OXY Benefits

Summary Plan Description

MEDICAL PLAN

OXY RETIREE NON-MEDICARE ELIGIBLE

Aetna Choice POS II Network

2019

your health.
your life.
your future.

CONTENTS

Your Retiree Medical Plans

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

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

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

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

Medical Plans

The Retiree Medical Plans offer eligible participants the following medical options:

- **Oxy Retiree Medical Plan**—A Point of Service (POS) health plan that covers care received from network or non-network providers with no physician referral.
- **Regional HMO** *(in some areas)*—A Health Maintenance Organization (HMO) generally requires you to receive medical treatment or services from participating providers. Services received outside the network may not be covered except in the case of a medical emergency.

  If you retired after January 1, 2016, you must enroll in the Oxy Retiree Medical Plan option. If you retired prior to January 1, 2016, and are enrolled in a regional HMO option, you may continue participation in this coverage, as long as you remain in the regional coverage area and are not Medicare-eligible. If you later move out of the area, you must make a new medical coverage election within 31 days after your move.

All benefits, limits and exclusions for the HMO options are listed in their respective member brochures, contacts and certificates. Upon request, the OxyLink Employee Service Center will provide written materials that describe the benefits, including prescription drug benefits, coordination of benefits, claim and benefit payments and defined terms.

Medical Plan Eligibility

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

Who's Eligible	• All regular, full-time, non-represented employees who were regularly scheduled to work at least 30 hours per week and, effective March 1, 2018, part-time non-represented employees approved for the Phased Retirement Program who are: – At least age 55 with 10 or more years of regular, full-time service. – Enrolled in an Oxy medical plan for active employees the day before retirement, unless covered under another medical plan before retirement, then lost that coverage and you elect coverage under this Plan within 31 days of the event. – Not eligible to participate in the Oxy Medicare Advantage PPO Plan. – Not independently enrolled in an individual Medicare Part C or similar plan. • Represented employees are eligible if provided for in their collective bargaining agreement.
Eligible Dependents	Generally, your eligible dependents are your: • Legal spouse***** (unless legally separated); and • Children under age 26. Eligible dependent children, regardless of the child's student, employment or marital status or residence, include: – Your natural children; – Children legally adopted or placed for adoption with you; – Stepchildren and foster children; and – Other children whom you claim as dependents on your federal income tax return, for whom you and/or your spouse have primary legal custody, whom live with you in a regular parent-child relationship and for whom you can provide required documentation. • Disabled children age 26 or over (see **Dependent Eligibility** Section)

*****All legal marriages will be recognized for purposes of benefit eligibility, regardless of the state in which you reside. Domestic partners may be eligible for the regional medical plans per state law.

About This SPD

This Summary Plan Description (SPD) summarizes your Occidental Petroleum Corporation Retiree Medical Plan, also known as the Oxy Retiree Medical Plan, the Plan or the Medical Plan. The Plan's complete provisions are contained in the Plan documents that legally govern the Plan's operation. The Plan documents include the official Plan text and other documents and reports that are maintained by the Plan. **If there is ever a conflict or difference between this SPD and the Plan documents and contracts, the official Plan documents and contracts will govern.**

This SPD reflects the provisions of the Plan documents in effect on January 1, 2019. These provisions may not apply to you if your employment ended before this date. Refer to future Summary of Material Modifications (SMMs) for any material changes to the Plan made after the date of this document.

Benefits at a Glance—Oxy Retiree Medical Plan

The chart below shows the deductibles, coinsurance and out-of-pocket maximums you pay under the Oxy Retiree Medical Plan. Network benefits are based on negotiated fees. Non-network benefits are based on the **recognized charges**. Network benefits apply to non-Medicare eligible participants and any Medicare-eligible participants covered under this Plan. **Non-network benefits apply only to non-Medicare eligible participants.** Since Medicare is primary for Medicare-eligible participants who are eligible for this Plan, the lower non-network coinsurance levels **will not apply** if you use a provider that does not participate in Aetna's network and you are **not subject to** precertification requirements. Allowed charges are limited to the Medicare-approved amount for any Medicare-eligible participants in this Plan. Refer to the Medicare section for further details.

