SUMMARY PLAN DESCRIPTION

GENERAL PURPOSE HEALTH FLEXIBLE SPENDING ARRANGEMENT

Effective January 1, 2021

General Purpose Health Flexible Spending Arrangement Benefit Program Summary Plan Description Effective as of January 1, 2021

The General Purpose Health Flexible Spending Arrangement Program ("Program") allows participants to make certain pre-tax deductions from their base compensation which can then be used to pay for certain copayments, deductibles, and qualifying health care expenses.

The Program is incorporated into the Occidental Petroleum Corporation Welfare Plan* (the "Plan") solely for the purposes of mandatory reporting on IRS Form 5500. The following pages consist of the Summary of the Occidental Petroleum Corporation Cafeteria Benefit Plan ("Cafeteria Benefit Plan") which covers the terms and conditions of the Program. The Cafeteria Benefit Plan is separate from the Plan and the provisions of the Plan do not govern the Cafeteria Benefit Plan or otherwise apply to it.

About the Summary Plan Description:
The Program is a part of the Occidental Petroleum Corporation Welfare Plan (the "Plan").[*] The full Summary Plan Description consists of a wrap-around summary plan description document ("Wrap-SPD") and the Benefit Program Summary Plan Descriptions ("Benefit Program SPDs") for each benefit program under the Plan.

This document that you are reading is the Benefit Program SPD for the Program. This Benefit Program SPD must be read together with the Wrap-SPD because both documents contain terms and provisions that are applicable to the Program. For additional information regarding the interaction of this Benefit Program SPD (including the Certificate) with the Wrap-SPD, please consult Article II "Interpretation" of the Wrap-SPD.

To view the Wrap-SPD click here. Alternatively, to request a hardcopy or an electronic copy please contact the OxyLink Employee Service Center (OxyLink) by email or call 1-800-699-6903 (inside US) and 1-918-610-1990 (outside US) and an OxyLink representative will be happy to assist you.

[*] The Program is provided under the "General Health & Welfare Component" of the Plan. Other benefits unrelated to the Program are provided under a separate component of the Plan. For purposes of this Benefit Program SPD, references to the "Plan" will mean the General Health & Welfare Component unless otherwise specified or appropriate in context.

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I. PLAN INTRODUCTION

The Better You Plan, the More You Save.

It's more than a slogan. The Occidental Petroleum Corporation Cafeteria Benefit Plan (the "**Plan**"), which is sponsored by Occidental Petroleum Corporation (the "**Company**") is a real solution to issues facing all of us. Simply stated, by taking advantage of tax laws, the Plan works to save you money.

The Plan offers you tax-advantaged ways to help pay for (1) medical, dental and/or vision benefit coverage provided to you and your eligible dependents under the Oxy Welfare Plan through the Premium Conversion Benefit, (2) dependent care expenses that you incur which allow you and your Spouse to work through the Dependent Care Assistance Program, and (3) out-of-pocket health care expenses that are not covered by the Oxy Welfare Plan or any other health benefit plan or insurance through the Health Flexible Spending Arrangement. In addition, if you meet certain eligibility criteria described in this "Summary of the Occidental Petroleum Corporation Cafeteria Benefit Plan" ("**Summary**"), the Plan provides you with funding of (a) pre-tax, compensation-reduction contributions to an individual "health savings account" ("**HSA**") that you maintain with the Company's designated HSA Custodian through the Participant HSA Contribution Benefit and (b) employer matching contributions to your HSA through the Employer HSA Matching Contribution Benefit. The Participant HSA Contribution Benefit and Employer HSA Matching Contribution Benefit, together, constitute the HSA Contribution Benefit.

The Premium Conversion Benefit, Dependent Care Assistance Program, Health Flexible Spending Arrangement, and Participant HSA Contribution Benefit are referred to collectively in this Summary as the "**Optional Benefits**". The Optional Benefits and the Employer HSA Matching Contribution Benefit are referred to collectively in this Summary as the "**Covered Benefits**".

The Company is pleased to sponsor the Plan for you and your fellow employees. Under federal tax laws, the Plan is considered a "cafeteria plan" because it lets you choose from several different Optional Benefits according to your individual needs. The Plan provides you with the opportunity to use pre-tax dollars to pay for your benefits instead of using a corresponding amount of your after-tax regular pay. This arrangement helps you because the benefits you elect are nontaxable; you save Social Security and income taxes on the amount of your Optional Benefits. In addition, the benefits that you may receive under the Employer HSA Matching Contribution Benefit are paid on a pre-tax basis.

This Summary describes the basic features of the Plan, how it operates, and how you can get the maximum advantage from it. The various Covered Benefits available under the Plan are described in this Summary, as well as in information materials distributed prior to each open enrollment period.

This Summary will help you understand the Plan. It covers how the Plan (including the Premium Conversion Benefit, the Dependent Care Assistance Program, the Health Flexible Spending Arrangement and the HSA Contribution Benefit) works, how the Plan can save you money, the Plan's rules, and how you can elect to participate in the Plan.

Because using the Plan wisely can save you a significant amount of money each year, it is important that you understand how the Plan works and how you can make the most of the advantages that the Plan has to offer.

After you read this material, if you have any questions, or if you would like a copy of the official Plan document, please contact the OxyLink Employee Service Center (see contact information in Article XII). The capitalized terms in this Summary are defined in Article II below. Whenever appropriate, the use of masculine pronouns in this Summary includes the feminine gender, and the singular tense includes the plural. References in this Summary to "you" mean a Participant (or Employee, as applicable in context). The capitalized terms used in this Summary will have the meanings set forth in Article II and as provided elsewhere in this Summary; provided, however, the definitions of certain capitalized terms contained in this introduction are provided solely for convenience of reference within this introduction. Any reference to an "Appendix" in this Summary will mean an Appendix to this Summary unless otherwise stated.

Applicable Law

It is intended that the Plan meet all applicable requirements of the Code and the Employee Retirement Income Security Act of 1974, as amended ("**ERISA**"), and the regulations and other authority issued thereunder, although ERISA does not apply to the Dependent Care Assistance Program, the HSA Contribution Benefit or the Premium Conversion Benefit (although ERISA does apply to the Oxy Welfare Plan which underlies the Premium Conversion Benefit). The Health Flexible Spending Arrangement is intended to qualify as an "employee welfare benefit plan" under ERISA Section 3(1). The Plan will be construed, operated, and administered accordingly.

Plan Controls

This Summary contains only a summary of the Plan. In the event of any discrepancy between the legal Plan document and this Summary, the legal Plan document will control.

II. IMPORTANT TERMS

The following is a list of defined terms that are used in this Summary.

1. "**Affordable Care Act**" means the Patient Protection and Affordable Care Act of 2010, as amended, and any regulations and other legal authority promulgated thereunder by the appropriate governmental authority, as appropriate in context.

2. "**Annual Enrollment Period**" means the time period during a Plan Year, as designated by the Plan Administrator, for eligible Employees and Participants to make elections for Optional Benefits to be effective with respect to the next following Plan Year.

3. "**Claims Administrator**" means the person or third-party entity, if any, that has been retained by the Company or Plan Administrator to provide claims processing and other administrative services under the Plan. The Claims Administrator for both the Health Flexible Spending Arrangement and Dependent Care Assistance Program is:

PayFlex
P.O. Box 4000
Richmond, KY 40476
Telephone (toll-free): 844-PAYFLEX (844-729-3539)
Outside the U.S.: 402-345-0666

The Plan Administrator has designated the Claims Administrator as the named claims

fiduciary with respect to reviewing and making final decisions regarding benefit claims under the Health Flexible Spending Arrangement and Dependent Care Assistance Program and has delegated sole responsibility and authority to the Claims Administrator for such purpose.

4. "**Code**" means the Internal Revenue Code of 1986, as amended, and any Treasury Regulations and other legal authority issued under the Code by the appropriate governmental authority, as appropriate in context. References to any section of the Code or the Treasury Regulations include reference to any successor section or provision thereof, as applicable.

5. **"Company"** means Occidental Petroleum Corporation, or its successor in interest.

6. "**Compensation**" means your earned wages or salary from the Employer.

7. "**Covered Benefit**" means each of (a) the Premium Conversion Benefit, (b) the Dependent Care Assistance Program, (c) the Health Flexible Spending Arrangement, and (d) the HSA Contribution Benefit.

   The rules regarding the Premium Conversion Benefit, the Dependent Care Assistance Program, the Health Flexible Spending Arrangement and the HSA Contribution Benefit are described in more detail in the Plan and this Summary. However, the rules regarding benefits coverage under the Oxy Welfare Plan (which underlies the Premium Conversion Benefit) are set forth in the separate governing documents of the Oxy Welfare Plan. You can obtain a copy of certain documents regarding the Oxy Welfare Plan upon written request to the OxyLink Employee Service Center (see contact information in Article XII).

8. "**COVID Disregarded Period**" means as applicable to each Participant individually, and with respect to each elapsed timeframe ("**Compliance Timeframe**") or specified deadline date ("**Compliance Deadline Date**") under the Health Flexible Spending Arrangement that is subject to relief under the "Extension of Certain Timeframes for Employee Benefit Plans, Participants, and Beneficiaries Affected by the COVID-19 Outbreak", at 86 FR 26351 (May 4, 2020) (the "**Relief Notice**"), the period described as follows:

   (a) With respect to any such Compliance Timeframe:

      (i) If the first day of the Compliance Timeframe ("**Timeframe Start Date**") occurs on or prior to March 1, 2020, the period which (A) begins on March 1, 2020 and (B) ends on the 60th day following the announced end of the COVID National Emergency or such other date announced by the DOL in authoritative guidance issued subsequent to the Relief Notice ("**Relief End Date**"), or February 28, 2021, if earlier; or

      (ii) If the Timeframe Start Date occurs after March 1, 2020 (but on or prior to the Relief End Date), the period which begins on the Timeframe Start Date and ends on the Relief End Date (or the date that is 364 days following the Timeframe Start Date, if earlier); and

   (b) With respect to any such Compliance Deadline Date that occurs on or after March 1, 2020 and on or prior to the Relief End Date, the period which (i) begins on March 1, 2020 and (ii) ends on the Relief End Date (or the date that is 364 days following the Compliance Deadline Date, if earlier).

The COVID Disregarded Period will be inapplicable in the case of a Compliance Timeframe that begins after the Relief End Date or a Compliance Deadline Date that occurs prior to March 1, 2020 or after the Relief End Date. The COVID Disregarded Period is intended to comply with ERISA Section 518, Code Section 7508A(b), the Relief Notice, and any applicable authoritative guidance related to the foregoing, as issued or adopted by the appropriate government agencies, and will be interpreted and construed accordingly.

9. "**COVID National Emergency**" means the national emergency beginning on March 1, 2020, as determined by the President of the United States on March 13, 2020, under Section 501(b) of the Robert T. Stafford Disaster Relief and Emergency Assistance Act, 42 USC § 5121 *et seq.*, as a result of the COVID-19 outbreak and declared by the President on March 13, 2020, in the "Proclamation on Declaring a National Emergency Concerning the Novel Coronavirus Disease (COVID-19) Outbreak".

10. "**Dependent**" means an individual who qualifies as your dependent for federal income tax purposes, as defined in Code Section 152, with the following exceptions:

    (a) For purposes of accident or health coverage under a Covered Benefit, including the Health Flexible Spending Arrangement, "Dependent" means an individual who qualifies as your dependent as defined in Code Sections 105(b) and 106, as amended by the Affordable Care Act; and

    (b) For purposes of the Dependent Care Assistance Program, "Dependent" means a Qualifying Individual.

    The Plan Administrator and/or Claims Administrator each reserve the right to require evidence from a Participant of an individual's status as a "Dependent". If the Plan Administrator and/or Claims Administrator so requires, the Participant must provide such evidence to the Plan Administrator and/or the Claims Administrator (or the delegate of either) in the form and manner, and within the timeframe, specified by the Plan Administrator and/or the Claims Administrator (or the delegate of either). Such evidence may include, but is not limited to, certifications, affidavits or other written or electronic documentation. The Plan Administrator and/or the Claims Administrator (or the delegate of either) will determine, in its or their discretion, whether such evidence reasonably substantiates such individual's status as a "Dependent" under the Plan.

    Nothing in this section is intended to restrict or enlarge the definition of "Dependent" established by any Covered Benefit offered under the Plan.

11. "**Dependent Care Assistance Program**" means the Covered Benefit under the Plan which provides reimbursements of qualifying dependent care expenses, as described in Article VI.

12. "**Earned Income**" means all income derived from wages, salaries, tips, self-employment and other employee compensation (such as disability benefits), but only if such amounts are includible in gross income for the taxable year. However, "Earned Income" does not include (a) any amounts received under any dependent care assistance program under Code Section 129, or (b) any other amounts excluded from earned income under Code Section 32(c)(2). The Spouse of a Participant who is not employed during a month in which the Participant incurs

a qualifying dependent care expense, and who is either a full-time student or a Qualifying Individual who is physically or mentally incapable or self-care under Section II.44(c) during that month, will be deemed for each such month to be gainfully employed and to have a monthly Earned Income of $250 for one Dependent or $500 for two or more Dependents.

13. "**Election Agreement**" means the written, electronic or telephonic agreement, as prescribed by the Plan Administrator, pursuant to which an eligible Employee's Compensation is reduced each payroll period in an amount equal to his elected contributions to the Plan or a particular Optional Benefit. The Plan Administrator may revise the Election Agreement at any time to satisfy the requirements of the Code and other applicable law.

14. "**Employee**" means an individual who is in an employer-employee relationship as a "common law" employee with the Employer and on the United States payroll records of the Employer for federal income tax withholding purposes. The term "Employee" will not include any person during any period that such person was classified on the Employer's records as other than an Employee, including anyone classified as an independent contractor, agent, leased employee, contract employee or similar classification, regardless of a determination by a governmental agency or court that any such person is or was a common law employee of an Employer. The term "Employee" also does not include a non-resident alien who does not receive any United States source income from the Employer, any sole proprietors, partners in a partnership, directors solely serving on the Employer's board of directors (and not otherwise providing services to the Employer as an employee), and 2% shareholders of an S corporation.

15. "**Employee Benefits Committee**" means the Occidental Petroleum Corporation Employee Benefits Committee, which is a committee of one or more Employees appointed by the Fiduciary Appointment Officer to act as named fiduciary and Plan Administrator of the Plan. References in this Summary to the Employee Benefits Committee or Plan Administrator will include, when appropriate, any Claims Administrator, claims fiduciary or other person or entity who has been delegated the appropriate authority by the Plan Administrator under the terms of the Plan or a separate written agreement.

16. "**Employer**" means the Company or an entity related to the Company that has adopted the Plan in accordance with its terms. The adopting Employers of the Plan are listed in the Adopting Employers Appendix.

17. "**Employer HSA Matching Contribution Benefit**" means the component of the HSA Contribution Benefit which provides for pre-tax, matching contributions by the Employer to the Health Savings Accounts of Participants in the Participant HSA Contribution Benefit, as described in Article VII.

18. "**ERISA**" means the Employee Retirement Income Security Act of 1974, as amended, and any regulations and other legal authority promulgated thereunder by the appropriate governmental authority, as appropriate in context. References to any section of ERISA or such regulations in this Summary include any successor section or provision of ERISA or such regulations, as applicable.

19. "**Fiduciary Appointment Officer**" means the Vice President of Human Resources of the Plan Sponsor (or the successor to such position) or his or her designee.

20. "**Flexible Spending Account**" means a Participant's account under the Dependent Care

Assistance Program or Health Flexible Spending Arrangement, as applicable in context.

21. "**Flexible Spending Account Benefit**" means either the Dependent Care Assistance Program or the Health Flexible Spending Arrangement, as applicable in context.

22. "**FMLA**" means the Family and Medical Leave Act of 1993, as amended.

23. "**General Purpose Health FSA**" means the coverage option of the Health Flexible Spending Arrangement under which reimbursement of qualifying health expenses is not limited to Limited Coverage Expenses.

24. "**Health Flexible Spending Arrangement (Health FSA)**" means the Covered Benefit under the Plan which provides for reimbursements of qualifying health expenses, as described in Article V. Two types of Health FSAs are provided under the Plan: (a) the Limited Purpose Health FSA, and (b) the General Purpose Health FSA. To the extent of, and solely for purposes of, the applicable Form 5500 reporting requirements under Title I of ERISA, the Health Flexible Spending Arrangement is considered a component of the Oxy Welfare Plan.

25. "**Health Savings Account" or "HSA**" means a health savings account under Code Section 223 that is established by an eligible Employee with the HSA Custodian and funded with contributions under the Plan. A Health Savings Account is not intended to be a plan which is subject to ERISA, nor is it sponsored by the Plan Sponsor or any other Employer, but it is an individual trust or custodial account owned by the Participant. No Health Savings Account is itself a Covered Benefit under the Plan

26. "**HSA Catch-up Contributions**" means the additional contributions that a Participant who attains age fifty-five (55) before the end of the Plan Year is permitted to make under the Participant HSA Contribution Benefit, in accordance with Code Section 223(b)(3). The Plan Administrator will decide whether a Participant is eligible to make HSA Catch-up Contributions based on its determination of the Participant's age, and, for that purpose, the Plan Administrator is permitted to rely on the Participant's representation as to his date of birth.

