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Refer to subsequent issues of Benefits News for any material changes to the Plan made after the date of this document.
BENEFITS AT A GLANCE

The Dental Plan is designed to promote and encourage preventive dental care, provide benefits for services that are essential to the proper care of your teeth and help you pay for a portion of your covered dental expenses.

The dental benefits described in this booklet are offered to Occidental Petroleum Corporation and/or affiliated company employees, as defined in the Eligibility and Enrollment section. This information serves as your Summary Plan Description. You should keep and refer to it when you have questions about your dental benefits.

This Plan is administered by Aetna Life Insurance Company (referred to as “Aetna”). The dental benefits described in this booklet are not insured with Aetna or any of its affiliates, but are paid from Occidental Petroleum Corporation’s general assets.

Capitalized words or phrases are defined in the Glossary at the end of this booklet.

The chart below summarizes the Plan’s deductibles, maximums and Plan payment percentages (percentage of covered expenses paid by the Plan). See What the Plan Covers for more detail.

<table>
<thead>
<tr>
<th>DENTAL PLAN INFORMATION</th>
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<tbody>
<tr>
<td><strong>Calendar Year Deductible</strong></td>
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<tr>
<td>• Individual</td>
<td>$50</td>
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<td>• Family</td>
<td>$150</td>
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<tr>
<td><strong>Calendar Year Maximum</strong></td>
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<tr>
<td>(applies to diagnostic/preventive, basic and major services)</td>
<td>$2,000 per individual</td>
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<tr>
<td><strong>Orthodontia Lifetime Maximum</strong></td>
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<tr>
<td>(for Dependent child(ren) under age 19 only)</td>
<td>$2,000 per individual</td>
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<tr>
<td>Covered Services</td>
<td>Dental Plan Pays</td>
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<td>-------------------------------------------------------</td>
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<tr>
<td><strong>Diagnostic and Preventive Services</strong></td>
<td>100% not subject to deductible</td>
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<tr>
<td>(e.g., exams, cleanings, fluoride applications,</td>
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<tr>
<td>diagnostic X-rays)</td>
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<tr>
<td><strong>Basic Restorative Services</strong></td>
<td>80% after deductible</td>
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<tr>
<td>(e.g., fillings, extractions, periodontal treatment)</td>
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<tr>
<td><strong>Major Restorative Services</strong></td>
<td>50% after deductible</td>
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<tr>
<td>(e.g., crowns, bridges, dentures, inlays)</td>
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<tr>
<td><strong>Orthodontia</strong></td>
<td>50% not subject to deductible</td>
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<tr>
<td>(for Dependent child(ren) under age 19 only)</td>
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Visit Aetna Navigator™ at www.aetna.com

Aetna Navigator is a web-based portal designed to provide access to a wide range of tools and information 24 hours a day, 7 days a week. The website is secure, private, and accessible anywhere an internet connection is available. From Aetna Navigator you can obtain health and benefits information using self-service features and interactive tools. After a simple registration process, a personal home page is created where you can:

- Access your claim Explanations of Benefits (EOBs),
- Check remaining deductibles and balances,
- Request an ID card or print a temporary card,
- Download a list of claims for each covered family member, and
- Contact Member Services.

You can also take advantage of many other features, including:

- DocFind®, Aetna’s online provider directory,
- Intelihealth®, Aetna’s health website,
- Healthwise® Knowledgebase, an innovative decision-support tool, and
- Estimate the Cost of Care, for many diseases and conditions.

Your Aetna ID Card

When you enroll in the Plan, you will receive an Aetna ID card. The ID card shows:

- Your name and Aetna identification number,
- Whether you have Dependent coverage, and
- The telephone number, address and web address for Aetna Member Services.

Be sure to keep your ID card handy and show it whenever you receive care. If you need a temporary card, additional cards or if you lose your card, log on to Aetna Navigator at www.aetna.com and click on “ID Card” under “Requests & Changes.” You may also call Aetna Member Services.
ELIGIBILITY AND ENROLLMENT

Eligibility

You are eligible to participate in the Dental Plan if you are a regular, full-time, nonbargaining hourly or salaried employee of Occidental Petroleum Corporation or an affiliated company (Oxy). For this purpose, “affiliated company” means any company in which 80 percent or more of the equity interest is owned by Occidental Petroleum Corporation. Temporary employees are not eligible to participate. You are considered a full-time employee under the Plan if you are regularly scheduled to work at least 30 hours per week. Generally, you are eligible to participate if you are paid on a U.S. dollar payroll, are designated as eligible to participate by your employer, and do not participate in a similar type of employer-sponsored plan. If you are part of a collective bargaining group, you are eligible to participate in the Dental Plan only if your negotiated bargaining agreement specifically provides for your participation.

You may not be covered as both an employee and a Dependent. If both you and your spouse work for Oxy, only one of you may cover your child or children as Dependents.

Dependents

Generally, those persons eligible to be covered as dependents include your legal spouse (unless legally separated) and your children under age 26.

For a complete definition, refer to “Dependent” in the Glossary section.

Enrollment

You may enroll yourself and your eligible Dependents within 31 days of your date of hire or eligibility under the Dental Plan. If you enroll within the first 31 days, your coverage will start as of the date of initial eligibility. If you have any questions or need additional information, contact the OxyLink Employee Service Center (OxyLink).

When you enroll, you may elect one of the following levels of coverage:

• Employee Only
• Employee + One Dependent
• Family (employee plus two or more Dependents)
Changing Your Elections

Open Enrollment Period

Each year Oxy designates a period of time during which you may change your election for the following Plan year (January 1 through December 31).

Between Open Enrollments

Under IRS rules, once you make your enrollment election, either when you are first eligible or during Open Enrollment, your election will remain in effect for the entire Plan year. However, you may be able to change your election before the next Open Enrollment if:

• A Status Change, as described below, occurs and your election change is consistent with the Status Change as allowed by the IRS regulations.