More coverage details for specific services and supplies are included in **Covered Medical Expenses**.

All covered expenses are subject to the annual deductible until it is met unless otherwise noted.

AETNA RETIREE MEDICAL PLAN		
Medical Network	Aetna Choice® POS II Open Access **www.aetna.com** **800-334-0299**	
ANNUAL DEDUCTIBLE*	**YOU PAY**	
	NETWORK	**NON-NETWORK**
• Individual	$400	$800
• Family	$800	$1,600
	Individual deductible also applies. Applies to medical expenses only. Some retirees may have a higher deductible based on when they retired and when they became Medicare-eligible. See the **Deductible** section for more information.	
OUT-OF-POCKET (OOP) MAXIMUM*	**YOU PAY**	
	NETWORK	**NON-NETWORK**
• Individual	$2,500	$5,000
• Family	$4,500	$9,000
When your share of covered expenses (including the deductible) reaches the OOP limit, covered expenses for the remainder of the calendar year are paid at 100%.	Individual OOP maximum also applies. Excludes prescriptions.	
LIFETIME MAXIMUM		
	Unlimited	
REQUIREMENTS		
Inpatient Care Precertification (non-Medicare participants only)	• All inpatient care must be precertified. • In most cases, network providers will handle precertification. • If you use non-network providers, it is your responsibility to obtain precertification to avoid a noncompliance penalty of up to **$500.**	

*Charges, whether for network or non-network care, will count toward meeting your deductibles and benefit maximums, unless stated otherwise.

PREVENTIVE CARE	PLAN PAYS	
	NETWORK	NON-NETWORK
See **Preventive Care** for more information: • Routine physicals (adult and child) • Flu shots • Mammography • PSA test • Cervical cancer screening and exam • Colorectal cancer screening	100% covered, **no** deductible	70%
OFFICE VISITS		
Primary Care Physician	80%	70%
Specialist	80%	70%
TELADOC		
24/7 Telemedicine Services Register at **Teladoc.com/Aetna**, download the app from your mobile device app store or call 855-Teledoc (835-2362).	See a doctor, 24/7, without having to go to a doctor's office. You have access to private online video or phone sessions with a board-certified doctor. Teladoc doctors treat non-emergency health conditions, including: • Cold and flu • Allergies • Sinus problems • Sore throat • Respiratory infection • Skin problems They can also send prescriptions to your pharmacy. Your cost is $40 per session until you've met your deductible. Then, the Plan pays 80% and you pay 20% ($8) per visit.	
DIAGNOSTIC PROCEDURES		
Outpatient Diagnostic X-rays, Lab and Testing	80%	70%
Outpatient Complex Imaging	80%	70%
EMERGENCY CARE		
Emergency Admissions Must be certified within 48 hours of admission	90%	90%
Urgent Care	80%	70%
Ambulance	80%	80%
Non-Emergency Use of Emergency Room	Not covered	Not covered
HOSPITAL/SURGICAL CENTER		
Inpatient Requires precertification	90%	70%
Outpatient Surgery	90%	70%

VISION CARE	PLAN PAYS	
	NETWORK	NON-NETWORK
Routine Eye Exam One per calendar year	100% covered, **no** deductible	70%
Materials	Not covered	Not covered
MENTAL HEALTH AND SUBSTANCE ABUSE TREATMENT		
Inpatient Facility Requires precertification	90%	70%
Outpatient Facility	90%	70%
Outpatient Office Visit	80%	70%
OTHER MEDICAL SERVICES		
Skilled Nursing Facility Up to 120 days per calendar year	90%	70%
Home Health Care Up to 120 visits combined with private duty nursing per calendar year	80%	70%
Hospice Care	90%	70%
Short Term Rehabilitation Physical, occupational, speech and cognitive therapy	80%	70%
Acupuncture Therapy Maximum 26 visits per year	80%	70%
Chiropractic Care Maximum 26 visits per year	80%	70%
Durable Medical Equipment One for similar purpose	80%	70%
Surgery Not Billed by Physician, Lab, Ambulance	80%	70%
Hearing Aids Maximum benefit of $2,500 every 3 years	80%	70%
Infertility $20,000 lifetime benefit	80%	70%

