



Summary Plan Description

MEDICAL PLAN – AETNA BASIC

Aetna Choice POS II (Open Access) Network

2015

your health.
your life.
your future.

Your Medical Plan Options

The Medical Plan offers eligible participants the following coverage options.

- **Aetna Basic Option** – A Point of Service (POS) health plan that covers care received from in-network or out-of-network providers with no physician referral. Refer to this Summary Plan Description for plan details, including deductibles, coinsurance levels for in-network and out-of-network care and out-of-pocket limits.
- **Aetna HealthFund Option** – A high deductible POS health plan compatible with Health Savings Accounts (HSAs). HSAs allow you to save money for current or future medical expenses (or other retirement expenses after age 65) on a tax-advantaged basis. Refer to the separate Summary Plan Description for plan details including deductibles, coinsurance levels for in-network and out-of-network care, out-of-pocket limits and HSA contribution limits.
- **Anthem Blue Cross Option** – A Preferred Provider Organization (PPO) health plan which provides access to a nationwide network and out-of-network coverage with no physician referral. Refer to the separate Summary Plan Description of plan details, including fixed-dollar office visits, deductibles, coinsurance levels for in-network and out-of-network care and out-of-pocket limits.
- **Regionally Available HMO Options** – A Health Maintenance Organization (HMO) is a plan in which you must receive medical treatment or services from participating providers, and services received outside the network may not be covered except in the case of a medical emergency.

All benefits, limitations and exclusions for the regional options are listed in their respective member brochures and contracts. Upon request, the OxyLink Employee Service Center will provide written materials that describe the regionally available options, their respective covered and non-covered benefits, plan copayments/coinsurance, procedures to be followed in obtaining benefits, and the circumstances under which benefits may be denied.

You may elect a regional plan option if you live in the applicable geographic area. If you enroll in a regional plan and move out of the applicable geographic area, you must make a new medical coverage election within 31 days after the date of your move. To make a new election, you must notify OxyLink and complete and return any appropriate forms within the 31-day period.

The eligibility and participation requirements described in this booklet apply to all available options.

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Refer to subsequent issues of *Benefits News* for any material changes to the Plan made after the date of this document.

BENEFITS AT A GLANCE

The Plan is designed to provide financial protection when you or a covered family member needs medical care. It provides medical coverage you need when an Illness or Injury strikes, certain preventive care, and access to special programs that focus on improving your health or helping you stay healthy.

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

This Plan is administered by Aetna Life Insurance Company (referred to as “Aetna”) and Medco Health Solutions (“Medco”). The medical and pharmacy benefits described in this booklet are not insured with Aetna or Medco or any of their affiliates and are paid from Occidental Petroleum Corporation’s general assets.

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

Here are some important points to remember about your medical benefits:

When you need care, you have a choice. You can select a doctor or facility that belongs to Aetna’s **Open Access Choice® POS II** network (a Network Provider) or one that does not belong (an Out-of-Network Provider).

- ***If you use a Network Provider***, you may pay less out of your own pocket for your care. You will not have to fill out claim forms because your Network Provider will file claims for you. In addition, your provider will make the necessary telephone call to start the Precertification process when necessary.
- ***If you use an Out-of-Network Provider***, you may pay more out of your own pocket for your care. It is your responsibility to make sure your claims are filed and any required Precertification is obtained.

Negotiated Fees vs. Recognized Charges

When you receive care from a Network Provider, your covered benefits are based on Aetna’s Negotiated Fees. These are the fees that Network Providers agree to charge Aetna members for their services. In this case, the Recognized Charge rule does not apply. Aetna’s Negotiated Fees do not apply to care that is not covered under the Plan.

When you receive care from an Out-of-Network Provider, your benefits are based on the Recognized Charge for a service or supply (as determined by Aetna). The Recognized Charge is the usual and recognized charge for health care services in a given geographic area. If an Out-of-Network Provider charges you more than the Recognized Charge, you must pay the difference. This excess amount will not apply toward your deductible or out-of-pocket maximum.

For prescription drugs, if you purchase prescriptions from a Medco network retail or mail order pharmacy, your coinsurance amount is based on Medco's discounted pricing. Reimbursement for prescriptions obtained through a non-network pharmacy is described in the section entitled *Prescription Drug Benefit*.

IMPORTANT

If you are a retiree, refer to the separate SPD for a description of your medical benefits. If you are an LTD beneficiary, refer to the separate supplement for eligibility and enrollment information.

Summary of Benefits

The charts in this section show the deductibles, coinsurance for major types of covered expenses, and out-of-pocket maximums under the Aetna Basic option. Network benefits are based on Negotiated Fees and Out-of-Network benefits are based on Recognized Charges. Sections later in this booklet include more detail about coverage for specific services and supplies.

All coverage levels apply to covered expenses after the applicable deductible is met unless otherwise noted.

MEDICAL PLAN INFORMATION		
Annual Deductible	Individual	Family
	\$300	\$600
Deductible does not apply to retail or mail order prescription drugs.		
Medical Out-of-Pocket Maximum <i>(includes your deductible)</i>	Individual	Family
Annual Salary <i>(as of prior December 31)</i>		
Less than \$50,000	\$1,300	\$2,000
\$50,000 or more	\$2,000	\$4,000
Medco Prescription Drug Out-of-Pocket Maximum	\$1,000 per person	
Lifetime Maximum	Unlimited	

HOSPITAL AND EMERGENCY ROOM		
	Medical Plan Pays	
Covered Services	Network	Out-of-Network
Hospital Services		
Inpatient Coverage	90%	70%
Outpatient Coverage	90%	70%
Ancillary Charges <i>(other than room, board, nursing services)</i>	90%	70%
Mental Health, Alcohol & Drug Abuse Care Covered same as Hospital Services	90%	70%
Emergency Care <i>(non-emergency care not covered)</i>	90%	90%
Urgent Care	80%	70%
Ambulance	80%	80%
Non-Emergency Ambulance	80%	70%
Skilled Nursing Facility <i>(up to 120 days per calendar year)</i>	90%	70%

OTHER MEDICAL BENEFITS		
	Medical Plan Pays	
Covered Services	Network	Out-of-Network
Preventive Care <i>(age and frequency limits apply)</i> Routine Physicals/Well Child Exams Routine Mammograms Cervical Cancer Screening Prostate Specific Antigen (PSA) Test and Digital Rectal Exam (DRE) Colorectal Cancer Screening	100% not subject to deductible	70%
Physician Services Office Visits; Surgeon Charges	80%	70%
Diagnostic Lab & X-Ray	80%	70%
Spinal Manipulation <i>(e.g., chiropractic care; up to 25 visits per calendar year)</i>	80%	70%
Mental Health, Alcohol & Drug Abuse Care Office Visits	80%	70%
Short-Term Rehabilitation <i>(physical, occupational and speech therapy)</i>	80%	70%
Home Health Care <i>(up to 120 visits per calendar year)</i>	80%	70%
Hospice Care	80%	70%
Durable Medical Equipment	80%	70%
Prosthetic Devices	80%	70%

PRESCRIPTION DRUG BENEFITS (ADMINISTERED BY MEDCO)	
Annual Deductible	None
Retail Pharmacy, up to a 30-day supply <i>(for initial prescription and 2 refills)</i>	Your Coinsurance
Generic	\$10
Preferred Brand	25% (\$10 min/\$50 max)
Non-Preferred Brand	25% (\$25 min/\$100 max)
Mail Order Pharmacy, up to a 90-day supply	Your Coinsurance
Generic	\$20
Preferred Brand	25% (\$20 min/\$100 max)
Non-Preferred Brand	25% (\$50 min/\$200 max)
If a generic drug is available, you will pay the generic coinsurance plus the difference in price between the brand name and the generic drug.	

Note

Deductibles and benefit maximums above are combined maximums between Network and Out-of-Network Care, unless stated otherwise.

Coverage Outside the Network Service Area

If you or your covered Dependent(s) live outside the network service area, your coverage is generally the same as the network benefits listed in the chart above. Refer to “Out-of-Area Benefits” in the *Using the Plan* section.

FOR HELP AND INFORMATION

Contact Information		
Provider:	Address:	Phone:
Aetna	P.O. Box 14586 Lexington, KY 40512-4586 Website: www.aetna.com	800-334-0299
Medco (Prescription Drugs)	P.O. Box 14711 Lexington, KY 40512 Website: www.medcohealth.com	800-551-7680
OxyLink Employee Service Center	4500 South 129th East Avenue Tulsa, OK 74134-5870 Email: oxylink@oxy.com Website: oxylink.oxy.com	800-699-6903 918-610-1990 (International)

Visit Aetna Navigator™ at www.aetna.com

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

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

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

- **DocFind®**, Aetna's online provider directory,
- **Intelihealth®**, Aetna's health website,
- **Healthwise® Knowledgebase**, an innovative decision-support tool, and
- **Estimate the Cost of Care**, for many diseases and conditions.
- **Aetna SmartSourceSM**, search on a health topic, get personalized results.

Your Aetna ID Card

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

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

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

Visit Medco at www.medcohealth.com

Through the online services at www.medcohealth.com, you can:

- Review Plan highlights and get health and wellness information,
- Compare brand name and generic drug prices,
- Obtain order forms, claim forms, and envelopes,
- Request renewals or refills of mail-order prescriptions,
- Check the status of **Medco Pharmacy** mail orders, and
- Check and pay mail-order account balances.

If you are a first time visitor to the site, you will need your Medco member ID number located on your Medco ID card to register.

Your Medco ID Card

You will receive a separate prescription benefit ID card from Medco to use when purchasing a prescription at a participating retail pharmacy. Contact Medco Member Services or log on to www.medcohealth.com if you need additional cards.

ELIGIBILITY AND ENROLLMENT

Eligibility

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

If you lose eligibility under the Medical Plan as a result of a reduction in work hours (i.e., you are regularly scheduled to work fewer than 30 hours per week), and meet the eligibility requirements for retiree coverage (generally age 55 with 10 or more years of service), you may enroll in any retiree medical options available in your area and pay active employee rates through pretax payroll deductions while you remain employed. You will also continue to accrue age and service credits toward your retiree medical contribution multiple during such reduced work schedule.

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

Dependents

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

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

Enrollment

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

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

- Employee Only
- Employee + One Dependent
- Family (employee plus two or more Dependents)

Changing Your Elections

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

Between Open Enrollments – Under IRS rules, once you make your enrollment decisions, either when you are first eligible or during Open Enrollment, your elections for optional benefits remain in effect for the entire Plan year. However, you may be able to change your election for optional benefits before the next Open Enrollment if the change would be permitted under one of the following sets of rules:

- A Status Change, as described below, occurs and your election change is consistent with the Status Change as allowed by the IRS regulations.
- Another IRS-recognized event occurs (e.g., Qualified Medical Child Support Order, judgments, and decree orders).
- Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), you have a special enrollment right to enroll yourself or an eligible Dependent in the Medical Plan, including when you or an eligible Dependent lose coverage under your spouse's employer-sponsored group medical or another group medical plan because of termination of employment, a reduction in work hours, death, plan termination, or expiration of a COBRA* period.

* The Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

Status Change

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

- Marriage, divorce or legal separation
- Change in number of Dependents
- Employment status change
- Change in Dependent coverage eligibility
- Change in eligibility under Medicaid or the Child Health Insurance Program (CHIP)
- Change of work or residence

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

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

You may also change medical options during Open Enrollment, or if your available medical options change due to a relocation. To change your benefits election, contact OxyLink. You must submit any required paperwork within 31 days of the Status Change, or within 60 days of a Medicaid or CHIP event.

CONTRIBUTIONS

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

Pretax contributions are deducted from your pay before federal income and Social Security taxes are calculated and withheld. If you live in a state that recognizes the federal tax treatment of pretax medical contributions, your state income tax also will be withheld after your contributions are deducted.

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

Certain states may provide medical assistance under their state Medicaid plan or child health assistance under their state child health plan. Such state assistance may come in the form of premium assistance for the purchase of group health plan coverage. For additional information, see Notice Regarding Child Health Insurance Plan available online at oxylink.oxy.com.

Pretax Contributions: Effect on Social Security and Other Statutory Benefits

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

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

Pretax Contributions: Effect on Other Oxy Benefits

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

USING THE PLAN

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

Aetna Basic Option

Under the Basic option, which utilizes Aetna's Open Access Choice[®] POS II network, you have the freedom to choose your doctor or health care facility when you need medical care.

Using Network and Out-of-Network Providers

When you need care, you can select a Provider that belongs to the network (a Network Provider) or one that does not belong (an Out-of-Network Provider). The Network Providers represent a wide range of services from basic, routine care (general practitioners, pediatricians, internists, OB/GYNs), to specialty care (cardiologists, urologists), to health care facilities (Hospitals, Skilled Nursing Facilities).

If you receive care from a Network Provider, your covered benefits are calculated using Aetna's Negotiated Fees. Aetna's Negotiated Fees do not apply to care that is not covered under the Plan. When you use an Out-of-Network Provider, your benefits are determined using the Recognized Charge. If the Out-of-Network Provider's charge is more than the Recognized Charge (as defined by Aetna), you pay the difference. This excess amount will not apply toward your deductible or out-of-pocket maximum.

Aetna Provider Network

To participate in Aetna's network, a Provider must meet certain standards in a process called credentialing—which looks at factors such as education and licensing.

To find a Network Provider in your area:

- **Use DocFind at www.aetna.com.** Follow the prompts to select the type of search you want, the area in which you want to search and the number of miles you are willing to travel. When you are asked to select a plan category, choose "Aetna Open Access[®] Plans," then select "Aetna Choice[®] POS II (Open Access)" from the list of plans. You can search the online directory for a specific provider or all providers in a given ZIP code and/or travel distance. You can also get information about a provider's practice, such as address, phone numbers, and access for the disabled.
- **Call or email Aetna Member Services.** A representative can also help you find a Network Provider in your area. The Aetna Member Services toll-free number is shown on your ID card. You also may email Aetna Member Services from Aetna's secure member website, Aetna Navigator. Just go to www.aetna.com and select "Member Log In."

Primary Care Physician (PCP)

You may decide to choose a Primary Care Physician for routine care such as health screenings and care for everyday health problems. A PCP can be a general practitioner, family practitioner, internist, pediatrician or an OB/GYN. You can choose a different PCP for each member of the family, and you can change your PCP at any time.

You are not required to choose a PCP; however, you are encouraged to develop a relationship with a primary doctor.

- Your PCP or other primary doctor is your personal health care manager. He or she gets to know your personal health history and health care needs, maintains all of your records, and can recommend a Specialist when you need care that he or she cannot provide.
- Your Network Provider takes care of Precertification. This is an approval process that is required for certain types of care. If you receive care from an Out-of-Network Provider, it is your responsibility to ensure that any required Precertification is obtained.

Specialists

Specialists are doctors such as oncologists, cardiologists, chiropractors, neurologists or podiatrists. When you need specialty care, you can make an appointment directly with any licensed Specialist. *No referral is required.* Remember, you will pay less out of your own pocket when you use a Network Provider. You can find a network Specialist the same way you find a PCP.

If you decide to choose a PCP, he or she can help you find the right Specialist.

Remember to use DocFind at www.aetna.com to find Network Providers. From the list of Aetna Open Access[®] Plans, choose "Aetna Choice[®] POS II (Open Access)".

Out-of-Area Benefits

Aetna's Open Access Choice[®] POS II network is not available in a few geographical areas. If you reside outside of a network area and elect the Basic option, your benefits will be administered as though you reside within a network area except that out-of-network coinsurance levels will not apply and allowed charges will be limited to the Recognized Charge.

When you need care, choose any licensed provider. You may need to pay for your care at the time you receive it, and then file a claim for reimbursement, or your provider may submit the claim for you and bill you for the balance after the claim is processed. All benefits are based on the Recognized Charge for a given service or supply. If you are charged more than the Recognized Charge, you must pay the difference, which does not apply to your deductible or out-of-pocket limit.

Coverage for Dependents Outside the Service Area

The medical coverage for covered Dependents who permanently reside outside the Aetna Open Access Choice[®] POS II network service area are the same as the network benefits. All benefits are based on the Recognized Charge for a given service or supply. If a charge is more than the Recognized Charge, you must pay the difference, which does not apply to the deductible or out-of-pocket limit.

Sharing the Cost

You share in the cost of your care by making contributions and paying deductibles and coinsurance. These terms are explained below and specific amounts and Plan coinsurance percentages are shown in the "Summary of Benefits" charts in the section entitled *Benefits at a Glance*.

Individual Deductible: The individual deductible is the part of covered expenses you pay each year before the Plan starts to pay benefits. Expenses for both Network and Out-of-Network Care are applied to the deductible during the year. Once you meet the individual deductible, the Plan starts to pay benefits. Each January 1, you start over with a new deductible.

Family Deductible: Once the sum of covered expenses applied toward the individual deductibles for you and any covered Dependents reaches the family limit, you and your Dependents will all be considered to have met your separate individual deductible limits for the rest of the calendar year.

Coinsurance: Once you meet the calendar year deductible, the Plan pays part of your covered expense and you pay the rest. The part you pay is called your coinsurance.

Out-of-Pocket Maximum: The Plan puts a limit on the dollar amount you pay for covered expenses (both network and out-of-network) out of your own pocket—called the out-of-pocket maximum. Your out-of-pocket maximum is based on your annual salary as of the end of the prior calendar year. If you are an LTD beneficiary, your out-of-pocket maximum is based on your annual salary as of the date you were last actively at work. Once your share of covered expenses (including the deductible) reaches the individual out-of-pocket maximum, the Plan pays 100% of covered expenses for the rest of the calendar year. Each January 1, you start over with a new out-of-pocket maximum. There is a separate individual out-of-pocket maximum for Prescription Drugs as described in the *Prescription Drug Benefits* section.

Your Medical Plan contributions and any Precertification penalties do not apply toward the out-of-pocket maximum.

