years and months of age and eligible service as of the last day of your Medical Coverage Period, counting any partial month of age or service as a whole month. If you became an Oxy employee due to Oxy's purchase, merger or transfer of any unit, operation or business and, as a result, your eligibility for retiree coverage is subject to a required minimum number of service years directly with Oxy, you must meet such minimum by the end of your Medical Coverage Period.

Contributions for retiree medical coverage are normally a multiple (1x to 4x) of the retiree base rate established for the Plan year. This base rate is associated with your coverage level and a combination of your age and service. However, if you elect Option A under the Notice and Severance Pay Plan and you are eligible for retiree medical coverage at the end of your severance period, your contributions will be calculated using a combined age and service of at least 80 years, which qualifies you for the lowest multiple (1x) under the Plan. Refer to the **Paying for Coverage** section for details.

Dependent Eligibility

Generally, those persons eligible to be covered as dependents under the Oxy Medicare Advantage PPO Plan include your legal spouse (unless legally separated) and your disabled children (who may qualify), but only if your legal spouse and disabled child(ren) meet the eligibility requirements. If your legal spouse is not eligible at the time you enroll in the Plan, he or she can be enrolled later upon satisfaction of eligibility requirements.

If your legal spouse or other covered dependents under age 26 are not eligible for coverage under the Oxy Medicare Advantage PPO Plan, such individuals may be eligible for coverage under the Oxy Retiree Medical Plan. Please see the Summary Plan Description for the Oxy Retiree Medical Plan for additional information on coverage.

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.

Adding Dependents

If you marry after your Oxy retirement date, your new spouse will be eligible for coverage under this Plan provided he or she is Medicare-eligible. You must enroll your new spouse within 31 days of his or her first date of eligibility (the date of marriage), or if later, within 31 days of loss of other coverage.

After your retirement date, you may add a new non-spousal dependent within 31 days of his or her first date of eligibility (or within 31 days of a court-issued QMCSO), or if later, within 31 days of loss of other coverage. However, cost for the coverage is based on whether or not this dependent is Medicare-eligible or non-Medicare eligible and determined under the rules of the Oxy Retiree Medical Program.

Dependent Coverage After Your Death

If you die while you are covered as a retiree under this Oxy Medicare Advantage PPO Plan, your spouse may elect to continue his or her coverage and elect coverage for your eligible dependents under the Oxy Retiree Medical Program as of your date of death by paying the appropriate amount of retiree contributions, as shown in the chart below. If you had not elected retiree coverage for yourself and your dependents under this Oxy Medicare Advantage PPO Plan or the Oxy Retiree Medical Plan, as applicable, your surviving spouse may elect to enroll for coverage. Your surviving spouse may also enroll any eligible dependents under the applicable Plan within 31 days of loss of other coverage. Proof of loss of coverage will be required.

Coverage for your dependents may continue as described in the section entitled *When Coverage Ends.*

Enrollment

You and/or your spouse (or a surviving spouse) must complete and return an enrollment form (or waiver) for coverage no later than 31 days after your retirement date or attainment of age 65. You may waive coverage, but if you do, you may not reenroll for coverage under the Oxy Medicare Advantage PPO Plan, with the following exception:

If you or your spouse (or a surviving spouse) currently has other coverage and loses eligibility for that coverage, you or your spouse may reenroll in the Oxy Medicare Advantage PPO Plan within 31 days of loss of coverage. Proof of loss of creditable coverage 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 a retiree and a dependent spouse under a medical plan sponsored by Oxy. If you and your spouse both work for or are retired from Oxy, only one of you may cover your children as dependents under the plans comprising the Oxy Retiree Medical Program. If your spouse has dependents as an Oxy employee and later leaves Oxy for any reason, you may enroll yourself and your dependents under the applicable Plan within 31 days of the loss of coverage.

Paying for Coverage

If you are a retiree or LTD Plan beneficiary who became Medicare-eligible before January 1, 2000, you are not currently required to pay contributions to participate in the Oxy Medicare Advantage PPO Plan.