27. "**HSA Contribution Benefit**" means the Covered Benefit which provides for the funding of pre-tax contributions to the Health Savings Accounts of Participants, as described in Article VII. The HSA Contribution Benefit consists of two components: (a) the Participant HSA Contribution Benefit and (b) the Employer HSA Matching Contribution Benefit.

28. "**HSA Custodian**" means the person or entity that has been designated by the Plan Sponsor to serve as the custodian or trustee of the HSAs that are (a) established by Participants in conjunction with participation in the Oxy High Deductible Health Plan, and (b) funded through participation in the HSA Contribution Benefit.

29. "**HSA-Eligible Individual**" means an "eligible individual" for health savings account purposes, as defined in Section 223(c) of the Code. Whether an Employee is an HSA-Eligible Individual will be based solely on the Employee's certification of his HSA eligibility status during the Plan's enrollment (or disenrollment) process. The Employee must provide certification of his HSA eligibility status in a form and manner prescribed by the Plan Administrator; provided, however, the Plan Administrator will have no obligation to verify the Employee's status as an HSA-Eligible Individual except to the extent of determining

whether, as of the first day of a given month, the Employee is covered under (a) the Oxy High Deductible Health Plan, or (b) the General Purpose Health FSA or any other low deductible health plan(s) sponsored by the Plan Sponsor or other Employer that disqualifies the Employee from being an HSA-Eligible Individual.

30. "**Limited Coverage Expenses**" mean qualifying health expenses for:

    (a) dental care or vision care; and

    (b) preventive care as described in Code Section 223(c)(2)(C) and IRS Notice 2004-23.

31. "**Limited Purpose Health FSA**" means a combination limited purpose and post-deductible Health Flexible Spending Arrangement that meets the requirements of Section 1.125-5(m) of the proposed Treasury Regulations, and for which reimbursement of qualifying health expenses is limited to Limited Coverage Expenses until a Participant's deductible under the Oxy High Deductible Health Plan has been met. Once a Participant has met the deductible under the Oxy High Deductible Health Plan, any qualifying health expenses incurred thereafter may be reimbursed through the Limited Purpose Health FSA.

32. "**Election Agreement**" means a written or electronic agreement whereby your Compensation is reduced each payroll period in an amount equal to your elected contributions toward the Optional Benefits.

33. "**Oxy High Deductible Health Plan (Oxy HDHP)**" means a "high deductible health plan", as defined in Code Section 223(c), that is sponsored by the Plan Sponsor and provided as a benefit under the Oxy Welfare Plan.

34. "**Oxy Welfare Plan**" means the Occidental Petroleum Corporation Welfare Plan, as amended from time to time.

35. "**Participant**" means an eligible Employee who has properly enrolled and is participating in the Plan.

36. "**Participant HSA Contribution Benefit**" means the component of the HSA Contribution Benefit which provides for pre-tax, Compensation-reduction contributions to the Participant's Health Savings Account, as described in Article VII.

37. "**Period of Coverage**" generally means the Plan Year, except that for an eligible Employee who first becomes eligible to participate and enrolls (or is enrolled) in a Covered Benefit during the Plan Year (or for an eligible Employee who recommences participation during a Plan Year, as applicable), the Period of Coverage is the portion of the Plan Year beginning on the date on which participation in such Covered Benefit commences and ending on the last day of the Plan Year. In the event that a Participant's participation in a Covered Benefit terminates prior to the end of the Plan Year, the Period of Coverage will automatically end on the date of such termination of participation.

38. "**Permitted Change Event**" means an event described in the Plan which will permit a Participant to change his Optional Benefit election during a Plan Year.

39. "**Plan**" means the Occidental Petroleum Corporation Cafeteria Benefit Plan, as it may be amended from time to time.

40. "**Plan Administrator**" means the Employee Benefits Committee, which has the authority and responsibility to manage and direct the operation and administration of the Plan in its discretion. The day-to-day administration of the Plan will be the responsibility of the Plan Administrator. However, the Plan Administrator may assign or delegate duties to third parties, such as the Claims Administrator, under the terms of the Plan or by means of a separate written agreement. References in this Summary to the "Plan Administrator" will also include, when appropriate, any Claims Administrator, claims fiduciary or other person or entity who has been delegated the appropriate authority by the Plan Administrator under the terms of the Plan or a separate written agreement.

41. "**Plan Sponsor**" means the Company, or any successor of the Company that continues the Plan.

42. "**Plan Year**" means the twelve (12) month calendar year ending on each December 31st. For an Employer that adopts the Plan during a Plan Year, the Employer will be considered an adopting Employer under the Plan for the period beginning on the effective date of the adoption and ending on December 31st, *i.e.*, the last day of the Plan Year, unless the Employer terminates its participation in the Plan before the end of the Plan Year.

43. "**Premium Conversion Benefit**" means the Covered Benefit under the Plan which provides for pre-tax, Compensation-reduction contributions for medical, dental and/or vision benefit coverage elected by the Participant under the Oxy Welfare Plan, as described in Article III.

44. "**Qualifying Individual**" means, in accordance with Code Section 21(b)(1):

    (a) Your "qualifying child" dependent for federal income tax purposes (as defined in Code Section 152(a)(1)) who is under the age of thirteen (13);

    (b) Your dependent for federal income tax purposes under Code Section 152, determined without regard to subsections (b)(1) (*i.e.*, the "exclusion of dependents of dependents"), (b)(2) (*i.e.*, the "exclusion of married dependents filing joint tax return"), and (d)(1)(B) (*i.e.*, the "gross income limit for qualifying relatives") of Section 152, who is physically or mentally incapable of caring for himself and who has the same principal place of abode as you for more than half of the taxable year; or

    (c) Your Spouse, if your Spouse is physically or mentally incapable of caring for himself, and who has the same principal place of abode as you for more than half of the taxable year.

    If you are divorced or separated, a Qualifying Individual who is a child will, as provided in Code Section 21(e)(5), be treated as a Qualifying Individual of his custodial parent (within the meaning of Code Section 152(e)) and will not be treated as a Qualifying Individual with respect to his noncustodial parent.

45. "**Spouse**" means a person to whom you are lawfully married, which marriage was solemnized, authenticated and recorded as required by the state or foreign jurisdiction in which the marriage took place, to the extent such marriage is legally recognized as valid for purposes of applicable Federal law (including, but not limited to, the Code), and any regulations issued under such applicable Federal law, but will not include an individual who is (a) divorced from you under a court-approved divorce decree or (b) legally separated from

you. The term "Spouse" will also include your common law spouse if you and your spouse became common law married in a state which recognizes common law marriages and meet all the requirements for common law marriage in that state. You must provide proof of a ceremonial or common law marriage if and as requested by the Plan Administrator, such as, for example, an affidavit of marriage, or a marriage license or certificate of common law marriage issued by the applicable state

Notwithstanding the foregoing, for purposes of the Dependent Care Assistance Program, the term "Spouse" will not include an individual who is married to you, but files a separate federal income tax return, where (a) you maintain as your home a household that is the principal place of abode of a Qualifying Individual for more than one-half of the taxable year, (b) you furnish over one-half of the cost of maintaining that household during such taxable year, and (c) during the last six (6) months of such taxable year, the individual is not a member of that household.

46. "**Summary**" means this summary of the Plan. For purposes of the Health Flexible Spending Arrangement, this Summary constitutes the requisite "summary plan description" of the Health Flexible Spending Arrangement under ERISA.

47. "**Treasury Regulations**" means the regulations issued by the federal Department of the Treasury under the Code, including (as applicable in context) the proposed regulations issued by the federal Department of the Treasury under Code Section 125 at 72 FR 43937 (Aug. 6, 2007). References herein to any section of the Treasury Regulations include any successor section or provision thereto, as applicable.

III. OVERVIEW OF THE PLAN / ELIGIBILITY AND ENROLLMENT

This Summary will tell you important information about the Plan, such as the requirements that you must satisfy before you can join and the laws that protect your rights. One of the most important features of the Plan is that the Optional Benefits can be purchased with a portion of your Compensation *before* federal income and Social Security taxes are withheld. This means that your payroll "redirection" contributions to the Plan are made before you pay taxes; therefore, you pay less tax and have more money to spend or save.

Please read this Summary thoroughly and carefully so that you will understand the key provisions of the Plan. You should direct any questions to the OxyLink Employee Service Center (see contact information in Article XII).

The Plan is comprised of three basic types of tax-advantaged components:

(1) Premium Conversion Benefit. When you enroll for coverage under an Oxy Welfare Plan and you elect to participate in the Premium Conversion Benefit, your portion of the cost for such coverage will be deducted from your salary or wages on a *pre-tax* basis under the Plan, if you so elect. Please note that your share of the cost for coverage under the Oxy Welfare Plan may be changed periodically. Any such adjustment will be made on a nondiscriminatory basis with respect to similarly situated participants. No other changes to your election for Oxy Welfare Plan coverage will be allowed during a Period of Coverage, except if you have a Permitted Change Event as described in the section below entitled "Plan Rules and Limitations." Before the start

of each new Plan Year, you will also have an opportunity to modify your coverage elections for the next Plan Year during the Annual Enrollment Period.

(2) Flexible Spending Account Benefits. The second basic component of the Plan is the Flexible Spending Account Benefits component, which consists of the Dependent Care Assistance Program and the Health Flexible Spending Arrangement. Each eligible Employee may participate in the Dependent Care Assistance Program and/or the Health Flexible Spending Arrangement. If you elect to participate in either or both of these Flexible Spending Account Benefits, you may set aside part of your Compensation to pay for qualifying health and/or dependent care expenses on a pre-tax basis.

Two types of Health Flexible Spending Arrangements are provided under the Plan: (a) the Limited Purpose Health FSA, and (b) the General Purpose Health FSA. The Limited Purpose Health FSA is a combination limited purpose and post-deductible Health Flexible Spending Arrangement for which reimbursement of a Participant's qualifying health expenses is limited to Limited Coverage Expenses until his deductible under the Oxy High Deductible Health Plan has been met. Once a Participant has met the deductible under the Oxy High Deductible Health Plan, any qualifying health expenses incurred thereafter may be reimbursed through the Limited Purpose Health FSA. The General Purpose Health FSA is the Health Flexible Spending Arrangement under which reimbursement of a Participant's qualifying health expenses is not limited to qualifying expenses that constitute Limited Coverage Expenses.

The Flexible Spending Account Benefits are discussed in more detail later in this Summary.

(3) HSA Contribution Benefit. Employees who are HSA-Eligible Individuals, and meet other eligibility requirements, may elect to set aside part of their Compensation to contribute to their individual HSAs established with the Company's designated HSA Custodian under the Participant HSA Contribution Benefit. In addition, the Plan provides Participants in the Participant HSA Contribution Benefit with funding of matching contributions to their HSAs through the Employer HSA Matching Contribution Benefit. The Participant HSA Contribution Benefit and the Employer HSA Matching Contribution Benefit are described in more detail later in this Summary.

Eligibility and Enrollment Requirements

After you satisfy the applicable eligibility requirements below, and before the Period of Coverage begins, you will be furnished with information regarding the Plan and the Covered Benefits.

Eligibility / Premium Conversion Benefit

The Premium Conversion Benefit corresponds to your coverage under the Oxy Welfare Plan. You are eligible to participate in the Premium Conversion Benefit effective as of the date that you become a participant in the corresponding medical, dental and/or vision benefit coverage under the Oxy Welfare Plan. You will not be eligible to receive coverage under the Premium Conversion Benefit until you satisfy the eligibility and enrollment requirements for the corresponding medical, dental

and/or vision benefit coverage under the Oxy Welfare Plan.

Subject to the "Former Participants" section, below, if you are an eligible Employee who is rehired by an Employer following a severance of employment with your Employer, you will be eligible to participate in the Premium Conversion Benefit effective as of the same date that you recommence participation in the corresponding medical, dental and/or vision benefit coverage under the Oxy Welfare Plan.

Eligibility / Health Flexible Spending Arrangement

Further subject to subsections (a) and (b), below, an Employee will be eligible to participate in the Health Flexible Spending Arrangement effective as of the first date that he becomes eligible to participate in major medical coverage under the Oxy Welfare Plan.

(a) An eligible Employee who (i) is enrolled in the Oxy High Deductible Health Plan, and (ii) is an HSA-Eligible Individual that maintains a Health Savings Account with the HSA Custodian, will be eligible for coverage only under the Limited Purpose Health FSA.

(b) An eligible Employee who does not meet the criteria in subsection (a), above, will be eligible for coverage only under the General Purpose Health FSA.

Eligibility / Dependent Care Assistance Program

An Employee will be eligible to participate in the Dependent Care Assistance Program effective as of the first date that he becomes eligible to participate in major medical coverage under the Oxy Welfare Plan.

Eligibility / HSA Contribution Benefit

- Participant HSA Contribution Benefit. An Employee who, on the first day of a given month during the Plan Year (i) is a participant in the Oxy High Deductible Health Plan, (ii) is an HSA-Eligible Individual, (iii) maintains a Health Savings Account with the HSA Custodian, (iv) has a U.S. residential address (and does not reside in a non-U.S. location that requires local medical insurance), (v) has a U.S. Social Security Number, and (vi) is not covered under the General Purpose Health FSA or any other low deductible health plan which is sponsored by the Plan Sponsor or other Employer that disqualifies the Employee from being an HSA-Eligible Individual, will be eligible to participate in the Participant HSA Contribution Benefit during such month, effective as of the first day of such month.
- Employer HSA Matching Contribution Benefit. An Employee who is a Participant in the Participant HSA Contribution Benefit will be eligible to participate in the Employer HSA Matching Contribution Benefit effective as of the first day of his participation in the Participant HSA Contribution Benefit. However, the Employer may waive the payment of any matching contributions under the Employer HSA Matching Contribution Benefit for a given Plan Year, in which case the waiver will be communicated to eligible Employees during the Annual Enrollment Period for that Plan Year.

General Exclusions from Eligibility

Notwithstanding the "Eligibility and Enrollment Requirements", above, none of the following individuals are eligible to participate in the Plan (or the particular Covered Benefit, as applicable):

- an Employee who is included in a unit of Employees that is covered by a collective bargaining agreement between Employee representatives and the Employer, if the Plan (or a particular Covered Benefit, as applicable) was the subject of good faith bargaining, unless such agreement provides for coverage of such Employees in the Plan (or the particular Covered Benefit, as applicable); or
- an Employee who is employed by a division or operating unit of the Employer for which the Plan (or the particular Covered Benefit, as applicable) has not been adopted; or
- an individual who is not the Employee of an Employer.

New Enrollment

If you are an eligible Employee who is not yet a Participant, you become a Participant by completing and submitting the required individual Election Agreement in which you elect one or more of the Optional Benefits available under the Plan, as well as agree to a deduction from your Compensation to pay for your elected benefits, within the time period specified and in accordance with the Plan Administrator's procedures. You will be provided an Election Agreement when you first become eligible to participate. If you do not then complete and submit the Election Agreement as required for enrollment in the Plan or a particular Optional Benefit, you will be deemed to have elected to waive participation in the Plan or the particular Optional Benefit.

Except in limited circumstances, Employees who were eligible to participate in the Plan for a Plan Year, but who declined to do so, will not be eligible to participate in the Plan until the next January 1st, *i.e.*, the first day of the next Plan Year. Later in this Summary there is an explanation of the Permitted Change Events which permit an Employee to elect to participate or modify a Plan election during a Plan Year.

An eligible Employee's coverage as a Participant in the Plan (or a particular Optional Benefit) will become effective as of the first day of the month next following the date that he satisfies the Plan's enrollment requirements (or if his enrollment takes place as part of the Company's Annual Enrollment Period, the first day of the next Plan Year) ("***Coverage Effective Date***"). However, if the eligible Employee is a new employee of the Employer (*i.e.*, a "***New Hire***") who makes an election to participate in the Plan (or a particular Optional Benefit) within thirty (30) days following his hire date, the eligible Employee's Coverage Effective Date will be the later of (a) his hire date or (b) the date that he became eligible to participate in the Optional Benefit, even if the Coverage Effective Date is retroactive in relation to the date that his election is made. An Employee who terminates employment with the Employer and is rehired within 30 days thereafter (or who returns to active employment following an unpaid leave of absence of less than 30 days) is not considered a New Hire for this purpose.

An Employee who is eligible to participate in the Employer HSA Matching Contribution Benefit will be automatically enrolled in the Employer HSA Matching Contribution Benefit effective as of the first date that he becomes eligible to participate in the Employer HSA Matching Contribution Benefit.

Plan Elections for Existing Participants

After you enroll in the Plan, any coverage election you have in effect under the Premium Conversion Benefit will automatically be renewed each Plan Year unless you make an express election during the Annual Enrollment Period to change your coverage election (including an election to waive coverage) for the ensuing Plan Year. However, the Plan Administrator may decide in the future, in its discretion and with prior notice to Participants, to require you to affirmatively enroll in the Premium Conversion if you want to participate and will deem your failure to complete and submit an Election Agreement as an election to waive participation in the Premium Conversion Benefit.

You must make a new election before the start of each new Plan Year regarding any amounts that you want to contribute under the Dependent Care Assistance Program, the Health Flexible Spending Arrangement and/or the Participant HSA Contribution Benefit. Annual elections for participation in the Dependent Care Assistance Program, the Health Flexible Spending Arrangement and/or the Participant HSA Contribution Benefit must be made by completing and submitting a new Election Agreement prior to the beginning of each Plan Year during the Annual Enrollment Period.

