



Summary Plan Description

MEDICAL PLAN – ANTHEM BLUE CROSS

BlueCard PPO 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 the separate 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 this Summary Plan Description for 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, along with the booklet provided by Anthem Blue Cross, serves as your Summary Plan Description (SPD). You should keep and refer to it when you have questions about your medical benefits. Any capitalized term or phrase not defined in the Glossary of this supplement has the meaning ascribed to it in the booklet that follows.

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

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 Anthem’s BlueCard® PPO network (a Network Provider) or one that does not belong (an Out-of-Network Provider). Through the BlueCard® PPO provider network, you will have access to about 84 percent of doctors and 94 percent of hospitals in the United States. With the BlueCard Worldwide® Program, you have international access to hospitals and physicians in 200 countries.

For prescription drugs, if you purchase prescriptions from a Medco network retail or mail order pharmacy, you will pay a copayment as 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, copayments or coinsurance for major types of covered expenses, and out-of-pocket maximums under the Anthem PPO option. Sections later in this SPD include more detail about coverage for specific services and supplies as well as information about prescription drug coverage.

All coverage levels apply to covered expenses after the applicable deductible is met unless otherwise noted. Benefit payments are based on the amount of the provider's charge that Anthem Blue Cross recognizes for payment of benefits. The allowed amount may vary depending upon the type of provider and where services are received. Prior authorization for certain services is required. See the section entitled "Your Medical Benefits – How Covered Expense is Determined" in the attached Anthem Blue Cross booklet for additional details.

Medical Plan Information		
Annual Deductible	Individual	Family
Network	\$300	\$600
Out-of-Network	\$600	\$1,200
Deductible does not apply to retail or mail order prescription drugs.		
Annual Out-of-Pocket Maximum <i>(includes your deductible)</i>	Individual	Family
Network	\$1,500	\$3,000
Out-of-Network	\$2,500	\$5,000

The following do not apply to the calendar year deductible or out-of-pocket maximum:

- Copayments for medical services or prescription drugs
- Non-covered services
- Services deemed not Medically Necessary
- Penalties for non-compliance
- Charges over the allowed amount

After you reach the calendar year out-of-pocket maximum, covered applicable expenses are paid at 100% for the remainder of the calendar year. Copayments for services such as office visits and prescription drugs will continue.

HOSPITAL AND EMERGENCY ROOM		
Covered Services	Network	Out-of-Network
Hospital Services		
Inpatient Coverage	90%	70%
Outpatient Coverage	90%	70%
Ancillary Charges <i>(other than room and board and nursing services)</i>	90%	70%
Mental Health, Alcohol & Drug Abuse Care Covered same as Hospital Services	90%	70%
Emergency Care Emergency Room & Physician Charges <i>(non-emergency care not covered)</i>	90%	90%
Ambulance		
Emergency	90%	90%
Non-Emergency Ambulance	90%	70%
Convalescent (Skilled Nursing) Facility <i>(up to 100 days per year)</i>	90%	70%

OTHER MEDICAL BENEFITS		
Covered Services	Network	Out-of-Network
Preventive Care <i>(Age and frequency limits apply)</i> Routine Physical Exams Well Child Exams Routine Mammograms Cervical Cancer Screening Prostate Specific Antigen (PSA) Test and Digital Rectal Exam (DRE)	100%	70%
Colorectal Cancer Screening	90%	70%
Physician Services Office Visits & Consultations \$20 physician copay \$40 specialist copay Maternity Care <i>(first visit only)</i> \$20 physician copay Maternity Care <i>(all additional visits)</i> 90% Surgeon Charges 90%		70%
Diagnostic Lab & X-Ray	90%	70%
Chiropractic Services <i>(up to \$1,500 per year)</i>	90%	70%
Mental Health, Alcohol & Drug Abuse Care Office Visits	\$40 specialist copay	70%
Short-Term Rehabilitation <i>(physical, occupational and speech therapy; up to 24 visits per year)</i>	90%	70%
Private Duty Nursing (Home Health Care) <i>(up to 100 visits per year)</i>	90%	70%
Hospice Care	90%	70%
Durable Medical Equipment	90%	70%
Note: In case of illness or family history of cancer, services generally are not considered preventive and may be covered by other plan provisions.		

PRESCRIPTION DRUG BENEFITS	
Annual Deductible	None
Retail Pharmacy, up to a 30-day supply <i>(for initial prescription and 2 refills)</i>	Your Copayment
Generic	\$10
Preferred Brand	\$30
Non-Preferred Brand	\$50
Mail Order Pharmacy, up to a 90-day supply	Your Copayment
Generic	\$20
Preferred Brand	\$60
Non-Preferred Brand	\$100
If a generic drug is available, you will pay the generic copayment 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:
Anthem Blue Cross	P.O. Box 600007 Los Angeles, CA 90060 Website: www.anthem.com	877-442-4686
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 MyAnthem™ at www.anthem.com

MyAnthem is a convenient resource that offers access to a wide range of interactive online health tools 24 hours a day, 7 days a week. The website is secure, private, and accessible anywhere an internet connection is available. From **MyAnthem** 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:

- Check the status of a claim
- Order a new ID card
- View your benefits
- Learn which services need prior approval
- View deductibles and maximums
- Find a doctor, specialist, hospital or urgent care facility

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

- **MyHealth@Anthem®**, interactive health-related tools and resources,
- **SpecialOffers@AnthemSM**, select health-related product and service discounts, and
- **Decision Support Tool**, providing information about hospitals, drugs and health-care related costs such as *Healthcare Advisor*, *Coverage AdvisorSM*, and *Treatment Cost AdvisorTM* for many diseases and conditions.

Your Anthem Blue Cross ID Card

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

- Your name and Anthem identification number,
- The telephone number and address for Member Services, and
- Telephone numbers for additional services such as Pre-Authorization and the 24/7 NurseLine.

Be sure to keep your ID card handy and show it whenever you receive care. If you need an additional or replacement card, call Member Services or log in to www.anthem.com and order a new card. You may also print a temporary ID card from the website.

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,
- 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 unmarried children who are principally dependent on you for support and are 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 the *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.

Anthem Blue Cross PPO Option

Under the Anthem Blue Cross option, which utilizes Anthem's BlueCard PPO 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 Anthem's Negotiated Rate. When you use an Out-of-Network Provider, your benefits are determined using the Customary and Reasonable Charge for billed charges from a Physician and the Reasonable Charge for billed charges from a provider other than a Physician. If the Out-of-Network Provider's charge is more than the Customary and Reasonable Charge or the Reasonable Charge (as defined by Anthem), you pay the difference. This excess amount will not apply toward your deductible or out-of-pocket maximum.

Anthem BlueCard Provider Network

To find a Network Provider in your area:

- ***Locate network providers at www.anthem.com.*** Choose "Find a Doctor," then "Search the National BlueCard Directory" using the ID code **OMP**. To find network providers outside the United States, select "BlueCard Worldwide." 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. 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, any secondary language, specialty practices and hospital affiliation.
- ***Call Anthem Member Services.*** A representative can also help you find a Network Provider in your area. The Anthem Member Services toll-free number is shown on your ID card. You also may email Member Services from the **MyAnthem** website.

Just log on to www.anthem.com, enter your User Name and Password and click on the “Contact Us” link. For assistance locating a network provider outside the United States, call the BlueCard Worldwide service center collect at 804-673-1177.

Out-of-Area Benefits

Anthem’s BlueCard PPO network may not be available in a few geographical areas. If you or your covered Dependent(s) reside outside of a network area and elect the Anthem 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 Customary and Reasonable Charge or the Reasonable Charge (as defined by Anthem). Call Member Services to determine whether or not you reside outside of a network area.

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 Customary and Reasonable Charge or the Reasonable Charge for a given service or supply. If you are charged more than the Customary and Reasonable Charge or the Reasonable Charge, you must pay the difference, which does not apply to your deductible or out-of-pocket limit.

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.

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 generic copayment and the difference in price between the brand name and the generic drug.

Prescription Drug Benefits		
Annual Deductible	None	
Retail Pharmacy, up to a 30-day supply	<i>Your Copayment</i>	
	Initial Prescription & 2 Refills	Maintenance Drug Refills 3 and Over (4+ Fills)
Generic	\$10	\$20
Preferred Brand	\$30	\$60
Non-Preferred Brand	\$50	\$100
Mail Order Pharmacy, up to a 90-day supply	<i>Your Copayment</i>	
Generic	\$20	
Preferred Brand	\$60	
Non-Preferred Brand	\$100	
If a generic drug is available, you also pay 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 copayment.

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

You will pay a penalty of two times the retail copayment 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.

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 copayment 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 copayment amount to **Medco Pharmacy**. If you choose not to provide debit or credit card information and prefer to pay by check, you can contact Medco to find out the appropriate copayment. 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. 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.

* Limitations do not apply to expatriates.

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.

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,
- 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;
- Needles and syringes;
- Over-the-counter (OTC) diabetic supplies (except Glucowatch 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.

* Age restrictions apply to coverage for certain prescription drugs.

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;
- OTC non-systemic contraceptives and devices;
- 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.

CLAIMS AND BENEFIT PAYMENT

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

The Claims Administrator

Anthem Blue Cross, as the Claims Administrator, will decide your claims and appeals, Anthem has the exclusive discretionary authority to interpret the Plan provisions as well as to determine facts and other information related to claims and appeals. Anthem's decisions are conclusive and binding.

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 Providers,
- 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 Anthem'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, MyAnthem at www.anthem.com or by calling Anthem Member Services. 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 Coordination of Benefit (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:

Anthem Blue Cross
P.O. Box 600007
Los Angeles, CA 90060

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.

When You Disagree With a Claim Decision

The Appeal Process for Medical Claims

For information regarding Anthem's appeal procedures, refer to the section entitled "Disagreements with Medical Management Decisions" in the attached booklet.

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
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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
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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 POS 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 www.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.

The COBRA Billing Unit 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 the COBRA Billing Unit 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

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> Anthem Blue Cross Life and Health 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> Anthem Blue Cross Life and Health Insurance Company <i>For Prescription Drug Claims:</i> Medco Health Solutions
Medical Claim Administrator	Anthem Blue Cross Life and Health Insurance Company 21555 Oxnard Street Woodland Hills, CA 91367

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.

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 Anthem no later than 31 days after your child reaches the dependent age limit. Anthem 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.

Network Provider (Participating Provider)

This is a health care provider who belongs to Anthem’s network and has contracted to furnish services or supplies for a Negotiated Rate.

Out-of-Network Provider (Non-Participating Provider)

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

Physician

This means a legally qualified physician. The term "doctor" is also used throughout this booklet, and has the same meaning as "physician."

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."

OCCIDENTAL PETROLEUM CORPORATION

January 1, 2011

BlueCard PPO Plan

GRANDFATHERED HEALTH PLAN

Occidental Petroleum Corporation believes this *plan* is a “grandfathered health plan” under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered plan means that your *plan* may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to your employer.

If you are enrolled in an employer health plan that is subject to ERISA, you may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or at www.dol.gov/ebsa/healthreform. This web site has a table summarizing which protections do and do not apply to grandfathered health plans.

COMPLAINT NOTICE

All complaints and disputes relating to coverage under this *plan* must be resolved in accordance with the *plan's* grievance procedures. Grievances may be made by telephone (please call the number described on your Identification Card) or in writing (write to Anthem Blue Cross Life and Health Insurance Company, 21555 Oxnard Street, Woodland Hills, CA 91367 marked to the attention of the Customer Service Department named on your identification card). If you wish, the Claims Administrator will provide a Complaint Form which you may use to explain the matter.

All grievances received under the *plan* will be acknowledged in writing, together with a description of how the *plan* proposes to resolve the grievance.

Claims Administered by:

ANTHEM BLUE CROSS

on behalf of

ANTHEM BLUE CROSS LIFE AND HEALTH INSURANCE COMPANY

Dear Plan Beneficiary:

This Booklet provides a complete explanation of your benefits, limitations and other plan provisions which apply to you.

Employees and covered dependents (“beneficiaries”) are referred to in this booklet as “you” and “your”. The *plan administrator* is referred to as “we”, “us” and “our”.

All italicized words have specific definitions. These definitions can be found either in the specific section or in the DEFINITIONS section of this booklet.

Please read this Booklet (“*plan description*”) carefully so that you understand all the benefits your *plan* offers. Keep this Booklet handy in case you have any questions about your coverage.

Note: Anthem Blue Cross Life and Health Insurance Company provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims.

Anthem Blue Cross Life and Health Insurance Company is an independent licensee of the Blue Cross Association (BCA).

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TYPES OF PROVIDERS

PLEASE READ THE FOLLOWING INFORMATION SO YOU WILL KNOW FROM WHOM OR WHAT GROUP OF PROVIDERS HEALTH CARE MAY BE OBTAINED. IF YOU HAVE SPECIAL HEALTH CARE NEEDS, YOU SHOULD CAREFULLY READ THOSE SECTIONS THAT APPLY TO THOSE NEEDS. THE MEANINGS OF WORDS AND PHRASES IN ITALICS ARE DESCRIBED IN THE SECTION OF THIS BOOKLET ENTITLED DEFINITIONS.

Participating Providers. There are two kinds of *participating providers* in this *plan*:

- **PPO Providers** are primarily *hospitals* and *physicians* who participate in a BlueCard PPO network and have agreed to provide *beneficiaries* with health care services at a discounted rate that is generally lower than the rate charged by Traditional Providers.
- **Traditional Providers** are providers who might not participate in a BlueCard PPO network, but have agreed to provide *beneficiaries* with health care services at a discounted rate.

The level of benefits paid under this *plan* is determined as follows:

- You go to a PPO Provider, you will get the higher level of benefits of this *plan*.
- If you reside in an area where there are no PPO Providers, you will get the higher level of benefits of this *plan*.

Please call the toll-free BlueCard Provider Access number on your ID card to find a *participating provider* in your area. A directory of PPO Providers is available upon request.

Non-Participating Providers. *Non-participating providers* are *hospitals*, *physicians* and other providers which have not agreed to participate in a BlueCard PPO Network or Blue Cross and/or Blue Shield Plan. They have not agreed to the *negotiated rates* and other provisions.

Physicians. "Physician" means more than an M.D. Certain other practitioners are included in this term as it is used throughout the *plan*. This doesn't mean they can provide every service that a medical doctor could; it just means that the *plan* will cover expense you incur from them when they're practicing within their specialty the same as if the care were provided by a medical doctor.

Other Health Care Providers. *Other health care providers* are neither *physicians* nor *hospitals*. See the definition of "Other Health Care Providers" in the DEFINITIONS section for a complete list of those providers. *Other health care providers* may not be *participating providers*.

SUMMARY OF BENEFITS

THE BENEFITS OF THIS PLAN ARE PROVIDED ONLY FOR THOSE SERVICES THAT ARE CONSIDERED TO BE MEDICALLY NECESSARY AS DEFINED IN THE PLAN DESCRIPTION. THE FACT THAT A PHYSICIAN PRESCRIBES OR ORDERS THE SERVICE DOES NOT, IN ITSELF, MAKE IT MEDICALLY NECESSARY OR A COVERED EXPENSE. CONSULT THIS BOOKLET OR TELEPHONE THE CLAIMS ADMINISTRATOR AT THE NUMBER SHOWN ON YOUR IDENTIFICATION CARD IF YOU HAVE ANY QUESTIONS REGARDING WHETHER SERVICES ARE COVERED.

THIS PLAN CONTAINS MANY IMPORTANT TERMS (SUCH AS “MEDICALLY NECESSARY” AND “COVERED EXPENSE”) THAT ARE DEFINED IN THE DEFINITIONS SECTION. WHEN READING THROUGH THIS BOOKLET, CONSULT THE DEFINITIONS SECTION TO BE SURE THAT YOU UNDERSTAND THE MEANINGS OF THESE ITALICIZED WORDS.

For your convenience, this summary provides a brief outline of your benefits. You need to refer to the entire *plan description* for more complete information about the benefits, conditions, limitations and exclusions of your *plan*.

Second Opinions. If you have a question about your condition or about a plan of treatment which your *physician* has recommended, you may receive a second medical opinion from another *physician*. This second opinion visit will be provided according to the benefits, limitations, and exclusions of this *plan*. If you wish to receive a second medical opinion, remember that greater benefits are provided when you choose a *participating provider*. You may also ask your *physician* to refer you to a *participating provider* to receive a second opinion.

All benefits are subject to coordination with benefits under certain other plans.