If you are a retiree who retired or became eligible for Medicare on or after January 1, 2000, your contributions are a multiple of the Oxy retiree base rate (see page 15), as shown below.

IF YOUR COMBINED AGE AND YEARS OF SERVICE ON YOUR OXY RETIREMENT DATE* IS:	YOUR MONTHLY CONTRIBUTION IS THE FOLLOWING MULTIPLE OF THE RETIREE BASE RATE FOR THE LEVEL OF COVERAGE YOU ELECT:
65 to 69	2 times
70 to 74	2 times
75 to 79	2 times
80 or more	1 times

*Your retirement date is the first of the month following your termination date.

The amount of your contribution is based on:

- Your combined age and years of service,
- The date you become eligible for Medicare and the Medicare status of your covered dependents, and
- Your elected level of coverage (i.e., Retiree Only, Retiree + One Dependent or Family).

Your combined age and service will be calculated by adding together your years and months of age and service as of your retirement date, which is the first of the month following your termination date. A partial month of age or service will be considered a full month for purposes of this calculation.

The retiree base rate for coverage is established each year. It is typically announced in the 4th quarter of each year in a retiree newsletter, which is also posted online at **oxylink.oxy.com** > Plan Documents & Information > Newsletters.

For 2019, the retiree base rate is $65 per month for most participants covered under this Plan.

For example, in 2019, a Medicare-eligible retiree with a combined age and service of 73 years would pay two times the base rate for retiree and spouse coverage of $260 per month ($65 base rate x 2 individuals x 2).

Contributions are billed monthly by PayFlex. Once your retirement is processed you will receive detailed information from PayFlex with the available payment options.

Additionally, you must pay any applicable premiums for Medicare Part A and B (including any late enrollment penalties for Part B or Part D and applicable IRMAA) directly to the Center for Medicare and Medicaid Services (CMS) to be eligible to participate in the Oxy Medicare Advantage PPO Plan.

Information regarding Medicare-provided premium assistance is provided in Chapter 1, Section 4 and Medicare's **Extra Help** Program in Chapter 2, Section 7 of the Evidence of Coverage (EOC). Chapter 6 of the EOC discusses costs for prescription drug benefits under the Medicare Advantage PPO Plan.

What the Plan Covers

Full details regarding coverage under the Oxy Medicare Advantage PPO Plan is provided under the EOC. Be sure to review the EOC carefully to understand how to use the Plan, what services are covered, what costs you are responsible for paying and other important Plan information. The EOC will be updated annually. You should also refer to the EOC for details about:

- How to use Plan services – EOC *Chapter 3.*
- What services are *not covered* under the Oxy Medicare Advantage PPO Plan – EOC *Chapter 4*
- Prescription drug coverage – EOC *Chapter 5*.

Coordination of Benefits (COB)

If you have other insurance coverage, there are rules set by Medicare that decide which plan pays primary and which plan pays secondary. Please see *Chapter 1, Section 10* of the EOC for additional information.

Claims and Appeals Procedures

Claims and appeals under the Oxy Medicare Advantage PPO Plan are governed by special procedures set forth under Centers for Medicare and Medicaid Services ("CMS") regulations. Because you are enrolled in Medicare Parts A, B and D and are provided benefits under this Medicare Advantage Program, you must follow the same claims and appeal process as applies under Medicare.

Additional information regarding how to make a claim or other complaint or appeal a coverage decision is provided in *Chapter 9* of the EOC. Because the Oxy Medicare Advantage PPO Plan is insured and administered by Aetna, Aetna has complete authority to determine who is entitled to benefits under the Medicare Advantage Plan and to construe any disputed or doubtful terms under the Plan. Aetna is solely responsible for providing and paying benefits hereunder, and thus, neither Oxy nor the Plan Administrator can interfere in medical or administrative decisions made under the Oxy Medicare Advantage PPO Plan or direct the way in which benefits or coverage is provided.