Former Participants

(a) Except as provided in subsection (b), below, a Participant who ceases to participate in an Covered Benefit due to the occurrence of a Permitted Change Event may, to the extent that he is an eligible Employee with respect to such Covered Benefit, recommence participation at any time upon the occurrence of another Permitted Change Event (subject to the terms of the "Changing Your Plan Election (Permitted Change Events)" section of Article VIII, below, and the particular Covered Benefit) or as of the first day of any subsequent Plan Year.

(b) Except as otherwise provided in subsection (c), below, if a Participant ceases to participate in the Plan because of his termination of employment or because he is no longer an eligible Employee and then again becomes an eligible Employee, he will be treated as a newly hired employee for purposes of recommencement of participation in the Plan.

(c) If a former Participant again becomes eligible to participate in the Plan (or a particular Covered Benefit) within 30 days of the date his participation previously ceased, his election that was in effect on the date participation previously ceased will be reinstated, effective as of the date on which he regains eligibility, unless he has experienced a separate Permitted Change Event (other than a termination of employment and reemployment) that otherwise allows him to make an election change under the "Changing Your Plan Election (Permitted Change Events)" section of Article VIII, below, as applicable.

Mid-Year Election Changes

Except with respect to the Participant HSA Contribution Benefit, your elections of Optional Benefits will remain in effect for the Plan Year (or the remainder of the Plan Year if you make a mid-year election) unless and until your participation ceases under the Plan or your election is properly modified, revoked or terminated based on the occurrence of a "Permitted Change Event". You may change your election under the Participant HSA Contribution Benefit at any time during the Plan Year, prospectively and once for a given month, even if you do not experience a Permitted Change Event. "Permitted Change Events" are discussed in more detail in the "Changing Your Plan Election (Permitted Change Events)" section of Article VIII, below.

If you become ineligible for an Optional Benefit, your election with respect to such Optional Benefit will automatically adjust or terminate to reflect your ineligibility as of the effective date of your ineligibility.

IV. THE PLAN'S FLEXIBLE SPENDING ACCOUNT BENEFITS AT A GLANCE

There are two Flexible Spending Account Benefits available to you under the Plan:

- A ***Health Flexible Spending Arrangement*** which allows you to set aside money tax-free to help pay for your out-of-pocket health expenses; and
- A ***Dependent Care Assistance Program*** which lets you use tax-free money to help pay for dependent care services that are necessary in order for you (or, if married, for you and your Spouse) to go to work.

These Flexible Spending Account Benefits let you deduct dollars from your paycheck on a pre-tax basis. These accounts are exempt from federal income taxes, Social Security (FICA) taxes and, in most cases, state income taxes (if applicable). The more money you put in, the less tax you pay. When you use the money in your account to pay for qualifying out-of-pocket expenses, you avoid paying taxes on those dollars. Depending on your tax bracket, you may save 1/3 or more on such expenses.

How You Use the Plan's Flexible Spending Account Benefits

In short, the Plan lets you set aside tax-free money to reimburse yourself for eligible expenses that you pay out of your own pocket. During the Annual Enrollment Period prior to the beginning of each Plan Year, you will be asked if you want to participate in the Flexible Spending Account Benefits for the next Plan Year. Your accounts under the Flexible Spending Account Benefits are non-interest bearing.

First, you should carefully estimate your upcoming health and dependent care expenses that would be eligible for reimbursement. Later in this Summary you will find worksheets to help you estimate your expenses. You might also want to consult a tax adviser to investigate various alternatives and determine which of your expenses qualify. If you participate in the HSA Contribution Benefit under the Plan and are therefore enrolled in the Limited Purpose Health FSA, you should keep in mind that only Limited Coverage Expenses are reimbursable under the Limited Purpose Health FSA until you meet your deductible under the Oxy High Deductible Health Plan.

You should then decide how much of your Compensation you would like to contribute to the Flexible Spending Account Benefits. When you elect to participate, you designate how much of your wages will be contributed to the Health Flexible Spending Arrangement, and how much will be contributed to the Dependent Care Assistance Program. You do not have to contribute to any Flexible Spending Account Benefit, or you can contribute to one but not the other. The money that you elect to set aside will be "redirected" from your paychecks in equal amounts throughout the year.

The term "redirected" is used because your money is contributed to your Flexible Spending Account Benefits before federal income or Social Security taxes are taken out. By doing this, your taxable income is reduced, and thus you pay less in taxes.

When you have qualifying out-of-pocket expenses, you can be reimbursed from either the

Health Flexible Spending Arrangement (for qualifying health expenses) or the Dependent Care Assistance Program (for qualifying dependent care expenses), as applicable. You can file for payment or reimbursement of your qualifying expenses, as well as the qualifying expenses of your Spouse or Dependent, after each expense has been incurred.

You will have until ***March 31st*** of the year following the end of the Plan Year in which a qualifying expense was incurred to submit a claim for reimbursement under the Health Flexible Spending Arrangement (for qualifying health expenses) or the Dependent Care Assistance Program (for qualifying dependent care expenses), as applicable. Notwithstanding the foregoing, effective as of March 1, 2020, and with respect to the Health Flexible Spending Arrangement only, if the March 31st deadline to file a claim with the Claims Administrator would fall during the COVID Disregarded Period, then the deadline to file such claim with the Claims Administrator will instead be the date that immediately follows the last day of the COVID Disregarded Period, or such later date as determined by the Plan Sponsor and communicated to Participants.

Health expenses are treated as having been incurred when you, your Spouse or your Dependent is provided with the medical care and not when you pay for or are formally billed or charged for the medical care; provided, however, if you have made payment in advance in order to receive orthodontia services, the health expenses for such orthodontia services are deemed to be incurred when the advance payment is made. Dependent care expenses are treated as having been incurred when the dependent care is provided and not when you pay for or is formally billed or charged for the care.

The amount reimbursed is not subject to taxes. Since that money originally came out of your pay *before* taxes were calculated, the result of the Plan is that you pay for the eligible expenses on a tax-free basis.

Statements showing how much is in your accounts under the Health Flexible Spending Arrangement and/or the Dependent Care Assistance Program are available online at the website for the Claims Administrator. Please see Article XII for the Claims Administrator's website address. These statements will let you know how much you have spent and how much you have left.

Forfeiture of Unused Amounts

As you read this booklet and decide how the Plan can help you, there are some very important points to remember. Because you do not pay taxes on the money you put in, the Code places some restrictions on the Plan. In addition to the restrictions on mid-year election changes (as discussed above under the "Mid-Year Election Changes" section), another Code and Plan limitation requires that you forfeit any money that you contributed to the Flexible Spending Account Benefits but do not use for reimbursements of qualifying expenses during the Plan Year. Such excess contributions will not be returned back to you. If you plan ahead carefully, you can avoid being affected by this restriction.

V. HEALTH FLEXIBLE SPENDING ARRANGEMENT

Benefit Description

You can use the Health Flexible Spending Arrangement to pay for certain health expenses that you would normally pay out of your own pocket for yourself and your eligible Spouse and

Dependents. The "Qualifying Health Expenses" section below describes which types of expenses are reimbursable under the Health Flexible Spending Arrangement ("**qualifying health expenses**").

By using this Covered Benefit, you pay for qualifying health expenses with pre-tax dollars, and you save a percentage of each dollar you spend on qualifying health expenses that are not covered, or fully covered, under the Oxy Welfare Plan or other health plans.

Annual Benefit Election Maximum

If you are eligible and participate in the Health Flexible Spending Arrangement, the maximum annual amount by which you can reduce your Compensation in order to have contributions contributed to the Health Flexible Spending Arrangement on your behalf is $2,750, as indexed for inflation (or other amount, not to exceed such indexed amount, as determined by the Plan Sponsor and communicated to eligible Employees during the Annual Enrollment Period or any mid-year enrollment or election change period for the applicable Plan Year). The minimum annual amount that may be elected for each 12-month Plan Year is $100 (or such other amount as determined by the Plan Sponsor and communicated to eligible Employees during the Annual Enrollment Period or any mid-year enrollment or election change period for the applicable Plan Year). In any event, your elected contributions will be deducted from your pay on a pro-rata basis each payroll period.

Qualifying Health Expenses

A qualifying health expense is an expense incurred during your Period of Coverage by you or your Spouse or Dependent for "medical care", as defined in Code Section 213(d), for which you have not otherwise been reimbursed through insurance or some other source (including the Oxy Welfare Plan, your Health Savings Account, or Medicare); provided, however, qualifying health expenses do *not* include:

- Premium payments for other accident and health coverage;
- Expenses incurred for cosmetic surgery or other similar procedures, unless the surgery or procedure is necessary to ameliorate a deformity arising from, or directly related to, a congenital abnormality, a personal injury resulting from an accident or trauma, or a disfiguring disease (for this purpose, "cosmetic surgery" (i) means any procedure that is directed at improving the patient's appearance and does not meaningfully promote the proper function of the body or prevent or treat illness or disease, but (ii) does not include mastectomy-related services including reconstructions and surgery to achieve symmetry between the breasts, as required by the Women's Health and Cancer Rights Act of 1998);
- Long-term care services and insurance premiums;
- Any expense that is claimed as a federal income tax deduction under Code Section 213;
- Expenses incurred on, or prior to, December 31, 2019 for medicines or drugs (other than insulin) that are not prescribed (determined without regard to whether such drug is available without a prescription); and
- Any other benefit not deemed a "qualified benefit" under Code Section 125(f) and Section 1.125-1(a)(3) of the proposed Treasury Regulations.

For purposes of clarity, expenses incurred for medicines or drugs after December 31, 2019 are not excluded from constituting qualifying health expenses solely because such medicines or drugs are not prescribed (*i.e.*, they are "over-the-counter" medicines or drugs) or are not insulin. Expenses incurred after December 31, 2019, for (a) a "menstrual care product" (as defined in Code Section 223(d)(2)(D)) or (b) personal protective equipment, such as masks, hand sanitizer and sanitizing wipes, for the primary purpose of preventing the spread of COVID-19, will be treated as incurred for "medical care".

Generally, qualifying health expenses under the Health Flexible Spending Arrangement include most medical, dental and vision care expenses that are not covered by the Oxy Welfare Plan or other health plans, such as:

- Oxy Welfare Plan deductibles [§];
- Oxy Welfare Plan copayments;
- Amounts over the maximum that the Oxy Welfare Plan pays; and
- Other qualifying health expenses not covered by the Oxy Welfare Plan or other health plans;

provided, however, if you are a participant in a Limited Purpose Health FSA, your reimbursement of qualifying health expenses is limited to Limited Coverage Expenses until you meet your deductible under the Oxy High Deductible Health Plan. [Note: IRS publications 17 and 502, available at www.irs.gov, have more information on qualifying health expenses; the IRS will provide you with free copies upon request.]

You must enroll in the Health Flexible Spending Arrangement to take advantage of the tax savings and, to be eligible for reimbursement, the qualifying health expense must be incurred during your Period of Coverage. If you terminate employment during the year, any qualifying health expenses you incurred while you were still employed by the Employer and covered under the Health Flexible Spending Arrangement are reimbursable under the Health Flexible Spending Arrangement.

In addition, a health care service must be actually rendered prior to the time that the qualifying health expense is reimbursed. For example, even if your doctor requires that an expense be paid in advance, you cannot be reimbursed from the Health Flexible Spending Arrangement until the service relating to the expense has been rendered; provided, however, if you have made payment in advance in order to receive orthodontia services, the health expenses for such orthodontia services are deemed to be incurred when the advance payment is made. In order to ensure compliance with this requirement, you (and/or your doctor) may be required to submit additional substantiation (such as a proposed treatment plan) with respect to certain long-term treatments (*e.g.*, obstetric expenses). Failure to submit the required forms could result in your reimbursement being pended and/or denied.

The following is a *partial list* of the more common qualifying health expenses for individual personal use as of January 1, 2021 (except as otherwise noted). For many of these expenses, you will first file a claim for coverage under the Oxy Welfare Plan. Any amount not paid by the Oxy Welfare Plan may then be submitted for payment through the Health Flexible Spending Arrangement (subject

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[§] The deductible under the Oxy High Deductible Health Plan (Oxy HDHP) is only eligible for reimbursement if you are covered under the General Purpose Health FSA.

to the applicable limitations on reimbursements under the Limited Purpose Health FSA).

Inclusion on the list below does not guarantee that an expense will be eligible for reimbursement from the Health Flexible Spending Arrangement.

General qualifying health expenses		
• Abdominal Supports, if prescribed by doctor • Abortion Services, if legal • Acupuncture • Ambulance Hire • Air Conditioner for Allergy Relief, if prescribed by doctor (not central air conditioning) • Anesthesia • Arches • Artificial Limbs/Prosthesis • Alcoholism • Back Supports • Birth Control Pills, if prescribed by a doctor • Blood Donor Expenses • Braces • Braille Books/Magazines (only the value above the regular price of the publication) • Breast Reconstruction Surgery (following a mastectomy to ameliorate a deformity related to a disease) • Car Controls for Handicapped • Chiropodist Services • Chiropractic Services • Christian Science Practitioner Services • Convalescent Home Expense (medical treatment only – not custodial care) • Cosmetic Surgery necessary to correct a deformity due to congenital abnormality or	• Dermatologist Fees • Diathermy • Doctor's Office Visits • Drug Treatment • Fertility Enhancement (certain expenses only) • Gynecological Exams • Hospital Bills • Hypnosis for treatment of illness • Hydrotherapy • Immunization • Insulin • Invalid Chair and other supplies • Kidney Donor Expenses • Lab Expenses • Laetrile by Prescription • Lip Reading Lessons • Medical Equipment/Supplies • Midwife Expense • Neurologist Fees • Nurses Fee (including room and board charges)[+] • Nursing Home Expenses[+] • Nursing Care[+] • Obstetrician Fees (upon delivery) • Orthopedic Shoes • Osteopath • Oxygen • Pediatrician Fees • Physical Therapy • Physicians Fees • Physical Exams • Podiatrist • Practical Nurse[+] • Prescription Drugs • Psychiatric Care • Psychologist	• Remedial Reading for Dyslexia • Sacroiliac Belt • Sanitarium" Seeing-Eye" Dog and its upkeep • Sex Therapy, if received as medical treatment • Smoking Cessation Program (including stop smoking drugs by prescription) • Special Diets if not a substitute for regular diet • Special Education for the Blind • Sterilization Fees • Support or Corrective Devices • Surgeon Fees • Therapeutic Care for drug and alcohol abuse • Therapy Treatments • Transportation and Lodging Expenses if paid primarily for and essential to medical care • Transplants • Truss • Vasectomy • Vitamins, if prescribed by doctor • Weight Loss Program, only for treatment of a specific disease diagnosed by a physician (*e.g.*, obesity, hypertension or heart disease) • Well Baby Care • Wheelchair • Wigs, if prescribed by doctor for hair loss by

one caused by personal injury or disfiguring disease • Cost of Operations and related treatments • Co-Payments you pay • Crutches • Deductibles++	• Psychotherapist • Reclining Chair, if prescribed by doctor • Rental of Medical Equipment	disease • Whirlpool Bath, if prescribed by doctor and does not increase the value of the residence • X-rays
Dental Expenses		
• Bridges • Crowns • Dentures	• Exams • Fillings • Orthodontia	• X-rays • Deductibles • Co-Payments you pay
Hearing Expenses		
• Exams	• Hearing Devices and Aids (including batteries)	• Special Communication Equipment for the Deaf
Vision Care Expenses		
• Exams • Contact Lenses • Frames	• Lenses • Solutions • Oculist Services	• Optician Services • Optometrist Services • Radial Keratotomy
Over the Counter Drugs +++		
• Antacids • Allergy Medicine	• Cold Medicine	• Pain Relievers
Other Health Care Expenses		
• Special Schools for Handicapped Persons, if have specific programs to deal with handicapped • Special Home Modifications for Handicapped, if does not increase value of the residence • Life Fees to Retirement Home for Medical Care, if contract allocates an amount to medical fees	• Menstrual Care Products (as defined in Section 223(d)(2)(D) of the Code), if incurred after December 31, 2019 • Personal protective equipment, such as masks, hand sanitizer and sanitizing wipes, for the primary purpose of preventing the spread of COVID-19, if incurred after December 31, 2019	• Membership Fees in association furnishing medical services, hospitalization and clinical care

+ If necessary for medical care (not long-term care).

++ The deductible under the Oxy High Deductible Health Plan (Oxy HDHP) is only eligible for reimbursement if you are covered under the General Purpose Health FSA.

+++ On or prior to, December 31, 2019, only if prescribed.

A more detailed list of qualifying health expenses is available on the Claims Administrator's website.

Estimating Your Reimbursable Qualifying Health Expenses

It is very important that you use all of the money that you have contributed to the Health Flexible Spending Arrangement for a Plan Year because any amounts that are not paid out of your account to reimburse claims must be forfeited and will not be returned back to you. Good planning and careful estimating are the best ways to take full advantage of your account.