The benefits of this <i>plan</i> may be subject to the REIMBURSEMENT FOR ACTS OF THIRD PARTIES section.

MEDICAL BENEFITS

DEDUCTIBLES

Calendar Year Deductibles

- Individual Deductible:
 - *Participating providers and other health care providers* **\$300**
 - *Non-participating providers* **\$600**
 - Family Deductible:
 - *Participating providers and other health care providers* **\$600**
 - *Non-participating providers* **\$1,200**
- Additional Non-Certification Deductible (Penalty) \$500**

Exceptions: In certain circumstances, one or more of these Deductibles may not apply, as described below:

- The Calendar Year Deductible will not apply to office visits to a *physician* who is a *participating provider*.

Note: This exception only applies to the charge for the visit itself. It does not apply to any other charges made during that visit, such as for testing procedures, surgery, etc.
- The Calendar Year Deductible will not apply to diabetes education program services provided by a *physician* who is a *participating provider*.
- The Calendar Year Deductible will not apply to the following Well Baby and Well Child Care services provided by a *participating provider*: (a) *physician's* services for routine examinations; or (b) immunizations.
- The Calendar Year Deductible will not apply to services provided by a *participating provider* under the Physical Exam benefit.
- The Calendar Year Deductible will not apply to benefits for services provided by a *participating provider* for screening for blood lead levels in children at risk for lead poisoning.
- The Calendar Year Deductible will not apply to services under the Adult Preventive Services benefit.
- The Additional Non-Certification Deductible will not apply to *emergency* admissions or services, nor to the services provided by a *participating provider*. See UTILIZATION REVIEW PROGRAM.

CO-PAYMENTS

Co-Payments.* After you have met your Calendar Year Deductible, and any other applicable deductible, you will be responsible for the following percentages of *covered expense* you incur:

- *Participating Providers and Other Health Care Providers* **10%**
- *Non-Participating Providers* **30%**

Note: In addition to the Co-Payment shown above, you will be required to pay any amount in excess of *covered expense* for the services of an *other health care provider* or *non-participating provider*.

***Exceptions:**

- If members reside in an area where there are no *participating providers*, claims will be paid at the highest level of benefits.
- There will be no Co-Payment for any covered services provided by a *participating provider* under the Well Baby and Well Child Care benefit.
- Your Co-Payment for office visits to a *physician* who is a *participating provider* will be as follows:
 - **\$20** for a provider who is not a *specialist*.
 - **\$40** for a provider who is a *specialist*.

This Co-Payment will not apply toward the satisfaction of any deductible, nor will it apply toward satisfaction of the Out-Of-Pocket Amount.

Note: This exception applies only to the charge for the visit itself. It does not apply to any other charges made during that visit, such as testing procedures, surgery, etc.

- Your Co-Payment for diabetes education program services provided by a *physician* who is a *participating provider* will be as follows:
 - **\$20** for a provider who is not a *specialist*.
 - **\$40** for a provider who is a *specialist*.

This Co-Payment will not apply toward the satisfaction of any deductible, nor will it apply toward satisfaction of the Out-of-Pocket Amount.

- There will be no Co-Payment for any covered services provided by a *participating provider* under the Physical Exam benefit.
- There will be no Co-Payment for any covered services provided by a *participating provider* under the Screening for Blood Lead Levels benefit.

- There will be no Co-Payment for any covered services provided by a *participating provider* under the Adult Preventive Services benefit.
- There will be no Co-Payment for preventive and routine diagnostic imaging and laboratory services provided by a *participating provider* under the Diagnostic Services benefit.
- Your Co-Payment for *non-participating providers* will be the same as for *participating providers* for the following services. You may be responsible for charges which exceed *covered expense*.
 - a. All *emergency services*;
 - b. An *authorized referral* from the *claims administrator* to a *non-participating provider*;
 - c. Charges by a type of *physician* not represented in a BlueCard PPO Network or Blue Cross and/or Blue Shield Plan;
 - d. Cancer Clinical Trials;
 - e. Services of an anesthesiologist;
 - f. Ambulance services;
 - g. Diabetic and medicinal supplies;
 - h. Hospice Care; and
 - i. Blood.
- If you receive services from an *other health care provider* of a type participating in a BlueCard PPO Network or Blue Cross and/or Blue Shield Plan, your Co-Payment if you go to a provider participating in the BlueCard PPO Network or Blue Cross and/or Blue Shield Plan will be the same as for a *participating provider* shown above. But, if you go to a provider not participating in the BlueCard PPO Network or Blue Cross and/or Blue Shield Plan, your Co-Payment will be the same as for *non-participating provider* shown above.

Out-of-Pocket Amount*. After you have made the following total out-of-pocket payments for *covered expense* you incur during a *calendar year*, including deductibles, you will no longer be required to pay a Co-Payment for the remainder of that *year*, but you remain responsible for costs in excess of *covered expense*.

Per *insured person*

- *Participating providers and other health care providers***\$1,500/beneficiary**
- *Non-participating providers***\$2,500/beneficiary**

Per family

- *Participating providers and other health care providers***\$3,000/family**
- *Non-participating providers***\$5,000/family**

***Exceptions:**

- Your Co-Payment for office visits to a *physician* who is a *participating provider* will not be applied toward the satisfaction of your Out-Of-Pocket Amount. In addition, you are required to continue to pay your Co-Payment for such visits even after you have reached that amount.
- Your Co-Payment for diabetes education program services provided by a *physician* who is a *participating provider* will not be applied toward the satisfaction of your Out-of-Pocket Amount. In addition, you will be required to continue to pay your Co-Payment for such services even after you have reached that amount.
- Expense which is incurred for non-covered services or supplies, or which is in excess of the amount of *covered expense*, will not be applied toward your Out-of-Pocket Amount, and is always your responsibility.
- Any Non-Certification Deductible (Penalty) will not be applied toward the satisfaction of your Out-of-Pocket Amount.

MEDICAL BENEFIT MAXIMUMS

The *plan* will pay for the following services and supplies, up to the maximum amounts, or for the maximum number of days or visits shown below:

Skilled Nursing Facility

- For covered *skilled nursing facility* care **100 days**
per *calendar year*

Home Health Care

- For covered home health services **100 visits**
per *calendar year*

Prosthetic Devices

- Wigs for hair loss due to alopecia areata or alopecia totalis, chemotherapy, radiation therapy, or permanent hair loss due to injury..... **Limit 1**
per illness

Speech Therapy (treatment limited to restore ability only)

- For covered outpatient services **24**
visits per *calendar year*,
additional visits as authorized
by us if *medically necessary*

Physical Therapy, Physical Medicine, Occupational Therapy and Chiropractic Care

- For covered outpatient services for Physical Therapy, Physical Medicine, and Occupational Therapy **24**
visits per type therapy, per *calendar year*,
additional visits as authorized by the *claims administrator* if *medically necessary*
- For covered outpatient services for Chiropractic Care **25**
visits per *calendar year*

Jaw Joint Disorders

- For splint therapy **6 months**
during your lifetime

Transplant Travel Expense

- For the Recipient and One Companion per Transplant Episode (limited to **\$10,000** per episode combined with Donor benefits)
 - For transportation to the *COE* **\$250**
per trip for each person
for round trip coach airfare
 - For hotel accommodations **\$50**
per day, for up to 21 days per trip,
limited to one room,
double occupancy
 - For expenses such as meals..... **\$25**
per day for each person,
for up to 21 days per trip

- For the Donor per Transplant Episode (limited to **\$10,000** per episode combined with Recipient and Companion benefits)
 - For transportation to the *COE* **\$250**
for round trip coach airfare
 - For hotel accommodations **\$50**
per day, for up to 7 days
 - For expenses such as meals..... **\$25**
per day, for up to 7 days

Lifetime Maximum

- For all medical benefits **Unlimited**

YOUR MEDICAL BENEFITS

HOW COVERED EXPENSE IS DETERMINED

The *plan* will pay for *covered expense* you incur. A charge is incurred when the service or supply giving rise to the charge is rendered or received. *Covered expense* for medical benefits is based on a maximum charge for each covered service or supply that will be accepted for each different type of provider. It is not necessarily the amount a provider bills for the service.

Participating Providers. The maximum *covered expense* for services provided by a *participating provider* will be the lesser of the billed charge or the *negotiated rate*. *Participating providers* have agreed not to charge you more than the *negotiated rate* for covered services. When you choose a *participating provider*, you will not be responsible for any amount in excess of the *negotiated rate*.

If you go to a *hospital* which is a *participating provider*, you should not assume all providers in that *hospital* are also *participating providers*. To receive the greater benefits afforded when covered services are provided by a *participating provider*, you should request that all your provider services be performed by *participating providers* whenever you enter a *hospital*.

Note: If an *other health care provider* is participating in a BlueCard PPO Network or Blue Cross and/or Blue Shield Plan at the time you receive services, such provider will be considered a *participating provider* for the purposes of determining *covered expense*.

Non-Participating Providers and Other Health Care Providers. The maximum *covered expense* for services provided by a *non-participating* or *other health care provider* will always be the lesser of the billed charge or (1) for a *physician*, the *customary and reasonable charge* or (2) for other than a *physician*, the *reasonable charge*. You will be responsible for any billed charge which exceeds the *customary and reasonable charge* or the *reasonable charge*.

The maximum *covered expense* for *non-participating providers* for services and supplies provided in connection with Cancer Clinical Trials will be the lesser of the billed charge or the amount that ordinarily applies when services are provided by a *participating provider*.

Exception: If Medicare is the primary payor, *covered expense* does not include any charge:

1. By a *hospital*, in excess of the approved amount as determined by Medicare; or
2. By a *physician* or *other health care provider*, in excess of the lesser of the maximum *covered expense* stated above, or:
 - a. For providers who accept Medicare assignment, the approved amount as determined by Medicare; or
 - b. For providers who do not accept Medicare assignment, the limiting charge as determined by Medicare.

You will always be responsible for expense incurred which is not covered under this *plan*.

DEDUCTIBLES, CO-PAYMENTS, OUT-OF-POCKET AMOUNTS AND MEDICAL BENEFIT MAXIMUMS

After subtracting any applicable deductible and your Co-Payment, benefits will be paid up to the amount of *covered expense*, not to exceed the applicable Medical Benefit Maximum. The Deductible amounts, Co-Payments, Out-Of-Pocket Amounts and Medical Benefit Maximums are set forth in the SUMMARY OF BENEFITS.

DEDUCTIBLES

Each deductible under this *plan* is separate and distinct from the other. Charges that are considered *covered expense* will apply toward satisfaction of any deductible except as specifically indicated in this booklet.

Calendar Year Deductibles. Each *year*, you will be responsible for satisfying the individual's Calendar Year Deductible before benefits are paid. If members of an enrolled family pay deductible expense in a *year* equal to the Family Deductible, the Calendar Year Deductible for all *family members* will be considered to have been met.

Additional Non-Certification Deductible (Penalty)

Each time you are admitted to a *hospital* without properly obtaining certification, you are responsible for paying the Additional Non-Certification Deductible. This deductible will not apply to an *emergency* admission or procedure. Certification is explained in UTILIZATION REVIEW PROGRAM.

CO-PAYMENTS

After you have satisfied any applicable deductible, your Co-Payment will be subtracted from the amount of *covered expense* remaining.

If your Co-Payment is a percentage, the applicable percentage will be applied to the amount of *covered expense* remaining after any deductible has been met. This will determine the dollar amount of your Co-Payment.

OUT-OF-POCKET AMOUNTS

Satisfaction of the Out-Of-Pocket Amount. If, after you have met your Calendar Year Deductible, you pay Co-Payments equal to your Out-Of-Pocket Amount per *beneficiary* during a *calendar year*, you will no longer be required to make Co-Payments for any *covered expense* you incur during the remainder of that *year*, other than for *covered expense* incurred for routine examinations provided by a *participating provider* under the Well Baby and Well Child Care benefit, *participating provider* services under the Physical Exam benefit, office visits to a *physician* who is a *participating provider*, and diabetic education program services provided by a *physician* who is a *participating provider*.

Participating Providers and Other Health Care Providers. *Covered expense* for the services of all providers will be applied to the *participating provider* and *other health care provider* Out-Of-Pocket Amount.

After this Out-Of-Pocket Amount per *insured person* has been satisfied during a *calendar year*, you will no longer be required to make any Co-Payment for the covered services provided by a *participating provider* or *other health care provider* for the remainder of that *year*. You will continue to be required to make Co-Payments for the covered services of a *non-participating provider* until the *non-participating provider* Out-of-Pocket Amount has been met.

Non-Participating Providers. *Covered expense* for the services of all providers will be applied to the *non-participating provider* Out-Of-Pocket Amount. After this Out-Of-Pocket Amount per *insured person* has been satisfied during a *calendar year*, you will no longer be required to make any Co-Payment for the covered services provided by a *non-participating provider* for the remainder of that *year*.

Charges Which Do Not Apply Toward the Out-Of-Pocket Amount. The following charges will not be applied toward satisfaction of an Out-Of-Pocket Amount:

- Charges which are not considered *covered expense*.
- Charges for office visits to a *physician* who is a *participating provider*.
- Charges for diabetic education program services provided by a *physician* who is a *participating provider*.

In addition, you will continue to be required to pay your Co-Payment for office visits to a *physician* who is a *participating provider*, and diabetic education program services provided by a *physician* who is a *participating provider*, even after the Out-Of-Pocket Amount is reached.

MEDICAL BENEFIT MAXIMUMS

The *plan* does not make benefit payments for any *beneficiary* in excess of any of the Medical Benefit Maximums.

CONDITIONS OF COVERAGE

The following conditions of coverage must be met for expense incurred for services or supplies to be considered as *covered expense*.

1. You must incur this expense while you are covered under this *plan*. Expense is incurred on the date you receive the service or supply for which the charge is made.
2. The expense must be for a medical service or supply furnished to you as a result of illness or injury or pregnancy, unless a specific exception is made.
3. The expense must be for a medical service or supply included in MEDICAL CARE THAT IS COVERED. Additional limits on *covered expense* are included under specific benefits and in the SUMMARY OF BENEFITS.

4. The expense must not be for a medical service or supply listed in MEDICAL CARE THAT IS NOT COVERED. If the service or supply is partially excluded, then only that portion which is not excluded will be considered *covered expense*.
5. The expense must not exceed any of the maximum benefits or limitations of this *plan*.
6. Any services received must be those which are regularly provided and billed by the provider. In addition, those services must be consistent with the illness, injury, degree of disability and your medical needs. Benefits are provided only for the number of days required to treat your illness or injury.
7. All services and supplies must be ordered by a *physician*.

MEDICAL CARE THAT IS COVERED

Subject to the Medical Benefit Maximums in the SUMMARY OF BENEFITS, the requirements set forth under CONDITIONS OF COVERAGE and the exclusions or limitations listed under MEDICAL CARE THAT IS NOT COVERED, the *plan* will provide benefits for the following services and supplies:

Hospital

1. Inpatient services and supplies, provided by a *hospital*. *Covered expense* will not include charges in excess of the *hospital's* prevailing two-bed room rate unless your *physician* orders, and the *claims administrator* authorizes, a private room as *medically necessary*.
2. Services in *special care units*.
3. Outpatient services and supplies provided by a *hospital*, including outpatient surgery.

Skilled Nursing Facility. Inpatient services and supplies provided by a *skilled nursing facility*, for up to 100 days per *calendar year*. The amount by which your room charge exceeds the prevailing two-bed room rate of the *skilled nursing facility* is not considered *covered expense*.

Skilled nursing facility services and supplies are subject to pre-service review to determine medical necessity. Please refer to UTILIZATION REVIEW PROGRAM for information on how to obtain the proper reviews.

Home Health Care. The following services provided by a *home health agency*:

1. Services of a registered nurse or licensed vocational nurse under the supervision of a registered nurse or a *physician*.
2. Services of a licensed therapist for physical therapy, occupational therapy, speech therapy, or respiratory therapy.
3. Services of a medical social service worker.
4. Services of a health aide who is employed by (or who contracts with) a *home health agency*. Services must be ordered and supervised by a registered nurse employed by the *home*

health agency as professional coordinator. These services are covered only if you are also receiving the services listed in 1 or 2 above.

5. *Medically necessary* supplies provided by the *home health agency*.

In no event will benefits exceed 100 visits during a *calendar year*. One home health visit by a home health aide is defined as a period of covered service of up to four hours during any one day.

Home health care services are not covered if received while you are receiving benefits under the "Hospice Care" provision of this section.