• Another IRS-recognized event occurs (e.g., Qualified Medical Child Support Orders, judgments, and decree orders).

• You may enroll yourself or an eligible Dependent in the Dental Plan, including when you or an eligible Dependent 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.

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 location or residence

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 your dental coverage, but you cannot drop dental coverage for your spouse.

• If your child reached the age limit for coverage under the Dental Plan, you could drop coverage for that child, but you could not add or drop dental coverage for your spouse or another child.

• If you marry you may add your spouse and any other eligible dependents to your dental coverage, but you may not drop coverage for yourself unless you are added to your new spouse’s dental coverage.

To change your benefits election, contact OxyLink. You must submit any required documentation within 31 days of the Status Change, or within 60 days of a Medicaid or CHIP event.
CONTRIBUTIONS

The coverage level you select determines the amount of your contribution. Current monthly rates and annual deductibles are available online at oxylink.oxy.com. Your per-pay-period portion of the monthly contribution amount will be deducted from each paycheck on a pretax basis.

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 dental contributions, your state income tax also will be withheld after your contributions are deducted.

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

Long-Term Disability beneficiaries who become disabled on or after October 1, 1995 currently are required to make the same contributions as active employees on an after-tax basis.

Pretax Contributions: Effect on Social Security and Other Statutory Benefits

Pretax dental contributions reduce the amount of your earnings that are reported for Social Security purposes. Therefore, 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.

Pretax Contributions: Effect on Other Oxy Benefits

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 Dental Plan contributions are deducted.
USING THE PLAN

This section describes how the Dental Plan works and how to make the most of your coverage. You will find information about choosing a Dentist and sharing the cost of your care, as well as details about certain important Plan rules and requirements.

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 an Out-of-Network Provider.

Using Network and Out-of-Network 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 network (a Network Provider) or one that does not belong to the network (an Out-of-Network Provider).

Your out-of-pocket expenses may be lower when your care is provided by a Network Provider because Network Providers have agreed to provide covered services and supplies at a Negotiated Charge. In no event will you have to 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.

If you use Network Providers, you will not have to submit dental claims for treatment received. Your Network Provider will take care of claim submission. You will receive notification of what the plan has paid toward your Covered Expenses and you will be responsible for the deductible and your payment percentage.

If you receive care from an Out-of-Network Provider, your benefits are limited to the Recognized Charge and your expenses will generally be higher. If the Out-of-Network Provider’s charge is more than the Recognized Charge (as defined by Aetna), 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 DocFind at www.aetna.com. Follow the prompts to select the type of search you want, the area in which you want to search and the number of miles you are willing to travel. When you are asked to select a plan, choose “Dental PPO/PDN with PPO II Network” from the “Dental PPO/PDN/EPP/HealthFund®/DentalFund® with PPO II network” plan list. You can search the online directory for a specific Dentist or all
Dentists in a given ZIP code and/or travel distance. You can also get information about a Dentist’s practice, such as address, phone number(s), and access for the disabled.

- **Call or email 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 [www.aetna.com](http://www.aetna.com) and select “Member Log In.”

**Sharing the Cost**

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/or your covered Dependents pay each year (January 1 to December 31) before the Plan starts to pay benefits. You start over each January 1 with a new calendar year deductible.

If the covered dental expenses of all family members reach the *family* deductible, no other deductible is required for the rest of the calendar year.

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.

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**Diagnostic and Preventive services are not subject to the deductible.**

The Plan’s benefits for Diagnostic and Preventive, Basic and Major services are limited to a calendar year maximum. There is a separate lifetime maximum benefit for orthodontia expenses.

You may access information regarding current deductibles and maximum benefits online at [oxylink.oxy.com](http://oxylink.oxy.com).

**Advance Claim Review**

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 online at [oxylink.oxy.com](http://oxylink.oxy.com). Your Dentist should send the form to Aetna before treatment begins. In processing the request, Aetna may ask for supporting X-rays and other diagnostic records. Once all of the information has been gathered, Aetna will review the proposed treatment plan and provide you and your Dentist with a statement
that outlines the benefits payable by the Plan. You and your Dentist 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.

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.

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

**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
- Deemed by the dental profession to be appropriate for treatment of the condition in question. 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 and your Dental Provider can still choose the more costly treatment method. You are responsible for any charges in excess of what the plan will cover.
WHAT THE PLAN COVERS

The Plan covers medically Necessary dental care expenses incurred while your coverage 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. Coverage for services and supplies applies only if they are provided to a person at the time he or she is covered under the Plan.

When a single charge is made for a series of services, each service will be assigned a pro rata (evenly divided) share of the expense. Aetna will determine the pro rata share. Only the pro rata share of the expense will be considered as incurred on the date of the dental service.

This section lists the services covered under each of the four types of dental care. If any limits apply, they are described below.

Diagnostic and Preventive Services

To encourage regular dental checkups, the Plan pays 100 percent of the Negotiated or Recognized Charges, with no deductible, for preventive and diagnostic services. For purposes of this Plan, diagnostic and preventive services include the following:

- Routine oral exams twice per calendar year (including cleaning and scaling)
- Problem-focused exams
- One topical application of fluoride per calendar year for Dependents under age 16
- Diagnostic X-rays, and other X-rays not to exceed one full mouth or panoramic series every three years
- Two sets of bitewing X-rays in a calendar year for Dependents under age 14
- One set of bitewing X-rays 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

The Plan will pay 80 percent of the Negotiated or Recognized Charges for basic restorative services after the annual deductible is satisfied. The following services are considered basic restorative services under the Plan:

- Simple extractions
- Oral surgery for non-impacted wisdom teeth extractions
- Oral surgery (including extraction of impacted teeth) if the procedure is not covered under your medical plan
- 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
• Relining/rebasing of dentures

Major Restorative Services

The Plan will pay 50 percent of the Negotiated or Recognized Charges for major restorative services after the annual deductible is satisfied. For purposes of the Dental Plan, the following are considered major restorative services:

• Inlays, gold fillings or crowns. This includes precision attachments for dentures.
• First installation of removable dentures and partial dentures to replace one or more natural teeth. This includes adjustments for the six-month period after they were installed.
• First installation of fixed bridgework to replace one or more natural teeth. This includes 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, subject to the Alternate Treatment provision. In many cases there is an alternate professionally accepted method of treatment.
• Replacement of an existing removable denture or fixed bridgework by a new denture or fixed bridgework, or addition of teeth to existing partial removable denture or fixed bridgework. The Replacement Rule below must be met.