This worksheet will help you determine the amount of your Compensation that you should consider redirecting into the Health Flexible Spending Arrangement. You should conservatively estimate enough to cover your family's allowable medical expenses. Because of that, when you estimate your expenses PLEASE BE SURE TO INCLUDE EXPENSES FOR YOU, YOUR SPOUSE, AND YOUR DEPENDENT CHILDREN. In addition, if you are a participant in a Limited Purpose Health FSA, you should keep in mind that your reimbursement of qualifying health expenses is limited to Limited Coverage Expenses until you meet your deductible under the Oxy High Deductible Health Plan.

Part of the worksheet shows an example of estimated amounts for a representative employee. This example assumes an employee who is married and has one child. This is an illustrative example that is only an estimate and is not tax advice. You are advised to consult a tax advisor to determine the appropriate tax advice for your situation. Review your family's medical, dental and vision care bills to estimate your expected expenses for the next Plan Year, and include only those expenses not paid by a group health plan or insurance.

		Example	You
1.	Medical, Dental and Vision Care Deductibles ++++	$ 1,500	____________
2.	Your share of Medical, Dental and Vision Care Copayments	200	____________
3.	Coinsurance	__________	____________
4.	Charges over "reasonable and customary"	__________	____________
5.	Surgical Expenses	__________	____________
6.	Routine Health Exams and Lab Work	__________	____________
7.	Medicines (whether prescription or over-the-counter)	__________	____________
8.	Vision Exams, Glasses, Contact Lenses	150	____________
9.	Hearing Aids	__________	____________
10.	Outpatient Psychiatric Care	__________	____________
11.	Orthodontia	450	____________
12.	Physical Examinations	__________	____________
13.	Other Allowable Expenses	__________	____________
	TOTAL ESTIMATED MEDICAL EXPENSES NOT PAID BY A GROUP HEALTH PLAN OR INSURANCE	$ 2,300	____________

14.	*Divide the total by 12*	$	191.66	____________

++++ The deductible under the Oxy High Deductible Health Plan (Oxy HDHP) is only eligible for reimbursement if you are covered under the General Purpose Health FSA.

This is the monthly figure you should consider redirecting to the Health Flexible Spending Arrangement.

The maximum annual amount by which you can reduce your Compensation in order to have contributions made to the Health Flexible Spending Arrangement on your behalf while you are a Participant is $2,750, as indexed for inflation (or other amount, not to exceed such indexed amount, as determined by the Plan Sponsor and communicated to eligible Employees during the Annual Enrollment Period or any mid-year enrollment or election change period for the applicable Plan Year). The minimum annual amount that may be elected for each 12-month Plan Year is $100 (or such other amount as determined by the Plan Sponsor and communicated to eligible Employees during the Annual Enrollment Period or any mid-year enrollment or election change period for the applicable Plan Year).

Requesting Reimbursement

A description of the specific procedures for filing benefit claims and submitting appeals of adverse benefit determinations is contained in the attached "Claims Procedures For Health Flexible Spending Arrangement Appendix".

The amount available at any given time under the Health Flexible Spending Arrangement to reimburse you for qualifying health expense reimbursement claims is the dollar amount of coverage that you elected for the entire Plan Year, less any amounts that have previously been paid or reimbursed to you for prior claims during the Plan Year. This is the case even though you may not have yet contributed amounts to the Health Flexible Spending Arrangement equal to the amount of your qualifying health expense being claimed. Accordingly, when you submit an acceptable claim, you will receive payment or reimbursement in the amount of your qualifying health expense up to the full amount of contributions you elected for the year, less any prior claim reimbursement amounts.

However, once you have received reimbursements of qualifying health expenses for a Plan Year that, in the aggregate, equal the dollar amount of coverage that you elected under the Health Flexible Spending Arrangement for the Plan Year, you will not be entitled to any additional reimbursements for qualifying health expenses incurred during that Plan Year.

Forfeiture of Unused Balances

Any positive balance remaining in your account under the Health Flexible Spending Arrangement following final payment of all proper claims for qualifying health expenses incurred during a Plan Year (or other Period of Coverage) will be forfeited, and you will forfeit all rights with respect to such balance.

Tax Deduction vs. Health Flexible Spending Arrangement?

The IRS allows you to deduct qualifying health expenses on your tax return if they exceed a specified percentage of your adjusted gross income. If your total out-of-pocket health care expenses

exceed that amount, you may prefer to claim them as itemized deductions on your tax return. However, you may not do so if those same expenses have already been paid with money through the Health Flexible Spending Arrangement.

You can use both the Health Flexible Spending Arrangement and the tax deduction, but you may not claim the same expenses for both.

Privacy and Security of Your Health Information under the Health Flexible Spending Arrangement

The Health Flexible Spending Arrangement is subject to the standards for privacy ("**Privacy Standards**") issued under the Health Insurance Portability and Accountability Act of 1996, as amended ("**HIPAA**"). The Health Flexible Spending Arrangement is also subject to a second set of regulations issued under HIPAA that govern the security of health information which is stored or transmitted electronically ("**Security Standards**"). The HIPAA Privacy and Security Standards require the Health Flexible Spending Arrangement to protect the privacy and security of your individually identifiable health information. This health information is called "Protected Health Information" or "PHI." It is called "Electronic Protected Health Information" or "ePHI" when it is stored or transmitted in an electronic format. Specifically, the Health Flexible Spending Arrangement cannot use or disclose PHI (including ePHI) in any way that would violate the HIPAA Privacy or Security Standards or the Company's privacy and security policies for PHI and ePHI. The HIPAA Privacy and Security Standards also impose a number of other requirements on the Health Flexible Spending Arrangement which are more fully described in the attached HIPAA Medical Privacy and Security Appendix.

COBRA Continuation Coverage

In certain circumstances, you may be entitled to elect COBRA continuation coverage under the Health Flexible Spending Arrangement on an after-tax basis. Please refer to Article VIII for more information.

VI. DEPENDENT CARE ASSISTANCE PROGRAM

Benefit Description

You can use the Dependent Care Assistance Program to pay for certain dependent care expenses that you would normally pay out of your own pocket. The "Qualifying Dependent Care Expenses" section below describes the types of expenses that are reimbursable under the Dependent Care Assistance Program ("**qualifying dependent care expenses**").

Whether it is day care for children, or special care for disabled people of any age, dependent care is expensive. The Plan can help. You can convert taxable pay into tax-free money to reimburse yourself for out-of-pocket qualifying dependent care expenses.

Annual Benefit Election Maximum

If you are eligible and participate in the Dependent Care Assistance Program, the maximum annual amount by which you can reduce your Compensation in order to have contribution made to the Dependent Care Assistance Program on your behalf is the *least* of the following amounts:

- $5,000 (or $2,500 in the case of a separate return by a married individual), provided, however, for only the taxable year beginning after December 31, 2020, the $5,000 amount

will instead be $10,500, and the $2,500 amount will instead be $5,250;

- if you are *not* married at the close of the taxable year, your Earned Income for the taxable year; or
- if you *are* married at the close of the taxable year, the lesser of (1) your Earned Income for the taxable year, or (2) your Spouse's Earned Income for the taxable year.

The minimum amount that you can contribute for a full Plan Year is $100 (or such other amount as determined by the Plan Sponsor and communicated to eligible Employees during the Annual Enrollment Period or any mid-year enrollment or election change period for the applicable Plan Year).

For each month in which your Spouse is not employed and is either a full-time student at an educational institution or a Qualifying Individual who is mentally or physically incapable of caring for himself or herself, your Spouse will be treated as having an Earned Income of $250 for that month if you have one Dependent, or $500 for that month if you have more than one Dependent. For this purpose, a "full-time student" is someone who enrolls for at least five months during the taxable year for what is considered a full-time course of study in an educational organization (as defined in Code Section 170) and does not attend courses only at night.

Qualifying Dependent Care Expenses

Qualifying dependent care expenses are expenses incurred by you during the Plan Year (or other Period of Coverage, as applicable) for the care of your Dependent or for household services, to enable you and your Spouse to be gainfully employed (or to enable your Spouse to be a full-time student at an educational institution) for any period during which you have at least one Dependent, and which, if such expenses were paid by you, would be considered employment-related expenses (as determined under Code Section 21(b)(2)).

Under the Dependent Care Assistance Program, the term "Dependent" means a person who is a "Qualifying Individual" (as defined in Section II.44 of this Summary).

If you are divorced or legally separated from the other parent of your child who is under the age of 13 or physically or mentally incapable of caring for himself or herself, you may be able to use the Dependent Care Assistance Program to obtain reimbursement of qualifying dependent care expenses for that child as your Dependent, provided (a) you and your child's other parent pay more than half of the child's support for the year, (b) the child is in the custody of either one or both of you for more than half of the taxable year, and (c) you are the parent having custody for the greater portion of the calendar year, in accordance with Code Section 21(e)(5).

Generally, qualifying dependent care expenses must meet all of the following conditions:

- The expenses are incurred for services rendered after the date that you become a Participant in the Dependent Care Assistance Program and during your Period of Coverage.
- The expenses are incurred for the care of a Dependent, or for related household services, and are incurred to enable you and your Spouse to be gainfully employed or to enable your Spouse to be a full-time student at an educational institution.
- If the expenses are incurred for services outside your household for the care of either (1) a

Dependent who is your mentally or physically incapacitated federal tax dependent as described in Section II.44(b), or (2) a Dependent who is your mentally or physically incapacitated Spouse as described in Section II.44(c), such Dependent must regularly spend at least 8 hours per day in your home.

- If the expenses are incurred for services provided by a dependent care center (*i.e.*, a facility that provides care for more than 6 individuals not residing at the facility), the center complies with all applicable state and local laws and regulations.
- The expenses are not paid or payable to (1) a child of yours who is under age 19 at the end of the year in which the expenses are incurred, (2) an individual for whom you or your Spouse could claim a federal income tax deduction, (3) an individual who is your Spouse at any time during the year in which the expenses are incurred, or (4) a parent of your child who is a Qualifying Individual.

Examples of expenses that generally constitute qualifying dependent care expenses include:

- Licensed nursery school and day care centers for children;
- Licensed day care centers for disabled Dependents; and
- Individuals who have the responsibility of providing care for your eligible Dependents, either inside or outside your home. If outside your home, generally the care provider must meet all applicable licensing requirements.

Examples of expenses that generally do not constitute qualifying dependent care expenses include:

- Expenses incurred on days that you are absent from work, such as sick leave (except for certain short, temporary absences during which you are required under your care-giving arrangement to pay for care during your absence);
- Care provided by your children who are under the age of 19;
- Amounts paid for services outside your household at a camp where the Dependent stays overnight;
- Expenses claimed as a deduction or credit for federal income tax purposes;
- Amounts paid solely for food, lodging, clothing, entertainment or education; and
- Babysitting for social events.

Expenses for food and education will be qualifying dependent care expenses if provided by the nursery school or day care center as part of its preschool care services. Expenses for a child during kindergarten or higher grade levels of school are generally not covered; provided, however, expenses for before-school or after-school care of a child in kindergarten or a higher grade may constitute qualifying dependent care expenses.

Only expenses that are documented in accordance with the Plan's applicable claim procedures will be reimbursed. The IRS requires the reporting of the dependent care provider's Taxpayer Identification Number or Social Security Number with each request for reimbursement.

Requesting Reimbursement

A description of the specific procedures for filing benefit claims and submitting appeals of claim denials under the Dependent Care Assistance Program is contained in the attached "Claims Procedures For Dependent Care Assistance Program Appendix".

The amount available at any given time during the Plan Year to reimburse you for qualifying dependent care expense claims is the dollar amount of your contributions that have been credited to your account under the Dependent Care Assistance Program at the time the particular claim is paid, less the amount of any prior reimbursements paid to you during the Plan Year. The Plan will reimburse you for qualifying dependent care expenses incurred by you during the Plan Year (or other Period of Coverage, as applicable), up to the available balance in your Dependent Care Assistance Program account. If you submit a claim for reimbursement of a qualifying dependent care expense that is more than the currently available balance in your Dependent Care Assistance Program account, a partial reimbursement (up to the amount of your available balance) will be made. Then, as more of your contributions are deposited to your account, you will continue to be reimbursed for your claim until the entire qualifying dependent care expense is covered.

In the event that your employment (and thus your status as a Participant) terminates during the Plan Year, any qualifying dependent care expenses that you incurred prior to the date of your employment termination are reimbursable under the Dependent Care Assistance Program to the extent of the remaining balance in your Dependent Care Assistance Program account.

A statement of your account under the Dependent Care Assistance Program will be provided to you periodically and at least once per year on or before January 31.

Estimating Your Reimbursable Dependent Care Expenses

It is very important that you use all of the money that you have contributed to the Dependent Care Assistance Program for a Plan Year because any amounts that are not paid out of your account to reimburse claims must be forfeited and will not be returned back to you. Good planning and careful estimating are the best ways to take full advantage of your account.

You have until ***March 31st*** of the year after the end of the Plan Year to submit claims for reimbursement of qualifying dependent care expenses that were incurred during that Plan Year.

The worksheet below can help you determine the amount of your Compensation that you might consider redirecting into the Dependent Care Assistance Program. Part of the worksheet shows an example of estimated amounts for a representative employee. The example assumes an employee who is married and has one child. This is an illustrative example that is only an estimate and is not tax advice. You are advised to consult a tax advisor to determine the appropriate tax advice for your situation.

Review your records for the last few months and estimate your expected dependent care expenses for the Plan Year:

		Example	You
1.	Child Day Care Expenses	$2,400	______
2.	Pre-School Expenses	________	______

3.	Summer Day Camp Expenses	________	______
4.	Adult Day Care Expenses	________	______
5.	Other Eligible Expenses	________	______
TOTAL ESTIMATED DEPENDENT CARE EXPENSES		$2,400	______
6.	*Divide the total amount by 12*	$ 200	______

This is the *monthly* figure you might consider contributing to the Dependent Care Assistance Program, keeping in mind that the annual limit for a full year is the *least* of the following amounts:

- $5,000 (or $2,500 in the case of a separate return by a married individual), provided, however, for only the taxable year beginning after December 31, 2020, the $5,000 amount will instead be $10,500, and the $2,500 amount will instead be $5,250;
- if you are *not* married at the close of the taxable year, your Earned Income for the taxable year; or
- if you *are* married at the close of the taxable year, the lesser of (1) your Earned Income for the taxable year, or (2) your Spouse's Earned Income for the taxable year.

Forfeiture of Unused Balances

Any positive balance remaining in your account under the Dependent Care Assistance Program following final payment of all proper claims for qualifying dependent care expenses incurred during a Plan Year (or other Period of Coverage) will be forfeited, and you will forfeit all rights with respect to such balance.

Dependent Care Tax Credit vs. Dependent Care Assistance Program?

You can pay for qualifying dependent care expenses through the Dependent Care Assistance Program with pre-tax dollars, or take a dependent care tax credit for these expenses on your federal income tax return (for purposes of this Section, "***Tax Credit***"). You cannot have dependent care expenses that are paid or reimbursed under the Dependent Care Assistance Program and then take the Tax Credit for those same expenses. The option that produces the greater tax savings for you depends on your personal situation. Therefore, you should determine, before enrolling in the Dependent Care Assistance Program, whether reimbursement under the Dependent Care Assistance Program is more advantageous to you than the Tax Credit. You are advised to consult a tax advisor to decide what is best based on your particular personal situation.

You may also receive related information for free from the IRS at www.irs.gov (Publications 17 and 503)[**] or consider the following guidelines:

The Tax Credit is a reduction of your federal income tax liability for dependent care expenses that are incurred to permit you, or, if you are married, you and your Spouse, to continue to work. The

[**] You should used Publication 503 as a general reference only, because it is meant to help taxpayers determine whether they can claim the Tax Credit, not to explain what is reimbursable under the Dependent Care Assistance Program. Not all expenses that qualify for the Tax Credit are reimbursable under the Dependent Care Assistance Program.

Tax Credit is subtracted from your actual tax liability. In contrast, the Dependent Care Assistance Program reduces your taxable income before your taxes are calculated.

The amount of the federal Tax Credit is calculated as a percentage of your total annual qualifying dependent care expenses (subject to certain limits). Your income level determines the percentage that will be applied in calculating the Tax Credit. The Code limits the amount of qualifying dependent care expenses that you may take into account in calculating your Tax Credit. Currently, these expenses may not exceed $3,000 for one eligible Dependent or $6,000 for two or more eligible Dependents (and these limits may be revised from time to time).

The amount of your qualifying dependent care expenses used to calculate your Tax Credit will also be reduced, dollar for dollar, by the amount of your qualifying dependent care expenses that are paid or reimbursed through the Dependent Care Assistance Program, if any. For example, if you have $3,000 in qualifying dependent care expenses for one child, and elected to pay $1,000 of those expenses through the Dependent Care Assistance Program, the expenses that would be used to calculate your Tax Credit would be reduced by that $1,000 reimbursement to $2,000 (*i.e.*, $3,000 limit - $1,000 of expenses reimbursed). In the alternative, you could elect during the Annual Enrollment Period to have the entire $3,000 in qualifying dependent care expenses reimbursed through the Dependent Care Assistance Program by redirecting $3,000 of your Compensation to the Dependent Care Assistance Program.

You do not have to itemize expenses on your income tax return to qualify for a Tax Credit for qualifying dependent care expenses. In general, the higher your tax bracket, the more advantageous it is for you to use the Dependent Care Assistance Program rather than take a Tax Credit. However, you are advised to consult a tax advisor to decide what is best based on your particular personal situation.