Thus, if you have a complaint about benefits provided under the Oxy Medicare Advantage PPO Plan, you must follow the claims and appeal procedures set forth in *Chapter 9* of the EOC, and Aetna is responsible for paying your providers for any services you receive. No financial assistance will be provided to you or your service provider by Oxy. Please note that the claims and appeals procedures set forth in the EOC only apply for purposes of the Oxy Medicare Advantage PPO Plan and will not be applicable for any other benefit plans sponsored by Oxy.

When Coverage Ends

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

When Your Coverage Ends

Your coverage under this Medicare Advantage Plan can end for a number of reasons, which may be voluntary or involuntary and includes failure to make any required contributions. Additional information is provided in *Chapter 10* of the EOC.

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;
- Your coverage terminates;
- Your death, if there is no surviving spouse;
- Your surviving spouse dies or remarries;
- Your surviving spouse is or becomes eligible for coverage under another group plan;* or
- Your surviving spouse does not elect to continue his or her medical coverage under this Plan (which means any covered dependent children would lose their coverage as a result of this action).

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 first of the month following the event. 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 under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). Contact the OxyLink Employee Service Center for more information.

*If your spouse subsequently loses eligibility under the other plan, he or she may reenroll in the Oxy Retiree Medical Program within 31 days of the loss of coverage. Proof of loss of eligibility may be required.

Continuation of Coverage

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 shown under **Qualifying Events**. If you pay the required premiums, you and your eligible dependents may continue participation in the Plan option in which you or your dependents are enrolled at the time of your qualifying event.

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 31 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**.

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 UP TO…	TAKE ACTION
• You are a retiree eligible for health coverage and the company files for bankruptcy	• You • Your spouse • Your dependent children	18 months	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.
• You die	• Your spouse • Your dependent children	36 months	
• Your surviving spouse dies	• Your dependent children	36 months	
• You divorce, legally separate or your marriage is annulled	• Your ex-spouse • Your dependent children	36 months	You or your qualified beneficiaries must notify the OxyLink Employee Service Center within 60 days of the event by the approved method, or your dependents lose their right to COBRA coverage. 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.
• Your dependent child is no longer eligible for coverage under the Plan (for example, your child reaches the age limit)	• Your dependent child	36 months	

Qualified Beneficiary

A qualified beneficiary under COBRA 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. You must enroll new beneficiaries in the Plan within 31 days of the event.

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 under the same Plan option in which you are enrolled at the time of the qualifying event. When Plan 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 retirees changes. You pay the cost of COBRA coverage with after-tax dollars.

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 preexisting 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** or mail to:

4500 South 129th East Avenue
Tulsa, Oklahoma 74134-5801

Plan materials are available on **oxylink.oxy.com** or contact 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 **www.dol.gov/ebsa** or call their toll-free number at **888-444-3272**. For more information about health insurance options available through a Health Insurance Marketplace, visit **healthcare.gov**.

Additional Information

Administrative Information

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

Plan Name	Oxy Medicare Advantage PPO Plan, also known as the Plan or the Medicare Advantage Plan.
Plan Sponsor's Employer Identification Number	95-4035997
Plan Number	653
Plan Year Ends	December 31
Plan Administrative Services	Administrative services contracts with Aetna Life Insurance Company
Plan Administrator	Occidental Petroleum Corporation Employee Benefits Committee 5 Greenway Plaza, Suite 110 Houston, TX 77046 713-215-7000
Claims Administrators	**For medical coverage:** Aetna Life Insurance Company Aetna Medicare Precertification Unit P.O. Box 14079 Lexington, KY 40512-4079 **For medical appeals:** Aetna Life Insurance Company Aetna Medicare Part C Appeals & Grievances P.O. Box 14067 Lexington, KY 40512 **For prescription drugs:** Aetna Life Insurance Company P.O. Box 7773 London, KY 40742 **For prescription drug appeals:** Aetna Life Insurance Company Aetna Medicare Part D Appeals & Grievances P.O. Box 14579 Lexington, KY 40512