PRESCRIPTION DRUG NETWORK BENEFITS	AETNA RETIREE MEDICAL PLAN
Prescription Drug Network	Express Scripts, Inc. (ESI)
Annual Deductible	None
Out-of-Pocket (OOP) Drug Limit	Using lowest-cost option, separate annual OOP drug limit is $1,500 per person.
Lifetime Maximum	Infertility prescription drug benefit has a maximum $10,000 lifetime benefit
Brand Name Drugs	If a generic drug is available, you pay the generic copay or coinsurance plus the difference in price between the brand name and the generic drug. The additional cost for the brand name drug is not applied to your prescription annual out-of-pocket cost.
	YOU PAY*
Retail Pharmacy up to a 30-day supply	
• Generic	$10 copay
• Preferred brand	25% ($10 min/$50 max)
• Non-preferred brand	25% ($25 min/$100 max)
• Maintenance Medication	**Initial fill plus 2 refills; then a penalty applies for additional fills at a retail pharmacy. Consider the mail order pharmacy for maintenance medications to avoid the penalty.**
Mail Order Pharmacy up to a 90-day supply	
• Generic	$20 copay
• Preferred brand	25% ($20 min/$100 max)
• Non-preferred brand	25% ($50 min/$200 max)

*Certain preventive drugs are covered at 100% ($0 copay). For more information, contact ESI at **800-551-7680** or OxyLink at **800-699-6903** or email **oxylink@oxy.com** to request a list of these preventive drugs.

Managing Your Benefits

For Plan information and forms, go to **oxylink.oxy.com**. Your providers' customer service representatives can help answer your benefit questions. In addition, your provider websites offer access to information about your benefits and tools to help you manage your health and benefits. All you need to do is complete a simple registration process.

BENEFIT CONTACTS	
OxyLink Employee Service Center 4500 South 129th East Avenue Tulsa, OK 74134-5801	For questions about retiree medical eligibility or other Oxy Retiree Medical Plans: • Call **800-699-6903.** Outside the U.S.: **918-610-1990** Monday through Friday (except holidays) 8 a.m. to 4:30 p.m. CT • Email questions to **oxylink@oxy.com** • Visit the website: **oxylink.oxy.com**
Aetna P.O. Box 14586 Lexington, KY 40512-4586	For questions about the medical option: • Aetna: **800-334-0299.** Outside the U.S.: **817-417-2000**, ext. 4154016; or • **Aetna.com**: Through the member website, you can: – Order a new ID card or print a temporary card – View benefits and check status of claims – Find a doctor, specialist, **hospital** or urgent care facility – Use the cost estimator to compare cost estimates in advance – Use personal health record to monitor and manage your health
Express Scripts, Inc. 1 Express Way St. Louis, MO 63121	For questions about the prescription drug program: • Express Scripts: **800-551-7680.** Outside U.S.: **800-497-4681** • **Express-scripts.com**: Through the online services, you can: – Compare brand name and generic drug prices – Order a new ID card or print a temporary card – Obtain order forms, claim forms and envelopes – Request renewals or refills of mail-order prescriptions – Check the status of Express Scripts mail orders – Check and pay mail-order account balances
PayFlex Retiree Billing Unit P.O. Box 953374 St. Louis, MO 63195-3374	For questions about billing: • PayFlex: **888-678-7835** Monday through Friday, 8 a.m. – 7 p.m. CT (except holidays) • **Payflex.com**

Provider ID Cards

You will receive medical and prescription drug ID cards when you enroll for medical coverage. Be sure to keep your ID cards handy and show them whenever you receive care or fill a retail prescription. The cards may include phone numbers you may need to contact the provider's Member Services. You may also use a digital ID card via the Aetna or Express Scripts mobile app or you may print temporary ID cards from the Aetna website at **www.aetna.com** or the Express Scripts website at **www.express-scripts.com**.