No COBRA Continuation Coverage

COBRA continuation coverage is not provided under the Dependent Care Assistance Program.

VII. HSA CONTRIBUTION BENEFIT

Benefit Description

Your individual Health Savings Account is not a Covered Benefit under the Plan; it is an individually-owned account that you establish with the Company's designated HSA Custodian if you want to participate in the HSA Contribution Benefit under the Plan. The Covered Benefit under the Plan is the funding of contributions on a pre-tax basis to your Health Savings Account through the Participant HSA Contribution Benefit and the Employer HSA Matching Contribution.

Participant HSA Contribution Benefit

If have met the applicable eligibility requirements for participation (as described in Article III) and have elected to participate in the Participant HSA Contribution Benefit, the Employer will deduct the amount that you elect as pre-tax Compensation-reduction contributions from your paycheck and contribute it to your Health Savings Account on your behalf.

Employer HSA Matching Contribution Benefit

If you are a Participant in the Participant HSA Contribution Benefit (and therefore have elected to make Compensation-reduction contributions to your Health Savings Account), the Employer will make a pre-tax, matching contribution each pay period to your Health Savings Account. The amount of the matching contribution will be equal to the amount of the corresponding contribution that you have elected and are making under the Participant HSA Contribution Benefit, subject to a maximum matching amount for the particular Plan Year that the Company will determine and communicate to you and other eligible Employees during the Annual Enrollment Period or any mid-year enrollment or election change period for the applicable Plan Year.

Notwithstanding the above, the Employer has reserved the right, and may decide, to waive the payment of any matching contributions under the Employer HSA Matching Contribution Benefit for a given Plan Year. If that occurs, the waiver will be communicated to eligible Employees during the Annual Enrollment Period for that Plan Year.

Maximum Contribution Amounts

The amount that you can contribute to your Health Savings Account through the Participant HSA Contribution Benefit, and that may be contributed on your behalf by the Employer through the Employer HSA Matching Contribution Benefit, is limited by the Code. The maximum amount of your annual total contribution depends on whether you have employee-only coverage or coverage other than employee-only coverage (*e.g.*, family coverage) under the Oxy High Deductible Health Plan. For 2021, the annual maximum that can be contributed to your Health Savings Account is $3,600 if you have employee-only coverage, or $7,200 if you have any other coverage level. In addition, you may be eligible to make age-related "catch up contributions" of up to $1,000 in the aggregate if you will have attained age 55 before the end of the taxable year.

These limits may be adjusted from year to year by the Internal Revenue Service. The Plan Administrator will communicate the applicable limitations and benefit amounts to Participants in writing (or electronically) during the Annual Enrollment Period (or any mid-year enrollment or election change period) for the Plan Year.

Any Employer matching contribution that is made to your Health Savings Account under the Employer HSA Matching Contribution Benefit counts towards the maximum amount that you may contribute for the year. It is your responsibility to ensure that you comply with the applicable contribution limits.

Mid-Year Election Changes

You may prospectively revoke an election under the Participant HSA Contribution Benefit (including an election to waive participation in the Participant HSA Contribution Benefit) and make a new election for the remainder of the Plan Year as follows:

(a) Based on the occurrence of a Permitted Change Event, as described in the "Changing Your Plan Election (Permitted Change Events)" section of Article VIII;

(b) In the event you cease to be an HSA-Eligible Individual, you may revoke an election of coverage in the Participant HSA Contribution Benefit and make a new election to waive coverage under the Participant HSA Contribution Benefit; and

(c) Absent the occurrence of an event described in subsection (a) or (b), above, for which you make an election change during a given month, you are permitted to make, change or revoke one election of coverage under the Participant HSA Contribution Benefit for that month, for any reason.

Any election change you make under this section will become effective as of the first day of the month following your submission, and the Plan Administrator's approval, of the election change. Any election you make to waive participation in the Participant HSA Contribution Benefit will automatically terminate your participation in the Employer HSA Matching Contribution Benefit as of the same effective date.

Additional Information

For more information on how health savings accounts work, and possible tax implications, you can refer to IRS Publication 969, which can be found online at www.irs.gov.

The HSA Contribution Benefit is not a plan that is subject to ERISA. The terms and conditions of your Health Savings Account are described in the trust or custodial agreement between you and the HSA Custodian and do not constitute a part of the Plan. Distributions from your Health Savings Account (whether before or after any termination of your employment) and all other matters related to the administration of your Health Savings Account are outside of the Plan and are to be handled by you and the HSA Custodian pursuant to the agreement between you and the HSA Custodian.

No COBRA Continuation Coverage

COBRA continuation coverage is not provided under the HSA Contribution Benefit.

VIII. TERMINATION OF COVERAGE AND LEAVES OF ABSENCE

When Coverage Ends

Your coverage under the Plan (or a particular Covered Benefit) ends on the earliest of the following dates:

(a) With respect to coverage under the Plan:

(1) The date on which your employment with the Employer terminates or you otherwise cease to be an eligible Employee for any reason;

(2) The date on which participation in the Plan (or a particular Covered Benefit) terminates with respect to your Employer;

(3) The date on which you cease to be eligible for any Covered Benefit;

(4) The effective date of termination of the Plan;

whereby the termination of your participation in the Plan shall automatically revoke your elections of Optional Benefits coverage hereunder; and

(b) *With respect to coverage under a particular Covered Benefit:*

(1) Any of the dates set forth in subsections (1) through (4), above;

(2) The date immediately prior to the first day of the period for which you fail to make a required contribution under the Covered Benefit that is an Optional Benefit;

(3) The date immediately prior to the effective date of your valid election to waive participation in the Covered Benefit that is an Optional Benefit;

(4) The last day of the Plan Year if you fail to make a required affirmative election during the Annual Enroll Period to participate in the Covered Benefit that is an Optional Benefit in the ensuing Plan Year; or

(5) The date on which you cease to be eligible for the Covered Benefit;

whereby the termination of your participation in a Covered Benefit that is an Optional Benefit shall automatically revoke the Participant's election of that Optional Benefit coverage hereunder; and

(c) The cessation of participation provisions in subsections (a) and (b) are subject to any requirements for continuation of coverage under the Plan or a Covered Benefit, as described in other provisions of the Plan.

Leaves of Absence (Other than under FMLA or USERRA)

Subject to any rights you may have to change your election due to the occurrence of a Permitted Change Event, the following provisions apply to a leave of absence other than a leave of absence under FMLA or USERRA:

Paid leaves of absence

Subject to any specific limitations that the terms of a particular Optional Benefit may impose, you will continue participation and pre-tax contribution payments under the Plan and each Covered Benefit in accordance with your election in effect for the Plan Year (or other Period of Coverage) during any paid leave of absence that does not affect your eligibility.

Unpaid leaves of absence

Your eligibility to participate in the Optional Benefits during an unpaid leave of absence will be determined by the Employer's leave of absence policy(ies) and procedures and the terms of the particular Optional Benefit.

If you are absent from work due to an approved unpaid leave of absence that *does not* affect your eligibility for Optional Benefits, you will continue to participate in the Plan, the Employer HSA Matching Contribution Benefit and each Optional Benefit in accordance with your election in effect for the Plan Year, and any contributions due from you for the Optional Benefits during the leave of absence will be paid (a) on a pre-payment basis before going on leave, (b) on a pay-as-you-go basis, by after-tax contributions while on leave, or (c) with catch-up contributions upon return from leave, as determined by the Plan Administrator.

If you are absent from work due to an approved unpaid leave of absence that *does* affect your eligibility for Optional Benefits, a corresponding election change regarding your Optional Benefits may be made before you go on leave.

If you return from leave within thirty (30) days, your election that was in effect immediately prior to the leave will automatically be reinstated upon your return (unless you experienced a separate Permitted Change Event during the leave which allows you to make an election change). Reinstatement of coverage under the Health Flexible Spending Arrangement and the Dependent Care Assistance Program will be at the same coverage level as was in effect before the leave, with increased contributions for the remainder of the Plan Year.

If your leave extends for longer than thirty (30) days, then upon return from leave you will be entitled to make a new election based on a Permitted Change Event, as applicable.

Leave of Absence under FMLA

Group Health Plan Benefits.

If you are absent from work due to a qualifying leave under the FMLA, then, to the extent required by the FMLA, your coverage under the Covered Benefits which are group health plan benefits will continue on the same terms and conditions as if you were still an active Employee. Accordingly, if you elect to continue your coverage while on leave of absence, the Employer shall continue to pay its share of the contributions, if any.

(a) Coverage During Unpaid FMLA Leave. The Employer may require all Participants to continue coverage under the Optional Benefits elected which are group health plan benefits (*i.e.*, "***elected health benefits***") while on unpaid FMLA leave. In that case, however, you will maintain coverage, but may elect to discontinue payment of your required contributions toward such coverage until you return from leave. Upon returning from leave, you will be required to repay the contributions which were not paid by you during the leave as a catch-up payment. The catch-up payment will be withheld from your Compensation either on a pre-tax or after-tax basis, as agreed by you and the Plan Administrator, or as the Plan Administrator otherwise deems appropriate.

In the event of an unpaid FMLA leave where continuation of elected health benefits coverage is not required, you may either revoke your coverage of elected health benefits or elect to continue such coverage during the leave. If you elect to continue coverage, then you may pay your share of the required contributions in one of the following ways:

- On a *pre-payment* basis, by either (1) making a special election to pre-pay all or a portion of the contributions for the expected duration of the leave on a pre-tax, Compensation-reduction basis prior to the leave (provided that pre-tax dollars may not be used to fund coverage during the next Plan Year), or (2) having such amounts withheld on a pre-tax basis from any ongoing Compensation paid to you during the leave of absence, including unused sick days and vacation days;
- On a *pay-as-you-go* basis, with after-tax dollars, by remitting payments to the Plan Administrator or its designee (1) on the same schedule as payments would have been made if you were not on leave, (2) under the Employer's existing rules for payment by Participants on unpaid non-FMLA leaves, (3) under any payment schedule permitted by FMLA, or (4) under any other system voluntarily agreed to between you and the Plan Administrator which is not inconsistent with FMLA or

the Treasury Regulations, as determined by the Plan Administrator; or

- On a *catch-up* basis, by making catch-up payments on a pre-tax or after-tax basis upon your return from leave, provided that you and the Plan Administrator must agree in advance of the leave of absence period that (1) you choose to continue elected health benefits coverage while on unpaid FMLA leave; (2) the Employer assumes responsibility for advancing payment of your share of required contributions on your behalf during the FMLA leave; and (3) the advanced amounts are to be repaid by you when you return from FMLA leave.

If your coverage under the Health Flexible Spending Arrangement terminates while you are on FMLA leave, you are not entitled to receive reimbursements for claims of qualifying health expenses (including Limited Coverage Expenses) incurred during the period when your Health Flexible Spending Arrangement coverage is terminated.

(b) Coverage During Paid FMLA Leave. The Employer may require Participants to continue coverage under their elected health benefits while they are on paid leave under the FMLA, provided that Participants on non-FMLA paid leave are also required to continue such coverage. If the Employer so requires, your share of the required contributions shall be paid by the method normally used during any paid leave.

In the event of a paid FMLA leave during which the Employer does not require coverage to be continued, you may elect to continue your elected health benefits during the leave. If you so elect, you may pay your share of the required contributions in one of the three ways listed in subsection (a), above, as determined by the Plan Administrator.

(c) Coverage Following FMLA Leave. If your elected health benefits coverage ceases while on FMLA leave due to nonpayment of required contributions, revocation of coverage, or other reason, then, upon return from such leave, you shall be permitted to reinstate coverage under the elected health benefits on the same terms as prior to the leave (subject to any changes in benefit levels that may have taken place during the period of FMLA leave), or as otherwise required by the FMLA. In the alternative, the Employer may require that elected health benefits coverage which terminated during an unpaid FMLA leave be reinstated upon your return from leave, provided that Participants who return from a period of unpaid, non-FMLA leave are also required to be reinstated in such coverage.

With regard to the Health Flexible Spending Arrangement, if your coverage ceased during leave, you will be permitted to elect whether to be reinstated in the Health Flexible Spending Arrangement (1) at the same coverage level as was in effect before the FMLA leave, with increased contributions for the remainder of the Plan Year, or (2) at a coverage level that is reduced pro-rata for the period of FMLA leave during which you did not pay contributions (under either option, the coverage level shall be reduced by prior reimbursements for the Plan Year). If you elect a coverage level that is reduced pro-rata for the period of FMLA leave, then the amount withheld from your Compensation on a pay period basis for the purpose of paying for reinstated coverage under the Health Flexible Spending Arrangement will be equal to the amount withheld prior to the period of FMLA leave.

(d) Permitted Election Change. Notwithstanding the provisions of this "Group Health Plan Benefits" subsection above, if you take an FMLA leave, you are entitled to revoke an election

of coverage under the elected health benefits and make a new election of coverage upon return from leave due to a Permitted Change Event based on the same terms and conditions that apply to Participants who are not on FMLA leave.

Non-Health Benefits

(a) Coverage During FMLA Leave. If you go on a qualifying leave of absence under the FMLA, your entitlement to non-health benefits coverage under the Plan during your leave shall be determined by the Employer's policy(ies) and procedures for providing non-health benefits coverage under the Plan when a Participant is on a paid or unpaid, as comparable, non-FMLA leave of absence. If such policy(ies) and procedures permit (or require) you to retain non-health benefits coverage under the Plan while on leave but permit you to discontinue payment of your share of any required contributions for such coverage, you will, upon return from leave, be required to repay the contributions not paid by you during the leave as a catch-up payment. The catch-up payment will be withheld from your Compensation either on a pre-tax or after-tax basis, as may be agreed upon by you and the Plan Administrator, or as the Plan Administrator otherwise deems appropriate.

(b) Coverage Following FMLA Leave. If your non-health benefits coverage under the Plan ceases during your FMLA leave due to nonpayment of required contributions, revocation of coverage, or other reason, then, upon return from such leave, you will be permitted to reinstate non-health benefits coverage under the Plan on the same terms as prior to the leave (subject to any changes in benefit levels that may have taken place during the period of FMLA leave), or as otherwise required by the FMLA.

(c) Permitted Election Change. If you take an FMLA leave, you are entitled to revoke an election of coverage under the Dependent Care Assistance Program and make a new election of coverage upon return from leave due to a Permitted Change Event based on the same terms and conditions that apply to Participants who are not on FMLA leave.

USERRA Requirements

In the event that you are absent from employment with your Employer by reason of service in the uniformed services, your right to maintain coverage under the Plan (and any Covered Benefit) during such absence, or to revoke a coverage election and reenter the Plan (and any Covered Benefit) upon return from such absence will be determined in accordance with the USERRA requirements applicable to the Plan and/or the Covered Benefit, which requirements are incorporated herein by reference. To the extent the Plan and/or a Covered Benefit are subject to USERRA, the Plan shall not be in violation of the Code and the Treasury Regulations solely because it permits a Participant to make a new election of coverage under the Plan or such Covered Benefit, either upon leaving active employment for an approved military leave of absence or upon return from such military leave of absence.

IX. MID-YEAR ELECTION CHANGES AND OTHER RULES AND LIMITATIONS

Changing Your Plan Election (Permitted Change Events)

Because the Plan allows you to save money on your taxes, the Code and the Treasury Regulations impose some restrictions on "cafeteria plans" like the Plan. Under these restrictions, once

you have made your Plan elections for the Plan Year, you cannot change them unless you experience a "Permitted Change Event" for which changes are allowed. Note: This restriction does not apply to the HSA Contribution Benefit; you can change your Participant HSA Contributions in other circumstances without a Permitted Change Event as provided in Article VII.

The following provisions of this Section are subject to the provisions of the subsection below entitled "Special Rules Related to the COVID-19 National Emergency".

Permitted Change Events

The following events are Permitted Change Events that may allow you to revoke your existing election and make a new election under the Optional Benefit as noted. There are other events that are considered to be Permitted Change Events under the Plan and the Treasury Regulations. You must refer to the actual Plan document for complete information, or contact the OxyLink Employee Service Center (see contact information in Article XII) for additional information.

<table>
<tr><td>Under any Optional Benefit:</td></tr>
<tr><td>

You get married or divorced;
You have a child or adopt one;
Your Spouse or one or more of your children dies;
You (or your Spouse or Dependent) change your place of residence or work;
Your Dependent becomes eligible, or ceases to be eligible, for an Optional Benefit on account of attainment of age or similar circumstance;
You, your Spouse, or your Dependent commences or terminates employment; or
You or your Spouse takes an unpaid leave of absence;

but only if the event affects eligibility for coverage under the Optional Benefit and the revocation and new election are on account of, and consistent with, the Permitted Change Event (for example, you cannot drop coverage because you gained a new Dependent child).
</td></tr>
<tr><td>Under the Premium Conversion Benefit (and Health Flexible Spending Arrangement, as noted):</td></tr>
<tr><td>

An event occurs that triggers special enrollment rights in the Oxy Welfare Plan under HIPAA, including special enrollment rights provided under the Children's Health Insurance Program Reauthorization Act of 2009 and the Affordable Care Act (a "CHIPRA Event"); or
You, your Spouse or your Dependent becomes entitled to certain coverage under Medicare or Medicaid (also a Permitted Change Event under the Health Flexible Spending Arrangement).