Family Out-of-Pocket Maximum: Once the sum of amounts applied toward the individual out-of-pocket maximums for you and your family members reaches the family out-of-pocket maximum, the Plan pays 100% of covered expenses for all covered family members for the rest of the calendar year. There is no separate family out-of-pocket maximum for Prescription Drugs.

You may access information regarding current deductibles and maximum benefits online at oxylink.oxy.com.

PRECERTIFICATION

Understanding Precertification

Certain services, such as inpatient stays, certain tests, procedures and outpatient surgery require Precertification by Aetna. Precertification is a process that helps you and your Physician determine whether the services being recommended are covered expenses under the plan. It also allows Aetna to help your provider coordinate your transition from an inpatient setting to an outpatient setting (called discharge planning), and to register you for specialized programs or case management when appropriate.

You do not need to precertify services provided by a Network Provider. Network Providers will be responsible for obtaining necessary Precertification for you. Since Precertification is the provider's responsibility, there is no additional out-of-pocket cost to you as a result of a Network Provider's failure to precertify services.

When you go to an Out-of-Network Provider, it is your responsibility to obtain Precertification from Aetna for any services or supplies on the Precertification list below. If you do not precertify, your benefits may be reduced, or the Plan may not pay any benefits. The list of services requiring Precertification follows on the next page.

Important Note

Read the following sections in their entirety for important information on the Precertification process, and any impact it may have on your coverage.

The Precertification Process

Prior to being hospitalized or receiving certain other medical services or supplies there are certain Precertification procedures that must be followed.

You or a member of your family, a Hospital staff member, or the attending Physician, must notify Aetna to precertify the admission or medical services and expenses prior to receiving any of the services or supplies that require Precertification.

Precertification should be secured within the timeframes specified below. To obtain Precertification, you, your Physician or the facility must call Aetna at the telephone number listed on your ID card. This call must be made:

For non-emergency admissions	At least 5 days before the date you are scheduled to be admitted.
For an emergency outpatient medical condition	Prior to the outpatient care, treatment or procedure if possible; or as soon as reasonably possible.
For an Emergency Admission	Within 48 hours or as soon as reasonably possible after you have been admitted.

For an Urgent Admission	Before you are scheduled to be admitted. An Urgent Admission is a Hospital admission by a Physician due to the onset of or change in an Illness; the diagnosis of an Illness; or an Injury.
For outpatient non-emergency medical services requiring Precertification	At least 5 days before the outpatient care is provided, or the treatment or procedure is scheduled.

Aetna will provide a written notification to you and your Physician of the Precertification decision. If your precertified expenses are approved the approval is good for 60 days as long as you remain enrolled in the plan.

When you have an inpatient admission to a facility, Aetna will notify you, your Physician and the facility about your precertified length of stay. If your Physician recommends that your stay be extended, additional days will need to be certified. You, your Physician, or the facility will need to call Aetna at the number on your ID card as soon as reasonably possible, but no later than the final authorized day. Aetna will review and process the request for an extended stay. You and your Physician will receive a notification of an approval or denial.

If Precertification determines that the stay or services and supplies are not covered expenses, the notification will explain why and how Aetna's decision can be appealed. You or your provider may request a review of the Precertification decision as described in the section entitled *Claims and Benefit Payment: When You Disagree With a Claim Decision*.

Services and Supplies Which Require Precertification

Precertification is required for the following types of medical expenses:

Inpatient and Outpatient Care

- Stays in a Hospital
- Stays in a Skilled Nursing Facility
- Stays in a rehabilitation facility
- Stays in a Hospice facility
- Outpatient Hospice Care
- Stays in a Residential Treatment Facility for treatment of mental disorders and substance abuse
- Partial Hospitalization Programs for mental disorders and substance abuse
- Home Health Care
- Private duty nursing care
- Intensive Outpatient Programs for mental disorders and substance abuse
- Amytal interview
- Applied Behavioral Analysis
- Biofeedback
- Electroconvulsive therapy

- Neuropsychological testing
- Outpatient Detoxification
- Psychiatric home care services
- Psychological testing

How Failure to Precertify Affects Your Benefits

A Precertification penalty of \$500, or the cost of the treatment, if less, will be applied to the benefits paid if you fail to obtain a required Precertification prior to incurring medical expenses. This means Aetna will reduce the amount paid towards your coverage, or your expenses may not be covered. You will be responsible for the unpaid balance of the bills.

You are responsible for obtaining the necessary Precertification from Aetna prior to receiving services from an Out-of-Network Provider. Your provider may precertify your treatment for you; however you should verify with Aetna prior to the procedure, that the provider has obtained Precertification from Aetna. If your treatment is not precertified by you or your provider, the benefit payable may be significantly reduced or your expenses may not be covered.

How Your Benefits are Affected

The chart below illustrates the effect on your benefits if necessary Precertification is not obtained.

If Precertification is:	then the expenses are:
• requested and approved by Aetna.	• covered.
• requested and denied.	• not covered, may be appealed.
• not requested, but would have been covered if requested.	• covered after a Precertification penalty is applied.
• not requested, would not have been covered if requested.	• not covered, may be appealed.

It is important to remember that any additional out-of-pocket expenses incurred because your Precertification requirement was not met will not count toward your deductible or payment percentage or maximum out-of-pocket limit.

The Plan pays benefits for covered medical expenses only. If a service or supply you receive while confined as an inpatient is not covered by the Plan, benefits will not be paid for it—whether or not your inpatient confinement has been precertified.

WHAT THE PLAN COVERS

This section describes the services and supplies covered under the Aetna Basic option. Unless otherwise noted in the “Summary of Benefits” charts in the *Benefits at a Glance* section, generally, Network charges are covered at 90% or 80% and Out-of-Network charges are covered at 70%. The deductible applies unless otherwise noted.

Although a service may be listed as a covered benefit, it will not be covered unless it is Medically Necessary for the diagnosis or treatment of your Illness or Injury. Also, regardless of whether you use a Network or Out-of-Network Provider, in most cases the Plan does not cover treatments, procedures, or tests that are considered “experimental or investigational,” as described in the section entitled *What the Plan Does Not Cover*. To find out if a service is considered experimental or investigational, you may contact Aetna Member Services or refer to Aetna’s Clinical Policy Bulletins available online at www.aetna.com.

Hospital Services

Inpatient Hospital Expenses*

The Plan covers charges made by a Hospital for Room and Board, and other Hospital services and supplies for a person confined as an inpatient. Room and Board Charges are covered up to the Hospital’s Semi-Private Rate.

Room and Board Charges include:

- Services of the Hospital’s nursing staff;
- Admission and other fees;
- General and special diets; and
- Sundries and supplies.

The Plan also pays for other services and supplies provided during an inpatient stay, such as:

- Ambulance services
- Physician and surgeon services;
- Operating and recovery rooms;
- Intensive or special care facilities;
- Administration of blood and blood products, but not the cost of the blood or blood products;
- Radiation therapy;
- Speech therapy, physical therapy and occupational therapy;
- Oxygen and oxygen therapy;

* To receive Network benefits for certain transplant procedures and related services, you must participate in the National Medical Excellence Program. See the *Special Programs* section for more information.

- Radiological services, laboratory testing and diagnostic services;
- Medications and intravenous (IV) preparations; and
- Discharge planning.

Important Reminder

Hospital admissions need to be precertified by Aetna. Refer to the *Precertification* section for details.

Outpatient Hospital Expenses

The Plan covers charges made by a Hospital for Hospital services and supplies provided to a person who is not confined as an inpatient. Charges include:

- Professional fees;
- Services and supplies furnished by the Hospital on the day of a treatment, procedure or test.

Emergency and Urgent Care***Coverage for Emergency Medical Conditions***

Covered expenses include charges made by a Hospital or a Physician for services provided in an emergency room to evaluate and treat an Emergency Medical Condition.

The Emergency Care benefit covers:

- Use of emergency room facilities;
- Emergency room Physicians services;
- Hospital nursing staff services; and
- Radiologists and pathologists services.

You should contact your Physician after receiving treatment for an Emergency Medical Condition.

Important Reminder

With the exception of Urgent Care described below, if you visit a Hospital emergency room for a non-emergency condition, the plan will not cover your expenses, as shown in the section entitled *Benefits at a Glance*. No other plan benefits will pay for non-emergency care in the emergency room.

Coverage for Urgent Conditions

Covered expenses include charges made by a Hospital or Urgent Care Provider to evaluate and treat an Urgent Condition.

Urgent Care coverage includes:

- Use of emergency room facilities when network urgent care facilities are not in the service area and you cannot reasonably wait to visit your Physician;
- Use of urgent care facilities;
- Physicians services;
- Nursing staff services; and
- Radiologists and pathologists services.

You should contact your Physician after receiving treatment of an Urgent Condition.

Physician Services

Physician Visits

Covered medical expenses include charges made by a Physician during a visit to treat an Illness or Injury. The visit may be at the Physician's office, in your home, in a Hospital or other facility during your stay or in an outpatient facility. Covered expenses also include:

- Allergy testing, treatment and injections; and
- Charges made by the Physician for supplies, radiological services, x-rays, and tests provided by the Physician.

Surgery

Covered expenses include charges made by a Physician for:

- Performing your surgical procedure;
- Pre-operative and post-operative visits; and
- Consultation with another Physician to obtain a second opinion prior to the surgery.

Coverage for certain services including, but not limited to, secondary and/or multiple surgeries and assistant surgeon charges may be limited or reduced.

Anesthetics

Covered expenses include charges for the administration of anesthetics and oxygen by a Physician, other than the operating Physician, or Certified Registered Nurse Anesthetist (C.R.N.A.) in connection with a covered procedure.

Preventive Care

The Plan covers certain preventive services that are submitted and billed by your provider as preventive care. If an exam or service is given to diagnose or treat an Illness or Injury, it is not considered a physical exam, well child exam or routine screening.

Well Child Exams

The Plan covers charges made by a Physician for a physical exam given to your Dependent child through age 18, including:

- X-rays, laboratory and other tests given in connection with the exam; and
- Materials for giving immunizations for infectious diseases and testing for tuberculosis.

The physical exam must include at least:

- A review and written record of the patient's complete medical history;
- A check of all body systems; and
- A review and discussion of exam results with the patient or with the parent or guardian.

The Plan covers seven exams in the first 12 months of the child's life, three exams between age 13-24 months, three exams between age 25-36 months and one every 12 months thereafter through age 18. Also included are charges for immunizations for infectious disease.

The Plan does *not* cover (as part of any routine physical exam):

- Services covered to any extent under any other part of this Plan;
- Services covered to any extent under any other group plan sponsored by your employer;
- Services to diagnose or treat a suspected or identified Illness or Injury;
- Exams given while the person is confined in a Hospital or other facility for medical care;
- Services not provided by a Physician or under the direct supervision of a Physician;
- Medicines, drugs, appliances, equipment or supplies;
- Psychiatric, psychological, personality, or emotional testing or exams;
- Any employment-related exams;
- Premarital exams; or
- Vision, hearing, or dental exams.

Routine Physicals

Covered expenses include charges made by your physician for routine physical exams. A routine exam is a medical exam given by a physician for a reason other than to diagnose or treat a suspected or identified Illness or Injury, and also includes:

- Radiological services, X-rays, lab and other tests given in connection with the exam; and
- Immunizations for infectious diseases and the materials for administration of immunizations as recommended by the Advisory Committee on Immunization

Practices of the Department of Health and Human Services, Center for Disease Control; and

- Testing for Tuberculosis.

Unless specified above, not covered under this benefit are charges for:

- Services which are covered to any extent under any other part of this plan;
- Services which are for diagnosis or treatment of a suspected or identified Illness or Injury;
- Exams given during your stay for medical care;
- Services not given by a physician or under his or her direction;
- Psychiatric, psychological, personality or emotional testing or exams.

Routine Screenings for Cancer

The Plan covers preventive services using the age and frequency schedule shown below:

- Colorectal Cancer Screening*
 - Beginning at age 50 and as ordered by your Physician:
- A yearly stool blood test (FOBT);
- Flexible sigmoidoscopy every 5 years;
- Yearly stool blood test plus flexible sigmoidoscopy every 5 years;
- Double contrast barium enema every 5 years; or
- Colonoscopy every 10 years.
- Mammography
 - One mammogram per calendar year for women age 40 and older.
- Cervical Cancer Screening
 - A routine gynecological exam with Pap smear once per calendar year, including medically necessary screening for Human Papilloma Virus (HPV) for women age 30 and older.
- Prostate Specific Antigen (PSA) Test
 - One digital rectal exam and one PSA test every calendar year for men age 40 and older.

Spinal Manipulation Benefit

The Plan covers expenses for manipulative (adjustive) treatment or other physical treatment for conditions caused by (or related to) biomechanical or nerve conduction disorders of the spine. Benefits are paid for up to 25 visits per calendar year.

* Any office visits prior to screening are covered as any other Physician Services office visits or surgeon charges.

The maximum does not apply to expenses incurred:

- While the person is a full-time inpatient in a Hospital;
- For treatment of scoliosis;
- For fracture care; or
- For surgery. This includes pre- and post-surgical care provided or ordered by the operating Physician.

Family Planning

Pregnancy Coverage

The Plan pays benefits for pregnancy-related expenses on the same basis as it would for a disease. For inpatient care of a mother and newborn child, benefits will be payable for a minimum of:

- 48 hours after a vaginal delivery; and
- 96 hours after a cesarean section.

Precertification is not required for the first 48 hours of Hospital confinement after a vaginal delivery or 96 hours after a cesarean delivery. Any days of confinement over these limits must be precertified. You, your doctor or other health care provider can request Precertification by calling the number on your ID card.

To be covered, expenses must be incurred while covered by the Plan. Any pregnancy benefits payable by a previous group medical coverage will be subtracted from benefits payable under this Plan.

Covered expenses include charges for family planning services, including:

- Voluntary sterilization.
- Voluntary termination of pregnancy.

Infertility Coverage

The Plan covers services to diagnose and treat an underlying medical condition which causes infertility when provided by or under the direction of a Physician.

Dental Care

Oral and Maxillofacial Treatment (Mouth, Jaws and Teeth)

Covered expenses include charges made by a Physician, a Dentist and Hospital for non-surgical treatment of infections or diseases of the mouth, jaw joints or supporting tissues.

Services and supplies for treatment of, or related conditions of, the teeth, mouth, jaws, jaw joints or supporting tissues, (this includes bones, muscles, and nerves), for surgery needed to:

- Treat a fracture, dislocation, or wound;
- Cut out teeth that are partly or completely impacted in the bone of the jaw; teeth that will not erupt through the gum; other teeth that cannot be removed without cutting into bone; the roots of a tooth without removing the entire tooth; cysts, tumors, or other diseased tissues;
- Cut into gums and tissues of the mouth. This is only covered when not done in connection with the removal, replacement or repair of teeth; or
- Alter the jaw, jaw joints, or bite relationships by a cutting procedure when appliance therapy alone cannot result in functional improvement.

Hospital services and supplies received for a stay required because of your condition.

Dental work, surgery and orthodontic treatment needed to remove, repair, restore or reposition natural teeth damaged, lost, or removed; or other body tissues of the mouth fractured or cut due to Injury.

Any such teeth must have been free from decay or in good repair, and are firmly attached to the jaw bone at the time of the Injury.

Treatment must be completed in the calendar year of or calendar year following the accident.

If crowns, dentures, bridges, or in-mouth appliances are installed due to Injury, covered expenses only include charges for:

- The first denture or fixed bridgework to replace lost teeth;
- The first crown needed to repair each damaged tooth; and
- An in-mouth appliance used in the first course of orthodontic treatment after the Injury.

Jaw Joint Disorders

The Plan also covers charges for the following services and supplies for treatment of a jaw joint disorder if they are the result of a disease:

- Diagnosis;
- Non-surgical treatment (including appliance therapy and adjustments to a maximum of 6 months per lifetime);
- Surgery to alter the jaw, jaw joints, or bite relationships by a cutting procedure when appliance therapy alone cannot result in functional improvement; and
- Hospital services and supplies.

If treatment is for an Injury, the treatment must be done in the calendar year of the accident which caused the Injury or in the next calendar year.

Obesity Treatment

Covered expenses include charges made by a Physician, licensed or certified dietician, nutritionist or Hospital for the non-surgical treatment of Morbid Obesity for the following outpatient weight management services:

- An initial medical history and physical exam; and
- Diagnostic tests given or ordered during the first exam.

Covered expenses include one Morbid Obesity surgical procedure, within a two-year period, beginning with the date of the first Morbid Obesity surgical procedure, unless a multi-stage procedure is planned.

Limitations

Unless specified above, not covered under this benefit are charges incurred for:

Weight control services including surgical procedures, medical treatments, weight control/loss programs, dietary regimens and supplements, food or food supplements, appetite suppressants and other medications; exercise programs, exercise or other equipment; and other services and supplies that are primarily intended to control weight or treat obesity, including Morbid Obesity, or for the purpose of weight reduction, regardless of the existence of comorbid conditions; except as provided in this SPD.

Short-Term Rehabilitation Therapy Services

Covered expenses include charges for short-term therapy services when prescribed by a Physician as described below. The services have to be performed by:

- A licensed or certified physical, occupational or speech therapist;
- A Hospital, Skilled Nursing Facility, or hospice facility; or
- A Physician.

Charges for the following short term rehabilitation expenses are covered:

Cardiac and Pulmonary Rehabilitation Benefits

- Cardiac rehabilitation benefits are available as part of an inpatient Hospital stay. A limited course of outpatient cardiac rehabilitation is covered when following angioplasty, cardiovascular surgery, congestive heart failure or myocardial infarction. The Plan will cover charges in accordance with a treatment plan as determined by your risk level when recommended by a Physician. This course of treatment is limited to a maximum of 36 sessions in a 12 week period.
- Pulmonary rehabilitation benefits are available as part of an inpatient Hospital stay. A limited course of outpatient pulmonary rehabilitation is covered for the treatment of reversible pulmonary disease states. This course of treatment is limited to a maximum of 36 hours or a six week period.