Replacement Rule

Inlays, onlays and veneers, complete dentures, removable partial dentures, fixed partial dentures (bridges) and other prosthetic services are subject to the plan's replacement rule. That means certain replacements of, or additions to, existing inlays, onlays, veneers, dentures or bridges 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 inlay and onlay, veneer, complete denture, removable partial denture, fixed partial denture (bridge), or other prosthetic service was installed at least 5 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 Termination of Coverage

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 terminates. There is an exception. 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); and
- 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 which will serve as retainers or supports, or the teeth which are being restored:
  - Must have been fully prepared to receive the item; and
  - Impressions have been taken from which the item will be prepared.

Orthodontic Treatment

Orthodontic coverage is only for covered dependent children who are under age 19 on the date active orthodontic treatment begins.

The Plan does not cover the following orthodontic services and supplies:

- Replacement of broken appliances;
- Re-treatment 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")*; or
- Removable acrylic aligners (i.e. "invisible aligners")*

* These services may be subject to the Alternate Treatment provision.
WHAT THE 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 and included in the What the Plan Covers section. Charges made for the following are not covered except to the extent listed under the What the Plan Covers section. In addition, some services are specifically limited or excluded. This section describes expenses that are not covered or are subject to special limitations.

The Plan does not cover expenses for:

• Any instruction for diet, plaque control and oral hygiene.

• Cosmetic services and supplies including plastic surgery, reconstructive surgery, cosmetic surgery, personalization or characterization of dentures or other services and supplies which improve alter or enhance appearance, augmentation and vestibuoplasty, 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 coverage is specifically provided in the What the Plan Covers section.

• Crown, inlays and onlays, and veneers unless:
  – It is treatment 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
  – Under any other plan of group benefits provided by the contractholder.

• Dentures, crowns, inlays, onlays, bridges, or other appliances or services used for the purpose of splinting, to alter vertical dimension, to restore occlusion, or correcting attrition, abrasion, or erosion.

• Except as covered in the What the Plan Covers section, treatment of any Jaw Joint Disorder and treatments to alter bite or the alignment or operation of the jaw, including temporomandibular joint disorder (TMJ) treatment, orthognathic surgery, and treatment of malocclusion or devices to alter bite or alignment.

• First installation of a denture or fixed bridge, and any inlay and crown that serves as an abutment to replace congenitally missing teeth or to replace teeth all of which were lost while the person was not covered.
• General anesthesia and intravenous sedation, unless specifically covered and only when done in connection with another necessary covered service or supply.

• Orthodontic treatment except as covered in the What the Plan Covers section.

• Prescribed drugs; pre-medication; or analgesia.

• Replacement of a device or appliance that is lost, missing or stolen, and for the replacement of appliances that have been damaged due to abuse, misuse or neglect and for an extra set of dentures.

• Services and supplies done where there is no evidence of pathology, dysfunction, or disease other than covered preventive services.

• Services and supplies provided for your personal comfort or convenience, or the convenience of any other person, including a provider.

• Services and supplies provided 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. However, the plan will cover some services provided by a licensed dental hygienist under the supervision and guidance of a dentist. These are:
  – Scaling of teeth;
  – Cleaning of teeth; and
  – Topical application of fluoride.

Additional Items Not Covered By A Health Plan

Not every health 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 and included in the What the Plan Covers section. Charges made for the following are not covered except to the extent listed under the What The Plan Covers section.

• Acupuncture, acupressure and acupuncture therapy, except as provided in the What the Plan Covers section.

• Any charges in excess of the benefit, dollar, day, visit or supply limits stated in this booklet.
• 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.

• Examinations:
  – Any dental examinations:
    • required by a third party, including examinations and treatments required 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; and
    • 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 as described in the What the Plan Covers section. A drug, a device, a procedure, or treatment will be determined to be 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; or
  – Approval required by the FDA has not been granted for marketing; or
  – A recognized national medical or dental society or regulatory agency has determined, in writing, that it is experimental or investigational, or for research purposes; or
  – 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.

• Medicare: 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 or charges to complete claim forms;
- Charges the recipient has no legal obligation to pay; or the charges would not be made if the recipient did not have coverage (to the extent exclusion is permitted by law) including:
  - Care in charitable institutions;
  - Care for conditions related to current or previous military service; or
  - Care while in the custody of a governmental authority.

- Non-Medically Necessary services, including but not limited to, those treatments, services, prescription drugs and supplies which 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 as specifically provided in the What the Plan Covers section.

- Services rendered before the effective date or after the termination of coverage, unless coverage is continued under the Continuation of Coverage section of this booklet.

- 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.
COORDINATION WITH OTHER PLANS

Some persons have health coverage in addition to coverage under this Plan. Under these circumstances, it is not intended that a plan provide duplicate benefits. For this reason, many plans, including this Plan, have a "coordination of benefits" provision.

Under the coordination of benefits provision of this Plan, the amount normally reimbursed under this Plan is reduced to take into account payments made by "other plans".