Hospice Care. The *plan* will pay for:

1. Room and board charges in an inpatient *hospice* unit.
2. Services of a registered nurse, licensed practical nurse and licensed vocational nurse.
3. Services of a licensed therapist for physical therapy, occupational therapy, speech therapy and respiratory therapy.
4. Medical social services.
5. Services of a home health aide.
6. Dietary and nutritional guidance. Nutritional support such as intravenous feeding or hyperalimentation.
7. Drugs and medicines approved for general use by the Food and Drug Administration that are available only if prescribed by a *physician*.
8. Medical supplies. Oxygen and related respiratory therapy supplies.
9. Bereavement counseling for your family.
10. Palliative care (care which controls pain and relieves symptoms, but does not cure) which is appropriate for the illness.

You must be suffering from a terminal illness for which the prognosis of life expectancy is six months or less, as certified by your *physician* and submitted to the *claims administrator*.

Your *physician* must consent to your care by the *hospice* and must be consulted in the development of your treatment plan. The *hospice* must submit a written treatment plan to the *claims administrator* every 30 days.

Home Infusion Therapy. The following services and supplies when provided by a *home infusion therapy provider* in your home for the intravenous administration of your total daily nutritional intake or fluid requirements, medication related to illness or injury, chemotherapy, antibiotic

therapy, aerosol therapy, tocolytic therapy, special therapy, intravenous hydration, or pain management:

1. Medication, ancillary medical supplies and supply delivery, (not to exceed a 14-day supply); but medication which is delivered but not administered is not covered;
2. Pharmacy compounding and dispensing services (including pharmacy support) for intravenous solutions and medications;
3. Hospital and home clinical visits related to the administration of infusion therapy, including skilled nursing services including those provided for: (a) patient or alternative caregiver training; and (b) visits to monitor the therapy;
4. Rental and purchase charges for durable medical equipment (as shown below); maintenance and repair charges for such equipment;
5. Laboratory services to monitor the patient's response to therapy regimen.

Home infusion therapy provider services are subject to prior authorization to determine medical necessity. See UTILIZATION REVIEW PROGRAM for details.

Ambulatory Surgical Center. Services and supplies provided by an *ambulatory surgical center* in connection with outpatient surgery.

Birth Center. Services and supplies provided by a *birth center* for pregnancy.

Professional Services

1. Services of a *physician*.
2. Services of an anesthetist (M.D. or C.R.N.A.).

Reconstructive Surgery. Reconstructive surgery performed to correct deformities caused by congenital or developmental abnormalities, illness, or injury for the purpose of improving bodily function or symptomatology or creating a normal appearance.

Ambulance. The following ambulance services:

1. Base charge, mileage and non-reusable supplies of a licensed ambulance company for ground service to transport you to and from a *hospital*.
2. Emergency services or transportation services that are provided to you by a licensed ambulance company as a result of a "911" emergency response system* request for assistance if you believe you have an *emergency* medical condition requiring such assistance.

3. Base charge, mileage and non-reusable supplies of a licensed air ambulance company to transport you from the area where you are first disabled to the nearest *hospital* where appropriate treatment is provided if, and only if, such services are *medically necessary* and ground ambulance service is inadequate.
 4. Monitoring, electrocardiograms (EKGs; ECGs), cardiac defibrillation, cardiopulmonary resuscitation (CPR) and administration of oxygen and intravenous (IV) solutions in connection with ambulance service. An appropriately licensed person must render the services.
- * If you have an *emergency* medical condition that requires an emergency response, please call the "911" emergency response system if you are in an area where the system is established and operating.

Diagnostic Services. Outpatient diagnostic imaging and laboratory services. Coverage for routine bone density testing begins at age 55.

Radiation Therapy

Chemotherapy

Hemodialysis Treatment

Prosthetic Devices

1. Breast prostheses following a mastectomy.
2. *Prosthetic devices* to restore a method of speaking when required as a result of a covered *medically necessary* laryngectomy.
3. The *plan* will pay for other *medically necessary prosthetic devices*, including:
 - a. Surgical implants;
 - b. Artificial limbs or eyes;
 - c. The first pair of contact lenses or eye glasses when required as a result of a covered *medically necessary* eye surgery;
 - d. Scalp hair prostheses when required as a result of hair loss due to alopecia areata or alopecia totalis, chemotherapy, radiation therapy, or permanent hair loss due to injury, limited to one per illness;
 - e. Therapeutic shoes and inserts for the prevention and treatment of diabetes-related foot complications; and
 - f. Orthopedic footwear used as an integral part of a brace; shoe inserts that are custom molded to the patient.

Durable Medical Equipment. Rental or purchase of dialysis equipment; dialysis supplies. Rental or purchase of other medical equipment and supplies which are:

1. Of no further use when medical needs end;
2. For the exclusive use of the patient;
3. Not primarily for comfort or hygiene;
4. Not for environmental control or for exercise; and
5. Manufactured specifically for medical use.

The *claims administrator* will determine whether the item satisfies the conditions above.

Pediatric Asthma Equipment and Supplies. The following items and services when required for the *medically necessary* treatment of asthma in a dependent *child*:

1. Nebulizers, including face masks and tubing, inhaler spacers, and peak flow meters. These items are covered under the *plan's* medical benefits and are not subject to any limitations or maximums that apply to coverage for durable medical equipment (see "Durable Medical Equipment").
2. Education for pediatric asthma, including education to enable the *child* to properly use the items listed above. This education will be covered under the *plan's* benefits for office visits to a *physician*.

Blood. Blood transfusions, including blood processing and the cost of unreplaced blood and blood products. Charges for the collection, processing and storage of self-donated blood are covered, but only when specifically collected for a planned and covered surgical procedure.

Dental Care

1. **Admissions for Dental Care.** Listed inpatient *hospital* services for up to three days during a *hospital stay*, when such *stay* is required for dental treatment and has been ordered by a *physician* (M.D.) and a dentist (D.D.S. or D.M.D.). The *claims administrator* will make the final determination as to whether the dental treatment could have been safely rendered in another setting due to the nature of the procedure or your medical condition. *Hospital stays* for the purpose of administering general anesthesia are not considered necessary and are not covered except as specified in #2, below.
2. **General Anesthesia.** General anesthesia and associated facility charges when your clinical status or underlying medical condition requires that dental procedures be rendered in a *hospital* or *ambulatory surgical center*. This applies only if (a) the *beneficiary* is less than seven years old, (b) the *beneficiary* is developmentally disabled, or (c) the *beneficiary's* health is compromised and general anesthesia is *medically necessary*. Charges for the dental procedure itself, including professional fees of a dentist, are not covered.

3. **Dental Injury.** Services of a *physician* (M.D.) or dentist (D.D.S. or D.M.D.) solely to treat an *accidental injury* to natural teeth. Coverage shall be limited to only such services that are *medically necessary* to repair the damage done by *accidental injury* and/or restore function lost as a direct result of the *accidental injury*. Damage to natural teeth due to chewing or biting is not *accidental injury*.

Pregnancy and Maternity Care

1. All medical benefits when provided for pregnancy or maternity care, including diagnosis of genetic disorders in cases of high-risk pregnancy. Inpatient *hospital* benefits in connection with childbirth will be provided for at least 48 hours following a normal delivery or 96 hours following a cesarean section, unless the mother and her *physician* decide on an earlier discharge.
2. Medical *hospital* benefits for routine nursery care of a newborn *child*, if the *child's* natural mother is an *employee* or enrolled *spouse*.

Organ and Tissue Transplants. Services provided in connection with a non-investigative organ or tissue transplant, if you are: (1) the organ or tissue recipient; or (2) the organ or tissue donor.

If you are the recipient, an organ or tissue donor who is not a *beneficiary* is also eligible for services as described. Benefits are reduced by any amounts paid or payable by that donor's own coverage.

Covered expense does not include charges for services received without first obtaining pre-service review from the *claims administrator*, or which are provided at a facility other than an approved transplant center. See UTILIZATION REVIEW PROGRAM.

Transplant Travel Expense. The following travel expenses in connection with an approved, specified organ transplant (heart, liver, lung, heart-lung, kidney-pancreas, or bone marrow, including autologous bone marrow transplant, peripheral stem cell replacement and similar procedures) performed at an approved facility only when the recipient or donor's home is more than 250 miles from the facility, provided the expenses are approved by us in advance:

1. For the recipient and a companion, per transplant episode, up to **\$10,000** per episode, combined with donor benefits:
 - a. Round trip coach airfare to the *COE*, not to exceed **\$250** per person per trip.
 - b. Hotel accommodations, not to exceed **\$50** per day for up to 21 days per trip, limited to one room, double occupancy.
 - c. Other expenses, such as meals, not to exceed **\$25** per day for each person, for up to 21 days per trip.

2. For the donor, per transplant episode, limited to **\$10,000** combined with recipient and companion benefits:
 - a. Round trip coach airfare to the *COE*, not to exceed **\$250**.
 - b. Hotel accommodations, not to exceed **\$50** per day for up to 7 days.
 - c. Other expenses, such as meals, not to exceed **\$25** per day, for up to 7 days.

Mental or Nervous Disorders or Substance Abuse. Covered services shown below for the *medically necessary* treatment of *mental or nervous disorders* or substance abuse.

1. Inpatient *hospital* services as stated in the "Hospital" provision of this section, services from a *residential treatment center*, and visits to a *day treatment center*.
2. *Physician* visits during a covered inpatient *stay*.
3. *Physician* visits for outpatient psychotherapy or psychological testing or outpatient rehabilitative care (such as physical therapy, occupational therapy, or speech therapy) for the treatment of *mental or nervous disorders* or substance abuse.

Treatment for substance abuse does not include smoking cessation programs, nor treatment for nicotine dependency or tobacco use.

Well Baby and Well Child Care. The following services for a dependent *child* under 19 years of age:

1. A *physician's* services for routine physical examinations.
2. Immunizations given as standard medical practice for children.
3. Radiology and laboratory services in connection with routine physical examinations. This includes human immunodeficiency virus (HIV) testing, regardless of whether the testing is related to a primary diagnosis.

See the definition of "Preventive Care Services" in the DEFINITIONS section for more information about services that are covered by this *plan* as *preventive care services*.

Screening For Blood Lead Levels. Services and supplies provided in connection with screening for blood lead levels if your dependent *child* is at risk for lead poisoning, as determined by your *physician*, when the screening is prescribed by your *physician*. This is considered to be a *preventive care service*. The *calendar year deductible* will not apply to these services when they are provided by a *participating provider*. No copayment will apply to these services when they are provided by a *participating provider*.

Physical Exam (Beneficiaries Age 19 and Over). In addition to any services specified elsewhere in the *plan description*, the *plan* will pay for the following *preventive care services* when provided for *beneficiaries* age 19 and over. The *calendar year deductible* will not apply to these services. No copayment will apply to these services.

1. A *physician's* services for routine physical examinations.
2. Immunizations given as standard medical practice.
3. Radiology and laboratory services and tests that are ordered by the examining *physician* in connection with a routine physical examination excluding any such tests related to an illness or injury. Those radiology and laboratory services and tests related to an illness or injury will be covered as any other medical service available under the terms and conditions of the provision "Diagnostic Services".
4. Preventive counseling and risk factor reduction intervention services in connection with tobacco use and tobacco use-related diseases.

See the definition of "Preventive Care Services" in the DEFINITIONS section for more information about services that are covered by this *plan* as *preventive care services*.

Prostate cancer screenings, cervical cancer screenings including human papillomavirus (HPV) screening, breast cancer screenings, colorectal cancer screenings, and other generally medically accepted cancer screenings performed in the absence of a diagnosed illness, injury, or health condition are not covered under this "Physical Exam" benefit, but are covered under the medical care provisions of this *plan* as described under "Adult Preventive Services" benefit, subject to the terms and conditions of this *plan* that apply to that benefit.

Adult Preventive Services. Services and supplies provided in connection with all generally medically accepted cancer screening tests including FDA-approved cancer screenings for cervical cancer and human papillomavirus (HPV) screening, mammography testing and appropriate screening for breast cancer, prostate cancer screenings, colorectal cancer screenings, and the office visit related to those services. Also included is human immunodeficiency virus (HIV) testing, regardless of whether the testing is related to a primary diagnosis. The Calendar Year Deductible will not apply to these services. Adult Preventive Services are considered to be *preventive care services*. No copayment will apply to these services when they are provided by a *participating provider*.

Cholesterol Screening. Coverage for routine cholesterol screening begins at age 35.

Breast Cancer. Services and supplies provided in connection with the screening for, diagnosis of, and treatment for breast cancer whether due to illness or injury, including:

1. Diagnostic mammogram examinations for the treatment of a diagnosed illness or injury. Routine mammograms will be covered initially with Adult Preventive Services benefits (see "Adult Preventive Services").
2. Mastectomy and lymph node dissection; complications from a mastectomy including lymphedema.
3. Reconstructive surgery performed to restore and achieve symmetry following a *medically necessary* mastectomy.

4. Breast prostheses following a mastectomy (see "Prosthetic Devices").

This coverage is provided according to the terms and conditions of this *plan* that apply to all other medical conditions.

Cancer Clinical Trials. Coverage is provided for services and supplies for routine patient care costs, as defined below, in connection with phase I, phase II, phase III and phase IV cancer clinical trials if all of the following conditions are met:

1. The treatment provided in a clinical trial must either:
 - a. Involve a *drug* that is exempt under federal regulations from a new drug application, or
 - b. Be approved by (i) one of the National Institutes of Health, (ii) the federal Food and Drug Administration in the form of an investigational new drug application, (iii) the United States Department of Defense, or (iv) the United States Veteran's Administration.
2. You must be diagnosed with cancer to be eligible for participation in these clinical trials.
3. Participation in such clinical trials must be recommended by your *physician* after determining participation has a meaningful potential to benefit the *beneficiary*.
4. For the purpose of this provision, a clinical trial must have a therapeutic intent. Clinical trials to just test toxicity are not included in this coverage.

Routine patient care costs means the costs associated with the provision of services, including drugs, items, devices and services which would otherwise be covered under this *plan*, including health care services which are:

1. Typically provided absent a clinical trial.
2. Required solely for the provision of the investigational drug, item, device or service.
3. Clinically appropriate monitoring of the investigational item or service.
4. Prevention of complications arising from the provision of the investigational drug, item, device, or service.
5. Reasonable and necessary care arising from the provision of the investigational drug, item, device, or service, including the diagnosis or treatment of the complications.

Routine patient care costs do not include the costs associated with any of the following:

1. *Drugs* or devices not approved by the federal Food and Drug Administration that are associated with the clinical trial.
2. Services other than health care services, such as travel, housing, companion expenses and other nonclinical expenses that you may require as a result of the treatment provided for the purposes of the clinical trial.

3. Any item or service provided solely to satisfy data collection and analysis needs not used in the clinical management of the patient.
4. Health care services that, except for the fact they are provided in a clinical trial, are otherwise specifically excluded from this *plan*.
5. Health care services customarily provided by the research sponsors free of charge to *beneficiaries* enrolled in the trial.

Note: You will be financially responsible for the costs associated with non-covered services.

Physical Therapy, Physical Medicine, Occupational Therapy and Chiropractic Care. The following services provided by a *physician* under a treatment plan:

1. Physical therapy and physical medicine provided on an outpatient basis for the treatment of illness or injury including the therapeutic use of heat, cold, exercise, electricity, ultra violet radiation, manipulation of the spine, or massage for the purpose of improving circulation, strengthening muscles, or encouraging the return of motion. (This includes many types of care which are customarily provided by chiropractors, physical therapists and osteopaths.)
2. Occupational therapy provided on an outpatient basis when the ability to perform daily life tasks has been lost or reduced by illness or injury including programs which are designed to rehabilitate mentally, physically or emotionally handicapped persons. Occupational therapy programs are designed to maximize or improve a patient's upper extremity function, perceptual motor skills and ability to function in daily living activities.

Benefits are not payable for care provided to relieve general soreness or for conditions that may be expected to improve without treatment. For the purposes of this benefit, the term "visit" shall include any visit by a *physician* in that *physician's* office, or in any other outpatient setting, during which one or more of the services covered under this limited benefit are rendered, even if other services are provided during the same visit.

For the chiropractic care only, the *plan's* maximum payment is limited to 25 visits per *calendar year*. Up to 24 visits in a *year* for each other type of therapy are payable. But, if it is determined that an additional period of physical therapy, physical medicine or occupational therapy is *medically necessary*, the *claims administrator* will specify a specific number of additional visits.