Plan Sponsor	Occidental Petroleum Corporation 5 Greenway Plaza, Suite 110 Houston, TX 77046 713-215-7000
Named Fiduciary	Aetna Life Insurance Company for medical and prescription drug claims
Plan Type	An ERISA welfare plan
Address for Legal Process	Service for legal process related to the Plan may be made upon the Plan Administrator: Occidental Petroleum Corporation Employee Benefits Committee 5 Greenway Plaza, Suite 110 Houston, TX 77046 713-215-7000
Funding	Medical and prescription drug benefits are insured by Aetna Life Insurance Company

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

In accordance with section 503 of Title I of ERISA, Aetna has been designated as the Named Fiduciary for the Oxy Medicare Advantage Plan and has complete authority to review all denied claims for benefits under the Plan. In exercising its fiduciary responsibilities, the Named Fiduciary shall have discretionary authority to determine whether and to what extent covered participants are eligible for benefits and to construe disputed or doubtful Medicare Advantage Plan terms. A Named Beneficiary shall be deemed to have properly exercised such authority unless it has abused its discretion hereunder by acting arbitrarily and capriciously.

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.

Required Notices

Federal law affects how certain health conditions are covered. Your rights under these laws are described below.

The Newborns' and Mothers' Health Protection Act

The Plan provides minimum hospital stay benefits for the mother and newborn of 48 hours following a normal delivery or 96 hours following a cesarean section. However, the Plan may pay for a shorter stay if the attending provider (physician, nurse midwife or physician assistant) discharges the mother or newborn earlier, after consulting with the mother.

Also, federal law states that the Plan may not, for the purpose of benefits or out-of-pocket costs, treat the later portion of a hospital stay in a manner less favorable to the mother or newborn than any earlier portion of the stay.

Finally, federal law states that a plan may not require a physician or other health care provider to obtain authorization of a length of stay up to 48 hours or 96 hours, as described above. However, precertification may be required for more than 48 or 96 hours of confinement.

The Women's Health and Cancer Rights Act

The Women's Health and Cancer Rights Act requires that the following procedures be covered for a person who receives benefits for a medically necessary mastectomy and who elects to have reconstructive surgery after the mastectomy:

- Reconstruction of the breast on which a mastectomy has been performed;
- Surgery and reconstruction of the other breast to create a symmetrical (balanced) appearance;
- Prostheses; and
- Treatment of physical complications of all stages of mastectomy, including lymphedemas.

This coverage will be provided in consultation with the attending physician and the patient, and will be subject to the same annual deductibles and coinsurance provisions that apply to the mastectomy.

For answers to questions about the Plan's coverage of mastectomies and reconstructive surgery, call Aetna's Member Services.

Privacy Notice for Health Plans

A federal law, the Health Insurance Portability and Accountability Act of 1996 (HIPAA), requires the Plan to protect the confidentiality of your private health information. A complete description of your rights under HIPAA can be found in the Plan's privacy notice, which was distributed to you when you enrolled and is available at **OxyLink Online** at **oxylink.oxy.com**.

The Medicare Advantage Plan and Oxy will not use or further disclose information that is protected by HIPAA (protected health information) except as necessary for treatment, payment, Medicare Advantage Plan operations and Plan administration, or as permitted or required by law. By law, the Medicare Advantage Plan has required all of its business associates to also observe HIPAA's privacy rules. In particular, the Medicare Advantage Plan will not, without authorization, use or disclose protected health information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan.

Under HIPAA, you have certain rights with respect to your protected health information, including certain rights to see and copy the information, receive an accounting of certain disclosures of the information and, under certain circumstances, amend the information. You also have the right to file a complaint with the Medicare Advantage Plan or with the U.S. Department of Health and Human Services if you believe your rights under HIPAA have been violated.