**Other Plan**: Any other plan of health expense coverage under:

- Group insurance.
- Any other type of coverage for persons in a group. This includes plans that are insured and those that are not.
- No-fault auto insurance required by law and provided on other than a group basis. Only the level of benefits required by the law will be counted.

When this and another health expenses coverage plan applies, the order in which the various plans will pay benefits must be figured. This will be done as follows using the first rule that applies:

1. A plan with no rules for coordination with other benefits will be deemed to pay its benefits before a plan which contains such rules.

2. A plan which covers a person other than as a dependent will be deemed to pay its benefits before a plan which covers the person as a dependent; except that if the person is also a Medicare beneficiary and as a result of the Social Security Act of 1965, as amended, 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;

   The benefits of a plan which covers the person as a dependent will be determined before the benefits of a plan which:
   - covers the person as other than a dependent; and
   - is secondary to Medicare.

3. Except in the case of a dependent child whose parents are divorced or separated; the plan which covers the person as a dependent of a person whose birthday comes first in a calendar year will be primary to the plan which covers the person as a dependent of a person whose birthday comes later in that calendar year. If both parents have the same birthday, the benefits of a plan which covered one parent longer are determined before those of a plan which covered the other parent for a shorter period of time.
If the other plan does not have the rule described in this provision (3) but instead has a rule based on the gender of the parent and if, as a result, the plans do not agree on the order of benefits, the rule in the other plan will determine the order of benefits.

4. In the case of a dependent child whose parents are divorced or separated:
   a. If there is a court decree which 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 expenses of the child, the order of benefit determination rules specified in (3) above will apply.
   b. If there is a court decree which makes one parent financially responsible for the medical, dental or other health care expenses of such child, the benefits of a plan which covers the child as a dependent of such parent will be determined before the benefits of any other plan which covers the child as a dependent child.
   c. If there is not such a court decree:
      – If the parent with custody of the child has not remarried, the benefits of a plan which covers the child as a dependent of the parent with custody of the child will be determined before the benefits of a plan which covers the child as a dependent of the parent without custody.
      – If the parent with custody of the child has remarried, the benefits of a plan which covers the child as a dependent of the parent with custody shall be determined before the benefits of a plan which covers that child as a dependent of the stepparent. The benefits of a plan which covers that child as a dependent of the stepparent will be determined before the benefits of a plan which covers that child as a dependent of the parent without custody.

5. If 1, 2, 3 and 4 above do not establish an order of payment, the plan under which the person has been covered for the longest will be deemed to pay its benefits first; except that:

   The benefits of a plan which covers the person on whose expenses claim is based as a:
   – laid-off or retired employee; or
   – the dependent of such person.

   Shall be determined after the benefits of any other plan which covers such person as:
   – an employee who is not laid-off or retired; or
   – dependent of such person.

   If the other plan does not have a provision:
   – regarding laid-off or retired employees; and
   – as a result, each plan determines its benefits after the other;

   then the above paragraph will not apply.

   The benefits of a plan which covers the person on whose expenses claim is based under a right of continuation pursuant to federal or state law shall be determined after
the benefits of any other plan which covers the person other than under such right of continuation.

If the other plan does not have a provision:
– regarding right of continuation pursuant to federal or state law; and
– as a result, each plan determines its benefits after the other;

then the above paragraph will not apply.

The general rule is that the benefits otherwise payable under this Plan for all expenses processed during a single "processed claim transaction" will be reduced by the total benefits payable under all "other plans" for the same expenses. An exception to this rule is that when the coordination of benefits rules of this Plan and any "other plan" both agree that this Plan is primary, the benefits of the other plan will be ignored in applying this rule. As used in this paragraph, a "processed claim transaction" is a group of actual or prospective charges submitted to Aetna for consideration, that have been grouped together for administrative purposes as a "claim transaction" in accordance with Aetna's then current rules. If the contract includes both medical and dental coverage, those coverages will be considered separate plans. The Medical/Pharmacy coverage will be coordinated with other Medical/Pharmacy plans. In turn, the dental coverage will be coordinated with other dental plans.

In order to administer this provision, Aetna can release or obtain data. Aetna can also make or recover payments.
CLAIMS AND BENEFIT PAYMENT

This section explains the rules and provisions that affect claim filing and processing, and payment of benefits.

Keeping Records of Expenses

It is important to keep records of dental expenses for yourself and all covered family members. These will be required when you file a claim for benefits. Of particular importance are:

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

Filing Claims

Generally, if you use an Out-of-Network Provider, you must complete and submit a claim form to be reimbursed for covered expenses. Claim forms are available on oxylink.oxy.com, Aetna Navigator at www.aetna.com or by calling Aetna Member Services at 800-334-0299. The form contains instructions on how and when to file a claim, as well as the address to which you should send your completed form.

Claims should always be submitted to the primary plan first. When filing a claim for COB, the Explanation of Benefits statement received from the primary plan and all associated bills must be submitted to the secondary plan.

<table>
<thead>
<tr>
<th>Claims should be submitted to:</th>
<th>Aetna</th>
</tr>
</thead>
<tbody>
<tr>
<td>P.O. Box 14094</td>
<td></td>
</tr>
<tr>
<td>Lexington, KY 40512-4094</td>
<td></td>
</tr>
</tbody>
</table>

All claims must be filed promptly. The deadline for filing a claim is 90 days after the date you incurred 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.

You can file claims for benefits and appeal adverse claim decisions yourself or through an authorized representative. An “authorized representative” is 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 that 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.
**Time Frames for Claim Processing**

Aetna will make a decision on your claim. For concurrent care claims, Aetna will send you written notification of an affirmative benefit determination. For other types of claims, you may only receive written notice if Aetna makes an 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.