Outpatient Cognitive Therapy, Physical Therapy, Occupational Therapy and Speech Therapy Rehabilitation Benefits

Inpatient rehabilitation benefits for the services listed will be paid as part of your Inpatient Hospital and Skilled Nursing Facility benefits provision in this SPD.

- Physical therapy is covered for non-chronic conditions and acute Illnesses and Injuries, provided the therapy is expected to significantly improve, develop or restore physical functions lost or impaired as a result of an acute Illness, Injury or surgical procedure. Physical therapy does not include educational training or services designed to develop physical function.
- Occupational therapy (except for vocational rehabilitation or employment counseling) is covered for non-chronic conditions and acute Illnesses and Injuries, provided the therapy is expected to significantly improve, develop or restore physical functions lost or impaired as a result of an acute Illness, Injury or surgical procedure, or to relearn skills to significantly improve independence in the activities of daily living. Occupational therapy does not include educational training or services designed to develop physical function.
- Speech therapy is covered for non-chronic conditions and acute Illnesses and Injuries if expected to restore the speech function or correct a speech impairment resulting from Illness or Injury; or for delays in speech function development as a result of a gross anatomical defect present at birth. Speech function is the ability to express thoughts, speak words and form sentences. Speech impairment is difficulty with expressing one's thoughts with spoken words.
- Cognitive therapy associated with physical rehabilitation is covered when the cognitive deficits have been acquired as a result of neurologic impairment due to trauma, stroke, or encephalopathy, and when the therapy is part of a treatment plan intended to restore previous cognitive function.

A "visit" consists of no more than one hour of therapy. Covered expenses include charges for two therapy visits of no more than one hour in a 24-hour period.

The therapy should follow a specific treatment plan that details the treatment, and specifies frequency and duration; and provides for ongoing reviews and is renewed only if continued therapy is appropriate.

Unless specifically covered above, not covered under this benefit are charges for:

- Therapies for the treatment of delays in development, unless resulting from acute Illness or Injury, or congenital defects amenable to surgical repair (such as cleft lip/palate), are not covered. Examples of non-covered diagnoses include Pervasive Developmental Disorders (including Autism), Down's Syndrome, and Cerebral Palsy, as they are considered both developmental and/or chronic in nature;
- Any services which are covered expenses in whole or in part under any other group plan sponsored by an employer;
- Any services unless provided in accordance with a specific treatment plan;

- Services provided during a stay in a Hospital, Skilled Nursing Facility, or hospice facility except as stated above;
- Services not performed by a Physician or under the direct supervision of a Physician;
- Treatment covered as part of the Spinal Manipulation Treatment. This applies whether or not benefits have been paid under that section;
- Services provided by a Physician or physical, occupational or speech therapist who resides in your home; or who is a member of your family, or a member of your spouse's family;
- Special education to instruct a person whose speech has been lost or impaired, to function without that ability. This includes lessons in sign language.

Reconstructive or Cosmetic Surgery and Supplies

Covered expenses include charges made by a Physician, Hospital, or surgery center for reconstructive services and supplies, including:

- Surgery needed to improve a significant functional impairment of a body part.
- Surgery to correct the result of an accidental Injury, including subsequent related or staged surgery, provided that the surgery occurs no more than 24 months after the original Injury. For a covered child, the time period for coverage may be extended through age 18.
- Surgery to correct the result of an Injury that occurred during a covered surgical procedure provided that the reconstructive surgery occurs no more than 24 months after the original Injury.
Note: Injuries that occur as a result of a medical (i.e., non surgical) treatment are not considered accidental Injuries, even if unplanned or unexpected.
- Surgery to correct a gross anatomical defect present at birth or appearing after birth (but not the result of an Illness or Injury) when
 - the defect results in severe facial disfigurement, or
 - the defect results in significant functional impairment and the surgery is needed to improve function.

Reconstructive Breast Surgery

Covered expenses include reconstruction of the breast on which a mastectomy was performed, including an implant and areolar reconstruction. Also included is surgery on a healthy breast to make it symmetrical with the reconstructed breast and physical therapy to treat complications of mastectomy, including lymphedema.

Skilled Nursing Facility Care

The Plan covers charges made by a Skilled Nursing Facility for the services and supplies listed below. These must be provided to a person while confined to convalesce from an Illness or Injury.

- Room and board, including charges for services (such as general nursing care) made in connection with room occupancy. Any charge for Room and Board in a private room that exceeds the Hospital's Semi-Private Room Rate is *not* covered.
- Use of special treatment rooms.
- X-ray and lab work.
- Physical, occupational or speech therapy.
- Oxygen and other gas therapy.
- Other medical services provided by a Skilled Nursing Facility. This does not include private or special nursing, Physician services, drugs, biologicals, solutions, dressings, casts and other supplies.

The Plan pays benefits to a maximum of 120 days for skilled nursing services per calendar year. The maximum is a combined limit for Network and Out-of-Network Care.

Skilled Nursing Facility care does *not* include charges for treatment of:

- Drug addiction.
- Chronic brain syndrome.
- Alcoholism.
- Mental retardation.
- Any other Mental Disorder.

Important Reminder

Admissions to a Skilled Nursing Facility must be Precertified by Aetna. Refer to the *Precertification* section for details.

Home Health Care

Covered expenses include charges for home health care services when ordered by a Physician as part of a home health plan and provided you are:

- Transitioning from a Hospital or other inpatient facility, and the services are in lieu of a continued inpatient stay; or
- Homebound.

Covered expenses include only the following:

- Skilled nursing services that require medical training of, and are provided by, a licensed nursing professional within the scope of his or her license. These services need to be provided during intermittent visits of four hours or less, with a daily maximum of three visits. Intermittent visits are considered periodic and recurring visits that skilled nurses make to ensure your proper care, which means they are not on site for more than four hours at a time. If you are discharged from a Hospital or Skilled Nursing Facility after an inpatient stay, the intermittent requirement may be waived to allow coverage for up to 12 hours (three visits) of continuous skilled nursing services. However, these services must be provided for within 10 days of discharge.
- Home health aide services, when provided in conjunction with skilled nursing care, that directly support the care. These services need to be provided during intermittent visits of four hours or less, with a daily maximum of three visits.

- Medical social services, when provided in conjunction with skilled nursing care, by a qualified social worker.

Benefits for home health care visits are payable up to the Home Health Care Plan maximum. Each visit by a nurse or therapist is one visit.

In figuring the calendar year maximum visits, each visit of up to 4 hours is one visit.

This maximum will not apply to care given by an R.N. or L.P.N. when:

- Care is provided within 10 days of discharge from a Hospital or Skilled Nursing Facility as a full-time inpatient; and
- Care is needed to transition from the Hospital or Skilled Nursing Facility to home care.

When the above criteria are not met, covered expenses include up to 12 hours of continuous care by an R.N. or L.P.N. per day.

Coverage for Home Health Care services is not determined by the availability of caregivers to perform them. The absence of a person to perform a non-skilled or Custodial Care service does not cause the service to become covered. If the covered person is a minor or an adult who is dependent upon others for non-skilled care (e.g. bathing, eating, toileting), coverage for home health services will only be provided during times when there is a family member or caregiver present in the home to meet the person's non-skilled needs.

Limitations

Unless specified above, not covered under this benefit are charges for:

- Services or supplies that are not a part of the Home Health Care Plan.
- Services of a person who usually lives with you, or who is a member of your or your spouse's family.
- Services of a certified or licensed social worker.
- Services for Infusion Therapy.
- Transportation.
- Services or supplies provided to a minor or Dependent adult when a family member or caregiver is not present.
- Services that are Custodial Care.

Important Reminders

The Plan does not cover Custodial Care, even if care is provided by a nursing professional, and family member or other caretakers cannot provide the necessary care.

Home Health Care needs to be Precertified by Aetna. Refer to the *Precertification* section for details.

Refer to the section entitled *Benefits at a Glance* for details about any applicable Home Health Care visit maximums.

Hospice Care

The Plan covers Hospice Care that is provided as part of a Hospice Care Program for a person with a prognosis of twelve months or less to live. Hospice Care coverage is described below.

Facility Expenses for Inpatient and Outpatient Care

The Plan covers charges made by a hospice facility, Hospital or Skilled Nursing Facility on its own behalf for:

- Inpatient Care – Room and Board Charges, up to the Semi-Private Room Rate, and other services and supplies provided to a person while a full-time inpatient for pain control, and other acute and chronic symptom management.
- Outpatient Care – Those services and supplies furnished to a person while not confined as a full-time inpatient.

Other Expenses for Outpatient Care

The Plan covers charges made by a Hospice Care Agency for:

- Part-time or intermittent nursing care by an R.N. or L.P.N. for up to 8 hours in any one day.
- Medical social services under a Physician's direction. These include:
 - Assessment of the person's social, emotional and medical needs, and the home and family situation;
 - Identifying community resources available to the person; and
 - Helping the person make use of these resources.
- Psychological and dietary counseling.
- Consultation or case management services provided by a Physician.
- Physical and occupational therapy.
- Part-time or intermittent home health aide services for up to 8 hours in any one day. These services consist mainly of caring for the person.
- Medical supplies.
- Drugs and medicines prescribed by a Physician.

Charges made by a Physician for consulting or case management services, and charges made by a physical or occupational therapist are also covered if:

- The provider is not an employee of a Hospice Care Agency; and
- A Hospice Care Agency is still responsible for the person's care.

As part of Hospice Care coverage, the Plan covers Home Health Care Agency expenses for:

- Physical and occupational therapy;
- Part-time or intermittent home health aid services for up to 8 hours in any one day; these consist mainly of caring for the person;
- Medical supplies;

- Drugs and medicines prescribed by a Physician; and
- Psychological and dietary counseling.

The Plan's Hospice Care benefit does *not* include coverage for:

-
- Funeral arrangements
- Pastoral counseling.
- Financial or legal counseling, including estate planning and the drafting of a will.
- Homemaker or caretaker services. These are services not entirely related to the care of a person and include sitter or companion services for the person who is ill or other family members; transportation; housecleaning and home maintenance.

Important Reminder

Inpatient Hospice Care and home health care needs to be Precertified by Aetna. Refer to the *Precertification* section for details.

Ambulance Services

The Plan covers charges for a professional ambulance to transport a person from the place where he/she is injured or becomes ill to the first Hospital where treatment is given. When, in a medical emergency, the first Hospital does not have the required services, transportation to another Hospital is also covered.

Durable Medical Equipment

The Plan covers Durable Medical Equipment (such as wheelchairs, walkers, crutches) as follows:

- Rental of Durable Medical Equipment. Instead of rental, the Plan may cover the initial purchase of this equipment if Aetna is shown that long-term use of it is planned and that it either cannot be rented or would cost less to purchase than to rent;
- Repair of purchased Durable Medical Equipment; and
- Replacement of purchased Durable Medical Equipment if Aetna is shown that it is needed because of a change in the person's physical condition, or if it is likely to cost less to purchase a replacement than to repair existing equipment or rent similar equipment.

Diagnostic and Preoperative Testing

Outpatient Complex Imaging Expenses

The Plan covers charges made on an outpatient basis by a Physician, Hospital or a licensing imaging or radiological facility for complex imaging services to diagnose an Illness or Injury, including:

- Computerized Axial Tomography (CAT or CT) scans;
- Magnetic Resonance Imaging (MRI);
- Positron Emission Tomography (PET) scans; and
- Any other outpatient diagnostic imaging service costing over \$500.

Limitations

The Plan does not cover diagnostic complex imaging expenses under this part of the Plan if such imaging expenses are covered under any other part of the Plan.

Outpatient Diagnostic Lab Work and Radiological Services

Covered expenses include charges for radiological services (other than diagnostic complex imaging), lab services, and pathology and other tests provided to diagnose an Illness or Injury. You must have definite symptoms that start, maintain or change a plan of treatment prescribed by a Physician. The charges must be made by a Physician, Hospital or licensed radiological facility or lab.

Coverage for certain services including, but not limited to, multiple x-rays performed on the same day may be limited or reduced.

Outpatient Preoperative Testing

Prior to a scheduled covered surgery, covered expenses include charges made for tests performed by a Hospital, surgery center, Physician or licensed diagnostic laboratory provided the charges for the surgery are covered expenses and the tests are:

- Related to your surgery, and the surgery takes place in a Hospital or surgery center;
- Completed within 14 days before your surgery;
- Performed on an outpatient basis;
- Covered if you were an inpatient in a Hospital;
- Not repeated in or by the Hospital or surgery center where the surgery will be performed.
- Test results should appear in your medical record kept by the Hospital or surgery center where the surgery is performed.

Limitations

The Plan does not cover diagnostic complex imaging expenses under this part of the Plan if such imaging expenses are covered under any other part of the Plan. If your tests indicate that surgery should not be performed because of your physical condition, the Plan will pay for the tests, however surgery will not be covered.

Prosthetic Devices

Covered expenses include charges made for internal and external prosthetic devices and special appliances, if the device or appliance improves or restores body part function that has been lost or damaged by Illness, Injury or congenital defect. Covered expenses also include instruction and incidental supplies needed to use a covered prosthetic device.

The Plan covers the first prosthesis you need that temporarily or permanently replaces all or part of a body part lost or impaired as a result of Illness or Injury or congenital defects as described in the list of covered devices below for an

- Internal body part or organ; or
- External body part.

Covered expenses also include replacement of a prosthetic device if:

- The replacement is needed because of a change in your physical condition; or normal growth or wear and tear; or
- It is likely to cost less to buy a new one than to repair the existing one; or
- The existing one cannot be made serviceable.

The list of covered devices includes but is not limited to:

- An artificial arm, leg, hip, knee or eye;
- Eye lens;
- An external breast prosthesis and the first bra made solely for use with it after a mastectomy;
- A breast implant after a mastectomy;
- Ostomy supplies, urinary catheters and external urinary collection devices;
- Speech generating device;
- A cardiac pacemaker and pacemaker defibrillators; and
- A durable brace that is custom made for and fitted for you.

The Plan will not cover expenses and charges for, or expenses related to:

- Orthopedic shoes, therapeutic shoes, foot orthotics, or other devices to support the feet, unless required for the treatment of or to prevent complications of diabetes, or if the shoes are the first pair of corrective shoes for a child up to age 2 years, or if an orthopedic shoe is an integral part of a covered leg brace;
- Trusses, corsets, and other support items; or
- Any item listed in the *Exclusions* section.

Treatment of Mental Disorders and Substance Abuse

Treatment of Mental Disorders

Covered expenses include charges made for the treatment of Mental Disorders by Behavioral Health Providers.

Important Reminders

Not all types of services are covered. For example, educational services and certain types of therapies are not covered. See *What the Plan Does Not Cover* for more information.

Inpatient care, partial hospitalizations and outpatient treatment must be Precertified by Aetna. Refer to the *Precertification* section for details.

In addition to meeting all other conditions for coverage, the treatment must meet the following criteria:

- There is a written treatment plan prescribed and supervised by a Behavioral Health Provider;
- This plan includes follow-up treatment; and
- This plan is for a condition that can favorably be changed.

Benefits are payable for charges incurred in a Hospital, Psychiatric Hospital, Residential Treatment Facility or Behavioral Health Provider's office for the treatment of Mental Disorders as follows:

Inpatient Treatment

Covered expenses include Room and Board Charges at the Semi-Private Room Rate, and other services and supplies provided during your stay in a Hospital, Psychiatric Hospital or Residential Treatment Facility. Inpatient benefits are payable only if your condition requires services that are only available in an inpatient setting.

Partial Confinement Treatment

Covered expenses include charges made for Partial Confinement Treatment provided in a facility or program for the intermediate short-term or medically-directed intensive treatment of a Mental Disorder. Such benefits are payable if your condition requires services that are only available in a Partial Confinement Treatment setting.

Outpatient Treatment

Covered expenses include charges for treatment received while not confined as a full-time inpatient in a Hospital, Psychiatric Hospital or Residential Treatment Facility.

The Plan covers partial hospitalization services (more than 4 hours, but less than 24 hours per day) provided in a facility or program for the intermediate short-term or medically-directed intensive treatment. The partial hospitalization will only be covered if you would need inpatient care if you were not admitted to this type of facility.

Treatment of Substance Abuse

Covered expenses include charges made for the treatment of Substance Abuse by Behavioral Health Providers. In addition to meeting all other conditions for coverage, the treatment must meet the following criteria:

- There is a program of therapy prescribed and supervised by a Behavioral Health Provider.
- The program of therapy includes either:
 - A follow up program directed by a Behavioral Health Provider on at least a monthly basis; or
 - Meetings at least twice a month with an organization devoted to the treatment of alcoholism or Substance Abuse.

Important Reminders

Not all types of services are covered. For example, educational services and certain types of therapies are not covered. See *What the Plan Does Not Cover* for more information.

Inpatient treatment, partial-hospitalization care and outpatient treatment must be Precertified by Aetna. Refer to the *Precertification* section for details.

Inpatient Treatment

This Plan covers Room and Board Charges at the Semi-Private Room Rate and other services and supplies provided during your stay in a Psychiatric Hospital or Residential Treatment Facility, appropriately licensed by the state Department of Health or its equivalent.

Coverage includes:

- Treatment in a Hospital for the medical complications of Substance Abuse.
- “Medical complications” include Detoxification, electrolyte imbalances, malnutrition, cirrhosis of the liver, delirium tremens and hepatitis.
- Treatment in a Hospital is covered only when the Hospital does not have a separate treatment facility section.

Outpatient Treatment

Outpatient treatment includes charges for treatment of Substance Abuse received while not confined as a full-time inpatient in a Hospital, Psychiatric Hospital or Residential Treatment Facility.

This Plan covers partial hospitalization services (more than 4 hours, but less than 24 hours per day) provided in a facility or program for the intermediate short-term or medically-directed intensive treatment of alcohol or drug abuse. The partial hospitalization will only be covered if you would need inpatient treatment if you were not admitted to this type of facility.