Such additional visits are not payable if pre-service review is not obtained. (See UTILIZATION REVIEW PROGRAM.)

Contraceptives. Services and supplies provided in connection with the following methods of contraception when *medically necessary*:

1. Injectable drugs and implants for birth control, administered in a *physician's* office.
2. Intrauterine contraceptive devices (IUDs) and diaphragms, dispensed by a *physician*.

3. Professional services of a *physician* in connection with the prescribing, fitting, and insertion of intrauterine contraceptive devices or diaphragms.

If your *physician* determines that none of these contraceptive methods are appropriate for you based on your medical or personal history, coverage will be provided for another prescription contraceptive method that is approved by the Food and Drug Administration (FDA) and prescribed by your *physician*.

Outpatient Speech Therapy. Outpatient speech therapy following injury or organic disease to restore ability.

Up to 24 visits in a *year* are payable. But, if it is determined that an additional period of speech therapy is *medically necessary*, the *claims administrator* will specify a specific number of additional visits.

Such additional visits are not payable if pre-service review is not obtained. (See UTILIZATION REVIEW PROGRAM.)

Acupuncture. The services of a *physician* for acupuncture treatment in lieu of anesthesia.

Diabetes. Services and supplies provided for the treatment of diabetes, including:

1. The following equipment and supplies:
 - a. Blood glucose monitors, including monitors designed to assist the visually impaired, and blood glucose testing strips.
 - b. Insulin pumps.
 - c. Pen delivery systems for insulin administration (non-disposable).
 - d. Visual aids (but not eyeglasses) to help the visually impaired to properly dose insulin.
 - e. Podiatric devices, such as therapeutic shoes and shoe inserts, to treat diabetes-related complications.

Items a through d above are covered under your *plan's* benefits for durable medical equipment (see "Durable Medical Equipment"). Item e above is covered under your *plan's* benefits for prosthetic devices (see "Prosthetic Devices").

2. Diabetes education program which:
 - a. Is designed to teach a *beneficiary* who is a patient and covered members of the patient's family about the disease process and the daily management of diabetic therapy;
 - b. Includes self-management training, education, and medical nutrition therapy to enable the *beneficiary* to properly use the equipment, supplies, and medications necessary to manage the disease; and

c. Is supervised by a *physician*.

Diabetes education services are covered under your *plan's* benefits for office visits to *physicians*.

3. The following items are covered as medical supplies:

a. Insulin syringes, disposable pen delivery systems for insulin administration. Charges for insulin and other prescriptive medications are not covered.

b. Testing strips, lancets, and alcohol swabs.

Jaw Joint Disorders. The *plan* will pay for one period of treatment of up to six months in duration during your lifetime for splint therapy or surgical treatment for disorders or conditions of the joints linking the jawbones and the skull (the temporomandibular joints), including the complex of muscles, nerves and other tissues related to those joints.

Special Food Products. Special food products and formulas that are part of a diet prescribed by a *physician* for the treatment of phenylketonuria (PKU). These items will be covered as medical supplies.

Prescription Drug for Abortion. Mifepristone is covered when provided under the Food and Drug Administration (FDA) approved treatment regimen.

MEDICAL CARE THAT IS NOT COVERED

No payment will be made under this *plan* for expenses incurred for or in connection with any of the items below. (The titles given to these exclusions and limitations are for ease of reference only; they are not meant to be an integral part of the exclusions and limitations and do not modify their meaning.)

Not Medically Necessary. Services or supplies that are not *medically necessary*, as defined.

Experimental or Investigative. Any *experimental* or *investigative* procedure or medication. But, if you are denied benefits because it is determined that the requested treatment is *experimental* or *investigative*, you may request an independent medical review. (See COMPLAINT NOTICE at the beginning of this plan.)

Crime or Nuclear Energy. Conditions that result from: (1) your commission of or attempt to commit a felony, as long as any injuries are not a result of a medical condition or an act of domestic violence; or (2) any release of nuclear energy, whether or not the result of war, when government funds are available for treatment of illness or injury arising from such release of nuclear energy.

Uninsured. Services received before your *effective date* or after your coverage ends, except as specifically stated under EXTENSION OF BENEFITS.

Excess Amounts. Any amounts in excess of *covered expense*.

Work-Related. Work-related conditions if benefits are recovered or can be recovered, either by adjudication, settlement or otherwise, under any workers' compensation, employer's liability law or occupational disease law, even if you do not claim those benefits.

Government Treatment. Any services actually given to you by a local, state or federal government agency, except when payment under this *plan* is expressly required by federal or state law. The *plan* will not cover payment for these services if you are not required to pay for them or they are given to you for free.

Services of Relatives. Professional services received from a person who lives in your home or who is related to you by blood or marriage, except as specifically stated in the "Home Infusion Therapy" provision of MEDICAL CARE THAT IS COVERED.

Voluntary Payment. Services for which you are not legally obligated to pay. Services for which you are not charged. Services for which no charge is made in the absence of insurance coverage, except services received at a non-governmental charitable research *hospital*. Such a *hospital* must meet the following guidelines:

1. It must be internationally known as being devoted mainly to medical research;
2. At least **10%** of its yearly budget must be spent on research not directly related to patient care;
3. At least one-third of its gross income must come from donations or grants other than gifts or payments for patient care;
4. It must accept patients who are unable to pay; and
5. Two-thirds of its patients must have conditions directly related to the *hospital's* research.

Not Specifically Listed. Services not specifically listed in this *plan* as covered services.

Private Contracts. Services or supplies provided pursuant to a private contract between the *beneficiary* and a provider, for which reimbursement under the Medicare program is prohibited, as specified in Section 1802 (42 U.S.C. 1395a) of Title XVIII of the Social Security Act.

Inpatient Diagnostic Tests. Inpatient room and board charges in connection with a *hospital stay* primarily for diagnostic tests which could have been performed safely on an outpatient basis.

Mental or Nervous Disorders or Substance Abuse. Academic or educational testing, counseling, and remediation. Any treatment of *mental or nervous disorders* or substance abuse, including rehabilitative care in relation to these conditions, except as specifically stated in the "Mental or Nervous Disorders or Substance Abuse" provision of MEDICAL CARE THAT IS COVERED. Any educational treatment or any services that are educational, vocational, or training in nature except as specifically provided or arranged by the *claims administrator*.

Nicotine Use. Smoking cessation programs or treatment of nicotine or tobacco use. Smoking cessation *drugs*.

Orthodontia. Braces and other orthodontic appliances or services.

Dental Services or Supplies. Dental plates, bridges, crowns, caps or other dental prostheses, dental implants, dental services, extraction of teeth, or treatment to the teeth or gums, or treatment to or for any disorders for the jaw joint, except as specifically stated in the "Dental Care" or "Jaw Joint Disorders" provisions of MEDICAL CARE THAT IS COVERED. Cosmetic dental surgery or other dental services for beautification.

Hearing Aids or Tests. Hearing aids. Routine hearing tests, except as provided as part of routine physical examinations under "Well Baby and Well Child Care", "Physical Exam" or "Hearing Aid Services" provisions of MEDICAL CARE THAT IS COVERED.

Optometric Services or Supplies. Optometric services, eye exercises including orthoptics. Eyeglasses or contact lenses, except as specifically stated in the "Prosthetic Devices" provision of MEDICAL CARE THAT IS COVERED.

Outpatient Occupational Therapy. Outpatient occupational therapy, except by a *home health agency, hospice or home infusion therapy provider* as specifically stated in the "Home Health Care", "Hospice Care", "Home Infusion Therapy", or "Physical Therapy, Physical Medicine, Occupational Therapy and Chiropractic Care" provisions of MEDICAL CARE THAT IS COVERED.

Outpatient Speech Therapy. Outpatient speech therapy except as stated in the "Outpatient Speech Therapy" provision of MEDICAL CARE THAT IS COVERED.

Scalp Hair Prostheses. Scalp hair prostheses, including wigs or any form of hair replacement, except as specifically stated in the "Prosthetic Devices" provision.

Cosmetic Surgery. Cosmetic surgery or other services performed solely for beautification or to alter or reshape normal (including aged) structures or tissues of the body to improve appearance. This exclusion does not apply to reconstructive surgery (that is, surgery performed to correct deformities caused by congenital or developmental abnormalities, illness, or injury for the purpose of improving bodily function or symptomatology or to create a normal appearance), including surgery performed to restore symmetry following mastectomy. Cosmetic surgery does not become reconstructive surgery because of psychological or psychiatric reasons.

Weight Alteration Programs (Inpatient and Outpatient). Weight loss or weight gain programs including, but not limited to, dietary evaluations and counseling, exercise programs, behavioral modification programs, surgery, laboratory tests, food and food supplements, vitamins and other nutritional supplements associated with weight loss or weight gain. Dietary evaluations and counseling, and behavioral modification programs are covered for the treatment of anorexia nervosa or bulimia nervosa. Surgical treatment for morbid obesity will be covered only when criteria are met as recommended by the *claims administrator's* Medical Policy.

Sex Transformation. Procedures or treatments to change characteristics of the body to those of the opposite sex.

Sterilization Reversal. Reversal of sterilization.

Infertility Treatment. Any services or supplies furnished in connection with the diagnosis and treatment of *infertility*, including, but not limited to, diagnostic tests, medication, surgery, artificial insemination, in vitro fertilization, sterilization reversal, and gamete intrafallopian transfer. Diagnosis of an underlying medical condition is covered.

Orthopedic Supplies. Orthopedic shoes (other than shoes joined to braces) or non-custom molded and cast shoe inserts, except for therapeutic shoes and inserts for the prevention and treatment of diabetes-related foot complications as specifically stated in the "Prosthetic Devices" provision of MEDICAL CARE THAT IS COVERED.

Air Conditioners. Air purifiers, air conditioners, or humidifiers.

Custodial Care or Rest Cures. Inpatient room and board charges in connection with a *hospital stay* primarily for environmental change or physical therapy. *Custodial care* or rest cures, except as specifically provided under the "Hospice Care" or "Home Infusion Therapy" provisions of MEDICAL CARE THAT IS COVERED. Services provided by a rest home, a home for the aged, a nursing home or any similar facility. Services provided by a *skilled nursing facility*, except as specifically stated in the "Skilled Nursing Facility" provision of MEDICAL CARE THAT IS COVERED.

Chronic Pain. Treatment of chronic pain, except as specifically provided under the "Hospice Care" or "Home Infusion Therapy" provisions of MEDICAL CARE THAT IS COVERED.

Exercise Equipment. Exercise equipment, or any charges for activities, instrumentalities, or facilities normally intended or used for developing or maintaining physical fitness, including, but not limited to, charges from a physical fitness instructor, health club or gym, even if ordered by a *physician*.

Personal Items. Any supplies for comfort, hygiene or beautification.

Education or Counseling. Educational services or nutritional counseling; however, such services are provided under the "Home Infusion Therapy", "Pediatric Asthma Equipment and Supplies", or "Diabetes" provisions of MEDICAL CARE THAT IS COVERED. This exclusion does not apply to counseling for the treatment of anorexia nervosa or bulimia nervosa.

Food or Dietary Supplements. Food or dietary supplements, except as described under the provisions "Special Food Products" and "Home Infusion Therapy" under MEDICAL CARE THAT IS COVERED.

Electronic Consultations. Consultations provided by telephone, facsimile machine, internet or email.

Routine Exams or Tests. Routine physical exams or tests which do not directly treat an actual illness, injury or condition, including those required by employment or government authority, except as specifically stated in the "Well Baby and Well Child Care," "Physical Exam", "Breast Cancer", "Adult Preventive Services" or "Screening For Blood Lead Levels" provisions of MEDICAL CARE THAT IS COVERED.

Acupuncture. Acupuncture treatment except as specifically stated in the "Acupuncture" provision of MEDICAL CARE THAT IS COVERED. Acupressure, or massage to control pain, treat illness or promote health by applying pressure to one or more specific areas of the body based on dermatomes or acupuncture points.

Eye Surgery for Refractive Defects. Any eye surgery solely or primarily for the purpose of correcting refractive defects of the eye such as nearsightedness (myopia) and/or astigmatism. Contact lenses and eyeglasses required as a result of this surgery.

Physical Therapy or Physical Medicine. Services of a *physician* for physical therapy or physical medicine, except when provided during a covered inpatient confinement, or as specifically stated in the "Home Health Care", "Hospice Care", "Home Infusion Therapy" or "Physical Therapy, Physical Medicine, Occupational Therapy and Chiropractic Care" provisions of MEDICAL CARE THAT IS COVERED.

Outpatient Prescription Drugs and Medications. Outpatient prescription drugs or medications and insulin, except as specifically stated in the "Home Infusion Therapy" or "Prescription Drug for Abortion" provisions of MEDICAL CARE THAT IS COVERED. Cosmetics, health or beauty aids, or dietary supplements.

Contraceptive Devices. Contraceptive devices prescribed for birth control except as specifically stated in the "Contraceptives" provision in MEDICAL CARE THAT IS COVERED.

Private Duty Nursing. Inpatient or outpatient services of a private duty nurse.

Lifestyle Programs. Programs to alter one's lifestyle which may include but are not limited to diet, exercise, imagery or nutrition. This exclusion will not apply to cardiac rehabilitation programs approved by the *claims administrator*.

Clinical Trials. Services and supplies in connection with clinical trials, except as specifically stated in the "Cancer Clinical Trials" provision under the section MEDICAL CARE THAT IS COVERED.

REIMBURSEMENT FOR ACTS OF THIRD PARTIES

Under some circumstances, a *beneficiary* may need services under this *plan* for which a third party may be liable or legally responsible by reason of negligence, an intentional act or breach of any legal obligation. In that event, we will provide the benefits of this *plan* subject to the following:

1. We will automatically have a lien, to the extent of benefits provided, upon any recovery, whether by settlement, judgment or otherwise, that you receive from the third party, the third party's insurer, or the third party's guarantor. The lien will be in the amount of benefits we paid under this *plan* for the treatment of the illness, disease, injury or condition for which the third party is liable.
 - If we paid the provider other than on a capitated basis, our lien will not be more than amount we paid for those services.

- If we paid the provider on a capitated basis, our lien will not be more than 80% of the usual and customary charges for those services in the geographic area in which they were given.
 - If you hired an attorney to gain your recovery from the third party, our lien will not be for more than one-third of the money due you under any final judgment, compromise, or settlement agreement.
 - If you did not hire an attorney, our lien will not be for more than one-half of the money due you under any final judgment, compromise or settlement agreement.
 - If a final judgment includes a special finding by a judge, jury, or arbitrator that you were partially at fault, our lien will be reduced by the same comparative fault percentage by which your recovery was reduced.
 - Our lien is subject to a pro rata reduction equal to your reasonable attorney's fees and costs in line with the common fund doctrine.
2. You must advise us in writing, within 60 days of filing a claim against the third party and take necessary action, furnish such information and assistance, and execute such papers as we may require to facilitate enforcement of our rights. You must not take action which may prejudice our rights or interests under your *plan*. Failure to give us such notice or to cooperate with us, or actions that prejudice our rights or interests will be a material breach of this *plan* and will result in your being personally responsible for reimbursing us.
 3. We will be entitled to collect on our lien even if the amount you or anyone recovered for you (or your estate, parent or legal guardian) from or for the account of such third party as compensation for the injury, illness or condition is less than the actual loss you suffered.

COORDINATION OF BENEFITS

If you are covered by more than one group medical plan, your benefits under This Plan will be coordinated with the benefits of those Other Plans, as shown below. These coordination provisions apply separately to each *beneficiary*, per *calendar year*, and are largely determined by California law. Any coverage you have for medical or dental benefits will be coordinated as shown below.

DEFINITIONS

The meanings of key terms used in this section are shown below. Whenever any of the key terms shown below appear in these provisions, the first letter of each word will be capitalized. When you see these capitalized words, you should refer to this "Definitions" provision.

Allowable Expense is any necessary, reasonable and customary item of expense which is at least partially covered by at least one Other Plan. For the purposes of determining our payment, the total value of Allowable Expense as provided under This Plan and all Other Plans will not exceed the greater of: (1) the amount which the *plan* would determine to be eligible expense, if you were covered under This Plan only; or (2) the amount any Other Plan would determine to be eligible expenses in the absence of other coverage.

Other Plan is any of the following:

1. Group, blanket or franchise insurance coverage;
2. Group service plan contract, group practice, group individual practice and other group prepayment coverages;
3. Group coverage under labor-management trustee plans, union benefit organization plans, employer organization plans, employee benefit organization plans or self-insured employee benefit plans.
4. Medicare. This does not include Medicare when by law its benefits are secondary to those of any private insurance program or other non-governmental program, including a self-insured program.