Aetna will provide you with written notices of adverse benefit determinations within the time frames shown in the following chart. These time frames may be extended under certain limited circumstances. The notice you receive from Aetna will provide important information that will assist you in making an appeal of the adverse benefit determination, if you wish to do so. Refer to *When You Disagree With a Claim Decision* for more information about appeals.

<table>
<thead>
<tr>
<th>Type of Claim</th>
<th>Response Time</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Urgent care claim</strong>: a claim for dental care or treatment where delay could:</td>
<td>As soon as possible, but not later than 72 hours</td>
</tr>
<tr>
<td>• Seriously jeopardize your life or health, or your ability to regain maximum function; or</td>
<td></td>
</tr>
<tr>
<td>• Subject you to severe pain that cannot be adequately managed without the requested care or treatment.</td>
<td></td>
</tr>
<tr>
<td><strong>Pre-service claim</strong>: a request for a benefit determination in advance of obtaining dental care (Advance Claim Review).</td>
<td>15 calendar days</td>
</tr>
<tr>
<td><strong>Concurrent care claim extension</strong>: a request to extend a previously approved Course of Treatment.</td>
<td>• Emergency or urgent care claims - as soon as possible, but not later than 24 hours, provided the request was received at least 24 hours prior to the expiration of the approved treatment</td>
</tr>
<tr>
<td></td>
<td>• Other claims – 15 calendar days</td>
</tr>
<tr>
<td><strong>Concurrent care claim reduction or termination</strong>: a decision to reduce or terminate a Course of Treatment that was previously approved.</td>
<td>With enough advance notice to allow you to appeal</td>
</tr>
<tr>
<td><strong>Post-service claim</strong>: a claim for dental care or treatment that has been rendered.</td>
<td>30 calendar days</td>
</tr>
</tbody>
</table>
Extensions of Time Frames

The time frames described in the chart may be extended, as follows:

For urgent care claims: If Aetna does not have sufficient information to decide the claim, you will be notified as soon as possible (but no more than 24 hours after Aetna receives the claim) that additional information is needed. You will then have at least 48 hours to provide the information. A decision on your claim will be made within 48 hours of the earlier of the receipt of the additional information or the end of the 48-hour period given the Physician to provide Aetna with the information.

For non-urgent pre-service and post-service claims: The time frames may be extended for up to 15 additional days for reasons beyond the Plan’s control. In this case, Aetna will notify you of the extension before the original notification time period has ended.

If an extension is necessary because Aetna needs more information to process your post-service claim, Aetna will notify you and give you an additional period of at least 45 days after receiving the notice to provide the information. Aetna will then inform you of the claim decision within 15 days after the additional period has ended (or within 15 days after Aetna receives the information, if earlier). If you fail to provide the information, your claim will be denied.

Payment of 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 tell Aetna to make benefits payable to the provider when the claim is filed.

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 the section entitled When You Disagree With a Claim Decision for more information about appeals.

Recovery of Overpayment

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

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

This right does not affect any other right of overpayment recovery Aetna may have.
Legal Action

No legal action can be brought to recover a benefit after 3 years from the deadline for filing claims.

Complaints

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 that you think are relevant to the matter. 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.
WHEN YOU DISAGREE WITH A CLAIM DECISION

The Appeal Process

Aetna will send you written notice of an adverse benefit determination. The notice will give the reason for the decision and will explain what steps you must take if you wish to appeal. The notice will also tell you about your rights to receive additional information that may be relevant to the appeal. Requests for appeal must be made within 180 days from the receipt of the notice. However, appeals of adverse benefit determinations involving urgent care may be made orally to Aetna Member Services at 800-334-0299.

Your appeal should include:

- Your name;
- Your employer’s name;
- A copy of Aetna’s 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 appeals may be sent to:

Aetna
Attn: National Account CRT
P.O. Box 14463
Lexington, KY 40512

The Plan provides for two levels of appeal. If you are dissatisfied with the outcome of your Level One appeal and wish to file a Level Two appeal, your appeal must be filed no later than 60 days following receipt of the Level One notice of adverse benefit determination. The following chart summarizes some information about how appeals are handled for different types of claims.

<table>
<thead>
<tr>
<th>Type of Claim</th>
<th>Level One Appeal Response Time</th>
<th>Level Two Appeal Response Time</th>
</tr>
</thead>
</table>
| Urgent care claim: a claim for dental care or treatment where delay could:  
  • Seriously jeopardize your life or health, or your ability to regain maximum function; or  
  • Subject you to severe pain that cannot be adequately managed without the requested care or treatment. | 36 hours  
  Review provided by Aetna personnel not involved in making the adverse benefit determination. | 36 hours  
  Review provided by Aetna personnel not involved in making the adverse benefit determination. |
<table>
<thead>
<tr>
<th>Type of Claim</th>
<th>Level One Appeal Response Time</th>
<th>Level Two Appeal Response Time</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Pre-service claim</strong>: a request for a benefit determination in advance of obtaining dental care (Advance Claim Review).</td>
<td>15 calendar days</td>
<td>15 calendar days</td>
</tr>
<tr>
<td></td>
<td>Review provided by Aetna personnel not involved in making the adverse benefit determination.</td>
<td>Review provided by Aetna personnel not involved in making the adverse benefit determination.</td>
</tr>
<tr>
<td><strong>Concurrent care claim extension</strong>: a request to extend a previously approved Course of Treatment.</td>
<td>Treated like an urgent care claim or a pre-service claim depending on the circumstances.</td>
<td>Treated like an urgent care claim or a pre-service claim depending on the circumstances.</td>
</tr>
<tr>
<td><strong>Post-service claim</strong>: a claim for dental care or treatment that has been rendered.</td>
<td>30 calendar days</td>
<td>30 calendar days</td>
</tr>
<tr>
<td></td>
<td>Review provided by Aetna personnel not involved in making the adverse benefit determination.</td>
<td>Review provided by Aetna personnel not involved in making the adverse benefit determination.</td>
</tr>
</tbody>
</table>

You may also choose to have another person (an authorized representative) make the appeal on your behalf by providing written consent to Aetna. In the case of an urgent care claim or a pre-service claim, a Dentist familiar with the case may represent you in the appeal.