Partial Confinement Treatment

Covered expenses include charges made for Partial Confinement Treatment provided in a facility or program for the intermediate short-term or medically-directed intensive treatment of Substance Abuse.

Such benefits are payable if your condition requires services that are only available in a Partial Confinement Treatment setting.

PRESCRIPTION DRUG BENEFITS

This benefit has two components managed by Medco Health Solutions (Medco) that covers outpatient prescription drugs prescribed by a Physician to treat an Illness or Injury. The retail pharmacy benefit is designed to meet your short-term Prescription Drug needs of up to 30 days. For a longer-term prescription, you should use the **Medco Pharmacy** mail-order service.

Each covered individual has a \$1,000 annual maximum out-of-pocket expense for combined mail-order and retail prescriptions. This maximum is separate from, and in addition to, the medical annual maximum out-of-pocket expense.

For mail-order and retail prescriptions, if a generic equivalent drug is available and you or your doctor select a preferred or non-preferred brand name drug, the Plan will only pay up to what it would have paid for the generic. You will be responsible for the balance, and the coinsurance and out-of-pocket maximums do not apply.

Prescription Drug Benefits		
Annual Deductible	None	
Retail Pharmacy, up to a 30-day supply	Your Coinsurance	
	Initial Prescription & 2 Refills	Maintenance Drug Refills 3 and Over (4+ Fills)
Generic	\$10	\$20
Preferred Brand	25% (\$10 min/\$50 max)	50% (\$20 min/no max)
Non-Preferred Brand	25% (\$25 min/\$100 max)	50% (\$50 min/no max)
Mail Order Pharmacy, up to a 90-day supply	Your Coinsurance	
Generic	\$20	
Preferred Brand	25% (\$20 min/\$100 max)	
Non-Preferred Brand	25% (\$50 min/\$200 max)	
If a generic drug is available, you will pay the generic coinsurance the difference in price between the brand name and the generic drug.		

Retail Pharmacy

When you enroll in this Plan, you will receive a separate Medco prescription benefit ID card. You should use a participating retail pharmacy for your short-term prescriptions (up to a 30-day supply). When you show your prescription card to the pharmacist, you pay your retail coinsurance plus any cost difference between brand and generic drugs for each prescription at the time of purchase.

To find a participating retail pharmacy near you:

- Log on to www.medcohealth.com and select “Locate a pharmacy.”
- Ask your retail pharmacy whether it participates in the Medco network.

If you use a nonparticipating retail pharmacy, you must pay the entire non-discounted cost of the prescription and then submit a reimbursement claim form to Medco. You will be reimbursed for the amount the covered medication would have cost at a participating retail pharmacy less the appropriate coinsurance.

Important: The retail pharmacy program is designed for short-term prescriptions.

You will pay a penalty of two times the retail coinsurance at a retail pharmacy if you obtain 3 or more refills (4 fills) of the same prescription (i.e., maintenance drugs of identical dosage and strength) within 270 days, and the coinsurance maximum will not apply. Penalties also do not apply to your annual out-of-pocket limit.

To avoid these penalties, use **Medco Pharmacy** for your longer term prescription needs.

Medco Pharmacy

If you take maintenance prescription drugs or other medications for long-term treatment, you may order up to a 90-day supply through **Medco Pharmacy**, Medco’s mail-order drug service.* Mail order can also be used to fill non-urgent short-term prescriptions. The retail pharmacy coinsurance will apply to mail order prescriptions of 30 days or less. Typically, the mail-order service provides significant cost savings on medications that are dispensed by **Medco Pharmacy**.

To order by mail, send your original prescription, together with a completed order form and payment of the applicable coinsurance amount to **Medco Pharmacy**. If you choose not to provide debit or credit card information and prefer to pay by check, you can estimate your coinsurance by contacting Medco. Order forms are available online at oxylink.oxy.com or www.medcohealth.com, or by contacting Medco Member Services. You may also have your doctor fax your prescriptions. Ask your doctor to call 888-327-9791 for faxing instructions.

Refills can be ordered by mail, online at www.medcohealth.com, or by phone any time day or night. Refills are usually delivered within 3 to 5 days after the order is received.

Specialty Pharmacy

Specialty medications include many high-cost drugs that treat complex, chronic diseases such as hemophilia and rheumatoid arthritis, and may be given orally, by injection in your doctor’s office, or as a self-administered injectable. Certain specialty drugs are only covered when ordered through Medco’s Specialty Pharmacy, Accredo Health Group, Inc. Accredo provides enhanced clinical benefits as well as cost benefits to you and the plan.

* Limitations do not apply to expatriates.

There is a staff of Accredo pharmacists and nurses who are specially trained in these specific conditions, and are available 24 hours a day, 7 days a week to help ensure that the drugs and dosing you receive are clinically appropriate. Additional benefits include real-time safety checks to help prevent drug interactions, as well as ancillary supplies and equipment such as syringes and sharps containers.

Drugs within certain specialty drug categories will not be covered if obtained from an outpatient clinic, home infusion company, doctor’s office, or from another pharmacy and submitted as a medical claim to Aetna.

Examples of Specialty Drug Categories	Specialty Drug Examples
Self-Administered Drugs	Growth hormones
Anemia	Procrit, Aranesp
Rare Disease	Immune Globulin
Clinician Administered-Injectable	Synagis
Clinician Administered-Infused	Remicade, Orencia

Prior Authorization/Precertification

The Plan requires prior authorization for certain drugs and has certain coverage limits. For example, prescription drugs used for cosmetic purposes (e.g., Botox, Retin-A) may not be covered for a specific use, or a medication might be limited to a certain amount (such as the number of pills or total dosage) within a specific time period (e.g., Imitrex). Another example includes growth hormones.

If you submit a prescription for a drug that requires prior authorization or has coverage limits, your pharmacist will tell you that approval is needed before the prescription can be filled. The pharmacist will give you or your doctor a toll-free number to call. If you use **Medco Pharmacy**, your doctor will be contacted directly.

When a prior authorization or a coverage limit is triggered, more information is needed to determine whether your use of the medication meets the Plan’s coverage conditions. Medco will notify you and your doctor in writing of the decision. If coverage is approved, the letter will indicate the amount of time for which coverage is valid. If coverage is denied, an explanation will be provided, along with instructions on how to submit an appeal.

Step Therapy

Medco’s step therapy program is also a form of precertification under which certain drugs are covered by the Plan only after one or more other “prerequisite” (clinically appropriate and/or cost-effective alternative) drugs are tried first. Your doctor may also contact Medco to request coverage of a prerequisite drug without a trial.

If the drug that you are prescribed requires step therapy, you should arrange for your doctor to call the number shown on your ID card to begin the certification process. Benefits may not be payable unless the required procedures are followed and certification approved.

Coordination of Pharmacy Benefits

If your Dependent's primary coverage is provided by another plan and this Plan is secondary, you should submit Prescription Drug claims to Aetna for secondary benefits. Secondary benefits are provided by Aetna and will be subject to the medical deductible and 80% coinsurance. This is further described in the section entitled *Coordination With Other Plans*.

Contacting Member Services

Medco Member Services is available 24 hours a day, 7 days a week (except Thanksgiving and Christmas) by calling toll-free 800-551-7680. TTY is available for hearing-impaired members at 800-759-1089.

A representative can:

- Help you find a participating retail pharmacy,
- Send you order forms, claim forms, and envelopes, and
- Answer questions about your prescriptions or Plan coverage.

Through the online services at www.medcohealth.com, you can:

- Review Plan highlights and get health and wellness information,
- Compare brand name and generic drug prices,
- Obtain order forms, claim forms, and envelopes,
- Request renewals or refills of mail-order prescriptions,
- Check the status of **Medco Pharmacy** orders, and
- Check and pay mail-order account balances.

What the Prescription Drug Benefit Covers

The Prescription Drug Benefit covers:

- Federal legend drugs*—drugs that require a label stating: “Caution: Federal law prohibits dispensing without a prescription;”
- Compound medications of which at least one ingredient is a federal legend drug;
- Any other drug which, under applicable state law, may be dispensed only upon a Physician’s written prescription;
- Insulin;

* Age restrictions apply to coverage for certain prescription drugs.

- Needles and syringes;
- Over-the-counter (OTC) diabetic supplies (except Gluowatch products and insulin pumps);
- Oral, transdermal, intravaginal and injectable contraceptives;
- Legend contraceptive devices;
- Legend prenatal vitamins for females only;
- Legend pediatric fluoride vitamin drops up to a 50-day supply; and
- Legend smoking deterrents.

What the Prescription Drug Benefit Does Not Cover

The Prescription Drug Benefit does *not* cover the following prescription drug expenses:

- Any drug that does not, by federal law, require a prescription, such as an over-the-counter (OTC) drug or drugs with an equivalent OTC product, even when a prescription is written for it;
- Therapeutic devices and appliances;
- Any drug entirely consumed when and where it is prescribed;
- Medication which is to be taken by or administered to an individual, in whole or in part, while he or she is a patient in a licensed hospital, rest home, sanitarium extended care facility, skilled nursing facility, convalescent hospital, nursing home or similar institution which operates on its premises or allows to be operated on its premises, a facility for dispensing pharmaceuticals;
- Any refill of a drug dispensed more than one year after prescribed, or as permitted by law where the drug is dispensed;
- Drugs labeled “Caution-Limited by Federal Law to investigational use,” or experimental drugs, even though a charge is made to the individual;
- Drugs to treat impotency or sexual dysfunction;
- Drugs whose sole purpose is to stimulate or promote hair growth (e.g., Rogaine, Propecia);
- Drugs prescribed for cosmetic purposes (e.g., Renova, Vaniqa, Botox, Solage);
- Allergy sera;
- Immunization agents;
- Biologicals, blood and blood plasma;
- Performance, athletic performance or lifestyle enhancement drugs or supplies;
- Fertility agents; or
- Nutritional supplements, appetite suppressants and antiobesity preparations.

SPECIAL PROGRAMS

As participants in this Plan, you and your covered family members can take advantage of the special care programs described in this section.

National Medical Excellence Program[®]

The National Medical Excellence (NME) Program[®] helps you and covered family members receive care from nationally recognized doctors and facilities specializing in solid organ and bone marrow transplants and certain other specialized care.

Transplant Services

Covered expenses include charges incurred during a transplant occurrence. The following will be considered to be one transplant occurrence once it has been determined that you or one of your Dependents may require an organ transplant. Organ means solid organ; stem cell; bone marrow; and tissue.

- Heart;
- Lung;
- Heart/Lung;
- Simultaneous Pancreas Kidney (SPK);
- Pancreas;
- Kidney;
- Liver;
- Intestine;
- Bone Marrow/Stem Cell;
- Multiple organs replaced during one transplant surgery;
- Tandem transplants (Stem Cell);
- Sequential transplants;
- Re-transplant of same organ type within 180 days of the first transplant;
- Any other single organ transplant, unless otherwise excluded under the Plan.

The following will be considered to be more than one Transplant Occurrence:

- Autologous blood/bone marrow transplant followed by allogenic blood/bone marrow transplant (when not part of a tandem transplant);
- Allogenic blood/bone marrow transplant followed by an autologous blood/bone marrow transplant (when not part of a tandem transplant);
- Re-transplant after 180 days of the first transplant;
- Pancreas transplant following a kidney transplant;
- A transplant necessitated by an additional organ failure during the original transplant surgery/process;
- More than one transplant when not performed as part of a planned tandem or sequential transplant, (e.g., a liver transplant with subsequent heart transplant).

The Plan covers:

- Charges made by a Physician or transplant team.
- Charges made by a Hospital, outpatient facility or Physician for the medical and surgical expenses of a live donor, but only to the extent not covered by another plan or program.
- Related supplies and services provided by the facility during the transplant process. These services and supplies may include: physical, speech and occupational therapy; bio-medicals and immunosuppressants; home health care expenses and home infusion services.
- Charges for activating the donor search process with national registries.
- Compatibility testing of prospective organ donors who are immediate family members. For the purpose of this coverage, an “immediate” family member is defined as a first-degree biological relative. These are your biological parents, siblings or children.
- Inpatient and outpatient expenses directly related to a transplant.

Covered transplant expenses are typically incurred during the four phases of transplant care described below. Expenses incurred for one transplant during these four phases of care will be considered one transplant occurrence.

A transplant occurrence is considered to begin at the point of evaluation for a transplant and end either 180 days from the date of the transplant; or upon the date you are discharged from the Hospital or outpatient facility for the admission or visit(s) related to the transplant, whichever is later.

The four phases of one transplant occurrence and a summary of covered transplant expenses during each phase are:

1. Pre-transplant evaluation/screening: Includes all transplant-related professional and technical components required for assessment, evaluation and acceptance into a transplant facility’s transplant program;
2. Pre-transplant/candidacy screening: Includes HLA typing/compatibility testing of prospective organ donors who are immediate family members;
3. Transplant event: Includes inpatient and outpatient services for all covered transplant-related health services and supplies provided to you and a donor during the one or more surgical procedures or medical therapies for a transplant; prescription drugs provided during your inpatient stay or outpatient visit(s), including bio-medical and immunosuppressant drugs; physical, speech or occupational therapy provided during your inpatient stay or outpatient visit(s); cadaveric and live donor organ procurement; and
4. Follow-up care: Includes all covered transplant expenses; home health care services; home infusion services; and transplant-related outpatient services rendered within 180 days from the date of the transplant event.

Important Reminder

To ensure coverage, all transplant procedures need to be Precertified by Aetna. Refer to the *Precertification* section for details.

Limitations

Unless specified above, not covered under this benefit are charges incurred for:

- Outpatient drugs including bio-medicals and immunosuppressants not expressly related to an outpatient transplant occurrence;
- Services that are covered under any other part of this Plan;
- Services and supplies furnished to a donor when the recipient is not covered under this Plan;
- Home infusion therapy after the transplant occurrence;
- Harvesting or storage of organs, without the expectation of immediate transplantation for an existing illness;
- Harvesting and/or storage of bone marrow, tissue or stem cells, without the expectation of transplantation within 12 months for an existing illness;
- Cornea (Corneal Graft with Amniotic Membrane) or Cartilage (autologous chondrocyte or autologous osteochondral mosaicplasty) transplants, unless otherwise authorized by Aetna.

Network of Transplant Specialist Facilities

If you are a participant in the Institutes of Excellence™ (IOE) program, the program will coordinate all solid organ and bone marrow transplants and other specialized care you need. Through the IOE network, you will have access to a provider network that specializes in transplants. Benefits may vary if an IOE facility or non-IOE or Out-of-Network Provider is used. The Network level of benefits is paid only for a treatment received at a facility designated by the Plan as an Institute of Excellence™ for the type of transplant being performed. Services obtained from a facility that is not designated as an IOE for the transplant being performed will be covered as Out-of-Network services and supplies, even if the facility is a Network facility or IOE for other types of services. In addition, some expenses are payable only within the IOE network. The IOE facility must be specifically approved and designated by Aetna to perform the procedure you require. Each facility in the IOE network has been selected to perform only certain types of transplants, based on quality of care and successful clinical outcomes.

You can obtain a list of Institutes of Excellence facilities at DocFind (www.aetna.com) or by contacting Aetna Member Services at 800-334-0299.

Travel and Lodging

When significant travel is required to use an Institute of Excellence Facility, you may be eligible for travel and lodging allowances according to Aetna's standard internal policies and procedures.

Other Special Programs

Special Programs are available to provide you with education, guidance and tools to better handle certain conditions and health care events. Discount programs are also

available to give you access to savings on weight management, fitness, vision and hearing products and services, and alternative therapies.

For more details, log on to Aetna Navigator and select “Health Programs” for links to health management and family health program information and resources.

Case Management Program

Case Management is a voluntary, confidential program designed to assist you with the challenges you may face when you or a family member is seriously ill, injured, or has a certain chronic health condition. At the core of the program is a case manager who is a registered nurse with experience caring for patients, both in hospital and home settings. Aetna’s case managers also may negotiate fees with providers, when appropriate.

When Aetna becomes aware of a serious Illness or Injury or if you call for assistance, a case manager may be assigned. The case manager will work with you (or your family, if circumstances warrant) and your Physician to develop a plan designed to coordinate the care you need. Even though your case manager coordinates the plan, the actual care is always provided under the direction of your Physician or other health care providers.

In addition, case managers also work with participants who suffer from chronic conditions not included in Aetna’s disease management program. If you have a chronic condition, you may be contacted by a case manager. Often, they will be able to provide information that may be beneficial to your particular situation, help you make healthy life style changes and keep you informed of any specific benefits for your particular condition.

This program gives you a partner to help ensure you receive quality, cost-effective care during difficult times. You may contact a case manager by calling Aetna Member Services at 800-334-0299.

Aetna Health ConnectionsSM Disease Management

Aetna Health Connections combines education, counseling, self-care and Physician support to help you manage your chronic medical conditions. The program supports many different conditions including asthma, diabetes, a number of different cancers, arthritis, certain gastrointestinal conditions and others. The program emphasizes lifestyle changes to help you both avoid complications and improve the quality of your life.

Aetna Health Connections can help you:

- Get the most appropriate treatment and preventive care for your individual needs;
- Understand how to follow your doctor's treatment plan;
- Take charge of your own health and manage your chronic conditions;
- Make changes to reach your personal health goals; and
- Identify and manage your risks for other conditions.

If you have a chronic condition, the program offers you support using educational materials and online resources. If you are at high risk and you decide to participate in the program, a nurse will work with you to help monitor your condition for potential problem areas or concerns.

Participation is voluntary. If you have a chronic disease supported by the program or if you are at risk of developing a chronic condition, you can request to participate by calling Aetna Member Services or submit a request through Aetna Navigator at www.aetna.com. In addition, your Physician may refer you to the program or Aetna may identify you as a potential participant based on your medical and prescription drug claim activity.