The term "Other Plan" refers separately to each agreement, policy, contract, or other arrangement for services and benefits, and only to that portion of such agreement, policy, contract, or arrangement which reserves the right to take the services or benefits of other plans into consideration in determining benefits.

Principal Plan is the plan which will have its benefits determined first.

This Plan is that portion of this *plan* which provides benefits subject to this provision.

EFFECT ON BENEFITS

1. If This Plan is the Principal Plan, then its benefits will be determined first without taking into account the benefits or services of any Other Plan.
2. If This Plan is not the Principal Plan, then its benefits may be reduced so that the benefits and services of all the plans do not exceed Allowable Expense.
3. The benefits of This Plan will never be greater than the sum of the benefits that would have been paid if you were covered under This Plan only.

ORDER OF BENEFITS DETERMINATION

The following rules determine the order in which benefits are payable:

1. A plan which has no Coordination of Benefits provision pays before a plan which has a Coordination of Benefits provision. This would include Medicare in all cases except when the law requires that This Plan pays before Medicare.
2. A plan which covers you as an *employee* pays before a plan which covers you as a dependent. But, if you are retired and eligible for Medicare, Medicare pays (a) after the plan which covers you as a dependent of an active employee, but (b) before the plan which covers you as a retired *employee*.

For example: You are covered as a retired *employee* under this plan and eligible for Medicare (Medicare would normally pay first). You are also covered as a dependent of an active employee under another plan (in which case Medicare would pay second). In this situation, the plan which covers you as a dependent will pay first and the plan which covers you as a retired employee would pay last.

3. For a dependent *child* covered under plans of two parents, the plan of the parent whose birthday falls earlier in the *calendar year* pays before the plan of the parent whose birthday falls later in the *calendar year*. But if one plan does not have a birthday rule provision, the provisions of that plan determine the order of benefits.

Exception to rule 3: For a dependent *child* of parents who are divorced or separated, the following rules will be used in place of Rule 3:

- a. If the parent with custody of that *child* for whom a claim has been made has not remarried, then the plan of the parent with custody that covers that *child* as a dependent pays first.
- b. If the parent with custody of that *child* for whom a claim has been made has remarried, then the order in which benefits are paid will be as follows:
 - i. The plan which covers that *child* as a dependent of the parent with custody.
 - ii. The plan which covers that *child* as a dependent of the stepparent (married to the parent with custody).
 - iii. The plan which covers that *child* as a dependent of the parent without custody.
 - iv. The plan which covers that *child* as a dependent of the stepparent (married to the parent without custody).
- c. Regardless of a and b above, if there is a court decree which establishes a parent's financial responsibility for that *child's* health care coverage, a plan which covers that *child* as a dependent of that parent pays first.

4. The plan covering you as a laid-off or retired employee or as a dependent of a laid-off or retired employee pays after a plan covering you as other than a laid-off or retired employee or the dependent of such a person. But if either plan does not have a provision regarding laid-off or retired employees, provision 6 applies.
5. The plan covering you under a continuation of coverage provision in accordance with state or federal law pays after a plan covering you as an employee, a dependent or otherwise, but not under a continuation of coverage provision in accordance with state or federal law. If the order of benefit determination provisions of the Other Plan do not agree under these circumstances with the Order of Benefit Determination provisions of This Plan, this rule will not apply.
6. When the above rules do not establish the order of payment, the plan on which you have been enrolled the longest pays first unless two of the plans have the same effective date. In this case, Allowable Expense is split equally between the two plans.

OUR RIGHTS UNDER THIS PROVISION

Responsibility For Timely Notice. We are not responsible for coordination of benefits unless timely information has been provided by the requesting party regarding the application of this provision.

Reasonable Cash Value. If any Other Plan provides benefits in the form of services rather than cash payment, the reasonable cash value of services provided will be considered Allowable Expense. The reasonable cash value of such service will be considered a benefit paid, and our liability reduced accordingly.

Facility of Payment. If payments which should have been made under This Plan have been made under any Other Plan, we have the right to pay that Other Plan any amount we determine to be warranted to satisfy the intent of this provision. Any such amount will be considered a benefit paid under This Plan, and such payment will fully satisfy our liability under this provision.

Right of Recovery. If payments made under This Plan exceed the maximum payment necessary to satisfy the intent of this provision, we have the right to recover that excess amount from any persons or organizations to or for whom those payments were made, or from any insurance company or service plan.

BENEFITS FOR MEDICARE ELIGIBLE BENEFICIARIES

Beneficiaries entitled to Medicare receive the full benefits of this *plan*, except for those *beneficiaries* listed below:

1. *Beneficiaries* who are receiving treatment for end-stage renal disease following the first 30 months are entitled to end-stage renal disease benefits under Medicare; and

2. *Beneficiaries* who are entitled to Medicare benefits as disabled persons; unless, the *beneficiaries* have a current employment status, as determined by Medicare rules, through a group of 100 or more employees (according to OBRA legislation).

In cases where exceptions 1 or 2 apply, payment will be determined according to the provisions in the section entitled COORDINATION OF BENEFITS and the provision "Coordinating Benefits With Medicare", below.

Coordinating Benefits With Medicare. The *plan* will not provide benefits that duplicate any benefits to which you would be entitled under Medicare. This exclusion applies to all parts of Medicare in which you can enroll without paying additional premium. If you are required to pay additional premium for any part of Medicare, this exclusion will apply to that part of Medicare only if you are enrolled in that part.

If you are entitled to Medicare, your Medicare coverage will not affect the services covered under this *plan* except as follows:

1. Medicare must provide benefits first to any services covered both by Medicare and under this *plan*.
2. For services you receive that are covered both by Medicare and under this *plan*, coverage under this *plan* will apply only to Medicare deductibles, coinsurance, and other charges for covered services over and above what Medicare pays.
3. For any given claim, the combination of benefits provided by Medicare and the benefits provided under this *plan* will not exceed *covered expense* for the covered services.

The *claims administrator* will apply any charges paid by Medicare for services covered under this *plan* toward your *plan* deductible, if any.

UTILIZATION REVIEW PROGRAM

Benefits are provided only for *medically necessary* and appropriate services. Utilization Review is designed to work together with you and your provider to ensure you receive appropriate medical care and avoid unexpected out of pocket expense.

No benefits are payable, however, unless your coverage is in force at the time services are rendered, and the payment of benefits is subject to all the terms and requirements of this *plan*.

Important: The Utilization Review Program requirements described in this section do not apply when coverage under this *plan* is secondary to another plan providing benefits for you or your *dependents*.

The utilization review program evaluates the medical necessity and appropriateness of care and the setting in which care is provided. You and your *physician* are advised if it has been determined that services can be safely provided in an outpatient setting, or if an inpatient *stay* is recommended. Services that are *medically necessary* and appropriate are certified by the *claims administrator* and monitored so that you know when it is no longer *medically necessary* and appropriate to continue those services.

It is your responsibility to see that your *physician* starts the utilization review process before scheduling you for any service subject to the utilization review program. If you receive any such service, and do not follow the procedures set forth in this section, your benefits will be reduced as shown in the "Effect on Benefits".

UTILIZATION REVIEW REQUIREMENTS

Utilization reviews are conducted for the following services:

- All inpatient *hospital stays* and *residential treatment center* admissions.
- Organ and tissue transplants.
- Visits for speech therapy, physical therapy, physical medicine and occupational therapy beyond those described under the "Speech Therapy" and "Physical Therapy, Physical Medicine, Occupational Therapy and Chiropractic Care" provisions of YOUR MEDICAL BENEFITS: MEDICAL CARE THAT IS COVERED.
- Home infusion therapy.
- Admissions to a *skilled nursing facility*.

Exceptions: Utilization review is not required for inpatient *hospital stays* for the following services:

- Maternity care of 48 hours or less following a normal delivery or 96 hours or less following a cesarean section; and
- Mastectomy and lymph node dissection.

The stages of utilization review are:

1. **Pre-service review** determines in advance the medical necessity and appropriateness of certain procedures or admissions and the appropriate length of stay, if applicable. Pre-service review is required for the following services:
 - Scheduled, non-emergency inpatient *hospital stays* and *residential treatment center* admissions (except inpatient *stays* for maternity care or mastectomy and lymph node dissection).
 - Organ and tissue transplants.

- Visits for speech therapy, physical therapy, physical medicine and occupational therapy beyond those described under the “Speech Therapy” and “Physical Therapy, Physical Medicine, Occupational Therapy and Chiropractic Care” provisions of YOUR MEDICAL BENEFITS: MEDICAL CARE THAT IS COVERED.
 - Home infusion therapy.
 - Admissions to a *skilled nursing facility*.
2. **Concurrent review** determines whether services are *medically necessary* and appropriate when the *claims administrator* is notified while service is ongoing, for example, an *emergency admission* to the *hospital*.
 3. **Retrospective review** is performed to review services that have already been provided. This applies in cases when pre-service or concurrent review was not completed, or in order to evaluate and audit medical documentation subsequent to services being provided. Retrospective review may also be performed for services that continued longer than originally certified.

EFFECT ON BENEFITS

In order for the full benefits of this *plan* to be payable, the following criteria must be met:

1. The appropriate utilization reviews must be performed in accordance with this *plan*. When pre-service review is not performed as required for an inpatient *hospital* admission, the benefits to which you would have been otherwise entitled will be subject to the Additional Non-Certification Deductible shown in the SUMMARY OF BENEFITS.
2. When pre-service review is performed and the admission, procedure or service is determined to be *medically necessary* and appropriate, benefits will be provided for the following:
 - Scheduled, non-emergency inpatient *hospital stays*.
 - Authorizations for organ and tissue transplants will be provided only if the *physicians* on the surgical team and the facility in which the transplant is to take place are approved for the transplant requested.
 - A specified number of additional visits for speech therapy, physical therapy, physical medicine and occupational therapy if you need more visits than is provided under the “Speech Therapy” and “Physical Therapy, Physical Medicine, Occupational Therapy and Chiropractic Care” provisions of YOUR MEDICAL BENEFITS: MEDICAL CARE THAT IS COVERED.
 - Services of a home infusion therapy provider if the attending *physician* has submitted both a prescription and a plan of treatment before services are rendered.
 - Services provided in a *skilled nursing facility* if you require daily skilled nursing or rehabilitation, as certified by your attending *physician*.

If you proceed with any services that have been determined to be not *medically necessary* and appropriate at any stage of the utilization review process, benefits will not be provided for those services.

3. Services that are not reviewed prior to or during service delivery will be reviewed retrospectively when the bill is submitted for benefit payment. If that review results in the determination that part or all of the services were not *medically necessary* and appropriate, benefits will not be paid for those services.

HOW TO OBTAIN UTILIZATION REVIEWS

Remember, it is always your responsibility to confirm that the review has been performed. If you use a *non-participating provider* and a pre-service review is not performed, an Additional Non-Certification Deductible may apply.

Pre-service Reviews. If you use a *non-participating provider*, penalties will result for failure to obtain pre-service review, before receiving scheduled services, as follows:

1. For all scheduled services that are subject to utilization review, you or your *physician* must initiate the pre-service review at least five working days prior to when you are scheduled to receive services. The toll-free telephone number for pre-service reviews is printed on your identification card.
2. If you do not receive the certified service within 60 days of the certification, or if the nature of the service changes, a new pre-service review must be obtained.
3. The *claims administrator* will certify services that are *medically necessary* and appropriate. For inpatient *hospital* stays, the *claims administrator* will, if appropriate, certify a specific length of *stay* for approved services. You, your *physician* and the provider of the service will receive a written confirmation showing this information.

Concurrent Reviews

1. If pre-service review was not performed, you or the provider of the service must contact the *claims administrator* for concurrent review. For an *emergency* admission or procedure, the *claims administrator* must be notified within one working day of the admission or procedure. The toll-free number is printed on your identification card.
2. When the *claims administrator* determines that the service is *medically necessary* and appropriate, they will, depending upon the type of treatment or procedure, certify the service for a period of time that is medically appropriate. The *claims administrator* will also determine the medically appropriate setting.

3. If it is determined that the service is not *medically necessary* and appropriate, your *physician* will be notified by telephone no later than 24 hours following the *claims administrator's* decision. The *claims administrator* will send written notice to you and your *physician* within two business days following the decision. However, care will not be discontinued until your *physician* has been notified and a plan of care that is appropriate for your needs has been agreed upon.

Retrospective Reviews

1. Retrospective review is performed when the *claims administrator* is not notified of the service you received, and is therefore unable to perform the appropriate review prior to your discharge from the *hospital* or completion of outpatient treatment. It is also performed when pre-service or concurrent review has been done, but services continue longer than originally certified.

It may also be performed for the evaluation and audit of medical documentation after services have been provided, whether or not pre-service or concurrent review was performed.

2. Such services which have been retroactively determined to not be *medically necessary* and appropriate will be retrospectively denied certification.

THE MEDICAL NECESSITY REVIEW PROCESS

The *claims administrator* will work with you and your health care providers to cover *medically necessary* and appropriate care and services. While the types of services requiring review and the timing of the reviews may vary, the *claims administrator* is committed to ensuring that reviews are performed in a timely and professional manner. The following information explains the review process.

1. A decision on the medical necessity of a pre-service request will be made no later than 5 business days from receipt of the information reasonably necessary to make the decision, and based on the nature of your medical condition.
2. A decision on the medical necessity of a concurrent request will be made no later than one business day from receipt of the information reasonably necessary to make the decision, and based on the nature of your medical condition. However, care will not be discontinued until your *physician* has been notified and a plan of care that is appropriate for your needs has been agreed upon.
3. A decision on the medical necessity of a retrospective review will be made and communicated in writing no later than 30 days from receipt of the information necessary to make the decision to you and your *physician*.

4. If the *claims administrator* does not have the information they need, they will make every attempt to obtain that information from you or your *physician*. If unsuccessful and a delay is anticipated, the *claims administrator* will notify you and your *physician* of the delay and what is needed to make a decision. The *claims administrator* will also inform you of when a decision can be expected following receipt of the needed information.
5. All pre-service, concurrent and retrospective reviews for medical necessity are screened by clinically experienced, licensed personnel (called "Review Coordinators") using pre-established criteria and the *claims administrator's* medical policy. These criteria and policies are developed and approved by practicing providers not employed by the *claims administrator*, and are evaluated at least annually and updated as standards of practice or technology changes. Requests satisfying these criteria are certified as *medically necessary*. Review Coordinators are able to approve most requests.
6. A written confirmation including the specific service determined to be *medically necessary* will be sent to you and your provider no later than 2 business days after the decision, and your provider will be initially notified by telephone within 24 hours of the decision for pre-service and concurrent reviews.
7. If the request fails to satisfy these criteria or medical policy, the request is referred to a Peer Clinical Reviewer. Peer Clinical Reviewers are health professionals clinically competent to evaluate the specific clinical aspects of the request and render an opinion specific to the medical condition, procedure and/or treatment under review. Peer Clinical Reviewers are licensed in California with the same license category as the requesting provider. When the Peer Clinical Reviewer is unable to certify the service, the requesting *physician* is contacted by telephone for a discussion of the case. In many cases, services can be certified after this discussion. If the Peer Clinical Reviewer is still unable to certify the service, your provider will be given the option of having the request reviewed by a different Peer Clinical Reviewer.
8. Only the Peer Clinical Reviewer may determine that the proposed services are not *medically necessary* and appropriate. Your *physician* will be notified by telephone within 24 hours of a decision not to certify and will be informed at that time of how to request reconsideration. Written notice will be sent to you and the requesting provider within two business days of the decision. This written notice will include:
 - an explanation of the reason for the decision,
 - reference of the criteria used in the decision to modify or not certify the request,
 - the name and phone number of the Peer Clinical Reviewer making the decision to modify or not certify the request,
 - how to request reconsideration if you or your provider disagree with the decision.
9. Reviewers may be plan employees or an independent third party chosen at the sole and absolute discretion of the *claims administrator*.

10. You or your *physician* may request copies of specific criteria and/or medical policy by writing to the address shown on your plan identification card. Medical necessity review procedures may be disclosed to health care providers through provider manuals and newsletters.