**Exhaustion of Process**

You must exhaust the applicable Level One and Level Two processes of the appeal procedure before you initiate any litigation; arbitration; or administrative proceeding regarding an alleged breach of the contract terms by Aetna Life Insurance Company or any matter within the scope of the appeals procedure.

**Claim Fiduciary**

Aetna has complete discretionary authority to review all denied claims for benefits under the Dental Plan. This includes, but is not limited to, determining whether dental treatment is, or is not, medically Necessary. In exercising its responsibilities, Aetna has discretionary authority to:

- Determine whether, and to what extent, you and your covered Dependents are entitled to benefits; and
- Construe any disputed or doubtful terms of the Plan.

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

Your coverage under this Plan can end for a number of reasons. 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 this 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 if you receive benefits under Oxy’s Long-Term Disability Plan;
• The coverage described in this booklet is terminated;
• You are no longer eligible as defined in the Eligibility and Enrollment section of this booklet;
• You fail to make any required contribution; or
• Your employer notifies Aetna that your employment has ended.

Your dental coverage will cease on the last day of the month in which you lose eligibility. You may have a right to continue your coverage as described in the section entitled Continuation of Coverage. You may not convert your group dental coverage to an individual policy at termination.

Death

If you die in active employment and are 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 the section entitled Continuation of Coverage. There is no conversion policy available for your surviving Dependents for dental coverage.

Retirement

Retired employees and their Dependents are not eligible for coverage under the Dental Plan. Dental coverage for you and your Dependents will cease on the last day of the month in which you retire.
When Dependent Coverage Ends

Your Dependent’s eligibility for coverage will end on the earliest to occur of the following events:

• Dependent coverage is terminated under this Plan;
• A Dependent becomes covered as an employee;
• A dependent no longer meets the Plan’s definition of a Dependent; or
• When your coverage terminates.

Dental coverage will cease on the last day of the month in which your Dependent loses eligibility. You must notify OxyLink 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.

See the Continuation of Coverage section or contact OxyLink for details regarding how coverage may be continued.

Certificate of Group Health Coverage

When you and/or your covered Dependent loses dental coverage, OxyLink will provide a Certificate of Group Health Coverage. This certificate states how long you and/or your covered Dependent were continuously covered under the Dental Plan. The certificate will show only the most recent 18 months of coverage even if you were covered for a longer period.

You and/or your covered Dependent may also request a Certificate of Group Health Coverage before coverage ends or within 24 months after losing coverage.

Under current law, this certificate may help reduce the amount of time you are subject to any exclusion for a pre-existing health condition under a future non-Oxy health care plan, unless you have a break in coverage of more than 63 days.
CONTINUATION OF COVERAGE

During Illness or Injury

If you are an Oxy employee enrolled in the Dental Plan and you are absent from work because of illness or injury, Dental Plan coverage for you and your Dependents will continue while you remain disabled, pay your required contribution and are receiving payments under Oxy’s Short-Term Disability (STD) Plan or similar company-sponsored plan. You will also continue to be eligible for coverage while you receive benefits under Oxy’s Long-Term Disability (LTD) Plan, and make any required contributions. If you do not return to active employment at the end of your plan benefits under STD, and LTD if applicable, your eligibility for continued Dental Plan coverage will end, as described in the section entitled When Coverage Ends.

During Approved Leaves of Absence

If you are on an approved leave of absence, including a leave under the Family and Medical Leave Act of 1993 (FMLA) or applicable state law, you may continue coverage for yourself and your eligible Dependents during your approved leave, provided you make any required contributions. You can elect to continue your coverage for the duration of your leave of absence, up to a maximum of six months.

If you elect not to continue coverage during an approved leave under FMLA or similar state law, automatic reinstatement will be permitted upon your return to active employment. If you elect not to continue coverage during any other approved leave, you cannot reenroll until the next Open Enrollment period.

For additional information regarding an FMLA leave of absence, 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 Dental plan may continue for you and/or your covered Dependents for a maximum of six months commencing with the effective date of the leave, provided that you make any required contributions. However, coverage is excluded for service-connected illnesses or injuries. If you elect to discontinue your coverage during your USERRA military leave, automatic re-enrollment will be permitted if you return to work and request reinstatement within 31 days.

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 www.dol.gov/vets.

You may contact your Human Resources representative or OxyLink with any questions regarding continued dental coverage under USERRA. OxyLink must be contacted within

01/01/2011 Dental
thirty-one (31) days of the date that you return to work to reinstate your health benefits under the special USERRA rules.

**Under COBRA**

Under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), you and/or your Dependents have the right to continue health coverage if it ends for the reasons (“qualifying events”) described below. You may continue participation in the Plan option in which you are enrolled at the time of your qualifying event and must pay required premiums.

**Qualifying Events and Continuation Periods**

The chart below outlines:

- The qualifying events that trigger the right to continue coverage;
- Those eligible to elect continued coverage; and
- The maximum continuation period.