Beginning RightSM Maternity Program

This program helps pregnant women stay well and deliver healthier babies. The program provides:

- Educational materials about prenatal care, labor and delivery, postpartum depression and breastfeeding;
- Coordination of maternity care by trained obstetrical nurses;
- Access to a personalized smoking cessation program designed specifically for pregnant women;
- Specialized information for Dad or partner;
- Preterm labor education; and
- Access to breastfeeding support services.

Under the program, your pregnancy care is coordinated by your OB/GYN doctor and Aetna case managers.

Another important feature, the *Pregnancy Risk Assessment*, is a survey that identifies women who may need more specialized prenatal and/or postnatal care due to their medical history or present health status. The program assists women at risk and their Physician in coordinating any specialty care that may be Medically Necessary.

If you are eligible for this program, an Aetna nurse will call to get you started or you can also call 800-334-0299 to participate.

Informed Health® Line

Participants and their families have around-the-clock access to an Aetna team of nurses experienced in providing information on a variety of health topics. Aetna's Informed Health® Line (IHL) nurses provide information about health issues, medical procedures and treatment options, and help you communicate more effectively with your Physicians.

To reach the Informed Health® Line day or night, call 800-556-1555, which is also listed on your Aetna ID card. You may also access the Aetna Navigator website to review comprehensive and unbiased evidence-based information that helps consumers make decisions about their health.

WOMEN'S HEALTH PROVISIONS

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

The Newborns' and Mothers' Health Protection Act

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

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

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

The Women's Health and Cancer Rights Act

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

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

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

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

WHAT THE PLAN DOES NOT COVER

This section contains a general list of charges not covered under the Plan that have not been otherwise listed. Excluded charges will not be used when calculating benefits.

For prescription drug exclusions, also refer to “What the Prescription Drug Benefit Does Not Cover” in the section entitled *Prescription Drug Benefits*.

Any Plan exclusions will not apply to the extent that coverage of the charges is required under any law that applies to the coverage. Also, the law of the jurisdiction where a person lives when a claim occurs may prohibit some benefits. If so, they will not be paid.

General Exclusions

The Plan does *not* cover charges:

- For services and supplies that the Claim Administrator determines are not Necessary for the diagnosis, care or treatment of the Illness or Injury involved—even if they are prescribed, recommended or approved by a Physician or Dentist.
- For care, treatment, services or supplies not prescribed, recommended or approved by a Physician or Dentist.
- For services of a resident physician or intern.
- Made only because you have health coverage.
- You are not legally obligated to pay.
- That are not Recognized Charges, as determined by the Claims Administrator.
- For covered expenses used to satisfy Plan deductibles.
- In excess of the Negotiated Fee for a given service or supply given by a Network Provider. This exclusion will not apply to any service or supply for which a benefit is provided under Medicare before the benefits of the group contract are paid.
- For any condition or disability sustained as a result of being engaged in an activity primarily for wage, profit or gain, and that could entitle the covered person to a benefit under the Workers’ Compensation Act or similar legislation.
- For Illness or Injury arising from, or in the course of, self-employment or any employment with another employer.
- For services or supplies received as a result of Illness or Injury caused by participation in a riot or the commission of a crime in which the covered Medical Plan participant is the perpetrator.

Experimental or Investigational

The Plan does not cover charges for experimental or investigational drugs, devices, treatment or procedures. A drug, a device, a procedure, or treatment will be determined to be experimental or investigational if:

- There are insufficient outcomes data available from controlled clinical trials published in the peer-reviewed literature to substantiate its safety and effectiveness for the Illness or Injury involved; or

- Approval required by the FDA has not been granted for marketing; or
- A recognized national medical or dental society or regulatory agency has determined, in writing, that it is experimental or investigational, or for research purposes; or
- It is a type of drug, device or treatment that is the subject of a Phase I or Phase II clinical trial or the experimental or research arm of a Phase III clinical trial, using the definition of “phases” indicated in regulations and other official actions and publications of the FDA and Department of Health and Human Services; or
- The written protocol or protocols used by the treating facility, or the protocol or protocols of any other facility studying substantially the same drug, device, procedure, or treatment, or the written informed consent used by the treating facility or by another facility studying the same drug, device, procedure, or treatment states that it is experimental or investigational, or for research purposes.

However, the Plan may pay for experimental or investigational drugs, devices, treatments or procedures if *all* of the following conditions are met:

- You have been diagnosed with a cancer or a condition that is likely to cause death within one year;
- Standard therapies have not been effective or do not meet the definition of Medically Necessary;
- Aetna determines, based on at least two documents of medical and scientific evidence that you would likely benefit from the treatment; and
- You are enrolled in a clinical trial that meets *all* of these criteria:
 - The drug, device, treatment or procedure to be investigated has been granted investigational new drug (IND) or Group c/treatment IND status,
 - The clinical trial has passed independent scientific scrutiny and has been approved by an Institutional Review Board that will oversee the investigation,
 - The clinical trial is sponsored by the National Cancer Institute (“NCI”) or similar national organization (e.g. Food & Drug Administration, Department of Defense) and conforms to the NCI standards,
 - The clinical trial is not a single institution or investigator study unless the clinical trial is performed at an NCI-designated cancer center, and
 - You are treated according to the protocol.

Educational Services

The Plan does *not* cover charges for:

- Any services or supplies related to education, training or retraining services or testing, including: special education, remedial education, job training and job hardening programs;
- Evaluation or treatment of learning disabilities, minimal brain dysfunction, developmental, learning and communication disorders, behavioral disorders, (including pervasive developmental disorders) training or cognitive rehabilitation, regardless of the underlying cause; and
- Services, treatment, and educational testing and training related to behavioral (conduct) problems, learning disabilities and delays in developing skills.

Reproductive and Sexual Health

The Plan does *not* cover charges for:

- Sexual dysfunction/enhancement: Any treatment, drug, service or supply to treat sexual dysfunction, enhance sexual performance or increase sexual desire, including:
 - Surgery, drugs, implants, devices or preparations to correct or enhance erectile function, enhance sensitivity, or alter the shape or appearance of a sex organ; and
 - Sex therapy, sex counseling, marriage counseling or other counseling or advisory services.
- Sex change: Any treatment, drug, service or supply related to changing sex or sexual characteristics, including:
 - Surgical procedures to alter the appearance or function of the body;
 - Hormones and hormone therapy;
 - Prosthetic devices; and
 - Medical or psychological counseling.
- Infertility: except as specifically described in the *What the Plan Covers* section, any services, treatments, procedures or supplies that are designed to enhance fertility or the likelihood of conception, including but not limited to:
 - Drugs related to the treatment of non-covered benefits;
 - Injectable infertility medications, including but not limited to menotropins, hCG, GnRH agonists, and IVIG;
 - Artificial Insemination;
 - Any advanced reproductive technology (“ART”) procedures or services related to such procedures, including but not limited to in vitro fertilization (“IVF”), gamete intra-fallopian transfer (“GIFT”), zygote intra-fallopian transfer (“ZIFT”), and intra-cytoplasmic sperm injection (“ICSI”); Artificial Insemination for covered females attempting to become pregnant who are not infertile as defined by the plan;
 - Infertility services for couples in which one of the partners has had a previous sterilization procedure, with or without surgical reversal;
 - Procedures, services and supplies to reverse voluntary sterilization
 - Infertility services for females with FSH levels 19 or greater mIU/ml on day 3 of the menstrual cycle;
 - The purchase of donor sperm and any charges for the storage of sperm; the purchase of donor eggs and any charges associated with care of the donor required for donor egg retrievals or transfers or gestational carriers or surrogacy; donor egg retrieval or fees associated with donor egg programs, including but not limited to fees for laboratory tests;
 - Charges associated with cryopreservation or storage of cryopreserved eggs and embryos (e.g., office, Hospital, ultrasounds, laboratory tests, etc.); any charges associated with a frozen embryo or egg transfer, including but not limited to thawing charges;
 - Home ovulation prediction kits or home pregnancy tests; and

- Any charges associated with care required to obtain ART Services (e.g., office, Hospital, ultrasounds, laboratory tests); and any charges associated with obtaining sperm for any ART procedures; and
- Ovulation induction and intrauterine insemination services if you are not infertile.

Behavioral Health Services:

The Plan does *not* cover charges for:

- Alcoholism or Substance Abuse rehabilitation treatment on an inpatient or outpatient basis, except to the extent coverage for Detoxification or treatment of alcoholism or Substance Abuse is specifically provided in the *What the Plan Covers* section.
- Treatment of a covered health care provider who specializes in the mental health care field and who receives treatment as a part of their training in that field.
- Treatment of impulse control disorders such as pathological gambling, kleptomania, pedophilia, caffeine or nicotine use.
- Treatment of antisocial personality disorder.
- Treatment in wilderness programs or other similar programs.
- Treatment of mental retardation, defects, and deficiencies. This exclusion does not apply to mental health services or to medical treatment of the mentally retarded in accordance with the benefits provided in the *What the Plan Covers* section of this SPD.

Vision and Speech

The Plan does *not* cover charges for:

- Special supplies such as non-prescription sunglasses and subnormal vision aids;
- Vision service or supply which does not meet professionally accepted standards;
- Eye exams during your stay in a Hospital or other facility for health care;
- Eye exams for contact lenses or their fitting;
- Eyeglasses or duplicate or spare eyeglasses or lenses or frames;
- Replacement of lenses or frames that are lost or stolen or broken;
- Acuity tests;
- Eye surgery for the correction of vision, including radial keratotomy, LASIK and similar procedures;
- Services to treat errors of refraction.
- Speech therapy. (This exclusion does not apply to congenital defects or speech therapy expected to restore speech to a person who has lost this ability because of an Illness or Injury.)

Custodial Care and Maintenance Care

The Plan does *not* cover charges for Custodial Care or Maintenance Care, as defined, without regard to who prescribes, recommends or performs these services.

Cosmetic Services and Plastic Surgery

The Plan does *not* cover charges for any treatment, surgery (cosmetic or plastic), service or supply to alter, improve or enhance the shape or appearance of the body whether or not for psychological or emotional reasons including:

- Face lifts, body lifts, tummy tucks, liposuctions, removal of excess skin, removal or reduction of non-malignant moles, blemishes, varicose veins, cosmetic eyelid surgery and other surgical procedures;
- Procedures to remove healthy cartilage or bone from the nose (even if the surgery may enhance breathing) or other part of the body;
- Chemical peels, dermabrasion, laser or light treatments, bleaching, creams, ointments or other treatments or supplies to alter the appearance or texture of the skin;
- Insertion or removal of any implant that alters the appearance of the body (such as breast or chin implants); except removal of an implant will be covered when Medically Necessary;
- Removal of tattoos (except for tattoos applied to assist in covered medical treatments, such as markers for radiation therapy); and
- Repair of piercings and other voluntary body modifications, including removal of injected or implanted substances or devices;
- Surgery to correct Gynecomastia;
- Breast augmentation;
- Otoplasty.

Other therapies and tests:

The Plan does *not* cover charges for any of the following treatments or procedures:

- Aromatherapy;
- Bio-feedback and bioenergetic therapy;
- Carbon dioxide therapy;
- Chelation therapy (except for heavy metal poisoning);
- Computer-aided tomography (CAT) scanning of the entire body;
- Educational therapy;
- Gastric irrigation;
- Hair analysis;
- Hyperbaric therapy, except for the treatment of decompression or to promote healing of wounds;
- Hypnosis, and hypnotherapy, except when performed by a Physician as a form of anesthesia in connection with covered surgery;
- Lovaas therapy;
- Massage therapy;
- Megavitamin therapy;
- Primal therapy;
- Psychodrama;
- Purging;
- Recreational therapy;

- Rolfing;
- Sensory or auditory integration therapy;
- Sleep therapy;
- Thermograms and thermography.

The Plan does *not* cover charges for therapies for the treatment of delays in development, unless resulting from acute Illness or Injury, or congenital defects amenable to surgical repair (such as cleft lip/palate). Examples of non-covered diagnoses include Pervasive Developmental Disorders (including Autism), Down Syndrome, and Cerebral Palsy, as they are considered both developmental and/or chronic in nature.

Home and mobility:

The Plan does not cover charges for any addition or alteration to a home, workplace or other environment, or vehicle and any related equipment or device, such as:

- Purchase or rental of exercise equipment, air purifiers, central or unit air conditioners, water purifiers, waterbeds and swimming pools;
- Exercise and training devices, whirlpools, portable whirlpool pumps, sauna baths, or massage devices;
- Equipment or supplies to aid sleeping or sitting, including non-hospital electric and air beds, water beds, pillows, sheets, blankets, warming or cooling devices, bed tables and reclining chairs;
- Equipment installed in your home, workplace or other environment, including stair-glides, elevators, wheelchair ramps, or equipment to alter air quality, humidity or temperature;
- Other additions or alterations to your home, workplace or other environment, including room additions, changes in cabinets, countertops, doorways, lighting, wiring, furniture, communication aids, wireless alert systems, or home monitoring;
- Services and supplies furnished mainly to provide a surrounding free from exposure that can worsen your Illness or Injury;
- Removal from your home, worksite or other environment of carpeting, hypo-allergenic pillows, mattresses, paint, mold, asbestos, fiberglass, dust, pet dander, pests or other potential sources of allergies or Illness; and
- Transportation devices, including stair-climbing wheelchairs, personal transporters, bicycles, automobiles, vans or trucks, or alterations to any vehicle or transportation device.

Weight

Except as provided in *What the Plan Covers*, the Plan does *not* cover charges for any treatment, drug service or supply intended to decrease or increase body weight, control weight or treat obesity, including Morbid Obesity, regardless of the existence of comorbid conditions, including but not limited to:

- Liposuction, banding, gastric stapling, gastric by-pass and other forms of bariatric surgery; surgical procedures medical treatments, weight control/loss programs and

other services and supplies that are primarily intended to treat, or are related to the treatment of obesity, including Morbid Obesity;

- Drugs, stimulants, preparations, foods or diet supplements, dietary regimens and supplements, food or food supplements, appetite suppressants and other medications;
- Counseling, coaching, training, hypnosis or other forms of therapy; and
- Exercise programs, exercise equipment, membership to health or fitness clubs, recreational therapy or other forms of activity or activity enhancement.

Other Services and Supplies

The Plan also does *not* cover:

- Annual or other charges to be in a Physician's practice;
- Charges to have preferred access to a Physician's services such as boutique or concierge Physician practice;
- Disposable outpatient supplies including sheaths, bags, elastic garments, bandages, syringes, blood or urine testing supplies, except as specifically provided as covered;
- Personal comfort or service items while confined in a Hospital, such as but not limited to, radio, television, telephone and guest meals;
- Expenses for preparing or copying medical reports, itemized bills or claim forms; mailing and/or shipping and handling; broken or cancelled appointments; sales tax; or interest charges;
- Travel expenses of a Physician or covered person, except as specified in the *Special Programs* section;
- Food items, nutritional supplements, vitamins, medical foods and formulas, even if they are the sole source of nutrition;
- Foot care: Except as provided in *What the Plan Covers*, any services, supplies, or devices to improve comfort or appearance of toes, feet or ankles, including but not limited to:
 - Treatment of calluses, bunions, toenails, hammer-toes, subluxations, fallen arches, weak feet, chronic foot pain or conditions caused by routine activities such as walking, running, working or wearing shoes; and
 - Shoes (including orthopedic shoes), foot orthotics, arch supports, shoe inserts, ankle braces, guards, protectors, creams, ointments and other equipment, devices and supplies, even if required following a covered treatment of an Illness or Injury.
- Hospital, inpatient, or residential cognitive therapy, educational therapy or retraining unless part of a neurological rehabilitation program for an acute organic brain condition;
- Treatment for autism, developmental deficits, learning disability, pervasive development disorders, and chronic organic brain syndrome;
- Non-medical services in the treatment of mental disability (except initial diagnosis);
- Services and supplies provided for personal comfort or convenience, or for the convenience of any other person, including a provider;
- Drugs, medicines or supplies while not confined as an inpatient that do not require a Physician's prescription;
- Smoking cessation programs, treatments, and aids;
- Performance, athletic performance or lifestyle enhancement drugs or supplies;

- Routine physical exams, routine vision exams, routine dental exams, routine hearing exams, immunizations, or other preventive services and supplies, except to the extent coverage for such exams, immunizations, services, or supplies is provided for in this SPD;
- Acupuncture therapy, except when it is performed by a Physician as a form of anesthesia in connection with a surgery that is covered under the Plan;
- Dental procedures, except the procedures described in the *What the Plan Covers* section; or
- Durable Medical Equipment charges for more than one item for the same or similar purposes.
- Charges the recipient has no legal obligation to pay; or the charges would not be made if the recipient did not have coverage (to the extent exclusion is permitted by law) including:
 - Care in charitable institutions;
 - Care for conditions related to current or previous military service;
 - Care while in the custody of a governmental authority;
 - Any care a public Hospital or other facility is required to provide; or
 - Any care in a Hospital or other facility owned or operated by any federal, state or other governmental entity, except to the extent coverage is required by applicable laws.

COORDINATION WITH OTHER PLANS

When Coordination of Benefits Applies

This Coordination of Benefits (COB) provision applies to This Health Plan when you or your covered Dependent has health coverage under more than one plan. “Health Plan” and “This Health Plan” are defined herein. The Order of Benefit Determination Rules below determines which plan will pay as the primary plan. The primary plan pays first without regard to the possibility that another plan may cover some expenses. A secondary plan pays after the primary plan and may reduce the benefits it pays so that payments from all group plans do not exceed 100% of the total allowable expense.

Getting Started - Important Terms

When used in this provision, the following words and phrases have the meaning explained herein.