A determination of medical necessity does not guarantee payment or coverage. The determination that services are *medically necessary* is based on the clinical information provided. Payment is based on the terms of your coverage at the time of service. These terms include certain exclusions, limitations, and other conditions. Payment of benefits could be limited for a number of reasons, including:

- The information submitted with the claim differs from that given by phone;
- The service is excluded from coverage; or
- You are not eligible for coverage when the service is actually provided.

PERSONAL CASE MANAGEMENT

The personal case management program enables you to obtain medically appropriate care in a more economical, cost-effective and coordinated manner during prolonged periods of intensive medical care. The *claims administrator*, through a case manager, may recommend an alternative plan of treatment which may include services not covered under this *plan*. The *plan administrator* does not have an obligation to provide personal case management. These services are provided at the sole and absolute discretion of the *claims administrator*.

HOW PERSONAL CASE MANAGEMENT WORKS

You may be identified for possible personal case management through the *plan's* utilization review procedures, by the attending *physician*, *hospital* staff, or the *claims administrator's* claims reports. You or your family may also call the *claims administrator*.

Benefits for personal case management will be considered only when all of the following criteria are met:

1. You require extensive long-term treatment;
2. The *claims administrator* anticipates that such treatment utilizing services or supplies covered under this *plan* will result in considerable cost;
3. A cost-benefit analysis determines that the benefits payable under this *plan* for the alternative plan of treatment can be provided at a lower overall cost than the benefits you would otherwise receive under this *plan* while maintaining the same standards of care; and
4. You (or your legal guardian) and your *physician* agree, in a letter of agreement, with the *claims administrator's* recommended substitution of benefits and with the specific terms and conditions under which alternative benefits are to be provided.

Alternative Treatment Plan. If the claims administrator determines that your needs could be met more efficiently, an alternative treatment plan may be recommended. This may include providing benefits not otherwise covered under this plan. A case manager will review the medical records and discuss your treatment with the attending *physician*, you and your family.

The *claims administrators* make treatment recommendations only; any decision regarding treatment belongs to you and your *physician*. The *plan* will, in no way, compromise your freedom to make such decisions.

EFFECT ON BENEFITS

1. Benefits are provided for an alternative treatment plan on a case-by-case basis only. The *plan administrator* and *claims administrator* have absolute discretion in deciding whether or not to authorize services in lieu of benefits for any *beneficiary*, which alternatives may be offered and the terms of the offer.
2. Any authorization of services in lieu of benefits in a particular case in no way commits the *claims administrator* to do so in another case or for another *beneficiary*.
3. The personal case management program does not prevent the *claims administrator* from strictly applying the expressed benefits, exclusions and limitations of this *plan* at any other time or for any other *beneficiary*.

Note: The *claims administrator* reserves the right to use the services of one or more third parties in the performance of the services outlined in the letter of agreement. No other assignment of any rights or delegation of any duties by either party is valid without the prior written consent of the other party.

DISAGREEMENTS WITH MEDICAL MANAGEMENT DECISIONS

1. If you or your *physician* disagree with a decision, or question how it was reached, you or your *physician* may request reconsideration. Requests for reconsideration (either by telephone or in writing) must be directed to the reviewer making the determination. The address and the telephone number of the reviewer are included on your written notice of determination. Written requests must include medical information that supports the medical necessity of the services.
2. If you, your representative, or your *physician* acting on your behalf find the reconsidered decision still unsatisfactory, a request for an appeal of a reconsidered decision may be submitted in writing to us.
3. If the appeal decision is still unsatisfactory, your remedy may be binding arbitration. (See BINDING ARBITRATION.)

QUALITY ASSURANCE

Utilization review programs are monitored, evaluated, and improved on an ongoing basis to ensure consistency of application of screening criteria and medical policy, consistency and reliability of decisions by reviewers, and compliance with policy and procedure including but not limited to timeframes for decision making, notification and written confirmation. The Board of Directors is responsible for medical necessity review processes through its oversight committees including the Strategic Planning Committee, Quality Management Committee, and Physician Relations Committee. Oversight includes approval of policies and procedures, review and approval of self-audit tools, procedures, and results. Monthly process audits measure the performance of reviewers and Peer Clinical Reviewers against approved written policies, procedures, and timeframes. Quarterly reports of audit results and, when needed, corrective action plans are reviewed and approved through the committee structure.

GENERAL PROVISIONS

Providing of Care. We are not responsible for providing any type of *hospital*, medical or similar care, nor are we responsible for the quality of any such care received.

Independent Contractors. The *claims administrator's* relationship with providers is that of an independent contractor. *Physicians*, and other health care professionals, *hospitals*, *skilled nursing facilities* and other community agencies are not the *claims administrator's* agents nor is the *claims administrator*, or any of the employees of the *claims administrator*, an employee or agent of any *hospital*, medical group or medical care provider of any type.

Non-Regulation of Providers. The benefits of this *plan* do not regulate the amounts charged by providers of medical care, except to the extent that rates for covered services are regulated with *participating providers*.

Blue Cross and/or Blue Shield Providers. When you obtain covered health care services, the amount you pay, if it is not a flat dollar amount, is usually calculated on the lower of the:

- The billed charges for your covered services, or;
- The negotiated price that the on-site Blue Cross and/or Blue Shield Licensee ("Host Blue") passes on to us.

Often, this "negotiated price," referred to above, will consist of a simple discount which reflects the actual price paid by the Host Blue. But sometimes it is an estimated price that factors in expected settlements, withholds, any other contingent payment arrangements and non-claims transactions with your health care provider or with a specified group of providers. The negotiated price may also be billed charges reduced to reflect average expected savings with your health care provider or with a specified group of providers. If the negotiated price reflects average expected savings, it may result in greater variation (more or less) from the actual price paid than will the estimated price. The estimated or average price may be adjusted in the future to correct for over or underestimation of past prices. Regardless of how the negotiated price is determined, the amount you pay is considered a final price.

Statutes in a small number of states may require the Host Blue to use a basis for calculating *beneficiary* liability for covered services that does not reflect the entire savings realized, or expected to be realized, on a particular claim or to add a surcharge. Should any state statutes mandate *beneficiary* liability calculation methods that differ from the usual BlueCard Program method noted above in the second paragraph of this section or require a surcharge, the *claims administrator* would then calculate your liability for any covered health care services in accordance with the applicable state statute in effect at the time you received your care.

Providers available to you through the BlueCard Program have not entered into contracts with Anthem Blue Cross Life and Health. If you have any questions or complaints about the BlueCard Program, please call the customer service telephone number listed on your ID card.

Terms of Coverage

1. In order for you to be entitled to benefits under the *plan*, both the *plan* and your coverage under the *plan* must be in effect on the date the expense giving rise to a claim for benefits is incurred.
2. The benefits to which you may be entitled will depend on the terms of coverage in effect on the date the expense giving rise to a claim for benefits is incurred. An expense is incurred on the date you receive the service or supply for which the charge is made.
3. The *plan* is subject to amendment, modification or termination according to the provisions of the *plan* without your consent or concurrence.

Protection of Coverage. We do not have the right to cancel your coverage under this *plan* while: (1) this *plan* is in effect; (2) you are eligible; and (3) your required monthly contributions are paid according to the terms of the *plan*.

Free Choice of Provider. This *plan* in no way interferes with your right as a *beneficiary* entitled to *hospital* benefits to select a *hospital*. You may choose any *physician* who holds a valid *physician* and surgeon's certificate and who is a member of, or acceptable to, the attending staff and board of directors of the *hospital* where services are received. You may also choose any other health care professional or facility which provides care covered under this *plan*, and is properly licensed according to appropriate state and local laws. But your choice may affect the benefits payable according to this *plan*.

Medical Necessity. The benefits of this *plan* are provided only for services which the *claims administrator* determines to be *medically necessary*. The services must be ordered by the attending *physician* for the direct care and treatment of a covered condition. They must be standard medical practice where received for the condition being treated and must be legal in the United States. The process used to authorize or deny health care services under this *plan* is available to you upon request.

Expense in Excess of Benefits. We are not liable for any expense you incur in excess of the benefits of this *plan*.

Benefits Not Transferable. Only the *beneficiary* is entitled to receive benefits under this *plan*. The right to benefits cannot be transferred.

Notice of Claim. You or the provider of service must send the *claims administrator* properly and fully completed claim forms within 90 days of the date you receive the service or supply for which a claim is made. If it is not reasonably possible to submit the claim within that time frame, an extension of up to 24 months will be allowed. The *plan administrator* is not liable for the benefits of the *plan* if you do not file claims within the required time period. The *plan administrator* will not be liable for benefits if the *claims administrator* does not receive written proof of loss on time.

Services received and charges for the services must be itemized, and clearly and accurately described. Claim forms must be used; canceled checks or receipts are not acceptable.

Timely Payment of Claims. Any benefits due under this *plan* shall be due once the *claims administrator* has received proper, written proof of loss, together with such reasonably necessary additional information the *claims administrator* may require to determine our obligation.

Payment to Providers. The benefits of this *plan* will be paid directly to *participating providers* and medical transportation providers. Also, other providers of service will be paid directly when you assign benefits in writing. If another party pays for your medical care and you assign benefits in writing, the benefits of this *plan* will be paid to that party. These payments will fulfill our obligation to you for those covered services.

Exception: Under certain circumstances the *claims administrator* will pay the benefits of this *plan* directly to a provider or third party even without your assignment of benefits in writing. To receive direct payment, the provider or third party must provide them with the following:

1. Proof of payment of medical services and the provider's itemized bill for such services;
2. If the *employee* does not reside with the patient, either a copy of the judicial order requiring the *employee* to provide coverage for the patient or a state approved form verifying the existence of such judicial order which would be filed with us on an annual basis;
3. If the *employee* does not reside with the patient, and if the provider is seeking direct reimbursement, an itemized bill with the signature of the custodian or guardian certifying that the services have been provided and supplying on an annual basis, either a copy of the judicial order requiring the *employee* to provide coverage for the patient or a state approved form verifying the existence of such judicial order;
4. The name and address of the person to be reimbursed, the name and policy number of the *employee*, the name of the patient, and other necessary information related to the coverage.

Right of Recovery. When the amount we paid exceeds our liability under this *plan*, we have the right to recover the excess amount. This amount may be recovered from you, the person to whom payment was made or any other plan.

Plan Administrator - COBRA and ERISA. In no event will the *claims administrator* be *plan administrator* for the purposes of compliance with the Consolidated Omnibus Budget Reconciliation Act (COBRA) or the Employee Retirement Income Security Act (ERISA). The term "*plan administrator*" refers to Occidental Petroleum Corporation or to a person or entity other than the *claims administrator*, engaged by Occidental Petroleum Corporation to perform or assist in performing administrative tasks in connection with the *plan*. The *plan administrator* is responsible for satisfaction of notice, disclosure and other obligations of administrators under ERISA. In providing notices and otherwise performing, the *plan administrator* is fulfilling statutory obligations imposed on it by federal law and, where applicable, acting as your agent.

Workers' Compensation Insurance. The *plan* does not affect any requirement for coverage by workers' compensation insurance. It also does not replace that insurance.

Prepayment Fees. The *plan administrator* may require that you contribute all or part of the costs of these required monthly contributions. Please consult your *plan administrator* for details.

Liability to Pay Providers. In the event that the *plan* does not pay a provider who has provided benefits to you, you will be required to pay that provider any amounts not paid to them by the *plan*.

Renewal Provisions. The *plan* is subject to renewal at certain intervals. The required monthly contribution or other terms of the *plan* may be changed from time to time.

Financial Arrangements with Providers. The *claims administrator* or an affiliate has contracts with certain health care providers and suppliers (hereafter referred to together as "Providers") for the provision of and payment for health care services rendered to its members and *beneficiaries* entitled to health care benefits under individual certificates and group policies or contracts to which *claims administrator* or an affiliate is a party, including all persons covered under the *plan*.

Under the above-referenced contracts between Providers and *claims administrator* or an affiliate, the negotiated rates paid for certain medical services provided to persons covered under the *plan* may differ from the rates paid for persons covered by other types of products or programs offered by the *claims administrator* or an affiliate for the same medical services. In negotiating the terms of the *plan*, the *plan administrator* was aware that the *claims administrator* or its affiliates offer several types of products and programs. The members, *beneficiaries* and *plan administrator* are entitled to receive the benefits of only those discounts, payments, settlements, incentives, adjustments and/or allowances specifically set forth in the *plan*.

Also, under arrangements with some Providers certain discounts, payments, rebates settlements, incentives, adjustments and/or allowances, including, but not limited to, pharmacy rebates, may be based on aggregate payments made by the *claims administrator* or an affiliate in respect to all health care services rendered to all persons who have coverage through a program provided or administered by the *claims administrator* or an affiliate. They are not attributed to specific claims or plans and do not inure to the benefit of any covered individual or group, but may be considered by the *claims administrator* or an affiliate in determining its fees or subscription charges or premiums.

Certificate of Creditable Coverage. Certificates of creditable coverage are issued automatically when your coverage under this *plan* ends. We will also provide a certificate of creditable coverage in response to your request, or to a request made on your behalf, at any time while you are covered under this *plan* and up to 24 months after your coverage under this *plan* ends. The certificate of creditable coverage documents your coverage under this *plan*. To request a certificate of creditable coverage, please call OxyLink at 800-699-6903.

Continuity of Care after Termination of Provider: Subject to the terms and conditions set forth below, benefits will be provided at the *participating provider* level for covered services (subject to applicable copayments, coinsurance, deductibles and other terms) received from a provider at the time the provider's contract is terminated by a BlueCard PPO Network or Blue Cross or Blue Shield plan (unless the provider's contract is terminated for reasons of medical disciplinary cause or reason, fraud, or other criminal activity). This does not apply to a provider who voluntarily terminates his or her contract.

You must be under the care of the *participating provider* at the time the provider's contract terminates. The terminated provider must agree in writing to provide services to you in accordance with the terms and conditions of his or her agreement with the BlueCard PPO Network or Blue Cross or Blue Shield plan prior to termination. The provider must also agree in writing to accept the terms and reimbursement rates under his or her agreement with the BlueCard PPO Network or Blue Cross or Blue Shield plan prior to termination. If the provider does not agree with these contractual terms and conditions, the provider's services will not be continued beyond the contract termination date.

Benefits for the completion of covered services by a terminated provider will be provided only for the following conditions:

1. An acute condition. An acute condition is a medical condition that involves a sudden onset of symptoms due to an illness, injury, or other medical problem that requires prompt medical attention and that has a limited duration. Completion of covered services shall be provided for the duration of the acute condition.
2. A serious chronic condition. A serious chronic condition is a medical condition caused by a disease, illness, or other medical problem or medical disorder that is serious in nature and that persists without full cure or worsens over an extended period of time or requires ongoing treatment to maintain remission or prevent deterioration. Completion of covered services shall be provided for a period of time necessary to complete a course of treatment and to arrange for a safe transfer to another provider, as determined by the *claims administrator* in consultation with you and the terminated provider and consistent with good professional practice. Completion of covered services shall not exceed twelve (12) months from the date the provider's contract terminates.
3. A pregnancy. A pregnancy is the three trimesters of pregnancy and the immediate postpartum period. Completion of covered services shall be provided for the duration of the pregnancy.

4. A terminal illness. A terminal illness is an incurable or irreversible condition that has a high probability of causing death within one (1) year or less. Completion of covered services shall be provided for the duration of the terminal illness.
5. The care of a newborn *child* between birth and age thirty-six (36) months. Completion of covered services shall not exceed twelve (12) months from the date the provider's contract terminates.
6. Performance of a surgery or other procedure that the *claims administrator* has authorized as part of a documented course of treatment and that has been recommended and documented by the provider to occur within 180 days of the date the provider's contract terminates.

Please contact customer service at the telephone number listed on your ID card to request continuity of care or to obtain a copy of the written policy. Eligibility is based on your clinical condition and is not determined by diagnostic classifications. Continuity of care does not provide coverage for services not otherwise covered under the *plan*.

You will be notified by telephone, and the provider by telephone and fax, as to whether or not your request for continuity of care is approved. If approved, you will be financially responsible only for applicable deductibles, coinsurance, and copayments under the *plan*. Financial arrangements with terminated providers are negotiated on a case-by-case basis. The terminated provider will be asked to agree to accept reimbursement and contractual requirements that apply to *participating providers*, including payment terms. If the terminated provider does not agree to accept the same reimbursement and contractual requirements, that provider's services will not be continued. If you disagree with the determination regarding continuity of care, you may file a complaint as described in the COMPLAINT NOTICE.

BINDING ARBITRATION

Because your coverage is provided under an employer sponsored plan subject to ERISA, certain disputes may not be subject to this Binding Arbitration provision.