<table>
<thead>
<tr>
<th>Qualifying Event Causing Loss of Coverage</th>
<th>Covered Persons Eligible for Continued Coverage</th>
<th>Maximum Continuation Period</th>
</tr>
</thead>
<tbody>
<tr>
<td>Termination of active employment (except for gross misconduct)</td>
<td>You&lt;br&gt;Your spouse&lt;br&gt;Your Dependent children</td>
<td>18 months</td>
</tr>
<tr>
<td>Reduction in work hours</td>
<td>You&lt;br&gt;Your spouse&lt;br&gt;Your Dependent children</td>
<td>18 months</td>
</tr>
<tr>
<td>Divorce or legal separation</td>
<td>Your spouse&lt;br&gt;Your Dependent children</td>
<td>36 months</td>
</tr>
<tr>
<td>Children no longer qualify as eligible for Dependent coverage</td>
<td>Your Dependent children</td>
<td>36 months</td>
</tr>
<tr>
<td>Your death</td>
<td>Your spouse&lt;br&gt;Your Dependent children</td>
<td>36 months</td>
</tr>
</tbody>
</table>

The required premium for the 18- or 36-month continuation period will be 102% of the total Plan cost.

**Disability Extension**

The 18-month continuation period may be extended for an additional 11 months if you or your covered Dependents qualify for disability status under Title II or XVI of the Social Security Act during the 18-month continuation period. Your disability must begin within 60 days of the start of COBRA continuation coverage and continue until the end of the 18-month continuation period. The additional 11 months of continued coverage is available for the disabled individual and any family member of the disabled person.

Aetna must be notified of a determination of disability within 60 days of the date of the determination and before the end of the 18-month continuation period.
The required premiums for the 18th through 29th month of continued coverage may be up to 150% of the Plan cost.

**Multiple Qualifying Events**

If any one of your Dependents experiences a second qualifying event during the 18- or 29-month continuation period, the maximum continuation period can be extended to 36 months.

**ELECTING COBRA CONTINUATION COVERAGE**

OxyLink will provide detailed information about how to continue coverage under COBRA at the time you or your Dependents become eligible. Your Dependents will need to notify OxyLink within 60 days of a divorce or legal separation or loss of Dependent child eligibility, or the date coverage ends due to those circumstances, if later.

You or your Dependents will need to elect continued coverage within 60 days of the “qualifying event” or the date of the COBRA notice, if later. The election must include an agreement to pay required premiums.

**ACQUIRING NEW DEPENDENTS DURING CONTINUATION**

If you acquire any new Dependents during a period of continuation (through birth, adoption or marriage), they can be added for the remainder of the continuation period if:

- They meet the definition of an eligible Dependent;
- You notify Aetna within 31 days of their eligibility; and
- You pay the additional required premiums.

**WHEN COBRA CONTINUATION 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 begins under another group plan that does not restrict coverage for preexisting conditions;
- Oxy no longer offers a group health plan; or
- You or your Dependent die.

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

Contact OxyLink for information on how other continuation provisions may affect COBRA continuation provisions.

Keep the Plan Informed of Changes

In order to protect your family’s rights, you should keep the Plan informed in writing of any changes in the addresses of your family members 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 74134-5870.
GENERAL INFORMATION

Other Plan Provisions

Multiple Employers and Misstatement of Fact

You cannot receive multiple coverage under this Plan because you are connected with more than one employer.

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

Outcome of Covered Services and Supplies

Neither Aetna nor Oxy is responsible for, nor do they make any guarantees concerning, the outcome of the covered services and supplies you receive.

Reporting and Disclosures

The Plan Administrator is responsible for making reports and disclosures required by applicable laws and regulations.

Privacy Notice for Health Plans

A federal law, the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), requires the Dental 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 upon enrollment and is available through OxyLink.

The Dental Plan and Oxy will not use or further disclose information that is protected by HIPAA ("protected health information") except as necessary for treatment, payment, Dental Plan operations and Plan administration, or as permitted or required by law. By law, the Dental Plan has required all of its business associates to also observe HIPAA’s privacy rules. In particular, the 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 Plan or with the U.S. Department of Health and Human Services if you believe your rights under HIPAA have been violated.

The 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 Health, Life and Disability, 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.

Your Rights as a Plan Participant

As a participant in this 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 Dental Plan Coverage

You have the right to continue dental coverage for yourself, spouse or Dependents if there is a loss of coverage under the Dental 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 Dental Plan on the rules governing your COBRA continuation coverage rights.

You also have the right to reduced or eliminated exclusionary periods of coverage for preexisting conditions under a group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the group health plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months after your enrollment date in your coverage under a group health plan.
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
- 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.

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.

Discretionary Authority of Plan Administrator and Claims Administrator

In accordance with sections 402 and 503 of Title I of ERISA, the Plan sponsor has designated a Named Fiduciary under the Plan, who has 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 Administrator has discretionary authority to determine eligibility 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 Plan participants are eligible for benefits, and to construe disputed or doubtful Plan terms. The Named Fiduciary shall be deemed to have properly exercised such authority unless it has abused its discretion hereunder by acting arbitrarily and capriciously.
**No Guarantee of Employment**

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, this 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.

**Future of the Plan and Plan Amendment**

Oxy expects and intends to continue this 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, 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 change in this description of the Plan, such action will be evidenced by a written announcement to affected individuals.
Plan Administration

The additional information in this section is provided to you in accordance with the Employee Retirement Income Security Act of 1974 (ERISA) regarding the Dental Plan and the persons who have assumed responsibility for its operation.