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

1. If a covered person is confined in a private Hospital room, the difference between the cost of a semi-private room in the Hospital and the private room is not an allowable expense. This does not apply if one of the Health Plans provides coverage for a private room.
2. If a person is covered by two or more Health Plans that compute their benefit payments on the basis of reasonable or Recognized Charges, any amount in excess of the highest of the reasonable or Recognized Charges for a specific benefit is not an allowable expense.
3. If a person is covered by two or more Health Plans that provide benefits or services on the basis of negotiated charges, an amount in excess of the highest of the negotiated charges is not an allowable expense.
4. The amount a benefit is reduced or not reimbursed by the primary Health Plan because a covered person does not comply with the Health Plan provisions is not an allowable expense. Examples of these provisions are second surgical opinions, precertification of admissions, and preferred provider arrangements.
5. If all Health Plans covering a person are high deductible Health Plans and the person intends to contribute to a health savings account established in accordance with section 223 of the Internal Revenue Code of 1986, the primary high deductible Health

Plan's deductible is not an allowable expense, except as to any health expense that may not be subject to the deductible as described in section 223(c)(2)(C) of the Internal Revenue Code of 1986.

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

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

Closed Panel Plan(s). A plan that provides health benefits to covered persons primarily in the form of services through a panel of providers that have contracted with or are employed by the plan, and that limits or excludes benefits for services provided by other providers, except in cases of emergency or referral by a panel member.

Custodial Parent. A parent awarded custody by a court decree. In the absence of a court decree, it is the parent with whom the child resides more than one half of the calendar year without regard to any temporary visitation.

Health Plan. Any Health Plan providing benefits or services by reason of health care or treatment, which benefits or services are provided by one of the following:

- Group or nongroup, blanket, or franchise health insurance policies issued by insurers, including health care service contractors;
- Other prepaid coverage under service Health Plan contracts, or under group or individual practice;
- Uninsured arrangements of group or group-type coverage;
- Labor-management trustee Health Plans, labor organization plans, employer organization Health Plans, or employee benefit organization Health Plans;
- Medical benefits coverage in a group, group-type, and individual automobile "no-fault" and traditional automobile "fault" type contracts;
- Medicare or other governmental benefits;
- Other group-type contracts. Group type contracts are those which are not available to the general public and can be obtained and maintained only because membership in or connection with a particular organization or group.

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

This Health Plan is any part of the contract that provides benefits for health care expenses.

Primary Plan/Secondary Plan. The order of benefit determination rules state whether This Health Plan is a Primary Plan or Secondary Plan as to another Health Plan covering the person.

When This Health Plan is a primary Health Plan, its benefits are determined before those of the other Health Plan and without considering the other Health Plan's benefits.

When This Health Plan is a Secondary Plan, its benefits are determined after those of the other Health Plan and may be reduced because of the other Health Plan's benefits.

When there are more than two Health Plans covering the person, this Health Plan may be a Primary Plan as to one or more other Health Plans, and may be a Secondary Plan as to a different Health Plan or Health Plans.

Which Plan Pays First

When two or more plans pay benefits, the rules for determining the order of payment are as follows:

- The primary plan pays or provides its benefits as if the secondary plan or plans did not exist.
- A plan that does not contain a coordination of benefits provision that is consistent with this provision is always primary. There is one exception: coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits may provide that the supplementary coverage shall be excess to any other parts of the plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan Hospital and surgical benefits, and insurance type coverages that are written in connection with a closed panel plan to provide out-of-network benefits.
- A plan may consider the benefits paid or provided by another plan in determining its benefits only when it is secondary to that other plan.
- The first of the following rules that describes which plan pays its benefits before another plan is the rule to use:
 1. Non-Dependent or Dependent. The plan that covers the person other than as a dependent, for example as an employee, member, subscriber or retiree is primary and the plan that covers the person as a dependent is secondary. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the plan covering the person as a dependent; and primary to the plan covering the person as other than a dependent (e.g. a retired employee); then the order of benefits between the two plans is reversed so that the plan covering the person as an employee, member, subscriber or retiree is secondary and the other plan is primary.

2. Child Covered Under More than One Plan. The order of benefits when a child is covered by more than one plan is:
 - A. The primary plan is the plan of the parent whose birthday is earlier in the year if:
 - i. The parents are married or living together whether or not married;
 - ii. A court decree awards joint custody without specifying that one party has the responsibility to provide health care coverage or if the decree states that both parents are responsible for health coverage. If both parents have the same birthday, the plan that covered either of the parents longer is primary.
 - B. If the specific terms of a court decree state that one of the parents is responsible for the child's health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is primary. If the parent with responsibility has no health coverage for the dependent child's health care expenses, but that parent's spouse does, the plan of the parent's spouse is the primary plan.
 - C. If the parents are separated or divorced or are not living together whether or not they have ever been married and there is no court decree allocating responsibility for health coverage, the order of benefits is:
 - The plan of the custodial parent;
 - The plan of the spouse of the custodial parent;
 - The plan of the noncustodial parent; and then
 - The plan of the spouse of the noncustodial parent.

For a dependent child covered under more than one plan of individuals who are not the parents of the child, the order of benefits should be determined as outlined above as if the individuals were the parents.

3. Active Employee or Retired or Laid off Employee. The plan that covers a person as an employee who is neither laid off nor retired or as a dependent of an active employee, is the primary plan. The plan covering that same person as a retired or laid off employee or as a dependent of a retired or laid off employee is the secondary plan. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored. This rule will not apply if the Non-Dependent or Dependent rules above determine the order of benefits.
4. Continuation Coverage. If a person whose coverage is provided under a right of continuation provided by federal or state law also is covered under another plan, the plan covering the person as an employee, member, subscriber or retiree (or as that person's dependent) is primary, and the continuation coverage is secondary.

If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored. This rule will not apply if the Non-Dependent or Dependent rules above determine the order of benefits.

5. Longer or Shorter Length of Coverage. The plan that covered the person as an employee, member, subscriber longer is primary.
6. If the preceding rules do not determine the primary plan, the allowable expenses shall be shared equally between the plans meeting the definition of plan under this provision. In addition, this Plan will not pay more than it would have paid had it been primary.

How Coordination of Benefits Works

In determining the amount to be paid when this Plan is secondary on a claim, the secondary plan will calculate the benefits that it would have paid on the claim in the absence of other health insurance coverage and apply that amount to any allowable expense under this plan that was unpaid by the primary plan. The amount will be reduced so that when combined with the amount paid by the primary plan, the total benefits paid or provided by all plans for the claim do not exceed 100 percent of the total allowable expense.

In addition, a secondary plan will credit to its plan deductible any amounts that would have been credited in the absence of other coverage.

Under the COB provision of this Plan, the amount normally reimbursed for covered benefits or expenses under this Plan is reduced to take into account payments made by other plans. The general rule is that the benefits otherwise payable under this Plan for all covered benefits or expenses will be reduced by all other plan benefits payable for those expenses. When the COB rules of this Plan and another plan both agree that this Plan determines its benefits before such other plan, the benefits of the other plan will be ignored in applying the general rule above to the claim involved. Such reduced amount will be charged against any applicable benefit limit of this coverage.

If a covered person is enrolled in two or more closed panel plans COB generally does not occur with respect to the use of panel providers. However, COB may occur if a person receives emergency services that would have been covered by both plans.

Right To Receive And Release Needed Information

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits under this Plan and other plans. Aetna has the right to release or obtain any information and make or recover any payments it considers necessary in order to administer this provision.

Facility of Payment

Any payment made under another plan may include an amount which should have been paid under this Plan. If so, Aetna may pay that amount to the organization, which made that payment. That amount will then be treated as though it were a benefit paid under this Plan. Aetna will not have to pay that amount again. The term “payment made” means reasonable cash value of the benefits provided in the form of services.

Right of Recovery

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

Effect of Medicare

Important Information

If you or a covered Dependent become eligible for Medicare due to age while you are actively employed, neither you nor your Dependent need to enroll for Medicare until you retire or otherwise cease to be actively employed. If you become eligible for Medicare due to a medical condition (e.g., End Stage Renal Disease), you should enroll for Medicare as soon as you are eligible.

Health Expense Coverage will be changed for any person while eligible for Medicare. Medicare benefits will be taken into account for any person while he or she is eligible for Medicare. This will be done whether or not he or she is entitled to Medicare benefits.

A person is "eligible for Medicare" if he or she:

- is covered under it;
- is not covered under it because of:
 - having refused it;
 - having dropped it;
 - having failed to make proper request for it.

If a person is eligible for Medicare, coverage under this plan will not be changed at any time when your Employer’s compliance with federal law requires this Plan’s benefits for a person to be figured before benefits are figured under Medicare (then this plan will pay benefits before Medicare.)

However if a person is eligible for Medicare coverage and this plan is secondary to Medicare, these are the changes:

- With respect to Medicare Part A inpatient hospital expenses, all health expenses covered under this Plan will be reduced by any Medicare benefits available for those expenses. This will be done before the health benefits of this Plan are figured. With respect to all other covered expenses, the total amount of “regular benefits” under all Health Expense Benefits will be figured. (This will be the amount that would be payable if there were no Medicare benefits.” If this is more than the amount Medicare provides for the expenses involved, this Plan will pay the difference. Otherwise, this Plan will pay no benefits. This will be done for each claim.
- Charges used to satisfy a person’s Part B deductible under Medicare will be applied under this Plan in the order received by Aetna. Two or more charges received at the same time will be applied starting with the largest first.
- Medicare benefits will be taken into account for any person while he or she is eligible for Medicare. This will be done whether or not he or she is entitled to Medicare benefits.
- Any rule for coordinating "other plan" benefits with those under this Plan will be applied after this Plan's benefits have been figured under the above rules.

For further information, see the booklet entitled “Medicare and Other Health Benefits: Your Guide to Who Pays First” (Publication #02179). This booklet, which was prepared by the Centers of Medicare and Medicaid Services (part of the U.S. Department of Health and Human Services) is available online at www.medicare.gov/Publications.

CLAIMS AND BENEFIT PAYMENT

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

Keeping Records of Expenses

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

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

Filing Medical Claims

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

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

Claims should be submitted to:	Aetna P.O. Box 14586 Lexington, KY 40512-4586
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All claims must be filed promptly. The deadline for filing a claim is 90 days after the date you incurred a covered expense. If, through no fault of your own, you are unable to meet this deadline, your claim will still be accepted if you file as soon as possible. However, if a claim is filed more than two years after the 90-day deadline, it will not be covered unless you are legally incapacitated.

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

Time Frames for Medical Claim Processing

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

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

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

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

Type of Claim	Response Time
<p>Urgent care claim: a claim for medical care or treatment where delay could:</p> <ul style="list-style-type: none"> • Seriously jeopardize your life or health, or your ability to regain maximum function; or • Subject you to severe pain that cannot be adequately managed without the requested care or treatment. 	As soon as possible, but not later than 72 hours
<p>Pre-service claim: a claim for a benefit that requires Aetna's approval of the benefit in advance of obtaining medical care (Precertification).</p>	15 calendar days
<p>Concurrent care claim extension: a request to extend a previously approved course of treatment.</p>	<ul style="list-style-type: none"> • Emergency or urgent care claims - as soon as possible, but not later than 24 hours, provided the request was received at least 24 hours prior to the expiration of the approved treatment • Other claims - 15 calendar days
<p>Concurrent care claim reduction or termination: a decision to reduce or terminate a course of treatment that was previously approved.</p>	With enough advance notice to allow you to appeal
<p>Post-service claim: a claim for medical care or treatment that has been rendered.</p>	30 calendar days

Extensions of Time Frames

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

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

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

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

Payment of Medical Benefits

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

If your claim is denied in whole or in part, you will receive a written notice of the denial from Aetna. The notice will explain the reason for the denial and the review procedures. See the section entitled *When You Disagree With a Claim Decision* for more information about appeals.

Recovery of Overpayment

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

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

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

Legal Action

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

Complaints

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

Subrogation and Right of Recovery Provision

As used throughout this provision, the term Responsible Party means any party actually, possibly, or potentially responsible for making any payment to a Covered Person due to a Covered Person's Illness or Injury. The term Responsible Party includes the liability insurer of such party, or any insurance coverage.

For purposes of this provision, the term Insurance Coverage refers to any coverage providing medical expense coverage or liability coverage including, but not limited to, uninsured motorist coverage, underinsured motorist coverage, personal umbrella coverage, medical payments coverage, workers' compensation coverage, no-fault automobile insurance coverage or any first party insurance coverage.

For purposes of this provision, a Covered Person includes anyone on whose behalf the Plan pays or provides any benefit including, but not limited to, the minor child or dependent of any Plan member or person entitled to receive any benefits from the Plan.

Subrogation

Immediately upon paying or providing any benefit under this Plan, the Plan shall be subrogated to (stand in the place of) all rights of recovery a Covered Person has against any Responsible Party with respect to any payment made by the Responsible Party to a Covered Person due to a Covered Person's Illness or Injury to the full extent of benefits provided or to be provided by the Plan.

Reimbursement

In addition, if a Covered Person receives any payment from any Responsible Party or Insurance Coverage as a result of an Illness or Injury, the Plan has the right to recover from, and be reimbursed by, the Covered Person for all amounts this Plan has paid and will pay as a result of that Illness or Injury, up to and including the full amount the Covered Person receives from any Responsible Party.

Constructive Trust

By accepting benefits (whether the payment of such benefits is made to the Covered Person or made on behalf of the Covered Person to any provider) from the Plan, the Covered Person agrees that if he/she receives any payment from any Responsible Party as a result of an Illness or Injury, he/she will serve as a constructive trustee over the funds that constitute such payment. Failure to hold such funds in trust will be deemed a breach of the Covered Person's fiduciary duty to the Plan.

Lien Rights

Further, the Plan will automatically have a lien to the extent of benefits paid by the Plan for the treatment of the Illness or Injury for which Responsible Party is liable. The lien shall be imposed upon any recovery whether by settlement, judgment or otherwise, including from any Insurance Coverage, related to treatment for any Illness or Injury for which the Plan paid benefits. The lien may be enforced against any party who possesses funds or proceeds representing the amount of benefits paid by the Plan including, but not limited to, the Covered Person; the Covered Person's representative or agent; the Responsible Party; the Responsible Party's insurer, or a representative agent; and/or any other source possessing funds representing the amount of benefits paid by the Plan or by Oxy.

First-Priority Claim

By accepting benefits (whether the payment of such benefits is made to the Covered Person or made on behalf of the Covered Person to any provider) from the Plan, the Covered Person acknowledges that this Plan's recovery rights are a first priority claim against all Responsible Parties and are to be paid to the Plan before any other claim for the Covered Person's damages. This Plan shall be entitled to full reimbursement on a first-dollar basis from any Responsible Party's payments, even if such payment to the Plan will result in a recovery to the Covered Person which is insufficient to make the Covered Person whole or to compensate the Covered Person in part or in whole for the damages sustained. The Plan is not required to participate in or pay court costs or attorney fees to any attorney hired by the Covered Person to pursue the Covered Person's damage claim.

Applicability to All Settlements and Judgments

The terms of this entire subrogation and right of recovery provision shall apply and the Plan is entitled to full recovery regardless of whether any liability for payment is admitted by any Responsible Party and regardless of whether the settlement or judgment received by the Covered Person identifies the medical benefits the Plan provided or purports to allocate any portion of such settlement or judgment to payment of expenses other than medical expenses. The Plan is entitled to recover from any and all settlements or judgments, even those designated as pain and suffering, non-economic damages and/or general damages only.

Cooperation

The Covered Person shall fully cooperate with the Plan's efforts to recover its benefits paid. It is the duty of the Covered Person to notify the Plan within 30 days of the date when any notice is given to a party, including an insurance company or attorney, of the Covered Person's intention to pursue or investigate a claim to recover damages or obtain compensation due to Illness or Injury sustained by the Covered Person. The Covered Person and his/her agents shall provide all information requested by the Plan, the Claims Administrator or its representative including, but not limited to, completing and submitting any applications or other forms or statements as the Plan may reasonably request. Failure to provide this information may result in the termination of health benefits for the Covered Person or the institution of court proceedings against the Covered Person.

The Covered Person shall do nothing to prejudice the Plan's subrogation or recovery interest or to prejudice the Plan's ability to enforce the terms of this Plan provision. This includes, but is not limited to, refraining from making any settlement or recovery that attempts to reduce or exclude the full cost of all benefits provided by the Plan. The Covered Person acknowledges that the Plan has the right to conduct an investigation regarding the Illness or Injury to identify any Responsible Party. The Plan reserves the right to notify a Responsible Party and his/her agents of its lien. Agents include, but are not limited to, insurance companies and attorneys.

Interpretation

In the event that any claim is made that any part of this subrogation and right of recovery provision is ambiguous or questions arise concerning the meaning or intent of any of its terms, the Claims Administrator for the Plan shall have the sole authority and discretion to resolve all disputes regarding the interpretation of this provision.

Jurisdiction

By accepting benefits (whether the payment of such benefits is made to the Covered Person or made on behalf of the Covered Person to any provider) from the Plan, the Covered Person agrees that any court proceeding with respect to this provision may be brought in any court of competent jurisdiction as the Plan may elect. By accepting such benefits, the Covered Person hereby submits to each such jurisdiction, waiving whatever rights may correspond to him/her by reason of his/her present or future domicile.

When You Disagree With a Claim Decision

The Appeal Process for Medical Claims

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

Your appeal should include:

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

Written requests for medical claim appeals may be sent to:

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

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

Type of Claim	Level One Appeal Response Time	Level Two Appeal Response Time
<p>Urgent care claim: a claim for medical care or treatment where delay could:</p> <ul style="list-style-type: none"> • Seriously jeopardize your life or health, or your ability to regain maximum function; or • Subject you to severe pain that cannot be adequately managed without the requested care or treatment. 	<p>36 hours</p> <p>Review provided by Aetna personnel not involved in making the adverse benefit determination.</p>	<p>36 hours</p> <p>Review provided by Aetna personnel not involved in making the adverse benefit determination.</p>

Type of Claim	Level One Appeal Response Time	Level Two Appeal Response Time
Pre-service claim: a claim for a benefit that requires Aetna's approval of the benefit in advance of obtaining medical care (Precertification).	15 calendar days Review provided by Aetna personnel not involved in making the adverse benefit determination.	15 calendar days Review provided by Aetna personnel not involved in making the adverse benefit determination.
Concurrent care claim extension: a request to extend a previously approved course of treatment.	Treated like an urgent care claim or a pre-service claim depending on the circumstances.	Treated like an urgent care claim or a pre-service claim depending on the circumstances.
Post-service claim: a claim for medical care or treatment that has been rendered.	30 calendar days Review provided by Aetna personnel not involved in making the adverse benefit determination.	30 calendar days Review provided by Aetna personnel not involved in making the adverse benefit determination.