Any dispute or claim, of whatever nature, arising out of, in connection with, or in relation to this *plan* or breach or rescission thereof, or in relation to care or delivery of care, including any claim based on contract, tort, or statute, must be resolved by arbitration if the amount sought exceeds the jurisdictional limit of the small claims court. Any dispute or claim within the jurisdictional limits of the small claims court will be resolved in such court.

The Federal Arbitration Act will govern the interpretation and enforcement of all proceedings under this Binding Arbitration provision. To the extent that the Federal Arbitration Act is inapplicable, or is held not to require arbitration of a particular claim, state law governing agreements to arbitrate will apply.

The *beneficiary* and the *plan administrator* agree to be bound by this Binding Arbitration provision and acknowledge that they are each giving up their right to a trial by court or jury.

The *beneficiary* and the *plan administrator* agree to give up the right to participate in class arbitration against each other. Even if applicable law permits class arbitration, the *beneficiary* waives any right to pursue, on a class basis, any such controversy or claim against the *plan administrator* and the *plan administrator* waives any right to pursue on a class basis any such controversy or claim against the *beneficiary*.

The arbitration findings will be final and binding except to the extent that state or Federal law provides for the judicial review of arbitration proceedings.

The arbitration is begun by the *beneficiary* making written demand on the *plan administrator*. The arbitration will be conducted by Judicial Arbitration and Mediation Services (“JAMS”) according to its applicable Rules and Procedures. If, for any reason, JAMS is unavailable to conduct the arbitration, the arbitration will be conducted by another neutral arbitration entity, by mutual agreement of the *beneficiary* and the *plan administrator*, or by order of the court, if the *beneficiary* and the *plan administrator* cannot agree. The arbitration will be held at a time and location mutually agreeable to the beneficiary and the *plan administrator*.

DEFINITIONS

The meanings of key terms used in this *plan description* are shown below. Whenever any of the key terms shown below appear, it will appear in italicized letters. When any of the terms below are italicized in your *plan description*, you should refer to this section.

Accidental injury is physical harm or disability which is the result of a specific unexpected incident caused by an outside force. The physical harm or disability must have occurred at an identifiable time and place. Accidental injury does not include illness or infection, except infection of a cut or wound.

Ambulatory surgical center is a freestanding outpatient surgical facility. It must be licensed as an outpatient clinic according to state and local laws and must meet all requirements of an outpatient clinic providing surgical services. It must also meet accreditation standards of the Joint Commission on Accreditation of Health Care Organizations or the Accreditation Association of Ambulatory Health Care.

Authorized referral occurs when you, because of your medical needs, are referred to a *non-participating provider*, but only when:

1. There is no *participating provider* who practices in the appropriate specialty, which provides the required services, or which has the necessary facilities within a 50-mile radius of your residence; and
2. The *claims administrator* has authorized the referral before services are rendered.

You or your *physician* must call the toll-free telephone number printed on your identification card prior to scheduling an admission to, or receiving the services of, a *non-participating provider*.

Beneficiary is the *employee* or *dependent*.

Birth Center is a facility licensed by the state or approved by us to provide prenatal, birth, postpartum, newborn and gynecologic services to pregnant women.

Child meets the *plan's* eligibility requirements for children.

Claims administrator refers to Anthem Blue Cross Life and Health Insurance Company. On behalf of Anthem Blue Cross Life and Health Insurance Company, Anthem Blue Cross shall perform all administrative services in connection with the processing of claims under the *plan*.

Covered expense is the expense you incur for a covered service or supply, but not more than the maximum amounts described in YOUR MEDICAL BENEFITS: HOW COVERED EXPENSE IS DETERMINED. Expense is incurred on the date you receive the service or supply.

Creditable coverage is any individual or group plan that provides medical, hospital and surgical coverage, including continuation or conversion coverage, coverage under Medicare or Medicaid, TRICARE, the Federal Employees Health Benefits Program, programs of the Indian Health Service or of a tribal organization, a state health benefits risk pool, coverage through the Peace Corps, the State Children's Health Insurance Program, or a public health plan established or maintained by a state, the United States government, or a foreign country. Creditable coverage does not include accident only, credit, coverage for on-site medical clinics, disability income, coverage only for a specified disease or condition, hospital indemnity or other fixed indemnity insurance, Medicare supplement, long-term care insurance, dental, vision, workers' compensation insurance, automobile insurance, no-fault insurance, or any medical coverage designed to supplement other private or governmental plans. Creditable coverage is used to set up eligibility rules for children who cannot get a self-sustaining job due to a physical or mental condition.

If your prior coverage was through an employer, you will receive credit for that coverage if it ended because your employment ended, the availability of medical coverage offered through employment or sponsored by the employer terminated, or the employer's contribution toward medical coverage terminated, and any lapse between the date that coverage ended and the date you become eligible under this *plan* is no more than 180 days (not including any waiting period imposed under this *plan*).

If your prior coverage was not through an employer, you will receive credit for that coverage if any lapse between the date that coverage ended and the date you become eligible under this *plan* is no more than 63 days (not including any waiting period imposed under this *plan*).

Custodial care is care provided primarily to meet your personal needs. This includes help in walking, bathing or dressing. It also includes preparing food or special diets, feeding, administration of medicine which is usually self-administered or any other care which does not require continuing services of medical personnel.

Customary and reasonable charge, as determined annually by the *claims administrator*, is a charge which falls within the common range of fees billed by a majority of *physicians* for a procedure in a given geographic region. If it exceeds that range, the expense must be justified based on the complexity or severity of treatment for a specific case.

Day treatment center is an outpatient psychiatric facility which is part of or affiliated with a *hospital*. It must be licensed according to state and local laws to provide outpatient care and treatment of *mental or nervous disorders* or substance abuse under the supervision of *physicians*.

Dependent meets the *plan's* eligibility requirements for dependents.

Effective date is the date your coverage begins under this *plan*.

Emergency is a sudden, serious, and unexpected acute illness, injury, or condition which the *beneficiary* reasonably perceives could permanently endanger health if medical treatment is not received immediately. The *claims administrator* will have sole and final determination as to whether services were rendered in connection with an emergency.

Emergency services are services provided in connection with the initial treatment of a medical or psychiatric *emergency*.

Employee is the person who, by meeting the *plan's* eligibility requirements for employees, is allowed to choose membership under this *plan* for himself or herself and his or her eligible *dependents*.

Experimental procedures are those that are mainly limited to laboratory and/or animal research.

Full-time employee meets the *plan's* eligibility requirements for full-time employees.

Home health agencies are home health care providers which are licensed according to state and local laws to provide skilled nursing and other services on a visiting basis in your home, and recognized as home health providers under Medicare and/or accredited by a recognized accrediting agency such as the Joint Commission on the Accreditation of Healthcare Organizations.

Home infusion therapy provider is a provider licensed according to state and local laws as a pharmacy, and must be either certified as a home health care provider by Medicare, or accredited as a home pharmacy by the Joint Commission on Accreditation of Health Care Organizations.

Hospice is an agency or organization primarily engaged in providing palliative care (pain control and symptom relief) to terminally ill persons and supportive care to those persons and their families to help them cope with terminal illness. This care may be provided in the home or on an inpatient basis. A hospice must be: (1) certified by Medicare as a hospice; (2) recognized by Medicare as a hospice demonstration site; or (3) accredited as a hospice by the Joint Commission on Accreditation of Hospitals. A list of hospices meeting these criteria is available upon request.

Hospital is a facility which provides diagnosis, treatment and care of persons who need acute inpatient hospital care under the supervision of *physicians*. It must be licensed as a general acute care hospital according to state and local laws. It must also be registered as a general hospital by the American Hospital Association and meet accreditation standards of the Joint Commission on Accreditation of Health Care Organizations.

For the limited purpose of inpatient care, the definition of hospital also includes: (1) *psychiatric health facilities* (only for the acute phase of a *mental or nervous disorder*), and (2) *residential treatment centers*.

Infertility is: (1) the presence of a condition recognized by a *physician* as a cause of infertility; or (2) the inability to conceive a pregnancy or to carry a pregnancy to a live birth after a year or more of regular sexual relations without contraception.

Investigative procedures or medications are those that have progressed to limited use on humans, but which are not widely accepted as proven and effective within the organized medical community.

Medically necessary procedures, supplies equipment or services are those the *claims administrator* determines to be:

1. Appropriate and necessary for the diagnosis or treatment of the medical condition;
2. Provided for the diagnosis or direct care and treatment of the medical condition;
3. Within standards of good medical practice within the organized medical community;
4. Not primarily for your convenience, or for the convenience of your *physician* or another provider; and
5. The most appropriate procedure, supply, equipment or service which can safely be provided. The most appropriate procedure, supply, equipment or service must satisfy the following requirements:
 - a. There must be valid scientific evidence demonstrating that the expected health benefits from the procedure, supply, equipment or service are clinically significant and produce a greater likelihood of benefit, without a disproportionately greater risk of harm or complications, for you with the particular medical condition being treated than other possible alternatives; and
 - b. Generally accepted forms of treatment that are less invasive have been tried and found to be ineffective or are otherwise unsuitable; and
 - c. For *hospital stays*, acute care as an inpatient is necessary due to the kind of services you are receiving or the severity of your condition, and safe and adequate care cannot be received by you as an outpatient or in a less intensified medical setting.

Mental or nervous disorders are conditions that affect thinking and the ability to figure things out, perception, mood and behavior. A mental or nervous disorder is recognized primarily by symptoms or signs that appear as distortions of normal thinking, distortions of the way things are perceived (e.g., seeing or hearing things that are not there), moodiness, sudden and/or extreme changes in mood, depression, and/or unusual behavior such as depressed behavior or highly agitated or manic behavior.

Some mental or nervous disorders are: schizophrenia, manic-depressive and other conditions usually classified in the medical community as psychosis; drug, alcohol and other substance addiction or abuse; depressive, phobic, manic and anxiety conditions (including panic disorders); bipolar affective disorders including mania and depression; obsessive compulsive disorders; hypochondria; personality disorders (including paranoid, schizoid, dependent, anti-social and borderline); dementia and delirious states; post traumatic stress disorder; adjustment reactions; reactions to stress; hyperkinetic syndromes; attention deficit disorders; learning disabilities; conduct disorder; oppositional disorder; mental retardation; autistic disease of childhood; anorexia nervosa and bulimia.

Any condition meeting this definition is a mental or nervous disorder no matter what the cause of the condition may be.

Negotiated rate is the amount *participating providers* agree to accept as payment in full for covered services. It is usually lower than their normal charge. Negotiated rates are determined by Participating Provider Agreements.

Non-participating provider is a *hospital or physician* NOT participating in a BlueCard PPO Network or Blue Cross and/or Blue Shield Plan at the time services are rendered. They are not *participating providers*. Remember that only a portion of the amount which a *non-participating provider* charges for services may be treated as *covered expense* under this *plan*. See YOUR MEDICAL BENEFITS: HOW COVERED EXPENSE IS DETERMINED.

Other health care provider is one of the following providers:

1. A certified registered nurse anesthetist;
2. A blood bank;
3. A licensed ambulance company; or
4. A *hospice*.

The provider must be licensed according to state and local laws to provide covered medical services.

Participating provider is a *hospital or physician* participating in a BlueCard PPO Network or Blue Cross and/or Blue Shield Plan at the time services are rendered. *Participating providers* agree to accept the *negotiated rate* as payment for covered services. A directory of *participating providers* is available upon request.

Physician means:

1. A doctor of medicine (M.D.) or doctor of osteopathy (D.O.) who is licensed to practice medicine or osteopathy where the care is provided; or
2. One of the following providers, but only when the provider is licensed to practice where the care is provided, is rendering a service within the scope of that license, is providing a service for which benefits are specified in this booklet, and when benefits would be payable if the services were provided by a physician as defined above:
 - a. A dentist (D.D.S. or D.M.D.)
 - b. An optometrist (O.D.)
 - c. A dispensing optician
 - d. A podiatrist or chiropodist (D.P.M., D.S.P. or D.S.C.)
 - e. A licensed clinical psychologist
 - f. A chiropractor (D.C.)
 - g. An acupuncturist (A.C.)
 - h. A licensed midwife
 - i. A clinical social worker (L.C.S.W.)
 - j. A marriage and family therapist (M.F.T.)
 - k. A physical therapist (P.T. or R.P.T.)*
 - l. A speech pathologist*
 - m. An audiologist*
 - n. An occupational therapist (O.T.R.)*
 - o. A respiratory care practitioner (R.C.P.)*
 - p. A *psychiatric mental health nurse* (R.N.)*
 - q. A registered dietitian (R.D.)* for the provision of diabetic medical nutrition therapy only

***Note:** The providers indicated by asterisks (*) are covered only by referral of a physician as defined in 1 above.

Plan is the set of benefits described in this plan description and in the amendments to this *plan description*, if any. These benefits are subject to the terms and conditions of the *plan*. If changes are made to the plan, an amendment or revised *plan description* will be issued to each *employee* affected by the change. (The word "plan" here does not mean the same as "plan" as used in ERISA.)

Plan administrator refers to OCCIDENTAL PETROLEUM CORPORATION, the entity which is responsible for the administration of the *plan*.

Plan description is this written description of the benefits provided under the *plan*.

Preventive Care Services include routine examinations, screenings, tests, education, and immunizations administered with the intent of preventing future disease, illness, or injury. Services are considered preventive if you have no current symptoms or prior history of a medical condition associated with that screening or service. These services shall meet requirements as determined by federal and state law. Sources for determining which services are recommended include the following:

1. Services with an "A" or "B" rating from the United States Preventive Services Task Force (USPSTF);
2. Immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;
3. Preventive care and screenings for infants, children, and adolescents as provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; and
4. Additional preventive care and screening for women provided for in the guidelines supported by the Health Resources and Services Administration.

Please call the customer service number listed on your ID card for additional information about services that are covered by this *plan* as preventive care services. You may also refer to the following websites that are maintained by the U.S. Department of Health & Human Services.

<http://www.healthcare.gov/center/regulations/prevention.html>

<http://www.ahrq.gov/clinic/uspstfix.htm>

<http://www.cdc.gov/vaccines/recs/acip/>

Prior plan is a plan sponsored by us which was replaced by this *plan* within 60 days. You are considered covered under the prior plan if you: (1) were covered under the prior plan on the date that plan terminated; (2) properly enrolled for coverage within 31 days of this *plan's* Effective Date; and (3) had coverage terminate solely due to the prior plan's termination.

Prosthetic devices are appliances which replace all or part of a function of a permanently inoperative, absent or malfunctioning body part. The term "prosthetic devices" includes orthotic devices, rigid or semi-supportive devices which restrict or eliminate motion of a weak or diseased part of the body.

Psychiatric health facility is an acute 24-hour facility operating within the scope of a state license, or in accordance with a license waiver issued by the State. It must be:

1. Qualified to provide short-term inpatient treatment according to state law;
2. Accredited by the Joint Commission on Accreditation of Health Care Organizations; and

3. Staffed by an organized medical or professional staff which includes a *physician* as medical director.

Psychiatric mental health nurse is a registered nurse (R.N.) who has a master's degree in psychiatric mental health nursing, and is registered as a psychiatric mental health nurse with the state board of registered nurses.

Reasonable charge is a charge the *claims administrator* considers not to be excessive based on the circumstances of the care provided, including: (1) level of skill; experience involved; (2) the prevailing or common cost of similar services or supplies; and (3) any other factors which determine value.

Residential treatment center is an inpatient treatment facility where the *beneficiary* resides in a modified community environment and follows a comprehensive medical treatment regimen for treatment and rehabilitation as the result of a *mental or nervous disorder* or substance abuse. The facility must be licensed to provide psychiatric treatment of *mental or nervous disorders* or rehabilitative treatment of substance abuse according to state and local laws.

Skilled nursing facility is an institution that provides continuous skilled nursing services. It must be licensed according to state and local laws and be recognized as a skilled nursing facility under Medicare. The term "skilled nursing facility" includes *residential treatment center*.

Special care units are special areas of a *hospital* which have highly skilled personnel and special equipment for acute conditions that require constant treatment and observation.

Specialist is a *physician* who is not a general practitioner, internist, family practitioner, nurse practitioner, pediatrician, gynecologist, obstetrician, or certified nurse midwife.

Spouse meets the *plan's* eligibility requirements for spouses.

Stay is inpatient confinement which begins when you are admitted to a facility and ends when you are discharged from that facility.