Eligibility and Enrollment

Your Eligibility

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

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

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

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

You are not eligible to participate in the Plan if:

- You are independently enrolled in an individual Medicare Part C (i.e., Medicare Advantage) or similar plan; or
- You are eligible to participate in the Oxy Medicare Advantage PPO Plan (the Aetna Medicare Advantage PPO Plan).

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

You may not be covered as both a retiree and a dependent.

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

Part-Time Work and the Oxy Retiree Medical Plan

If you lose eligibility under an Oxy medical plan for active employees as a result of a reduction in work hours (i.e., you are regularly scheduled to work fewer than 30 hours per week), and you meet the eligibility requirements for retiree coverage (generally age 55 with 10 or more years of service), you may enroll in the Oxy Retiree Medical Plan. You will also continue to accrue age and service credits toward your retiree medical contribution multiple during such reduced work schedule.

Special Provisions Under the Notice and Severance Pay Plan

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

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

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

To determine your eligibility for such future coverage, calculate your combined age and service by adding your years and months of age and eligible service as of the last day of your Medical Coverage Period, counting any partial month of age or service as a whole month. If you became an Oxy employee due to Oxy's purchase, merger or transfer of any unit, operation or business and, as a result, your eligibility for retiree coverage under the Oxy Retiree Medical Plan is subject to a required minimum number of service years directly with Oxy, you must meet such minimum by the end of your Medical Coverage Period to qualify for such future coverage when you reach age 55.

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

Enrollment If Receiving Benefits Under the Notice and Severance Pay Plan

If you are under age 55 at the end of your Medical Coverage Period, you must contact OxyLink within 31 days of the date you turn age 55 to enroll. If you enroll at age 55, proof of loss of other coverage is not required, and coverage will be effective the first of the month following or coincident with attainment of age 55.

If you do not enroll at age 55 because you have other coverage, you may later enroll in retiree medical coverage if you lose that other coverage. However, you must enroll within 31 days of loss of coverage and proof of loss of coverage may be required.

Dependent Eligibility

Generally, your legal spouse (unless legally separated), your children under age 26, and your disabled children may qualify as eligible dependents under the Plan.

Your Spouse

Your eligible spouse is your spouse to whom you are legally married. All legal marriages will be recognized for purposes of benefit eligibility, regardless of the state in which you reside. This includes a spouse through common law marriage in applicable states. This does not include a spouse from whom you are legally separated.

Your Children

Your eligible 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.

Unless otherwise noted in a specific coverage section, your children must be under the age of 26 to be eligible for coverage under the Plan regardless of their marital, student, financial or residency status. However, a child who has reached the upper age limit (age 26) and who is mentally or physically incapable of self-sustaining employment may continue to be eligible (see **Disabled Dependent Children** for more details).

Qualified Medical Child Support Order

If, because of a divorce or legal separation, your children are not eligible for Plan coverage, it may be possible to obtain coverage through a Qualified Medical Child Support Order (QMCSO). A QMCSO is any judgment, decree or order issued by a court of competent jurisdiction, or other court or administrative order, requiring you to provide health care benefits for a child. You will be notified if any of your children are affected by a QMCSO. If so, the **Plan Administrator** will provide information to the child, custodial parent or legal guardian on how to obtain benefits and submit claims. The claims administrator will pay eligible claims to the child or the child's custodial parent or legal guardian, except to the extent paid directly to a service provider on behalf of the child.

You may ask the OxyLink Employee Service Center for a free copy of the procedures governing QMCSOs.