<table>
<thead>
<tr>
<th>Plan Name</th>
<th>Occidental Petroleum Corporation Welfare Plan (Dental Component)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employer Identification Number</td>
<td>95-4035997</td>
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<tr>
<td>Plan Number</td>
<td>591</td>
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<tr>
<td>Plan Administrative Services Provided by</td>
<td>Occidental Petroleum Corporation 10889 Wilshire Boulevard Los Angeles, California 90024 310-208-8800</td>
</tr>
<tr>
<td>Type of Administration</td>
<td>Administrative Services Contract with: Aetna Life Insurance Company 151 Farmington Avenue Hartford, CT 06156</td>
</tr>
<tr>
<td>Plan Administrator</td>
<td>Occidental Petroleum Corporation Employee Benefits Committee</td>
</tr>
<tr>
<td>Plan Sponsor and Address for Legal Process</td>
<td>Occidental Petroleum Corporation 10889 Wilshire Boulevard Los Angeles, CA 90024 310-208-8800</td>
</tr>
<tr>
<td>Named Fiduciary</td>
<td>Aetna Life Insurance Company</td>
</tr>
<tr>
<td>Claims Administrator</td>
<td>Aetna Life Insurance Company 151 Farmington Avenue Hartford, CT 06156</td>
</tr>
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<td>End of Plan Year</td>
<td>December 31</td>
</tr>
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<td>Type of Plan</td>
<td>ERISA Welfare Plan</td>
</tr>
<tr>
<td>Source of Contributions</td>
<td>Employee Contributions and Employer General Assets</td>
</tr>
</tbody>
</table>
GLOSSARY

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

**Course of Treatment**
A “course of treatment” is 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**
This is:

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

legally qualified to furnish dental services or supplies.

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

**Dependent**
Those persons eligible to be covered as dependents may include your:

- Legal spouse (unless legally separated), and
- Children, up to the end of the month in which their 26th birthday occurs.

Your children may include your:

- 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.

A dependent also includes a child for whom health care coverage is required through a “Qualified Medical Child Support Order” or other court or administrative order and who falls within one of the above three categories.
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 age limit; and
• Depends mainly on you for support and maintenance.

You must provide proof of your child’s disability to Aetna no later than 31 days after your child reaches the dependent age limit. Aetna 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.

**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; or
• A Myofacial Pain Dysfunction (MPD); or
• Any similar disorder in the relationship between the jaw joint and the related muscles and nerves.

**Medically Necessary or Medical Necessity**
Health care or dental services, and supplies or prescription drugs that a Physician, other health care provider or Dental 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:

a) In accordance with generally accepted standards of medical or dental practice;
b) Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's Illness, Injury or disease; and
c) Not primarily for the convenience of the patient, Physician, other health care or Dental Provider; and
d) 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 or Dentists practicing in relevant clinical areas and any other relevant factors.

**Network Provider**
This is a Dentist who belongs to Aetna’s network and has contracted to furnish services or supplies at a Negotiated Charge.

**Negotiated Charge (Fee)**
This is the maximum charge a Network Provider has agreed to make for any service or supply for the purpose of benefits under this Plan.

**Non-Occupational Illness**
A non-occupational illness is an illness that does not:

- Arise out of (or in the course of) any work for pay or profit; or
- Result in any way from an illness that does.

An Illness will be deemed to be non-occupational regardless of cause if proof is furnished 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**
A non-occupational injury is an accidental bodily injury that does not:

- Arise out of (or in the course of) any work for pay or profit; or
- Result in any way from an injury which does.

**Out-of-Network Provider**
This is a Dentist who does not belong to Aetna’s network and has not contracted with Aetna to furnish services or supplies at a Negotiated Charge.
**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 which 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 which 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
- A physician is not you or related to you.

**Plan**
“Plan” means the Occidental Petroleum Corporation Welfare Plan, and as used in this Summary Plan Description, unless the context otherwise plainly requires, “Plan” further means the dental benefits described here. Also, in this Summary Plan Description, “Plan” is used interchangeably with “Dental Plan.”

**Recognized Charge**
The covered expense is only that part of a charge which is the recognized charge.

As to dental expenses, the recognized charge for each 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 (below);
- for the Geographic Area where the service is furnished.

If Aetna has an agreement with a provider (directly, or indirectly through a third party) which sets the rate that Aetna will pay for a service or supply, then the recognized charge is the rate established in such agreement.

Aetna may also reduce the recognized charge by applying Aetna Reimbursement Policies. Aetna Reimbursement Policies address the appropriate billing of services, taking into account factors that are relevant to the cost of the service such as:

- the duration and complexity of a service;
• whether multiple procedures are billed at the same time, but no additional overhead is required;
• whether an assistant surgeon is involved and necessary for the service;
• if follow up care is included;
• whether there are any other characteristics that may modify or make a particular service unique; and
• 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.

Aetna Reimbursement Policies are based on Aetna's review of: the policies developed for Medicare; the generally accepted standards of medical and dental practice, which are based on credible scientific evidence published in peer-reviewed literature generally recognized by the relevant medical or dental community or which is otherwise consistent with physician or dental specialty society recommendations; and the views of physicians and dentists practicing in the relevant clinical areas. Aetna uses a commercial software package to administer some of these policies.

As used above, Geographic Area and Prevailing Charge Rates are defined as follows:

• Geographic Area: This means an expense area grouping defined by the first three digits of the U.S. Postal Service zip codes. If the volume of charges in a single three digit zip code is sufficient to produce a statistically valid sample, an expense area is made up of a single three digit zip code. If the volume of charges is not sufficient to produce a statistically valid sample, two or more three digit zip codes are grouped to produce a statistically valid sample. When it is necessary to group three digit zip codes, the grouping never crosses state lines.
• Prevailing Charge Rates: These are the rates reported by FAIR Health, a nonprofit company, in their database. FAIR Health reviews and, if necessary, changes these rates periodically. Aetna updates its systems with these changes within 180 days after receiving them from FAIR Health.

**Important Note**
Aetna periodically updates its systems with changes made to the Prevailing Charge Rates. What this means to you is that the recognized charge is based on the version of the rates that is in use by Aetna on the date that the service or supply was provided.

**Additional Information**
Aetna's website, [www.aetna.com](http://www.aetna.com), may contain additional information which may help you determine the cost of a service or supply. Log on to Aetna Navigator to access the "Estimate the Cost of Care" feature. Within this feature, view our "Cost of Care" and "Member Payment Estimator" tools, or contact our Customer Service Department for assistance.