</td></tr>
<tr><td>Under the Dependent Care Assistance Program:</td></tr>
<tr><td>

If a significant increase or decrease in the cost of qualifying dependent care expenses during a Period of Coverage is imposed by a dependent care provider who is not your relative, you may make a corresponding election change, on a prospective basis, to increase or decrease contributions under the Dependent Care Assistance Program.

</td></tr>
</table>

You cannot change your election of coverage under the Health Flexible Spending Arrangement during a Period of Coverage based on a change in your status as an HSA-Eligible

Individual unless otherwise permitted due to the occurrence of a Permitted Change Event. You also cannot revoke or change your election under the Premium Conversion Benefit if the Oxy Welfare Plan (to which the Premium Conversion Benefit applies) does not also permit revocations or new elections on account of such Permitted Change Event.

Requesting an Election Change

If a Permitted Change Event occurs, and you want to revoke an existing election and make a new election as a result, you must submit a request for your election change in the form and manner prescribed by the Plan Administrator within 30 days following the occurrence of the Permitted Change Event. However, if the Permitted Change Event is a CHIPRA Event, as described above, related to the termination of Medicaid or coverage under the State Children's Health Insurance Program established under the Social Security Act ("**CHIP**"), your request must be submitted within 60 days following the occurrence of the CHIPRA Event, and if the Permitted Change Event is a CHIPRA Event related to eligibility for employment assistance under Medicaid or CHIP, your request must be submitted within 60 days following the date that you or your Dependent is determined to be eligible for such assistance

Your revocation and new election shall become effective as of the first day of the month following your submission and the Plan Administrator's approval of your request for the revocation and new election, except that if the Permitted Change Event is the acquisition of a Dependent by birth, adoption or placement for adoption due to a special enrollment event under HIPAA, the effective date of such revocation and new election shall be the date of the Permitted Change Event (even if retroactive).

Special Rules Related to the COVID-19 National Emergency

Effective as of March 1, 2020, the required timeframes set forth above for submitting requests for election change under the Premium Conversion Benefit due to a Permitted Change Event that is a special enrollment event under HIPAA (including a CHIPRA Event) will be tolled during the COVID Disregarded Period.

Eligible Employees and Participants shall be permitted to revoke an election, make a new election, or decrease or increase an election under the Health Flexible Spending Arrangement for Plan Years 2020 and 2021 regardless of whether a Permitted Change Event has occurred, provided that any such election change for the particular Plan Year may not reduce the eligible Employee's or Participant's contribution under the Health Flexible Spending Arrangement to an amount that is less than the amount already reimbursed to or on behalf of such Employee or Participant with respect to such Plan Year. The election changes under this subsection shall be administered in accordance with the procedures of the Plan Administrator or its designee for such purpose.

In addition, eligible Employees and Participants shall be permitted to revoke an election, make a new election, or decrease or increase an election under the Dependent Care Assistance Program for Plan Years 2020 and 2021 regardless of whether a Permitted Change Event has occurred.

The election changes under this "Special Rules Related to the COVID-19 National Emergency" subsection shall be administered in accordance with the procedures of the Plan Administrator or its designee for such purpose.

Limitations that Apply to Highly Compensated and Key Employees

"Highly compensated employees" and "key employees" generally are Participants who are officers, shareholders or highly paid employees, as defined in the Code. If you are a member of one of these categories, the amount of your contributions and benefits may be limited so that the Plan as a whole does not disproportionately favor such employees and their Spouses and Dependents. Plan experience will dictate whether contribution limitations on "highly compensated employees" or "key employees" will apply. You will be notified if you are affected by these limits.

Non-Benefit Claims

If you have a claim under the Plan or a particular Covered Benefit that does not constitute a claim for *benefits* under the Plan, such as (a) a claim for *election changes* which are not benefit claims under a Covered Benefit, or (b) a claim for *coverage* under a Covered Benefit, your claim (and any appeal of a denial of your claim) will be reviewed under the Plan in accordance with procedures established by the Plan Administrator or its designee for such purpose. The Plan Administrator or its designee has the right to request and receive from you any representations, documents or other supporting evidence which it deems necessary or appropriate in order to make a determination on your claim. The Plan Administrator or its designee will decide the claim based on applicable law and regulation and the terms of the Plan, and such decision will be final, conclusive and binding on you and all other interested persons.

COBRA Continuation Coverage

Federal law requires most employers sponsoring group health plans to offer employees and their covered dependents the opportunity for a temporary extension of health care coverage (called "**COBRA continuation coverage**") at group rates in certain instances where coverage under the plans would otherwise end. *Under the Plan, these COBRA continuation rules apply only to the Health Flexible Spending Arrangement.*

The rules regarding COBRA continuation coverage which apply to the Health Flexible Spending Arrangement are described in the following sections. References to "Plan" in the following sections regarding COBRA continuation coverage mean the Health Flexible Spending Arrangement.

<u>*Eligibility*</u>

Subject to the other rules regarding COBRA continuation coverage below, *a Participant (and/or his Spouse and Dependents) is eligible for COBRA continuation coverage under his Health Flexible Spending Arrangement only if, as of the date of his Qualifying Event, the maximum remaining reimbursement amount that is available to the Participant in his Health Flexible Spending Arrangement exceeds the COBRA contribution payments that would be paid by the Participant to maintain COBRA continuation coverage under the Health Flexible Spending Arrangement for the remainder of the Plan Year.* The Participant (and or/his Spouse and Dependents) who is a Qualified Beneficiary (defined below) may elect COBRA continuation coverage under the Health Flexible Spending Arrangement only through the last day of the Plan Year in which his Qualifying Event occurred.

If you are a Participant in the Health Flexible Spending Arrangement and you are eligible for COBRA continuation coverage, then you have a right to choose continuation coverage under the Health Flexible Spending Arrangement if you lose your coverage because of:

- A reduction in your hours of employment; or
- A voluntary or involuntary termination of your employment (for reasons other than gross misconduct);
- A military leave of absence that lasts thirty-one (31) days or longer (in accordance with USERRA, as discussed below); or
- Your failure to return from FMLA leave.

Your Spouse or Dependent who is a Qualified Beneficiary has the right to choose continuation coverage for himself if he loses coverage for any of the following reasons:

- Death of the Participant;
- The Participant becomes entitled to Medicare benefits (under Part A, Part B, or both);
- Voluntary or involuntary termination of the Participant's employment (for reasons other than gross misconduct) or reduction in the Participant's hours of employment;
- Spouse's divorce or legal separation from the Participant;
- Spouse or Dependent ceases to qualify as such under the provisions of the Plan; or
- Failure of the Participant to return from FMLA leave.

Participants, Spouses and Dependents who are entitled to COBRA continuation coverage are called "Qualified Beneficiaries".

Notice of Qualifying Event

The Plan will offer COBRA continuation coverage to Qualified Beneficiaries only after the Plan Administrator has been notified that a qualifying event as described above ("**Qualifying Event**") has occurred. When the Qualifying Event is the end of employment or reduction of hours of employment, death of the Employee, or the Employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the Employer must notify the Plan Administrator of the Qualifying Event within thirty (30) days after it occurs. For the other Qualifying Events (divorce or legal separation of the Employee and Spouse or a Dependent child's losing eligibility for coverage as a Dependent child), you must notify the Plan Administrator within a maximum of sixty (60) days after the latest of (a) the Qualifying Event, (b) the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event, or (c) the date on which you are informed, including through this Summary or a COBRA general notice, of your responsibility to provide a Qualifying Event notice as described in this section and the Plan's procedures for providing such notice. You must provide this notice to the OxyLink Employee Service Center (see contact information in Article XII). This notice must be in writing and must contain the name of the Qualified Beneficiary, the name of the Plan to which the notice applies, a description of the Qualifying Event, and the date on which the Qualifying Event occurred. If you mail the notice, it must be postmarked no later than the last day of the applicable notice period described above. Failure to make timely notification will result in a termination of the Qualified Beneficiary's rights to COBRA continuation coverage under the Plan.

If you choose continuation coverage, you may continue the level of coverage you had in effect immediately preceding the Qualifying Event. However, if Plan benefits are modified for similarly situated active Employees, then they will be modified for you and other Qualified Beneficiaries as well. You will be eligible to make a change in your benefit election with respect to the Plan during

your COBRA continuation coverage period upon the occurrence of any event that permits a similarly situated active Employee to make a benefit election change during a Plan Year.

If you do not choose COBRA continuation coverage, your coverage under the Health Flexible Spending Arrangement will end with the date you would otherwise lose coverage.

Electing COBRA Continuation Coverage

Each Qualified Beneficiary is entitled to make a separate election for continuation coverage under the Plan. In order to elect continuation coverage, you must complete the election form(s) provided to you by the Plan Administrator. You have a maximum of sixty (60) days from the date you would lose coverage for one of the reasons described above or the date you are sent notice of your right to elect continuation coverage, whichever is later, to provide your completed election form to the Plan Administrator indicating that you wish to continue coverage. Failure to return the election form within the maximum 60-day period will be considered a waiver, and you will not be allowed to elect continuation coverage.

Contributions

You will have to pay the entire cost of your continuation coverage. Payments for continuation coverage are payable on an after-tax basis only. The cost of your continuation coverage will not exceed 102% of the applicable cost for the period of continuation coverage. The first contribution payment after electing continuation coverage will be due forty-five (45) days after making your election. Subsequent contributions must be paid within a 30-day grace period following the due date. Failure to pay contributions within this time period will result in termination of your continuation coverage. Claims incurred during any period will not be paid until your contribution payment is received for that period. If you timely elect continuation coverage and pay the applicable contribution, continuation coverage will relate back to the first day on which you lost regular coverage.

Duration of COBRA Continuation Coverage

The maximum period for which coverage may be continued under the Health Flexible Spending Arrangement will be through the last day of the Plan Year in which the Qualifying Event occurs. You will be notified of the duration of continuation coverage when you have a Qualifying Event. However, continuation coverage may end earlier for any of the following reasons:

- The contribution for your continuation coverage is not paid on time or it is insufficient (Note: If your payment is insufficient by the lesser of 10% of the required COBRA contribution, or $50, you will be given thirty (30) days to cure the shortfall);
- You first become covered under another group health plan under which you are not subject to a pre-existing condition exclusion limitation, after you elect continuation coverage;
- You first become entitled to Medicare, after you elect continuation coverage; or
- The Employer ceases to maintain a group health plan within its controlled group.

Questions and Other Information Regarding COBRA Continuation Coverage

It is your responsibility to keep the Plan Administrator informed of any changes in the address of you, your Spouse and your Dependents. You should also keep a copy for your records of any

notices you send to the Plan Administrator. Questions concerning your COBRA continuation coverage rights should be directed to the OxyLink Employee Service Center (see contact information in Article XII).

Tolling of Certain COBRA Deadlines Due to the COVID-19 National Emergency

Notwithstanding the foregoing, effective as of March 1, 2020, the following COBRA-related Compliance Timeframes (as defined in Section II.8) will be tolled during the COVID Disregarded Period:

(a) The timeframe within which the Plan Administrator (or its designee) must provide a COBRA election notice under ERISA Section 606(c) and Code Section 4980B(f)(6)(D);

(b) The 60-day election timeframe for COBRA continuation coverage under ERISA Section 605 and Code Section 4980B(f)(5);

(c) The 45-day timeframe (for initial premiums) or 30-day timeframe (for monthly premiums) within which COBRA qualified beneficiaries must make COBRA premium payments pursuant to ERISA Section 602(2)(C) and (3) and Code Section 4980B(f)(2)(B)(iii) and (C); and

(d) The timeframe within which individuals must notify the Plan Administrator (or its designee) of a COBRA qualifying event or determination of disability under ERISA Section 606(a)(3) and Code Section 4980B(f)(6)(C).

X. MISCELLANEOUS

Possible Effect of Plan On Social Security Benefits

Because you do not pay Social Security taxes on your Compensation that is contributed to the Plan, your eventual Social Security benefits at retirement or disability may be reduced. Any such reduction will depend on the length of time between today and the date that you retire (or become disabled) and whether or not your taxable income exceeds the Social Security maximum wage level.

For most Employees, the advantages of using the money tax-free under the Plan would likely outweigh any potential reduction in Social Security benefits in the future.

Plan Administration

The Employee Benefits Committee is the "Plan Administrator" of the Plan. Except to the extent of any allocation or delegation of its duties, as discussed further below, the Employee Benefits Committee shall be responsible for the day-to-day administration of the Plan and shall have sole discretionary authority for the administration of the Plan, with all authority and powers necessary to enable it to carry out its duties in that respect, including (but not limited to) the following:

- To make such uniform and nondiscriminatory rules and regulations for the administration and interpretation of the Plan as are consistent with the terms of the Plan or applicable law;
- To establish and maintain records appropriate to permit the Plan to be administered according to its terms and requirements of applicable law;

- To prepare and file or otherwise disseminate all reports, filings and documents required by applicable law or regulation;
- To have the sole discretionary authority to interpret the Plan, decide any equitable or other questions with respect to the administration or operation of the Plan, and determine eligibility to participate and the time, manner, amount and recipient of payment of any benefits under the Plan, and any interpretations or decisions so made will be conclusive and binding on all persons having an interest in the Plan;
- To take all other steps deemed necessary to properly administer the Plan in accordance with its terms and the requirements of applicable law; and
- To designate other persons to carry out any duty or power that would otherwise be a duty or power of the Plan Administrator under the terms of the Plan.

The Plan Administrator may provide for the allocation or delegation of its duties among its authorized agents or representatives, including, without limitation, the Claims Administrator (including in its capacity as claims fiduciary) and designated Employees. The Plan Administrator shall also be authorized to engage or employ attorneys, accountants, consultants, or other advisors or agents which it deems necessary or appropriate to assist it in discharging its duties hereunder.

In any case where any form, notification or election under the Plan is required to be filed with the Plan Administrator or the Employer, such form, notification or election shall be deemed to be filed with the Plan Administrator or the Employer, as applicable, if it is filed with a designated, authorized agent or representative of the Plan Administrator or the Employer, such as the Claims Administrator, unless the Plan Administrator or Employer has established and communicated procedures to the contrary.

The Plan Administrator will make available to each Participant any records under the Plan that pertain to him for examination at reasonable times during normal business hours. In administering the Plan, the Plan Administrator will be entitled to the extent permitted by law to rely conclusively on all tables, valuations, certificates, opinions and reports that are furnished by, or in accordance with the instructions of, the administrators of the Covered Benefits, or by accountants, counsel or other experts employed or engaged by the Plan Administrator.

Any notice, application, instruction, designation, or other form of communication required to be given or submitted by any eligible Employee shall be in such form as is prescribed from time to time by the Plan Administrator, sent by first class mail or delivered in person to the Plan Administrator (unless otherwise prescribed by the Plan Administrator's procedures for such purpose). Any notice, statement, report or other communication from the Plan Sponsor or other Employer or the Plan Administrator to any eligible Employee, as required or permitted by the Plan, shall be mailed by first class mail to such person at his address last appearing on the records of the Employer and the Plan Administrator, or in such other manner as may be selected by the Plan Sponsor or other Employer or Plan Administrator in its discretion. Each Participant shall file with the Plan Administrator, the Plan Sponsor and his Employer his complete mailing address and each change therein.

Overpayments

If, for any reason, any benefit under the Plan is erroneously paid to you or other person or entity for your benefit (collectively, a "**Payee**"), such person or entity will be responsible for refunding

the overpayment to the Plan. If such overpayment is not refunded within a reasonable time period as determined by the Plan Administrator, the overpayment will be (a) charged directly to you or other Payee as a reduction of the amount of future benefits otherwise payable to or on your behalf, or (b) recouped by any other method which the Plan Administrator or Claims Administrator deems appropriate in its discretion.

No Trust or Plan Assets

The Plan does not have any Plan assets, as determined under ERISA, and the Plan Sponsor will not establish a trust to fund the Plan unless required to do so by applicable law. Any "account" maintained under the Health Flexible Spending Arrangement or the Dependent Care Assistance Program for a Participant is a notional, recordkeeping account only, established in order to reimburse his qualifying health or dependent care expenses through the Health Flexible Spending Arrangement or the Dependent Care Assistance Program, as applicable.

No Guarantee of Tax Consequences.

Neither the Plan Sponsor, any Employer, the Plan Administrator nor any officer or employee of any of them makes any representation, commitment or guarantee that any amounts contributed to the Plan or paid to or for your benefit or the benefit of your Spouse, Dependent, beneficiary, or other person under the Plan (including any Covered Benefit) will be excludable from yours or their gross income for any tax purpose, or that any other particular tax treatment will apply or be available to you or them.

Waiver or Estoppel

No term, condition or provision of the Plan shall be waived, and there shall be no estoppel against the enforcement of any provision of the Plan, except by written direction of the Plan Administrator. No such waiver shall be deemed a continuing waiver unless specifically stated. Each waiver shall operate only as to the specific term or condition waived and shall not constitute a waiver of such term or condition for the future or as to any act other than that specifically waived.