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

Exhaustion of Process

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

Medical Claim Fiduciary

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

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

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

External Review

Aetna may deny a claim because it determines that the care is not appropriate or a service or treatment is experimental or investigational in nature. In either of these situations, you may request an external review if you or your provider disagrees with Aetna's decision. An external review is a review by an independent clinical reviewer, selected by an External Review Organization, who has expertise in the problem or question involved.

To request an external review, the following requirements must be met:

- You have received notice of the denial of a claim by Aetna; and
- Your claim was denied because Aetna determined that the care was not necessary or was experimental or investigational; and
- The cost of the service or treatment in question for which you are responsible exceeds \$500; and
- You have exhausted the applicable internal appeal processes.

The claim denial letter you receive from Aetna will describe the process to follow if you wish to pursue an external review, including a copy of the Request for External Review Form.

You must submit the Request for External Review Form to Aetna within 60 calendar days of the date you received the final claim denial letter. You also must include a copy of the final claim denial letter and all other pertinent information that supports your request.

Aetna will contact the External Review Organization that will conduct the review of your claim. The External Review Organization will select an independent clinical reviewer with appropriate expertise to perform the review. In making a decision, the external reviewer may consider any appropriate credible information that you send along with the Request for External Review Form, and will follow Aetna's contractual documents and plan criteria governing the benefits. You will be notified of the decision of the External Review Organization usually within 30 calendar days of Aetna's receipt of your request form and all necessary information. A quicker review is possible if your clinical reviewer certifies (by telephone or on a separate Request for External Review Form) that a delay in receiving the service would endanger your health. Expedited reviews are decided within 3 to 5 calendar days after Aetna receives the request.

Aetna, Oxy and the Plan will abide by the decision of the External Review Organization, except where Aetna can show conflict of interest, bias or fraud.

You are responsible for the cost of compiling and sending the information that you wish to be reviewed by the External Review Organization to Aetna. Aetna is responsible for the cost of sending this information to the External Review Organization and for the cost of the external review.

For more information about Aetna's External Review process, call the toll-free Customer Services telephone number shown on your ID card.

Prescription Drug Claim Appeal

Urgent Care Claims

An urgent care claim is any claim for treatment with respect to which the application of the time periods for making non-urgent care determinations could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function, or in the opinion of a Physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed.

In case of a claim for coverage involving urgent care, you will be notified of the benefit determination within 72 hours of receipt of the claim. If the claim does not contain sufficient information to determine whether, or to what extent, benefits are covered, you will be notified within 24 hours after receipt of your claim of the information necessary to complete the claim. You will then have 48 hours to provide the information and will be notified of the decision within 48 hours of the receipt of the information.

Urgent appeals for a prescription drug claim may be sent to:

Medco Health Solutions
P.O. Box 631850
Irving, TX 75063
ATTN: Clinical Appeals

Alternatively, you or your Physician may call 800-864-1135.

You have the right to request an urgent appeal of an adverse benefit determination if you request coverage of a claim that is urgent. Urgent appeal requests may be oral or written. You or your Physician may call 800-864-1135 or send a written request. In the case of an urgent appeal for coverage involving urgent care, you will be notified of the benefit determination within 72 hours of receipt of the claim. This coverage decision is final and binding. You have the right to receive, upon request and at no charge, the plan provision on which the decision is based and the information used to review your appeal. You also have the right to bring a civil action under section 502(a) of ERISA if your final appeal is denied.

Non-Urgent Care Claims

In the event you receive an adverse benefit determination of a non-urgent care claim following a request of coverage for a prescription benefit claim, you have the right to appeal the adverse benefit determination in writing within 180 days of receipt of notice of the initial coverage decision. To initiate an appeal for coverage, you or your authorized representative (such as your Physician) must provide in writing:

- your name,
- member ID,
- phone number,

- the prescription drug for which benefit coverage has been denied (or reduced in the case of member-submitted paper claims), and
- any additional information that may be relevant to your appeal.

Written requests for prescription drug claim appeals may be sent to: Medco Health Solutions
P.O. Box 631850
Irving, TX 75063
ATTN: Clinical Appeals

A decision regarding your appeal will be sent to you within 15 days of receipt of your written request (or 30 days, for member-submitted paper claims). The notice will include the specific reasons for the decision and the Plan provisions on which the decision was based. You have the right to receive, upon request and at no charge, the information used to review your appeal.

If you are not satisfied with the coverage decision made on appeal, you may request in writing, within 90 days of the receipt of notice of the decision, a second level appeal. To initiate a second level appeal, you or your authorized representative (such as your Physician), must provide in writing:

- your name,
- member ID,
- phone number,
- the prescription drug for which benefit coverage has been denied (or reduced in the case of member-submitted paper claims), and
- any additional information that may be relevant to your appeal.

Second level appeals for a prescription drug claim may be sent to: Medco Health Solutions
P.O. Box 631850
Irving, TX 75063
ATTN: Clinical Appeals

A decision regarding your request will be sent to you in writing within 15 days of receipt of your written request for appeal (or 30 days, for member-submitted paper claims). You have the right to receive, upon request and at no charge, the information used to review your second level appeal. The decision made on your second level appeal is final and binding.

If you are not satisfied with the decision of the second level appeal, you also have the right to bring a civil action under section 502(a) of ERISA if your final appeal is denied.

WHEN COVERAGE ENDS

Your coverage under this Plan can end for a number of reasons. This section explains how and why your coverage can be terminated, and how you may be able to continue coverage after it ends.

When Employee Coverage Ends

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

- The Plan is discontinued;
- You voluntarily stop your coverage;
- Termination of your employment, except if you are receiving benefits under Oxy's Long-Term Disability Plan;
- The coverage described in this booklet is terminated under the group contract;
- You are no longer eligible, as defined in the *Eligibility and Enrollment* section of this booklet; or
- You fail to make any required contribution.

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

Retirement

Generally, you and your Dependents covered under the Medical Plan may be eligible for retiree coverage under the **Aetna Basic** option if you are age 55 or older with at least 10 years of Oxy service. The special provisions described in the *Eligibility and Enrollment* section may apply if your employee coverage ceases as the result of a reduction in work hours. Contact OxyLink for additional information.

Death

If you die in active employment and are covered under the Medical Plan, coverage for your Dependents will continue until the end of the second month following the month in which you die. For example, if you die on March 20, coverage will continue through the following May 31. However, your surviving Dependents may have a right to further continue their coverage under COBRA as described in the section entitled *Continuation of Coverage*. There is no conversion policy available for your surviving Dependents for medical coverage.

If you die as an active employee but are eligible for retiree coverage under the Aetna Basic option as described above, your spouse may elect retiree coverage under the Plan for your covered Dependents as of the first of the month following your date of death as if you had retired on that date. If coverage is elected, your spouse must pay the applicable

retiree contribution. If this coverage is elected it will continue for your Dependents until the earliest occurrence of one of the following events:

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

Contact OxyLink for additional information.

When Dependent Coverage Ends

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

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

Medical coverage will cease on the last day of the month in which your Dependent loses eligibility. You must notify OxyLink within 31 days of your Dependent's change in eligibility status. Any applicable contribution change will take effect on the next available pay cycle. There will be no refund of contributions.

See the *Continuation of Coverage* section or contact OxyLink for further details.

Certificate of Group Health Coverage

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

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

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

CONTINUATION OF COVERAGE

During Illness or Injury

If you are an Oxy employee enrolled in the Medical Plan and you are absent from work because of Illness or Injury, Medical Plan coverage for you and your Dependents will continue while you remain disabled, pay your required contribution and are receiving payments under Oxy's Short-Term Disability (STD) Plan or similar company-sponsored plan.

You will also continue to be eligible for coverage if you receive benefits under Oxy's Long-Term Disability (LTD) Plan, and you make any required contributions (on an after-tax basis). However, if your medical plan option is not available to LTD Plan beneficiaries and you wish to retain medical coverage, you will be required to change your medical option. Contact OxyLink for additional information.

If you do not return to active employment at the end of your plan benefits under STD, and LTD if applicable, your eligibility for continued Medical Plan coverage will end, as described in the section entitled *When Coverage Ends*.

During Approved Leaves of Absence

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

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

For additional information regarding an FMLA leave of absence, contact your Human Resources representative.

During Military Leave

During a military leave under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), coverage under the Medical Plan may continue for you and/or your covered Dependents for a maximum of six months commencing with the effective date of the leave, provided that you make any required contributions. However, coverage is excluded for service-connected Illnesses or Injuries. If you elect to discontinue your coverage during your USERRA military leave, re-enrollment will be permitted if you return to work and request reinstatement within 31 days.

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

You may contact your Human Resources representative or OxyLink with any questions regarding continued medical coverage under USERRA. OxyLink must be contacted within thirty-one (31) days of the date that you return to work to reinstate your health benefits under the special USERRA rules.

Under COBRA

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

Qualifying Events and Continuation Periods

The chart below outlines:

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

Qualifying Event Causing Loss of Coverage	Covered Persons Eligible for Continued Coverage	Maximum Continuation Period
Termination of active employment (except for gross misconduct)	You Your spouse Your Dependent children	18 months
Reduction in work hours	You Your spouse Your Dependent children	18 months
Divorce or legal separation	Your spouse Your Dependent children	36 months
Children no longer qualify as eligible for Dependent coverage	Your Dependent children	36 months
Your death	Your spouse Your Dependent children	36 months

The required premium for the 18- or 36-month continuation period may be up to 102% of the Plan cost.

Disability Extension

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

Aetna must be notified of a determination of disability within 60 days of the date of the determination and before the end of the 18-month continuation period.

The required premiums for the 18th through 29th month of continued coverage may be up to 150% of the Plan cost.

Multiple Qualifying Events

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

Electing COBRA Continuation Coverage

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

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

Acquiring New Dependents During Continuation

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

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

When COBRA Continuation Ends

Continued coverage ends on the first of the following events:

- The end of the maximum COBRA continuation period;
- Failure to pay required premiums;
- Coverage under another group plan that does not restrict coverage for preexisting conditions;
- Oxy no longer offers a group health plan; or
- You or your Dependents die.

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

Other Continuation Provisions

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

Keep the Plan Informed of Changes

In order to protect your family's rights, you should keep the Plan informed in writing of any changes in the addresses of your family members and any changes in your marital status. You should also keep a copy, for your records, of any notices you provide. You may provide such notices to the OxyLink Employee Service Center via electronic mail to oxylink@oxy.com or mail to 4500 South 129th East Avenue, Tulsa, Oklahoma 74134-5870.

GENERAL INFORMATION

Other Plan Provisions

Type of Coverage

The Plan covers Medically Necessary health care expenses incurred due to Non-Occupational Injuries and Non-Occupational Illness. Coverage applies only to services and supplies that are provided to a person at the time he or she is covered under the Plan. An expense is incurred on the day a medical service or supply is received.

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

Multiple Employers and Misstatement of Fact

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

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

Assignment of Coverage

Coverage may be assigned (signed over to another person) only with Aetna's written permission.

Outcome of Covered Services and Supplies

Aetna is not responsible for, nor do they make any guarantees concerning, the outcome of the covered services and supplies you receive.

Reporting and Disclosures

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

Privacy Notice for Health Plans

A federal law, the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”), requires the Medical Plan to protect the confidentiality of your private health information. A complete description of your rights under HIPAA can be found in the Plan’s privacy notice, which was distributed to you upon enrollment and is available through OxyLink.

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

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

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

Your Rights as a Plan Participant

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

Receive Information About Your Plan and Benefits

- Examine, without charge, at the Plan Administrator’s office and at other specified locations, all documents governing the Plan, including insurance contracts and a copy of the latest annual report (Form 5500 Series) that is filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain, upon written request to the Plan Administrator, copies of all documents governing the operation of the Plan, including insurance contracts and the latest annual report (Form 5500 Series), and an updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.

- Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.
- Receive a copy of the procedures used by the Plan for determining a qualified medical child support order (QMCSO).

Continue Group Health Plan Coverage

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

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

Prudent Action by Plan Fiduciaries

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

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

Enforce Your Rights

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

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

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

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

Help With Your Questions

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

- The nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory; or
- Division of Technical Assistance and Inquiries

Employee Benefits Security Administration
U.S. Department of Labor
200 Constitution Avenue, N.W.
Washington, D.C. 20210

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

Plan Documents

This benefit plan description summarizes the main features of the Plan, and is not intended to amend, modify, or expand the Plan provisions. In all cases, the provisions of the Plan document and any applicable contracts control the administration and operation of the Plan. If a conflict exists between a statement in this summary and the provisions of the Plan document or any applicable contracts, the Plan document will govern.

Discretionary Authority of Plan Administrator and Claims Administrator

In accordance with sections 402 and 503 of Title I of ERISA, the Plan sponsor has designated two Named Fiduciaries under the Plan, who together have complete authority to review all denied claims for benefits under the Plan. The Plan Administrator has discretionary authority to determine who is eligible for coverage under the Plan and the Claims Administrators have discretionary authority to determine eligibility for benefits under the Plan. In exercising its fiduciary responsibilities, each Named Fiduciary shall have discretionary authority to determine whether and to what extent covered Plan participants are eligible for benefits, and to construe disputed or doubtful Plan terms. A Named Fiduciary shall be deemed to have properly exercised such authority unless it has abused its discretion hereunder by acting arbitrarily and capriciously.

No Guarantee of Employment

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

Future of the Plan and Plan Amendment

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

Plan Administration

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

Plan Name	Occidental Petroleum Corporation Welfare Plan (Medical Component)
Employer Identification Number	95-4035997
Plan Number	591
Plan Administrative Services Provided by	Occidental Petroleum Corporation 10889 Wilshire Boulevard Los Angeles, California 90024 310-208-8800
Type of Administration	<i>Administrative Services Contracts with:</i> Aetna Life Insurance Company and Medco Health Solutions
Plan Administrator	Occidental Petroleum Corporation Employee Benefits Committee
Plan Sponsor and Address for Legal Process	Occidental Petroleum Corporation 10889 Wilshire Boulevard Los Angeles, CA 90024 310-208-8800
Named Fiduciary	<i>For Medical Claims:</i> Aetna Life Insurance Company <i>For Prescription Drug Claims:</i> Medco Health Solutions
Medical Claim Administrator	Aetna Life Insurance Company 151 Farmington Avenue Hartford, CT 06156

Prescription Drug Claim
Administrator

**Medco Health Solutions
P.O. Box 14711
Lexington, KY 40512**

Plan Year Ends

December 31

Plan Type

ERISA Welfare Plan

Source of Contributions

**Employee Contributions and
Employer General Assets**

GLOSSARY

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

Behavioral Health Provider

A licensed organization or professional providing diagnostic, therapeutic or psychological services for behavioral health conditions.

Custodial Care

Services and supplies that are primarily intended to help you meet personal needs. Custodial care can be prescribed by a Physician or given by trained medical personnel. It may involve artificial methods such as feeding tubes, ventilators or catheters. Examples of custodial care include:

- Routine patient care such as changing dressings, periodic turning and positioning in bed, administering medications;
- Care of a stable tracheostomy (including intermittent suctioning);
- Care of a stable colostomy/ileostomy;
- Care of stable gastrostomy/jejunostomy/nasogastric tube (intermittent or continuous) feedings;
- Care of a stable indwelling bladder catheter (including emptying/changing containers and clamping tubing);
- Watching or protecting you;
- Respite care, adult (or child) day care, or convalescent care;
- Institutional care, including Room and Board for rest cures, adult day care and convalescent care;
- Help with the daily living activities, such as walking, grooming, bathing, dressing, getting in or out of bed, toileting, eating or preparing foods;
- Any services that a person without medical or paramedical training could be trained to perform; and
- Any service that can be performed by a person without any medical or paramedical training.

Day Care Treatment

A Partial Confinement Treatment program to provide treatment for you during the day. The Hospital, Psychiatric Hospital or Residential Treatment Facility does not make a room charge for day care treatment. Such treatment must be available for at least 4 hours, but not more than 12 hours in any 24-hour period.

Dentist

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

Dependent

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

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

Your children may include your:

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

A dependent also includes a child for whom health care coverage is required through a “Qualified Medical Child Support Order” or other court or administrative order and who falls within one of the above three categories.

If you have a disabled child, the child’s coverage may be continued past the Plan’s limiting age for dependents.

Your child is considered to be disabled if he or she:

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

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

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

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

Detoxification

The process by which an alcohol-intoxicated or drug-intoxicated; or an alcohol-dependent or drug-dependent person is medically managed through the period of time necessary to eliminate, by metabolic or other means, the:

- Intoxicating alcohol or drug;
- Alcohol or drug-dependent factors; or
- Alcohol in combination with drugs;

as determined by a Physician. The process must keep the physiological risk to the patient at a minimum, and take place in a facility that meets any applicable licensing standards established by the jurisdiction in which it is located.

Durable Medical and Surgical Equipment (DME)

Equipment, and the accessories needed to operate it, that is:

- Made to withstand prolonged use;
- Made for and mainly used in the treatment of a Illness or Injury;
- Suited for use in the home;
- Not normally of use to people who do not have a Illness or Injury;
- Not for use in altering air quality or temperature; and
- Not for exercise or training.

Durable Medical and Surgical Equipment does not include equipment such as whirlpools, portable whirlpool pumps, sauna baths, massage devices, over bed tables, elevators, communication aids, vision aids and telephone alert systems.