Disabled Dependent Children

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's age limit; and
- Depends mainly on you for support and maintenance.

You must provide proof of your child's disability to the claims administrator no later than 31 days after your child reaches the dependent age limit for review and determination of eligibility of continuation of coverage. The claims administrator may continue to ask you for proof that the child continues to meet 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.

Dependent Coverage After Your Death

If you die while you are covered as a retiree under this Plan, your spouse may elect to continue his or her coverage and coverage for your eligible dependents as of your date of death by paying the appropriate amount of retiree contributions, if any, as described under **Paying for Coverage**. If you had not elected retiree coverage for yourself and/or your dependents under this Plan, your surviving spouse may elect to enroll for coverage for his or herself and your dependents within 31 days of loss of other coverage. Proof of loss of coverage may be required.

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

Enrollment

You and/or your surviving spouse must complete and return an enrollment form (or waiver) for retiree medical coverage no later than 31 days after your retirement date. You may waive coverage, but if you do, you may not reenroll for coverage under the Oxy Retiree Medical Plan, with the following exception:

If you or your spouse (or a surviving spouse) currently have other coverage and lose eligibility for that coverage, you or your spouse may reenroll in the Oxy Retiree Medical Plan within 31 days of loss of coverage. Proof of loss of coverage may be required.

You may elect not to cover your spouse if he or she is covered under another group plan. You may not be covered as both a retiree and a dependent spouse under Oxy Retiree Medical Plan. If you and your spouse work for or are retired from Oxy, only one of you may cover your children as dependents. If your spouse has dependents as an Oxy employee and later leaves Oxy for any reason, you may enroll yourself and your dependents within 31 days of the loss of coverage.

When you enroll for coverage you will elect one of the following coverage levels:

- Retiree Only
- Retiree + One Dependent
- Family (retiree plus two or more dependents)

Adding or Dropping Dependents

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

After your retirement date, you may add a new non-spousal dependent for coverage under this Plan only by paying the full coverage cost (including company cost) in effect at the time you add your dependent. The cost is subject to change each year as Oxy's Retiree Medical Plan costs increase, as described under **Your Share of Medical Service Cost**. You must enroll your new dependent within 31 days of his or her first date of eligibility (or within 31 days of a court-issued QMCSO), or if later, within 31 days of loss of other coverage.

Dependents who are no longer eligible for coverage are not automatically dropped from coverage. You must remove them from the Plan. If you don't advise the Plan that a dependent is no longer eligible for coverage, the Plan may stop the dependent's coverage retroactive to the date the dependent became ineligible and you will **not** be refunded any premiums you paid for the ineligible dependent. You are required to repay the total cost of claims paid by the Plan for the ineligible dependent dating back to the original enrollment and/or termination of coverage date. The dependent is not eligible for COBRA coverage if his or her eligibility ends due to lack of (or insufficient) documentation for proof of eligibility.

To change your dependents, contact the OxyLink Employee Service Center.

Paying for Coverage

If you are a retiree or LTD Plan beneficiary who became Medicare-eligible before January 1, 2000, you and your covered dependent(s) are not currently required to pay contributions to participate in the Oxy Retiree Medical Plan; however, a correspondingly higher deductible may apply.

If you are a retiree who retired or became eligible for Medicare on or after January 1, 2000, the contributions for you and/or your Medicare-eligible dependents are a multiple of the Oxy retiree base rate, as shown below.

IF YOUR COMBINED AGE AND YEARS OF SERVICE ON YOUR OXY RETIREMENT DATE* IS:	YOUR MONTHLY CONTRIBUTION IS THE FOLLOWING MULTIPLE OF THE RETIREE BASE RATE FOR THE LEVEL OF COVERAGE YOU ELECT:	
	MEDICARE-ELIGIBLE	NON-MEDICARE ELIGIBLE
65 to 69	2 times	4 times
70 to 74	2 times	3 times
75 to 79	2 times	2 times
80 or more	1 times	1 times

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

The amount of your contribution is based on:

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

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

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

For 2019, the retiree base rate is $150 per month for all participants covered under this Plan.