XI. CONCLUSION

The Plan offers a unique and efficient way of saving money on taxes. Through convenient payroll redirection, you can save money on your share of contributions to the Covered Benefits provided under the Plan. You may also save money by paying for out-of-pocket health and dependent care expenses through the Health Flexible Spending Arrangement and Dependent Care Assistance Program offered under the Plan or by making contributions to your Health Savings Account through the HSA Contribution Benefit. In addition, through proper planning, you can be better prepared for the predictable health and dependent care expenses that affect you and your family.

The money you earn is important to you and your family. You need it to pay your bills, enjoy recreational activities, and save for the future. The Plan will help you keep more of your income by lowering the amount of taxes you pay. The Plan is the result of our continuing efforts to find ways to help you get the most for your money.

XII. GENERAL PLAN INFORMATION

Plan Name:	Occidental Petroleum Corporation Cafeteria Benefit Plan.††
Plan Sponsor:	Occidental Petroleum Corporation, Attn: Vice President Compensation & Benefits, 5 Greenway Plaza, Houston, TX 77046-0506, telephone: (713) 215-7000
Plan Administrator:	Occidental Petroleum Corporation Employee Benefits Committee, Attn: Director, Benefits & Wellbeing, 5 Greenway Plaza, Houston, TX 77046-0506, telephone: (713) 215-7000
Plan Number:	591‡‡
Plan Sponsor's Employer Identification Number:	95-4035997
Claims Administrator and HSA Custodian:	PayFlex, P.O. Box 4000, Richmond, KY 40476, Telephone (toll-free): 844-PAYFLEX (844-729-3539), outside the U.S.: 402-345-0666, www.payflex.com
Funding Medium:	Employer contributions and employee covered benefits contributions.
Agent for Service of Legal Process:	Service of process may be made to the Plan Administrator at the address listed above.
Amendment and Termination:	The Company intends to continue the Plan indefinitely, but reserves the right to amend or terminate the Plan at any time for any reason pursuant to the procedures described in the Plan. This Summary is intended to be brief; consequently, in the case of any conflict between the terms and provisions of the Plan (including each Covered Benefit available under the Plan), and the terms and provisions of this Summary, the Plan will control and govern.
Covered Benefits:	See attached Covered Benefits Appendix.
Adopting Employers:	See attached Adopting Employers Appendix.
OxyLink Employee Service Center:	Telephone: 1-800-699-6903 (U.S.) or +1-918-610-1990 (outside the U.S.) Email: OXYLINK@oxy.com Address: 4500 S 129th E. Ave, Tulsa, OK 74134-5801

†† To the extent of, and solely for purposes of, the applicable Form 5500 reporting requirements under Title I of ERISA, the Health Flexible Spending Arrangement is considered a component of the Oxy Welfare Plan.

‡‡ This is the Plan Number of the Occidental Petroleum Corporation Welfare Plan, as applicable to the Health Flexible Spending Arrangement solely for purposes of any Form 5500 reporting requirements under Title I of ERISA.

XIII. YOUR RIGHTS UNDER ERISA

Although the Plan itself is not an "employee welfare benefit plan" as defined in the Employee Retirement Income Security Act of 1974 (ERISA), the Health Flexible Spending Arrangement (referred to in this Article XIII as the "**ERISA Plan**") is governed by ERISA. With respect to the ERISA Plan, you, as a Plan participant, are entitled to certain rights and protections under ERISA, as follows:

Receive Information About Your Plan and Benefits

Examine, without charge, at the ERISA Plan administrator's office and at other specified locations, such as worksites and union halls, all documents governing the ERISA Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the ERISA 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 ERISA Plan administrator, copies of documents governing the operation of the ERISA Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description of the ERISA Plan. The administrator may make a reasonable charge for the copies.

Receive a summary of the ERISA Plan's annual financial report. The ERISA Plan administrator is required by law to furnish each Participant with a copy of this summary annual report.

Continue Coverage

Continue health care coverage for yourself, Spouse or Dependents if there is a loss of coverage under the ERISA Plan as a result of a Qualifying Event. You or your Dependents may have to pay for such coverage. Review this Summary and the documents governing the ERISA Plan on the rules governing your COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for ERISA Plan Participants, ERISA imposes duties upon the people who are responsible for the operation of the ERISA Plan. The people who operate the ERISA Plan, called "fiduciaries" of the ERISA Plan, have a duty to do so prudently and in the interest of you and other ERISA Plan Participants and beneficiaries. No one, including your employer, your union, 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 an ERISA Plan benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of 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 a copy of ERISA Plan documents or the latest annual report from the ERISA 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 ERISA Plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the

administrator. If you have a claim for benefits under an ERISA Plan which is denied or ignored, in whole or in part, and you disagree with that denial, you must file an appeal of that denial in accordance with the claims procedures described in this Summary, including any Appendices hereto, or in the other applicable ERISA Plan documents. If your appeal is denied, and you have exhausted the administrative remedies provided to you under the applicable claims procedures, you may file suit in a state or Federal court. In addition, if you disagree with the ERISA Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that ERISA Plan fiduciaries misuse the ERISA 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.

Assistance with Your Questions

If you have any questions about the ERISA 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 in 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.

**SUMMARY PLAN DESCRIPTION OF THE
OCCIDENTAL PETROLEUM CORPORATION CAFETERIA BENEFIT PLAN
(Amended and Restated Effective as of January 1, 2021)**

COVERED BENEFITS APPENDIX

As of January 1, 2021, the Covered Benefits, other than cash, offered under to the Plan are:

- Premium Conversion Benefit related to medical, dental and/or vision benefit coverage elected under the Oxy Welfare Plan;
- Health Flexible Spending Arrangement, under which the following two options are available:
  - Limited Purpose Health FSA; and
  - General Purpose Health FSA;
- Dependent Care Assistance Program;
- Health Savings Account Contribution Benefit, which consists of:
  - Participant HSA Contribution Benefit; and
  - Employer HSA Matching Contribution Benefit.

SUMMARY PLAN DESCRIPTION OF THE
OCCIDENTAL PETROLEUM CORPORATION CAFETERIA BENEFIT PLAN
(Amended and Restated Effective as of January 1, 2021)

CLAIMS PROCEDURES APPENDIX FOR HEALTH FLEXIBLE SPENDING ARRANGEMENT

Background

The procedures set forth in this Claims Procedures Appendix for Health Flexible Spending Arrangement apply only to claims submitted under the Health Flexible Spending Arrangement. The reimbursement of expenses covered under the Oxy Welfare Plan, as related to the Premium Conversion Benefit, are governed by separate claims provisions set forth under the Oxy Welfare Plan.

Claims Procedure

You (for purposes of this Appendix, the "**Claimant**") must submit a claim for benefits under the Health Flexible Spending Arrangement by the deadline specified in subsection (e) of the "Initial Claims Process" section of this Appendix. Furthermore, a submitted claim is not treated as filed until all information necessary to process the claim is submitted. If a Claimant's claim, as originally submitted, is not complete, the Claimant will be notified and then have the responsibility for providing the missing information.

Initial Claim Process

The Claims Administrator is responsible for processing all benefit claims under the Health Flexible Spending Arrangement. A claim for benefits (and any appeal thereof) may be submitted by the Claimant's authorized representative under ERISA, on behalf of the Claimant.

(a) *Standard Reimbursement*. Each Claimant seeking reimbursement of qualifying health expenses must submit to the Claims Administrator, at such times as the Claims Administrator may provide, evidence acceptable to the Claims Administrator substantiating such expenditures, including:

- a written statement from a third-party that is independent of the Claimant and the Claimant's Spouse and Dependents (such as the provider), describing the service or product to which the qualifying health expense relates, the date that the qualifying health expense was incurred and the amount of such qualifying health expense; and
- a written certification from the Claimant that the qualifying health expense has not been reimbursed and that the Claimant will not seek reimbursement of the qualifying health expense under any other health plan coverage.

For any item covered by health insurance or a health plan, but not paid by the insurer or health plan administrator because of deductibles, co-payments, maximum limits, or other reasons, the Claims Administrator may require a statement from the insurer or health plan administrator denying payment for such item.

"Self-substantiation" or "self-certification" of an expense by the Claimant does not constitute the required substantiation.

In addition, a claims administrator of the Oxy Welfare Plan may, on behalf of a Claimant, submit a claim under the Health Flexible Spending Arrangement for reimbursement of a qualifying health expense, in accordance with its procedures established for such purpose, provided that the information listed above is included with such claim.

(b) *Automatic Reimbursement*. Upon enrollment in the General Purpose Health Flexible Spending Arrangement for a Period of Coverage, a Claimant who is also covered under certain programs of the Oxy Welfare Plan, as designated by the Plan Administrator (each a "**Designated Health Program**"), may elect to be enrolled in the "automatic reimbursement" feature under the General Purpose Health Flexible Spending Arrangement ("**Auto-Pay Feature**") for that Period of Coverage. Notwithstanding subsection (a), above, the Claimant's claim for coverage of a qualifying health expense incurred during the Period of Coverage which were unpaid by the Designated Health Program will be deemed to be substantiated under the Auto-Pay Feature, provided that the claims administrator of the Designated Health Program gives the Claims Administrator, on behalf of the Employer, information which indicates (i) the date and amount of such qualifying health expense, and (ii) the Claimant's responsibility for payment of such qualifying health expense. In such a case, the Claimant's claim will be deemed fully substantiated without the need for submission of any receipt by the Claimant or further review for substantiation purposes by the Claims Administrator.

A Claimant who wishes to participate in the Auto-Pay Feature for a Plan Year (or other Period of Coverage) must affirmatively elect participation according to the Plan's procedures during the Annual Enrollment Period for such Plan Year (or by the due date with respect to such other Period of Coverage).

(c) *Substantiating Deductible and Limited Coverage Expenses*. For purposes of substantiating a claim for qualifying health expenses, in addition to the above, a Claimant who is covered under the Limited Purpose Health FSA must:

- Provide information to the Claims Administrator from an independent third party which confirms that the Claimant's deductible under the Oxy High Deductible Health Plan has been met; and
- Prior to satisfaction of his deductible under the Oxy High Deductible Health Plan, provide information from an independent third-party that the qualifying health expenses submitted for reimbursement are Limited Coverage Expenses.

(d) *Claims Administrator Determines Adequacy*. No reimbursements will be paid under the Plan for any qualifying health expense until the Claims Administrator has received what it deems to be adequate documentation or evidence of the actual qualifying health expense that has been incurred. Benefits are payable only to the extent the Claims Administrator determines they are properly payable under the Health Flexible Spending Arrangement.

(e) *Claims Due by Claim Filing Deadline*. All claims for reimbursement of a qualifying health expense must be submitted to the Claims Administrator by ***March 31st*** of the year following the end of the Plan Year in which the qualifying expense was incurred. Notwithstanding the foregoing, effective as of March 1, 2020, if the March 31st deadline to file a claim with the Claims Administrator would fall during the COVID Disregarded Period, then the deadline to file such claim with the Claims Administrator will instead be the ***date that immediately follows the last day of the COVID Disregarded Period***, or such later date as determined by

the Plan Sponsor and communicated to Claimants and Participants.

Any qualifying health expenses that a Claimant incurs during a Plan Year (or other Period of Coverage) will not be reimbursed if proper claims for such qualifying health expenses are not submitted to the Claims Administrator by the applicable deadline date specified in this subsection, except in the case of extenuating circumstances, as determined by the Claims Administrator and permitted by applicable law.

(f) *Applicable Time Limitations For Initial Benefit Decision*. The Claimant will be notified of the benefit determination by the Claims Administrator, regardless of whether the determination is adverse or not, no later than thirty (30) days after the Claimant's claim for benefits is filed. If the Claims Administrator requires additional time to make a benefit determination for matters beyond the control of the Plan, the time period for making the initial benefit determination may be extended for up to fifteen (15) additional days. If such extension is required, the Claims Administrator will notify the Claimant within the initial thirty (30) day period of the circumstances requiring the extension and the date by which a Plan expects to render a benefit decision.

If additional time is required to render a benefit decision because of the Claimant's failure to submit the information necessary to decide the claim (for example, the Claimant fails to submit copies of all bills related to the claim), the notice informing the Claimant of the extended period of time required to render a benefit determination will also include a specific description of the information necessary to decide the claim. The Claimant will then have at least 45 days from the day that the Claimant receives the notice to provide the specified information.

(g) *Notice of Adverse Benefit Determination*. The Claims Administrator will provide written or electronic notification of any adverse benefit determination. The notice will set forth the following:

- The specific reason(s) for the adverse determination;
- Reference to the specific Plan provision(s) on which the determination was based;
- A description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary;
- A description of the Plan's appeal procedures and the time limits applicable to such procedures, as well as a statement of the claimant's right to bring a civil action under Section 502(a) of ERISA following an adverse benefit determination on review, and any other statement required by law; and
- A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim.

For the purposes of the foregoing notice, a document, record, or other information will be considered "relevant" to a claimant's claim if such document, record, or other information:

- was relied upon in making the adverse benefit determination;

- was submitted, considered, or generated in the course of making the adverse benefit determination, without regard to whether such document, record, or other information was relied upon in making the adverse benefit determination;
- demonstrates compliance with any administrative processes and safeguards in making the adverse benefit determination; or
- constitutes a statement of policy or guidance with respect to the Plan concerning the denied treatment option or benefit for the claimant's diagnosis, without regard to whether such advice or statement was relied upon in making the adverse benefit determination.

In addition, if the adverse benefit determination was based on an internal rule, guideline, protocol, or other similar criterion, the specific rule, guideline, protocol, or criterion will be provided free of charge. If this is not practical, a statement will be included that such rule, guideline, protocol, or criterion was relied upon in making the adverse benefit determination and a copy will be provided free of charge to the claimant upon request.

If the adverse benefit determination is based on the fact that the treatment was not medically necessary or the experimental/investigational exclusion or similar exclusion or limit was applied, an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, will be provided. If this is not practical, a statement will be included that such explanation will be provided free of charge, upon request.

Appeal of Adverse Benefit Determination.

(a) *Submitting an Appeal*. If the Claimant receives an adverse benefit determination under the Health Flexible Spending Arrangement, he will have 180 days following his receipt of the notification of the initial benefit determination in which to submit a verbal or written (including electronic) appeal the decision to the Claims Administrator. However, notwithstanding the foregoing or any other provision of this Summary to the contrary, effective as of March 1, 2020, the timeframe within which claimants are permitted to file an appeal of a claim denial under the claim and appeal procedures of the Health Flexible Spending Arrangement (*i.e.*, a Compliance Timeframe, as defined in Section II.8) will be tolled during the COVID Disregarded Period.

The Claimant's appeal must include:

- The Claimant's name;
- The Claimant's Employer's name;
- A copy of the notification of the claim denial received by the Claimant;
- Any other information that the Claimant desires to be considered in the review of his appeal; and
- Any other information requested by the Claims Administrator pursuant to its procedures for reviewing the appeal.

The following rules apply with respect to an appeal:

- The Claimant may submit verbal or written (including electronic) comments,

documents, records, and other information relating to the claim. Upon request, the Claimant will be provided, free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim.

- The appeal will take into account all comments, documents, records, and other information that the Claimant submitted relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.
- The appeal will not afford deference to the initial adverse benefit determination and will be conducted by a fiduciary of the Plan who is neither the individual who made the initial adverse determination or any subordinate of that person.
- If the adverse determination was based on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate, the fiduciary will consult with a health care professional who was not involved in the initial benefit determination and is not the subordinate of any health care professional that was involved in the initial benefit determination. This health care professional will have appropriate training and experience in the field of medicine involved in the medical judgment. Additional medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the initial determination will be identified upon request.

(b) *Applicable Time Limitations For Appeal of Adverse Benefit Decision*. The Claims Administrator will notify the Claimant of its benefit determination on appeal no later than thirty (30) days after the Claims Administrator receives the Claimant's request for review; provided however, the 30-day timeframe may be extended to the extent permitted by ERISA upon the Claims Administrator's notification to the Claimant of such extension.

(c) *Notice of Adverse Determination on Appeal*. The Claims Administrator will provide written or electronic notification of an adverse benefit determination on appeal. The notice will set forth the following:

- The specific reason(s) for the adverse determination;
- A reference to the specific Plan provision(s) upon which the determination was based;
- A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of all documents, records, and other information relevant to the claimant's claim for benefits;
- A statement of the claimant's right to bring an action under Section 502(a) of ERISA;
- The following statement: "You and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor office and your state insurance regulatory agency"; and
- Any other information required by law.

For the purposes of the foregoing notice, a document, record, or other information will be considered "relevant" to a claimant's claim if such document, record, or other information:

- was relied upon in making the adverse benefit determination;
- was submitted, considered, or generated in the course of making the adverse benefit determination, without regard to whether such document, record, or other information was relied upon in making the adverse benefit determination;
- demonstrates compliance with any administrative processes and safeguards in making the adverse benefit determination; or
- constitutes a statement of policy or guidance with respect to the Plan concerning the denied treatment option or benefit for the claimant's diagnosis, without regard to whether such advice or statement was relied upon in making the adverse benefit determination.

In addition, if the determination was based upon an internal rule, guideline, protocol, or other similar criterion, the specific rule, guideline, protocol, or other similar criterion will be provided free of charge. If this is not practical, a statement will be included in the notice of adverse determination that such rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and a copy will be provided free of charge, upon request.