The Medicare Advantage Plan maintains a privacy notice, which provides a complete description of your rights under HIPAA's privacy rules. For a copy of the notice, you may either call the OxyLink Employee Service Center at **800-699-6903** or go directly to the OxyLink home page at **oxylink.oxy.com** and select *Required Notices*, then print the *HIPAA Privacy Notice.* If you have questions about the privacy of your health information or if you wish to file a complaint under HIPAA, contact the OxyLink Employee Service Center.

Nondiscrimination Notice—It's important we treat you fairly

That's why we follow federal civil rights laws in our health programs and activities. We don't discriminate, exclude people, or treat them differently on the basis of race, color, national origin, sex, age or disability. For people with disabilities, our medical providers offer free aids and services. For people whose primary language isn't English, our medical providers offer free language assistance services through interpreters and other written languages. Interested in these services? Call the Member Services number on your ID card. If you think we failed to offer these services or discriminated based on race, color, national origin, age, disability or sex, you can file a complaint, also known as a grievance. You can file a complaint with the Health and Welfare Team, Occidental Petroleum Corporation, 4500 S. 129th East Avenue, Tulsa, OK 74134-5801, **800-699-6903**, fax: 800-610-1944, oxylink@oxy.com. Or you can file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights at 200 Independence Avenue, SW; Room 509F, HHH Building; Washington, D.C. 20201 or by calling **800-368-1019** (TDD: 800-537-7697) or online at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf. Complaint forms are available at **http://www.hhs.gov/ocr/office/file/index.html**.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al Aetna Medicare Service Center (866) 539-6750; Aetna Rx Home Delivery (800) 594-9390.

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 Aetna Medicare Service Center (866) 539-6750; Aetna Rx Home Delivery (800) 594-9390.

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số Aetna Medicare Service Center (866) 539-6750; Aetna Rx Home Delivery (800) 594-9390.

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. Aetna Medicare Service Center (866) 539-6750; Aetna Rx Home Delivery (800) 594-9390.

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa Aetna Medicare Service Center (866) 539-6750; Aetna Rx Home Delivery (800) 594-9390.

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية المجان لك تتوافر. اتصل برقم Aetna Medicare

Service Center (866) 539-6750; Aetna Rx Home Delivery (800) 594-9390.

ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le Aetna Medicare Service Center (866) 539-6750; Aetna Rx Home Delivery (800) 594-9390.

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните Aetna Medicare Service Center (866) 539-6750; Aetna Rx Home Delivery (800) 594-9390.

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: Aetna Medicare Service Center (866) 539-6750; Aetna Rx Home Delivery (800) 594-9390.

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。Aetna Medicare Service Center (866) 539-6750; Aetna Rx Home Delivery (800) 594-9390.

સુચના: જો તમે ગુજરાતી બોલતા હો, તો મન:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો Aetna Medicare Service Center (866) 539-6750; Aetna Rx Home Delivery (800) 594-9390.

ध्यान दें: यदद आप ह दिी बोलते हैं तो आपके ललए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। Aetna Medicare Service Center (866) 539-6750; Aetna Rx Home Delivery (800) 594-9390.

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero Aetna Medicare Service Center (866) 539-6750; Aetna Rx Home Delivery (800) 594-9390.

ໂປດຊາບ: ຖ້າ ທ່ານ ເວົ້າ ພາສາ ລາວ, ການ ບໍ ລິ ການ ຊ່ວຍ ເຫ ຼືອ ດ້ານ ພາສາ, ໂດຍ ບໍ່ ເສັ ຽ ຄ່າ, ແມ່ ນ ພ້ ອມ ໃຫ້ ທ່ ານ. ໂທ Aetna Medicare Service Center (866) 539-6750; Aetna Rx Home Delivery (800) 594-9390.

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی رایگان به صورت شما می باشد. با شماره Aetna Medicare Service Center (866) 539-6750 تماس بگیرید. Aetna Rx Home Delivery (800) 594-9390

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).

In addition, review *Chapter 8* of the EOC, which discusses additional rights and responsibilities that you have under the Oxy Medicare Advantage Plan. Additional legal notices are provided in *Chapter 11* of the EOC.

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.