For example, a retiree with a combined age and service of 73 years would pay three times the base rate for retiree and spouse coverage of $900 per month ($150 base rate x 2 individuals x 3).

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

Additionally, if you are eligible for Medicare you must pay any applicable premiums for Medicare Part A and B (including any late enrollment penalties for Part B or Part D) directly to the Center for Medicare and Medicaid Services (CMS).

Dependent Contributions After Your Death

If you die while you are covered as a retiree under the Oxy Retiree Medical Plan, your spouse, if eligible (see **Death** for more details), may elect to continue his or her coverage and coverage for your eligible dependents as of your date of death by paying the appropriate amount of retiree contributions, as shown on the previous chart.

When Coverage Ends

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

When Your Coverage Ends

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

- The Plan is discontinued;
- You voluntarily stop your coverage;
- The coverage described in this SPD is terminated under the group contract;
- You are no longer eligible, as defined in **Your Eligibility**;
- You fail to make any required contribution; or
- You become eligible for the Medicare Advantage PPO Plan

The Plan coverage stops on the last day of the month in which you lose eligibility. You may have a right to continue your coverage as described in **Continuation of Coverage**. You may not convert your group health care coverage to an individual policy when you leave Oxy.

When Dependent Coverage Ends

Your dependent's eligibility for coverage will end on the earliest of the following events:

- Dependent coverage is terminated under the Plan;
- A dependent becomes covered as an employee;
- A dependent no longer meets the Plan's definition of a dependent;
- Your coverage terminates;
- Your death, if there is no surviving spouse;
- Your surviving spouse waives coverage, remarries or dies (This would result in any covered dependent children losing coverage. However, dependent children have the right to continue coverage under COBRA); or
- Dependent becomes eligible for the Oxy Medicare Advantage PPO Plan.

The Plan coverage stops on the last day of the month in which your dependent loses eligibility. You must notify the OxyLink Employee Service Center within 31 days of your dependent's change in eligibility status. Any applicable contribution change will take effect on the first of the month following the event. There will be no refund of contributions unless it is due to an Oxy administration error.

Your dependents may have a right to continue their coverage. See **Continuation of Coverage** or contact the OxyLink Employee Service Center for more information.

Death

If you die and are eligible for retiree medical coverage as described in the **Eligibility and Enrollment** section, your spouse may elect to continue his or her coverage and coverage for your covered dependents under this retiree Plan. If retiree medical coverage is elected, your spouse must pay the applicable retiree contribution. If dependent coverage (including spouse) is elected, coverage will continue for your dependents until the earliest occurrence of one of the following events:

- Dependent's coverage ends under the Plan;
- Dependent is or becomes covered as an employee;
- Failure to meet the requirements for dependent coverage;
- Spouse is or becomes eligible for coverage under another group plan;*
- Failure to pay any required contributions; or
- Your surviving spouse elects to waive coverage, remarries or dies.

Coverage is not available for only dependent children. If you die without a surviving spouse or if your spouse does not have coverage or it ends, dependent children have a right to **continue coverage** under COBRA.

Medicare

Medicare is a federal health insurance program, which provides health care services under the Original (Traditional) Medicare Plan (Part A and Part B) or in some areas, a Medicare Advantage Plan. Generally, you are eligible to receive benefits from Medicare when you reach age 65. Medicare is also available if you have been entitled to Social Security disability benefits for two years (waived if you have amyotrophic lateral sclerosis) or if you have end-stage renal disease (kidney failure).