If the adverse determination was based on a medical necessity, or experimental treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge, upon request, will be included in the notice of adverse determination.

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CLAIMS PROCEDURES APPENDIX FOR
DEPENDENT CARE ASSISTANCE PROGRAM

Background

The procedures set forth in this Claims Procedures Appendix for Dependent Care Assistance Program apply only to claims submitted under the Dependent Care Assistance Program.

Claims Procedure

You (for purposes of this Appendix, the "**Claimant**") must submit a claim for benefits under the Dependent Care Assistance Program by the deadline specified in Section 1(c) of this Appendix. Furthermore, a submitted claim is not treated as filed until all information necessary to process the claim is submitted. If the Claimant's claim, as originally submitted, is not complete, the Claimant will be notified and then have the responsibility for providing the missing information.

Initial Claim Process

The Claims Administrator is responsible for processing all benefit claims under the Dependent Care Assistance Program.

(a) *Reimbursement Procedures*. Each Claimant seeking reimbursement of qualifying dependent care expenses must submit to the Claims Administrator, at such times as the Claims Administrator may provide, evidence acceptable to the Claims Administrator substantiating such expenditures, including:

(i) a written statement from the dependent care provider who is a third-party, independent of the Claimant and the Claimant's Spouse and Dependents, describing the service to which the qualifying dependent care expense relates, the person(s) on whose behalf the qualifying dependent care expense was incurred, the date that the qualifying dependent care expense was incurred, the amount of such qualifying dependent care expense, and the dependent care provider's name, address and tax identification number; and

(ii) a written certification from the Claimant that the qualifying dependent care expense has not been reimbursed and that the Claimant will not seek reimbursement of the qualifying dependent care expense through any other source.

(b) *Claims Administrator Determines Adequacy*. No reimbursements will be paid under the Plan for any qualifying dependent care expense until the Claims Administrator has received what it deems to be adequate documentation or evidence of the actual qualifying dependent care expense that has been incurred. Benefits are payable only to the extent the Claims Administrator determines they are properly payable under the Dependent Care Assistance Program.

(c) *Claims Due by Claim Filing Deadline*. All claims for reimbursement of a qualifying dependent

care expense must be submitted to the Claims Administrator by ***March 31st*** of the year following the end of the Plan Year in which the qualifying expense was incurred. Any qualifying dependent care expenses that a Claimant incurs during a Plan Year (or other Period of Coverage) will not be reimbursed if proper claims for such qualifying dependent care expenses are not submitted to the Claims Administrator by the deadline date specified in this subsection, except in the case of extenuating circumstances, as determined by the Claims Administrator and permitted by applicable law.

(d) *Payments to Providers*. The Claims Administrator may, in its sole discretion, pay any such qualifying dependent care expenses directly to a dependent care provider in lieu of reimbursing a Claimant.

Appeal and Review of Denied Claims.

(a) *Submitting an Appeal*. If the Claimant receives a denial of his claim for reimbursement under the Dependent Care Assistance Program, he will have 60 days following his receipt of the notification of the initial benefit determination in which to submit a verbal or written (including electronic) appeal of the decision to the Claims Administrator. The Claimant's appeal must include:

- The Claimant's name;
- The Claimant's Employer's name;
- A copy of the notification of the claim denial received by the Claimant;
- Any other information that the Claimant desires to be considered in the review of his appeal; and
- Any other information requested by the Claims Administrator pursuant to its procedures for reviewing the appeal.

The following rules apply with respect to an appeal:

- The Claimant may submit to the Claims Administrator, verbally or in writing (including electronically), any comments, documents, records, and other information relating to the claim on appeal.
- The appeal will take into account all comments, documents, records, and other information that the Claimant submitted to the Claims Administrator in writing (including electronically) relating to the claim on appeal, without regard to whether such information was submitted or considered in the initial claim decision.

(b) *Applicable Time Limitations For Appeal of Adverse Benefit Decision*. The Claims Administrator will notify the Claimant of its decision on an appeal no later than sixty (60) days after the Claims Administrator receives the Claimant's appeal and request for review; provided however, the 60-day timeframe may be extended upon the Claims Administrator's notification to the Claimant of such extension.

(c) *Notice of Denial of Claim on Appeal*. The Claims Administrator will provide written or electronic notification of any denial of the claim on appeal. The notice will set forth the reason(s) for the claim denial on appeal and a reference to provision(s) of the Plan or this Summary upon which the appeal decision was based.

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HIPAA MEDICAL PRIVACY AND SECURITY APPENDIX

Background

This HIPAA Medical Privacy and Security Appendix ("**HIPAA Appendix**") is intended to comply with the requirements under the Health Insurance Portability and Accountability Act of 1996, as amended ("**HIPAA**"), the Standards for Privacy of Individually Identifiable Health Information at 45 CFR part 160 and part 164, subparts A and E ("**Privacy Standards**") and the Security Standards for the Protection of Electronic Protected Health Information at 45 CFR part 160 and part 164, subpart C ("**Security Standards**"), as promulgated under HIPAA, the HIPAA Enforcement Rule at 45 CFR part 160, subparts C through E ("**Enforcement Rules**") and the "**Breach Notification Rules**" issued under the Health Information Technology for Economic and Clinical Health Act ("**HITECH**"), as each of the foregoing were amended, generally effective as of September 23, 2013, by the regulations issued on January 25, 2013 ("**HIPAA Omnibus Rules**"). References to any section of the Privacy Standards, the Security Standards, the Enforcement Rules or the Breach Notification Rules will include any amendments or successor provisions thereto, including the HIPAA Omnibus Rules.

For purposes of this HIPAA Appendix, "Protected Health Information" ("**PHI**") means information, including genetic information, that is created or received by the Plan which (a) relates to the past, present, or future physical or mental health or condition of an individual, the provision of health care to an individual, or the past, present, or future payment for the provision of health care to an individual, (b) identifies the individual or for which there is a reasonable basis to believe the information can be used to identify the individual, and (c) is transmitted or maintained in any form or medium. "Electronic Protected Health Information" ("**ePHI**") means individually identifiable health information that is created or received by the Plan and transmitted by or maintained in electronic media.

Designation of Health Care Components and Safeguard

The Plan is a hybrid entity (as defined by 45 CFR § 164.103 of the Privacy Standards), and, as such, the provisions of this HIPAA Appendix will only apply to the health care component of the Plan (referred to as the "**Health Care Component**"), as set forth below in this HIPAA Appendix. All references to Protected Health Information (PHI) or Electronic Protected Health Information (ePHI) in this HIPAA Appendix refer to PHI or ePHI that is created or received by or on behalf of the Health Care Component. The Health Care Component will thus comply with the following requirements:

- The Health Care Component will not disclose PHI to another component of the Plan in circumstances in which the Privacy Standards would prohibit such disclosure if the Health Care Component and the other component were separate and distinct legal entities; and

- If an employee of the Plan Sponsor performs duties for both the Health Care Component and for another component of the Plan, such employee will not use or disclose PHI created or received in the course of, or incident to, the employee's work for the Health Care Component in a way prohibited by the Privacy Standards.

For purposes of this HIPAA Appendix, the Health Care Component of the Plan is the Health Flexible Spending Arrangement.

Use and Disclosure of PHI

The Plan Sponsor may only use and disclose PHI that it receives from the Health Care Component, which is considered a "group health plan" as defined by the Privacy Standards, as permitted and/or required by, and consistent with, the Privacy Standards. This includes, but is not limited to, the right to use and disclose a Participant's PHI in connection with payment, treatment, and health care operations, or as otherwise permitted or required by law. The Plan will not use or disclose PHI that is genetic information for underwriting purposes.

"Payment" includes activities undertaken by the Health Care Component to obtain contributions, premiums or determine or fulfill its responsibility for coverage and provision of Plan benefits that relate to an individual to whom health care is provided. These activities include, but are not limited to, the following:

- Determination of eligibility, coverage and cost sharing amounts (for example, cost of a benefit, Plan maximums and copayments as determined for an individual's claim);
- Coordination of benefits or non-duplication of benefits;
- Adjudication of health benefit claims (including appeals and other payment disputes);
- Subrogation of health benefit claims;
- Establishing employee contributions;
- Risk adjusting amounts due based on enrollee health status and demographic characteristics;
- Billing, collection activities and related health care data processing;
- Claims management and related health care data processing, including auditing payments, investigating and resolving payment disputes and responding to Participant inquiries about payments;
- Obtaining payment under a contract for reinsurance (including stop-loss and excess of loss insurance);
- Medical necessity reviews or reviews of appropriateness of care or justification of charges;
- Utilization review, including precertification, preauthorization, concurrent review and retrospective review;
- Disclosure to consumer reporting agencies related to the collection of contributions, premiums or reimbursement (the following PHI may be disclosed for payment purposes: name and address, date of birth, Social Security number, payment history, account number and name and address of the provider and/or health plan); and
- Obtaining reimbursements due to the Plan.

"Health Care Operations" include, but are not limited to, the following activities:

- Quality assessment;

- Population-based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination, disease management, contacting health care providers and patients with information about treatment alternatives and related functions;
- Rating provider and Plan performance, including accreditation, certification, licensing or credentialing activities;
- Enrollment, premium rating and other activities relating to the creation, renewal or replacement of a contract of health insurance or health benefits, and ceding, securing or placing a contract for reinsurance of risk relating to health care claims (including stop-loss insurance and excess loss insurance);
- Conducting or arranging for medical review, legal services and auditing functions, including fraud and abuse detection and compliance programs;
- Business planning and development, such as conducting cost-management and planning-related analyses related to managing and operating the Plan, including formulary development and administration, development or improvement of payment methods or coverage policies; and
- Business management and general administrative activities of the Plan, including, but not limited to:
    - Management activities relating to the implementation of, and compliance with, HIPAA's administrative simplification requirements;
    - Customer service, including the provision of data analyses for policyholders, plan sponsors or other customers;
    - Resolution of internal grievances; and
    - Due diligence in connection with the sale or transfer of assets to a potential successor in interest, if the potential successor in interest is a "covered entity" under HIPAA or, following completion of the sale or transfer, will become a covered entity.

Certification of Amendment of Plan Documents by the Plan Sponsor

The Plan will disclose PHI to the Plan Sponsor only upon receipt of a certification from the Plan Sponsor that the Plan documents have been amended to incorporate the provisions set forth in this HIPAA Appendix.

Plan Sponsor Agrees to Certain Conditions for PHI

The Plan Sponsor agrees to:

- Not use or further disclose PHI other than as permitted or required by the Plan document or as required by law;
- Ensure that any agents, including a subcontractor, to whom the Plan Sponsor provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such PHI;
- Not use or disclose PHI for employment-related actions and decisions unless the use

or disclosure is made pursuant to an authorization in compliance with HIPAA;

- Not use or disclose PHI in connection with any other benefit or employee benefit plan of the Plan Sponsor unless the use or disclosure is made pursuant to an authorization in compliance with HIPAA;
- Report to the Plan any PHI use or disclosure that is inconsistent with the uses or disclosures provided for of which it becomes aware;
- Make PHI available to an individual in accordance with HIPAA's access requirements;
- Make PHI available for amendment and incorporate any amendments to PHI in accordance with HIPAA;
- Make available the information required to provide an accounting of disclosures;
- Make internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the HHS Secretary for the purposes of determining the Plan's compliance with HIPAA;
- If feasible, return or destroy all PHI received from the Plan that the Plan Sponsor still maintains in any form, and retain no copies of such PHI when no longer needed for the purpose for which disclosure was made (or if return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction infeasible); and
- Establish separation between the Plan and the Plan Sponsor in accordance with 45 CFR § 164.504(f)(2)(iii).

With respect to ePHI, the Plan Sponsor agrees, on behalf of the Plan, to:

- Implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the ePHI that it creates, receives, maintains, or transmits on behalf of the Plan;
- Ensure that adequate separation required by 45 C.F.R. §164.504(f)(2)(iii) under the Privacy Standards is supported by reasonable and appropriate security measures;
- Ensure that any agent, including a subcontractor, to whom it provides this information or who receives this information on behalf of the Plan agrees to implement reasonable and appropriate security measures to protect the information; and
- Report to the Plan any security incident of which it becomes aware, in accordance with the administrative procedures adopted by the Plan for compliance with the Security Standards.

Adequate Separation Between the Plan and the Plan Sponsor

Only the following job classifications of employees (or classes of employees) are designated as being entitled to receive PHI of the Plan's Health Care Component under HIPAA (the "***HIPAA-Authorized Employees***"):

Employee/Position	Categories of PHI under the Health Care Component of the Plan to which Access is Needed and Conditions on Access
Vice President, Compensation & Benefits	PHI as needed to perform duties as Privacy Official of the Health Care Component of the Plan
Vice President, Compensation & Benefits	PHI as needed to perform duties as Complaint Official of the Health Care Component of the Plan
Members of the Employee Benefits Committee	PHI as needed to perform duties with respect to the Health Care Component as the Plan Administrator of the Plan
Vice President, Compensation & Benefits	PHI as needed to perform duties related to the operation and administration of the Health Care Component of the Plan
Director, Benefits & Well-Being	
Employees of the HR Benefits Planning Department of the HR Compensation and Benefits Department	
Legal counsel from HR and Legal Departments assigned to support the Benefits Department	PHI as needed to advise and counsel on any claims or other administrative issues that might arise under the Health Care Component of the Plan which involve PHI
Paralegals and administrative staff supporting legal counsel (above)	

Limitations of PHI Access and Disclosure

The HIPAA-Authorized Employees may only have access to and use and disclose PHI for Plan administration functions that the Plan Sponsor performs for the Plan.

Noncompliance Issues

If the HIPAA-Authorized Employees do not comply with the Plan document, the Plan Sponsor will provide a mechanism for resolving issues of noncompliance, including disciplinary sanctions.

Additional Requirements Imposed by HITECH

In accordance with, to the extent required by, and as of the effective dates specified therein, HITECH and the regulations and other authority promulgated thereunder by the appropriate governmental authority, the Plan will (a) comply with notification requirements when unsecured PHI has been accessed, acquired, or disclosed as a result of a breach, (b) comply with an individual's request to restrict disclosure of PHI, (c) limit disclosures of PHI to a limited data set or the minimum necessary, (d) provide an accounting of disclosures, and (e) provide access to PHI in electronic format.

Limitation on the Use and Disclosure of Genetic Information

Notwithstanding anything herein to the contrary, no "genetic information" (as defined by

Section 105 of the Genetic Information Nondiscrimination Act of 2008) will be used or disclosed for underwriting, premium rating and other activities relating to the creation, renewal or replacement of a contract of health insurance or health benefits, or ceding, securing or placing a contract for reinsurance of risk relating to health care claims (including stop-loss insurance and excess loss insurance).

Notification in Case of a Breach of Unsecured PHI

In the event of the acquisition, access, use, or disclosure of PHI in a manner not permitted by the Privacy Standards that constitutes a "Breach," as such term is defined in 45 CFR 164.402, the Plan, or its designee, will notify each individual whose PHI has been, or is reasonably believed to have been, accessed, acquired, used or disclosed as a result of the Breach no later than sixty (60) days after the Plan, or its designee, discovers the Breach, unless notification may be delayed as permitted by 45 CFR 164.412 because such notice would impede a criminal investigation or damage national security. The Plan, or its designee, will mail individual notifications by first-class mail to the individual's last known address or by electronic mail, provided that electronic disclosure is permitted by the applicable regulations. The individual notification will include the following information:

- A brief description of what happened, including the date of the Breach and the date of its discovery, if known;

- A description of the type of PHI involved, such as name, social security number, date of birth, address, account number, diagnosis, disability code, or other type of information involved;

- Any steps the individual should take to protect himself from potential harm resulting from the Breach;

- A brief description of what the Plan or its business associate is doing to investigate the Breach, mitigate harm to individuals, and to protect against further Breaches; and

- Contact procedures for individuals to ask questions or learn additional information, including a toll-free telephone number, e-mail address, web site, or postal address.

If the Breach involves more than 500 residents of a state or jurisdiction, the Plan, or its designee, will also notify prominent media outlets that service the state or jurisdiction of the Breach. Additionally, the Plan will notify the Secretary of the Department of Health and Human Services of the Breach as required by 45 CFR 164.408.

Other Medical Privacy Laws

The Plan will comply with the Privacy Standards and the Security Standards, as well as with any applicable federal, state and local laws governing confidentiality of health information, to the extent such laws are not preempted by HIPAA or ERISA.

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ADOPTING EMPLOYERS APPENDIX

As of January 1, 2021, the following Employers have adopted and are participating in the Plan:

- Occidental Petroleum Corporation (as Plan Sponsor);
- Occidental Chemical Corporation;
- Occidental Oil and Gas Corporation;
- Anadarko Petroleum Corporation;
- Glenn Springs Holdings, Inc.;
- Occidental Energy Marketing Inc.;
- Oxy Energy Services, LLC;
- Oxy USA Inc.; and
- Occidental Midstream Strategic Development, LLC.

The full Summary Plan Description includes this Benefit Program SPD and the wrap-around summary plan description (“Wrap SPD). The Wrap-SPD may be accessed here. Alternatively, to request a hardcopy or an electronic copy please contact the OxyLink Employee Service Center (OxyLink) by email or call 1-800-699-6903 (inside US) and 1-918-610-1990 (outside US).

Posted May 2022