Emergency Admission

This means a Hospital admission where the Physician admits the person to the Hospital right after the sudden and, at that time, unexpected onset of a change in the person's physical or mental condition:

- Which requires confinement right away as a full-time inpatient; and
- For which, if immediate inpatient care were not given, could (as determined by Aetna), reasonably be expected to result in:
 - Placing the person's health in serious jeopardy; or
 - Serious impairment to bodily function; or
 - Serious dysfunction of a body part or organ; or
 - Serious jeopardy to the health of the fetus (in the case of a pregnant woman).

Emergency Care

This means the treatment given in a Hospital's emergency room to evaluate and treat medical conditions of a recent onset and severity—including but not limited to severe pain—which would lead a prudent layperson, possessing an average knowledge of medicine and health, to believe that his or her Illness or Injury is of such a nature that failure to get immediate medical care could result in:

- Placing the person's health in serious jeopardy; or
- Serious impairment to bodily function; or
- Serious dysfunction of a body part or organ; or
- Serious jeopardy to the health of the fetus (in the case of a pregnant woman).

Emergency Condition

This means a recent and severe medical condition—including but not limited to severe pain—which would lead a prudent layperson, possessing an average knowledge of

medicine and health, to believe that his or her condition, illness, or injury is of such a nature that failure to get immediate medical care could result in:

- Placing the person's health in serious jeopardy; or
- Serious impairment to bodily function; or
- Serious dysfunction of a body part or organ; or
- Serious jeopardy to the health of the fetus (in the case of a pregnant woman).

Some examples of emergency conditions include:

- Serious injury, severe pain or infection;
- Poisoning;
- Uncontrollable bleeding;
- Sudden change of vision;
- Chest pain;
- Sudden weakness or trouble talking;
- Major burns;
- Spinal injury;
- Difficulty breathing; and
- Broken bones.

Home Health Care Agency

This is an agency that:

- Mainly provides skilled nursing and other therapeutic services; and
- Is associated with a professional group (of at least one Physician and one R.N.) which makes policy; and
- Has full-time supervision by a Physician or an R.N.; and
- Keeps complete medical records on each person; and
- Has an administrator; and
- Meets licensing standards.

Home Health Care Plan

This is a plan that provides for care and treatment in a person's home. It must be:

- Prescribed in writing by the attending Physician; and
- An alternative to confinement in a Hospital or Skilled Nursing Facility.

Hospice Care

This is care provided to a terminally ill person by or under arrangements with a Hospice Care Agency. The care must be part of a Hospice Care Program.

Hospice Care Agency

This is an agency or organization that:

- Has hospice care available 24 hours a day.
- Meets any licensing or certification standards established by the jurisdiction where it is located.

- Provides:
 - Skilled nursing services; and
 - Medical social services; and
 - Psychological and dietary counseling.
- Provides, or arranges for, other services which include:
 - Physician services; and
 - Physical and occupational therapy; and
 - Part-time home health aide services which mainly consist of caring for Terminally Ill people; and
 - Inpatient care in a facility when needed for pain control and acute and chronic symptom management.
- Has at least one Physician, one R.N. and one licensed or certified social worker employed by the agency.
- Establishes policies about how Hospice Care is provided.
- Assesses the patient's medical and social needs.
- Develops a Hospice Care Program to meet those needs.
- Provides an ongoing quality assurance program. This includes reviews by Physicians, other than those who own or direct the agency.
- Permits all area medical personnel to utilize its services for their patients.
- Keeps a medical record on each patient.
- Uses volunteers trained in providing services for non-medical needs.
- Has a full-time administrator.

Hospice Care Facility

This is a facility, or distinct part of one, which:

- Mainly provides inpatient Hospice Care to Terminally Ill persons.
- Charges patients for its services.
- Meets any licensing or certification standards established by the jurisdiction where it is located.
- Keeps a medical record on each patient.
- Provides an ongoing quality assurance program including reviews by Physicians other than those who own or direct the facility.
- Is run by a staff of Physicians. At least one staff Physician must be on call at all times.
- Provides 24-hour-a-day nursing services under the direction of an R.N.
- Has a full-time administrator.

Hospice Care Program

This is a written plan of Hospice Care that:

- Is established by and reviewed from time to time by the person's attending Physician and appropriate Hospice Care Agency personnel.
- Is designed to provide palliative (pain relief) and supportive care to Terminally Ill people and supportive care to their families.
- Includes an assessment of the person's medical and social needs, and a description of the care to be given to meet those needs.

Hospital

An institution that:

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

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

Illness

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

Injury

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

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

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

L.P.N.

This means a licensed practical nurse.

Maintenance Care

Care made up of services and supplies that:

- Are furnished mainly to maintain, rather than to improve, a level of physical, or mental function; and
- Provide a surrounding free from exposures that can worsen the person's physical or mental condition.

Medically Necessary

Health care or dental services, and supplies or prescription drugs that a Physician, other health care provider or dental provider, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an

Illness, Injury, disease or its symptoms, and that provision of the service, supply or prescription drug is:

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

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

Mental Disorder

An Illness commonly understood to be a mental disorder, whether or not it has a physiological basis, and for which treatment is generally provided by or under the direction of a Behavioral Health Provider such as a Psychiatric Physician, a psychologist or a psychiatric social worker.

Any one of the following conditions is a mental disorder under this Plan:

- Anorexia/Bulimia Nervosa.
- Bipolar disorder.
- Major depressive disorder.
- Obsessive compulsive disorder.
- Panic disorder.
- Pervasive Mental Developmental Disorder (including Autism).
- Psychotic Disorders/Delusional Disorder.
- Schizo-affective Disorder.
- Schizophrenia.

Morbid Obesity

This means a Body Mass Index that is: greater than 40 kilograms per meter squared; or equal to or greater than 35 kilograms per meter squared with a comorbid medical condition, including: hypertension; a cardiopulmonary condition; sleep apnea; or diabetes.

Negotiated Fee (Charge)

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

Network Provider

This is a health care provider who belongs to Aetna's network and has contracted to furnish services or supplies for a Negotiated Charge.

Network Service(s) or Supply(ies)

Health care service or supply that is:

- Furnished by a Network Provider; or
- Furnished or arranged by your PCP.

Night Care Treatment

A Partial Confinement Treatment program provided when you need to be confined during the night. A room charge is made by the Hospital, Psychiatric Hospital or Residential Treatment Facility. Such treatment must be available at least:

- 8 hours in a row a night; and
- 5 nights a week.

Non-Occupational Illness

A non-occupational illness is an illness that does not:

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

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

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

Non-Occupational Injury

A non-occupational injury is an accidental bodily injury that does not:

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

Out-of-Network Care

This is a health care service or supply provided by an Out-of-Network Provider (one who does not belong to Aetna's network).

Out-of-Network Provider

This is a health care provider who does not belong to Aetna's network and has not contracted with Aetna to furnish services or supplies at a Negotiated Fee.

Partial Confinement Treatment

A plan of medical, psychiatric, nursing, counseling, or therapeutic services to treat Substance Abuse or mental disorders. The plan must meet these tests:

- It is carried out in a Hospital; Psychiatric Hospital or Residential Treatment Facility; on less than a full-time inpatient basis.
- It is in accord with accepted medical practice for the condition of the person.

- It does not require full-time confinement.
- It is supervised by a Psychiatric Physician who weekly reviews and evaluates its effect.
- Day Care Treatment and Night Care Treatment are considered partial confinement treatment.

Precertification

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

Physician

A duly licensed member of a medical profession who:

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

This also includes a health professional who:

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

Plan

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

Primary Care Physician (PCP)

This is a Network Provider who is:

- Chosen by a covered person from the list of PCPs in the provider directory or at DocFind online;
- Responsible for a person’s ongoing health care; and
- Shown on Aetna’s records as the person’s PCP.

Psychiatric Hospital

This is an institution that meets all of the following requirements.

- Mainly provides a program for the diagnosis, evaluation, and treatment of alcoholism, substance abuse or Mental Disorders.
- Is not mainly a school or a custodial, recreational or training institution.
- Provides infirmary-level medical services. Also, it provides, or arranges with a Hospital in the area for, any other medical service that may be required.
- Is supervised full-time by a Psychiatric Physician who is responsible for patient care and is there regularly.
- Is staffed by Psychiatric Physicians involved in care and treatment.
- Has a Psychiatric Physician present during the whole treatment day.
- Provides, at all times, psychiatric social work and nursing services.
- Provides, at all times, skilled nursing services by licensed nurses who are supervised by a full-time R.N.
- Prepares and maintains a written plan of treatment for each patient based on medical, psychological and social needs. The plan must be supervised by a Psychiatric Physician.
- Makes charges.
- Meets licensing standards.

Psychiatric Physician

This is a physician who:

- Specializes in psychiatry; or
- Has the training or experience to do the required evaluation and treatment of alcoholism, substance abuse or Mental Disorders.

R.N.

This means a registered nurse.

Recognized Charge

Only that part of a charge which is less than or equal to the recognized charge is a covered benefit. The recognized charge for a service or supply is the lowest of

- The provider's usual charge for furnishing it; and
- The charge Aetna determines to be appropriate, based on factors such as the cost of providing the same or a similar service or supply and the manner in which charges for the service or supply are made, billed or coded; or
 - a) For non-facility charges: Aetna uses the provider charge data from the Ingenix Incorporated Prevailing HealthCare Charges System (PHCS) at the 85th percentile of PHCS data. This PHCS data is generally updated at least every six months.
 - b) For facility charges: Aetna uses the charge Aetna determines to be the usual charge level made for it in the geographic area where it is furnished.

In determining the recognized charge for a service or supply that is:

- Unusual; or

- Not often provided in the geographic area; or
- Provided by only a small number of providers in the geographic area;

Aetna may take into account factors, such as:

- The complexity;
- The degree of skill needed;
- The type of specialty of the provider;
- The range of services or supplies provided by a facility; and
- The recognized charge in other geographic areas.

In some circumstances, Aetna may have an agreement with a provider (either directly, or indirectly through a third party) which sets the rate that Aetna will pay for a service or supply. In these instances, in spite of the methodology described above, the recognized charge is the rate established in such agreement.

As used above, the term “geographic area” means a Prevailing HealthCare Charges System (PHCS) expense area grouping. Expense areas are defined by the first three digits of the U.S. Postal Service zip codes. If the volume of charges in a single three digit zip code is sufficient to produce a statistically valid sample, an expense area is made up of a single three digit zip code. If the volume of charges is not sufficient to produce a statistically valid sample, two or more three digit zip codes are grouped to produce a statistically valid sample. When it is necessary to group three digit zip codes, PHCS never crosses state lines. This data is produced semi-annually. Current procedure codes that have been developed by the American Medical Association, the American Dental Association, and the Centers for Medicare and Medicaid Services are utilized.

Residential Treatment Facility (Mental Disorders)

This is an institution that meets all of the following requirements:

-
- On-site licensed Behavioral Health Provider 24 hours per day/7 days a week.
- Provides a comprehensive patient assessment (preferably before admission, but at least upon admission).
- Is admitted by a Physician.
- Has access to necessary medical services 24 hours per day/7 days a week.
- Provides living arrangements that foster community living and peer interaction that are consistent with developmental needs.
- Offers group therapy sessions with at least an RN or Masters-Level Health Professional.
- Has the ability to involve family/support systems in therapy (required for children and adolescents; encouraged for adults).
- Provides access to at least weekly sessions with a Psychiatrist or psychologist for individual psychotherapy.
- Has peer oriented activities.
- Services are managed by a licensed Behavioral Health Provider who, while not needing to be individually contracted, needs to (1) meet the Aetna credentialing criteria as an individual practitioner, and (2) function under the direction/supervision of a licensed psychiatrist (Medical Director).

- Has individualized active treatment plan directed toward the alleviation of the impairment that caused the admission.
- Provides a level of skilled intervention consistent with patient risk.
- Meets any and all applicable licensing standards established by the jurisdiction in which it is located.
- Is not a Wilderness Treatment Program or any such related or similar program, school and/or education service.

Residential Treatment Facility (Substance Abuse)

This is an institution that meets all of the following requirements:

- On-site licensed Behavioral Health Provider 24 hours per day/7 days a week.
- Provides a comprehensive patient assessment (preferably before admission, but at least upon admission).
- Is admitted by a Physician.
- Has access to necessary medical services 24 hours per day/7 days a week.
- If the member requires Detoxification services, must have the availability of on-site medical treatment 24 hours per day/7days a week, which must be actively supervised by an attending Physician.
- Provides living arrangements that foster community living and peer interaction that are consistent with developmental needs.
- Offers group therapy sessions with at least an RN or Masters-Level Health Professional.
- Has the ability to involve family/support systems in therapy (required for children and adolescents; encouraged for adults).
- Provides access to at least weekly sessions with a Psychiatrist or psychologist for individual psychotherapy.
- Has peer oriented activities.
- Services are managed by a licensed Behavioral Health Provider who, while not needing to be individually contracted, needs to (1) meet the Aetna credentialing criteria as an individual practitioner, and (2) function under the direction/supervision of a licensed psychiatrist (Medical Director).
- Has individualized active treatment plan directed toward the alleviation of the impairment that caused the admission.
- Provides a level of skilled intervention consistent with patient risk.
- Meets any and all applicable licensing standards established by the jurisdiction in which it is located.
- Is not a Wilderness Treatment Program or any such related or similar program, school and/or education service.
- Ability to assess and recognize withdrawal complications that threaten life or bodily functions and to obtain needed services either on site or externally.
- 24-hours perday/7 days a week supervision by a Physician with evidence of close and frequent observation.
- On-site, licensed Behavioral Health Provider, medical or Substance Abuse professionals 24 hours per day/7 days a week.

Room and Board Charges

Charges made by an institution for room and board and other Necessary services and supplies. The charges must be regularly made at a daily or weekly rate.

If a Hospital or other health care facility does not identify the specific amounts charged for room and board charges and other charges, Aetna will assume that 40% of the total is the room and board charge, and 60% is other charges.

Semi-Private Room Rate

This is the Room and Board Charge that an institution applies to the most beds in its semi-private rooms with two or more beds. If there are no such rooms, Aetna will figure the rate. It will be the rate most commonly charged by similar institutions in the same geographic area.

Skilled Nursing Facility

An institution that meets all of the following requirements:

- It is licensed to provide, and does provide, the following on an inpatient basis for persons convalescing from Illness or Injury:
 - Professional nursing care by an R.N., or by a L.P.N. directed by a full-time R.N.;
 - and
 - Physical restoration services to help patients to meet a goal of self-care in daily living activities.
- Provides 24 hour a day nursing care by licensed nurses directed by a full-time R.N.
- Is supervised full-time by a Physician or an R.N.
- Keeps a complete medical record on each patient.
- Has a utilization review plan.
- Is not mainly a place for rest, for the aged, for drug addicts, for alcoholics, for mental retardates, for custodial or educational care, or for care of Mental Disorders.
- Charges patients for its services.
- An institution or a distinct part of an institution that meets all of the following requirements:
 - It is licensed or approved under state or local law.
 - Is primarily engaged in providing skilled nursing care and related services for residents who require medical or nursing care, or rehabilitation services for the rehabilitation of injured, disabled, or sick persons.
- Qualifies as a Skilled Nursing Facility under Medicare or as an institution accredited by:
 - The Joint Commission on Accreditation of Health Care Organizations;
 - The Bureau of Hospitals of the American Osteopathic Association; or
 - The Commission on the Accreditation of Rehabilitative Facilities

Skilled nursing facilities also include rehabilitation Hospitals (all levels of care, e.g., acute) and portions of a Hospital designated for skilled or rehabilitation services.

Skilled Nursing Facility does not include:

- Institutions which provide only:
 - Minimal care;
 - Custodial Care services;
 - Ambulatory; or
 - Part-time care services.

- Institutions which primarily provide for the care and treatment of alcoholism, Substance Abuse or Mental Disorders.

Specialist

A specialist is a Physician who practices in any generally accepted medical or surgical subspecialty, and provides care that is not considered routine medical care.

Substance Abuse

This is a physical or psychological dependency, or both, on a controlled substance or alcohol agent. (These are defined on Axis I in the Diagnostic and Statistical Manual of Mental Disorders (DSM) published by the American Psychiatric Association which is current as of the date services are rendered to you or your covered Dependents.) This term does not include conditions not attributable to a Mental Disorder that are a focus of attention or treatment (the V codes on Axis I of DSM); an addiction to nicotine products, food or caffeine intoxication.

Terminally Ill

This is a medical prognosis of 12 months or less to live.

Urgent Admission

An urgent admission is one where the Physician admits the person to the Hospital due to:

- The onset of or change in an Illness; or
- The diagnosis of an Illness; or
- An Injury caused by an accident;

which, while not needing an Emergency Admission, is severe enough to require confinement as an inpatient in a Hospital within 2 weeks from the date the need for the confinement becomes apparent.

Urgent Care Provider

This is:

- A freestanding medical facility that meets all of the following requirements.
 - Provides unscheduled medical services to treat an Urgent Condition if the person's Physician is not reasonably available.
 - Routinely provides ongoing unscheduled medical services for more than 8 consecutive hours.
 - Makes charges.
 - Is licensed and certified as required by any state or federal law or regulation.
 - Keeps a medical record on each patient.
 - Provides an ongoing quality assurance program. This includes reviews by Physicians other than those who own or direct the facility.
 - Is run by a staff of Physicians. At least one Physician must be on call at all times.
 - Has a full-time administrator who is a licensed Physician.
- A Physician's office, but only one that:
 - Has contracted with Aetna to provide urgent care; and

- Is, with Aetna's consent, included in the directory as a network urgent care provider.
- It is not the emergency room or outpatient department of a Hospital.

Urgent Condition

This means a sudden illness; injury; or condition; that:

- Is severe enough to require prompt medical attention to avoid serious deterioration of your health;
- Includes a condition which would subject you to severe pain that could not be adequately managed without urgent care or treatment;
- Does not require the level of care provided in the emergency room of a Hospital; and
- Requires immediate outpatient medical care that cannot be postponed until your Physician becomes reasonably available.