Medicare includes the following parts:

- *Part A Hospital Insurance* – Hospital coverage automatically provided at **no cost** when you become Medicare-eligible.
- *Part B Medical Insurance* – Physician and outpatient services coverage automatically provided if you are receiving your Social Security benefits. Otherwise, it requires you enroll. **You pay** a monthly premium for this coverage and you can opt out.
- *Part C Medicare Advantage Plans* – Include Health Maintenance Organization plans, Preferred Provider Organization plans, Private Fee for Service plans and Special Needs plans. Generally, you must be enrolled in Parts A and B to enroll in this coverage. Some plans also include Part D.
- *Part D Prescription Drug Plan* – Outpatient prescription drug coverage. You must be enrolled in Parts A and B to enroll in this coverage. **You pay** a monthly premium for this coverage.

When you and/or your dependents become Medicare-eligible, Medicare becomes effective the first of the month in which you or your dependent turns age 65, or otherwise becomes Medicare-eligible. At that time, coverage for most Medicare-eligible participants will be provided under the Oxy Medicare Advantage PPO Plan (see separate Oxy Medicare Advantage PPO Plan SPD). However, if you become Medicare-eligible but are deemed not eligible for the Oxy Medicare Advantage PPO Plan, you will remain in this Oxy Retiree Medical Plan and Medicare will generally be the primary insurance coverage and payer of your medical claims with this Plan as the secondary payer of your medical claims.

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

Important: Oxy Medicare Advantage PPO Plan Participation

If you are a retiree who is Medicare-eligible, you live in the United States and are otherwise eligible for Medicare, your coverage will be provided under the Oxy Medicare Advantage PPO Plan ***not*** under this Oxy Retiree Medical Plan. For additional information on benefits that are provided under the Oxy Medicare Advantage PPO Plan, refer to the separate SPD for that plan.

How to Apply for Medicare

To apply for Medicare, you should contact Social Security by telephone at **800-772-1213**. In most cases, the entire application process can be handled by telephone, online and/or through the mail.

Even if you fail to enroll in Parts A and B of Medicare, the Oxy Retiree Medical Plan benefit will be reduced by what Medicare would have paid. Therefore, you are encouraged to enroll in both Medicare Parts A and B to ensure maximum benefit coverage.

Medicare Part D

Those covered by Parts A or Part B can enroll in Medicare Part D, which helps pay for insurance coverage for outpatient prescription drugs. In some cases, a Medicare Part D plan may provide a better benefit than the prescription drug coverage provided under this Plan. You can, but do not have to, enroll in Medicare Part D because the Oxy Retiree Medical Plan is considered “creditable,” that is, the Plan provides coverage that is expected to be as good as or better than the lowest level of drug coverage authorized under a Medicare Part D plan.

If you decide to enroll in a Part D plan, use your Part D coverage to obtain your prescription drug benefits since the Plan is not eligible to receive the federal subsidy for your drug costs if you are enrolled in Medicare Part D. This will ultimately impact the Plan’s ability to control costs and, therefore, your contributions.

If you are enrolled in the Oxy Retiree Medical Plan and decide to enroll in a Medicare Part D plan at a later date, you may do so without incurring a late enrollment penalty provided the Plan is still considered creditable.

You can access detailed information regarding the Medicare program online at **Medicare.gov** or contact Medicare at 800-MEDICARE (800-633-4227).

Integration with Medicare

Benefits under the Oxy Retiree Medical Plan are integrated with Medicare to provide the same overall level of benefits for Medicare-eligible participants as for those participants who are not Medicare-eligible. This section describes how Medicare benefits are integrated with the Oxy Retiree Medical Plan.

If you are a retiree or a dependent of a retiree and you are eligible for Medicare and not deemed eligible for the Oxy Medicare Advantage PPO Plan, you will remain in this Plan. Plan benefits generally will be offset by benefits payable by Medicare. This approach calculates the amount you would have received under the Oxy Retiree Medical Plan as if you were not eligible for Medicare, subtracts the amount payable by Medicare and reimburses the difference. **Even if you fail to enroll in Parts A and B of Medicare, the Oxy Retiree Medical Plan benefit will be reduced by what Medicare would have paid.** Therefore, it is important to enroll in both Medicare Parts A and B to ensure maximum benefit coverage. As the secondary payer, the Plan will apply (deduct) what Medicare Part B paid or would have paid when processing your claims (this means if you do not enroll in Part B, the Plan will still deduct what Medicare Part B would have paid if you were enrolled). Refer to the **COB with Medicare** section for more information.