Totally disabled dependent is a *dependent* who is unable to perform all activities usual for persons of that age.

Totally disabled employee is an *employees* who, because of illness or injury, is unable to work for income in any job for which he/she is qualified or for which they become qualified by training or experience, and who are in fact unemployed.

Urgent care is the services received for a sudden, serious, or unexpected illness, injury or condition, other than one which is life threatening, which requires immediate care for the relief of severe pain or diagnosis and treatment of such condition.

We (us, our) refers to OCCIDENTAL PETROLEUM CORPORATION.

Year or calendar year is a 12 month period starting January 1 at 12:01 a.m. Pacific Standard Time.

You (your) refers to the *employee* and *dependents* who are enrolled for benefits under this *plan*.

YOUR RIGHT TO APPEALS

For purposes of these Appeal provisions, “claim for benefits” means a request for benefits under the *plan*. The term includes both pre-service and post-service claims.

- A pre-service claim is a claim for benefits under the *plan* for which you have not received the benefit or for which you may need to obtain approval in advance.
- A post-service claim is any other claim for benefits under the *plan* for which you have received the service.

If your claim is denied:

- you will be provided with a written notice of the denial; and
- you are entitled to a full and fair review of the denial.

The procedure the *claims administrator* will satisfy following the minimum requirements for a full and fair review under applicable federal regulations.

Notice of Adverse Benefit Determination

If your claim is denied, the *claims administrator's* notice of the adverse benefit determination (denial) will include:

- information sufficient to identify the claim involved;
- the specific reason(s) for the denial;
- a reference to the specific *plan* provision(s) on which the *claims administrator's* determination is based;
- a description of any additional material or information needed to perfect your claim;
- an *explanation* of why the additional material or information is needed;
- a description of the *plan's* review procedures and the time limits that apply to them, including a statement of your right to bring a civil action under ERISA (if applicable) if you appeal and the claim denial is upheld;
- information about any internal rule, guideline, protocol, or other similar criterion relied upon in making the claim determination and about your right to request a copy of it free of charge, along with a discussion of the claims denial decision;
- information about the scientific or clinical judgment for any determination based on medical necessity or experimental treatment, or about your right to request this explanation free of charge, along with a discussion of the claims denial decision; and

- the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman who may assist you.

For claims involving urgent/concurrent care:

- the *claims administrator's* notice will also include a description of the applicable urgent/concurrent review process; and
- the *claims administrator* may notify you or your authorized representative within 24 hours orally and then furnish a written notification.

Appeals

You have the right to appeal an adverse benefit determination (claim denial). You or your authorized representative must file your appeal within 180 calendar days after you are notified of the denial. You will have the opportunity to submit written comments, documents, records, and other information supporting your claim. The *claims administrator's* review of your claim will take into account all information you submit, regardless of whether it was submitted or considered in the initial benefit determination.

- The *claims administrator* shall offer a single mandatory level of appeal and an additional voluntary second level of appeal which may be a panel review, independent review, or other process consistent with the entity reviewing the appeal. The time frame allowed for the *claims administrator* to complete its review is dependent upon the type of review involved (e.g. pre-service, concurrent, post-service, urgent, etc.).

For pre-service claims involving urgent/concurrent care, you may obtain an expedited appeal. You or your authorized representative may request it orally or in writing. All necessary information, including the *claims administrator's* decision, can be sent between the *claims administrator* and you by telephone, facsimile or other similar method. To file an appeal for a claim involving urgent/concurrent care, you or your authorized representative must contact the *claims administrator* at the phone number listed on your ID card and provide at least the following information:

- the identity of the claimant;
- the date (s) of the medical service;
- the specific medical condition or symptom;
- the provider's name;
- the service or supply for which approval of benefits was sought; and
- any reasons why the appeal should be processed on a more expedited basis.

All other requests for appeals should be submitted in writing by the Member or the Member's authorized representative, except where the acceptance of oral appeals is otherwise required by

the nature of the appeal (e.g. urgent care). You or your authorized representative must submit a request for review to:

Anthem Blue Cross Life and Health Insurance Company
ATTN: Appeals
P.O. Box 54159, Los Angeles, CA 90054

Upon request, the *claims administrator* will provide, without charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim. "Relevant" means that the document, record, or other information:

- was relied on in making the benefit determination; or
- was submitted, considered, or produced in the course of making the benefit determination; or
- demonstrates compliance with processes and safeguards to ensure that claim determinations are made in accordance with the terms of the *plan*, applied consistently for similarly-situated claimants; or
- is a statement of the *plan's* policy or guidance about the treatment or benefit relative to your diagnosis.

The *claims administrator* will also provide you, free of charge, with any new or additional evidence considered, relied upon, or generated in connection with your claim. In addition, before you receive an adverse benefit determination on review based on a new or additional rationale, the *claims administrator* will provide you, free of charge, with the rationale.

How Your Appeal will be Decided

When the *claims administrator* considers your appeal, the *claims administrator* will not rely upon the initial benefit determination or, for voluntary second-level appeals, to the earlier appeal determination. The review will be conducted by an appropriate reviewer who did not make the initial determination and who does not work for the person who made the initial determination. A voluntary second-level review will be conducted by an appropriate reviewer who did not make the initial determination or the first-level appeal determination and who does not work for the person who made the initial determination or first-level appeal determination.

If the denial was based in whole or in part on a medical judgment, including whether the treatment is experimental, investigational, or not *medically necessary*, the reviewer will consult with a health care professional who has the appropriate training and experience in the medical field involved in making the judgment. This health care professional will not be one who was consulted in making an earlier determination or who works for one who was consulted in making an earlier determination.

Notification of the Outcome of the Appeal

If you appeal a claim involving urgent/concurrent care, the *claims administrator* will notify you of the outcome of the appeal as soon as possible, but not later than 72 hours after receipt of your request for appeal.

If you appeal any other pre-service claim, the *claims administrator* will notify you of the outcome of the appeal within 30 days after receipt of your request for appeal.

If you appeal a post-service claim, the *claims administrator* will notify you of the outcome of the appeal within 60 days after receipt of your request for appeal.

Appeal Denial

- If your appeal is denied, that denial will be considered an adverse benefit determination. The notification from the *claims administrator* will include all of the information set forth in the above subsection entitled "Notice of Adverse Benefit Determination."

Voluntary Second Level Appeals

If you are dissatisfied with the *Plan's* mandatory first level appeal decision, a voluntary second level appeal may be available. If you would like to initiate a second level appeal, please write to the address listed above. Voluntary appeals must be submitted within 60 calendar days of the denial of the first level appeal. You are not required to complete a voluntary second level appeal prior to submitting a request for an independent External Review.

External Review

If the outcome of the mandatory first level appeal is adverse to you, you may be eligible for an independent External Review pursuant to federal law.

You must submit your request for External Review to the *claims administrator* within four (4) months of the notice of your final internal adverse determination.

A request for a External Review must be in writing unless the *claims administrator* determines that it is not reasonable to require a written statement. You do not have to re-send the information that you submitted for internal appeal. However, you are encouraged to submit any additional information that you think is important for review.

For pre-service claims involving urgent/concurrent care, you may proceed with an Expedited External Review without filing an internal appeal or while simultaneously pursuing an expedited appeal through our internal appeal process. You or your authorized representative may request it orally or in writing. All necessary information, including the *claims administrator's* decision, can be sent between the *claims administrator* and you by telephone, facsimile or other similar method. To proceed with an Expedited External Review, you or your authorized representative must contact the *claims administrator* at the phone number listed on your ID card and provide at least the following information:

- the identity of the claimant;
- the date (s) of the medical service;
- the specific medical condition or symptom;
- the provider's name;
- the service or supply for which approval of benefits was sought; and
- any reasons why the appeal should be processed on a more expedited basis.

All other requests for External Review should be submitted in writing unless the *claims administrator* determines that it is not reasonable to require a written statement. Such requests should be submitted by you or your authorized representative to:

Anthem Blue Cross Life and Health Insurance Company
ATTN: Appeals
P.O. Box 54159, Los Angeles, CA 90054

This is not an additional step that you must take in order to fulfill your appeal procedure obligations described above. Your decision to seek External Review will not affect your rights to any other benefits under this health care *plan*. There is no charge for you to initiate an independent External Review. The External Review decision is final and binding on all parties except for any relief available through applicable state laws or ERISA (if applicable).

Requirement to file an Appeal before filing a lawsuit

No lawsuit or legal action of any kind related to a benefit decision may be filed by you in a court of law or in any other forum, unless it is commenced within three years of the *Plan's* final decision on the claim or other request for benefits. If the *Plan* decides an appeal is untimely, the *Plan's* latest decision on the merits of the underlying claim or benefit request is the final decision date. You must exhaust the *Plan's* internal Appeals Procedure but not including any voluntary level of appeal, before filing a lawsuit or taking other legal action of any kind against the *Plan*.

If your health benefit *plan* is sponsored by your employer and subject to the Employee Retirement Income Security Act of 1974 (ERISA) and your appeal as described above results in an adverse benefit determination, you have a right to bring a civil action under Section 502(a) of ERISA.

We reserve the right to modify the policies, procedures and timeframes in this section upon further clarification from Department of Health and Human Services and Department of Labor.

FOR YOUR INFORMATION

CLAIMS DISCLOSURE NOTICE REQUIRED BY ERISA

The plan document and this booklet contain information on reporting claims, including the time limitations on submitting a claim. Claim forms may be obtained from the Plan Administrator or from the Claims Administrator. (Note that the Claims Administrator is not the Plan Administrator nor the administrator for the purposes of ERISA.) In addition to this information, ERISA applies some additional claim procedure rules. The additional rules required by ERISA are set forth below.

Urgent Care. The Claims Administrator must notify you, within 72 hours after they receive your request for benefits, that they have it and what they determine your benefits to be. If your request for benefits does not contain all the necessary information, they must notify you within 24 hours after they get it and tell you what information is missing. Any notice to you by them will be orally, by telephone, or in writing by facsimile or other fast means. You have at least 48 hours to give them the additional information they need to process your request for benefits. You may give them the additional information they need orally, by telephone, or in writing by facsimile or other fast means.

If your request for benefits is denied in whole or in part, you will receive a notice of the denial within 72 hours after the Claims Administrator's receipt of the request for benefits, or 48 hours after receipt of all the information they need to process your request for benefits if the information is received within the time frame noted above. The notice will explain the reason for the adverse benefit determination and the plan provisions upon which the denial decision was based. You have 180 days to appeal their adverse benefit determination. You may appeal their decision orally, by telephone, or in writing by facsimile or other fast means. Within 72 hours after they receive your appeal, they must notify you of their decision, except as otherwise noted below. They will notify you orally, by telephone, or in writing by facsimile or other fast means. If your request for benefits is no longer considered urgent, it will be handled in the same manner as a Non-Urgent Care Pre-Service or Post-service appeal, depending upon the circumstances.

Non-Urgent Care Pre-Service (when care has not yet been received). The Claims Administrator must notify you within 15 days after they receive your request for benefits that they have it and what they have determined your benefits to be. If they need more than 15 days to determine your benefits, due to reasons beyond their control, they must notify you within that 15-day period that they need more time to determine your benefits. But, in any case, even with an extension, they cannot take more than 30 days to determine your benefits. If you do not properly submit all the necessary information for your request for benefits to them, they must notify you, within 5 days after they get it and tell you what information is missing. You have 45 days to provide them with the information they need to process your request for benefits. The time period during which the Claims Administrator is waiting for receipt of the necessary information is not counted toward the time frame in which the Claims Administrator must make the benefit determination.

If your request for benefits is denied in whole or in part, you will receive a written notice of the denial within the time frame stated above after the Claims Administrator has all the information

they need to process your request for benefits, if the information is received within the time frame noted above. The written notice will explain the reason for the adverse benefit determination and the plan provisions upon which the denial decision is based. You have 180 days to appeal their adverse benefit determination. Your appeal must be in writing. Within 30 days after they receive your appeal, they must notify you of their decision about it. Their notice of their decision will be in writing.

Concurrent Care Decisions:

- **Reduction of Benefits** – If, after approving a request for benefits in connection with your illness or injury, the Claims Administrator decides to reduce or end the benefits they have approved for you, in whole or in part:
 - They must notify you sufficiently in advance of the reduction in benefits, or the end of benefits, to allow you the opportunity to appeal their decision before the reduction in benefits or end of benefits occurs. In their notice to you, the Claims Administrator must explain their reason for reducing or ending your benefits and the plan provisions upon which the decision was made.
 - To keep the benefits you already have approved, you must successfully appeal the Claims Administrator’s decision to reduce or end those benefits. You must make your appeal to them at least 24 hours prior to the occurrence of the reduction or ending of benefits. If you appeal the decision to reduce or end your benefits when there is less than 24 hours to the occurrence of the reduction or ending of benefits, your appeal may be treated as if you were appealing an urgent care denial of benefits (see the section “Urgent Care,” above), depending upon the circumstances of your condition.
 - If the Claims Administrator receives your appeal for benefits at least 24 hours prior to the occurrence of the reduction or ending of benefits, they must notify you of their decision regarding your appeal within 24 hours of their receipt of it. If the Claims Administrator denies your appeal of their decision to reduce or end your benefits, in whole or in part, they must explain the reason for their denial of benefits and the plan provisions upon which the decision was made. You may further appeal the denial of benefits according to the rules for appeal of an urgent care denial of benefits (see the section “Urgent Care,” above).
- **Extension of Benefits** – If, while you are undergoing a course of treatment in connection with your illness or injury, for which benefits have been approved, you would like to request an extension of benefits for additional treatments:
 - You must make a request to the Claims Administrator for the additional benefits at least 24 hours prior to the end of the initial course of treatment that had been previously approved for benefits. If you request additional benefits when there is less than 24 hours till the end of the initially prescribed course of treatment, your request will be handled as if it was a new request for benefits and not an extension and, depending on the

circumstances, it may be handled as an Urgent or Non-Urgent Care Pre-service request for benefits.

- If the Claims Administrator receives your request for additional benefits at least 24 hours prior to the end of the initial course of treatment, previously approved for benefits, they must notify you of their decision regarding your request within 24 hours of their receipt of it if your request is for urgent care benefits. If the Claims Administrator denies your request for additional benefits, in whole or in part, they must explain the reason for their denial of benefits and the plan provisions upon which the decision was made. You may appeal the adverse benefit determination according to the rules for appeal for Urgent, Pre-Service or Post-Service adverse benefit determinations, depending upon the circumstances.

Non - Urgent Care Post-Service (reimbursement for cost of medical care). The Claims Administrator must notify you, within 30 days after they receive your claim for benefits, that they have it and what they determine your benefits to be. If they need more than 30 days to determine your benefits, due to reasons beyond their control, they must notify you within that 30-day period that they need more time to determine your benefits. But, in any case, even with an extension, they cannot take more than 45 days to determine your benefits. If you do not submit all the necessary information for your claim to them, they must notify you, within 30 days after they get it and tell you what information is missing. You have 45 days to provide them with the information they need to process your claim. The time period during which the Claims Administrator is waiting for receipt of the necessary information is not counted toward the time frame in which the Claims Administrator must make the benefit determination.

If your claim is denied in whole or in part, you will receive a written notice of the adverse benefit determination within the time frame stated above, or after the Claims Administrator has all the information they need to process your claim, if the information is received within the time frame noted above. The written notice will explain the reason for the adverse benefit determination and the plan provisions upon which the denial decision is based. You have 180 days to appeal their decision. Your appeal must be in writing. Within 60 days after they receive your appeal, they must notify you of their decision about it. Their notice to you or their decision will be in writing.

Note: You, your beneficiary, or a duly authorized representative may appeal any denial of a claim for benefits with the Claims Administrator and request a review of the denial. In connection with such a request:

- Documents pertinent to the administration of the Plan may be reviewed free of charge; and
- Issues outlining the basis of the appeal may be submitted.

You may have representation throughout the appeal and review procedure.

For the purposes of this provision, the meanings of the terms “urgent care,” “Non-Urgent Care Pre-Service,” and “Non - Urgent Care Post-Service,” used in this provision, have the meanings set forth by ERISA for a “claim involving urgent care,” “pre-service claim,” and “post-service claim,” respectively.

Legal Process. No legal action may be commenced prior to the completion of the benefits claims procedure as described in the applicable carrier booklet or plan summary. In addition, no legal action may be commenced after the later of: (i) 180 days after receiving the written response of the Claims Administrator to an appeal or (ii) 365 days after an applicant's original application for benefits.