Important Information

For non-prescription expenses, in most cases Medicare and the Oxy Retiree Medical Plan provide similar benefits and coverage levels. Since Medicare is considered primary and pays first, there is often no benefit payable by the Oxy Retiree Medical Plan for Parts A and B expenses. Most benefits payable by the Oxy Retiree Medical Plan are for prescription expenses.

To simplify claim processing you can enroll in the Medicare Direct Program described in the **Medicare Direct Program** section. If you live outside the United States, the Oxy Retiree Medical Plan will be integrated in a similar manner with the social insurance plans of the country in which the individual is eligible for benefits.

If you have group coverage in addition to Medicare and the Oxy Retiree Medical Plan, refer to the **Coordination of Benefits (COB)** section for more information.

Integration of benefits with Medicare does not apply to any private individual medical coverage a participant may have.

Medicare-Approved Amount and Medicare Assignment

The *Medicare-approved amount* is the maximum amount that Medicare will recognize for a particular service or procedure. It is often less than the actual charge, unless the provider accepts *Medicare assignment*. Medicare assignment is when a provider (physician, hospital, lab, etc.) will agree to accept the Medicare-approved amount as full and final settlement for the services. If the medical provider does not accept Medicare assignment, you and/or the Plan are responsible for any charges up to 15% over the Medicare-approved amount.

When providers agree to a Medicare assignment, they may not charge more than the Medicare-approved amount for services rendered. Under Medicare Part B, Medicare pays 80% of the Medicare-approved amount, after the Medicare deductible has been met. You or the Oxy Retiree Medical Plan are responsible for paying the balance of the Medicare-approved amount. There is no legal obligation for you or the Plan to pay the provider for charges above the Medicare-approved amount.

Effective January 1, 1993, physicians who do not accept Medicare assignment are limited by law to charge no more than 15% above the Medicare-approved amount for services rendered.

Important

Aetna Network provisions do not apply to Medicare-eligible participants because Medicare is your primary coverage.

Aetna Medical Option

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

Aetna Medical Plan Providers

Under the Aetna Basic option, you have the freedom to choose your doctor or health care facility when you need medical care. Your network is the Aetna Choice® POS II network.

Network Provisions for Non-Medicare Eligible Participants

This section describes how network provisions apply to non-Medicare eligible participants.

Using Network and Non-Network Providers for Non-Medicare Eligible Participants

When you need care, you can select a provider that belongs to the network (a network provider) or one that does not belong to the network (a non-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, endocrinologists, urologists) and health care facilities (hospitals, skilled nursing facilities).

If you receive care from a network provider, your covered benefits are calculated using Aetna's negotiated fees. Aetna's negotiated fees do not apply to care that is not covered under the Plan.

When you use a non-network provider, your benefits are determined using the **recognized charge**. If the non-network provider's charge is more than the recognized charge (as defined by Aetna), **you pay the difference**. This excess amount will not apply toward your deductible or out-of-pocket maximum.

Aetna Provider Network

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

To find a network provider in your area:

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

Primary Care Physician (PCP)

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

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

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

Specialists

Specialists are doctors such as oncologists, cardiologists, chiropractors, neurologists or podiatrists. When you need specialty care, you can make an appointment directly with any licensed specialist. *No referral is required.* Remember, you will pay less out of your own pocket when you use a network provider. You can find a network specialist the same way you find a PCP. If you decide to choose a PCP, he or she can help you find the right specialist.

Out-of-Area Benefits

The Aetna Choice® POS II network is not available in a few geographical areas. If you or a covered dependent lives outside of a network area, your benefits will be administered as though you live within a network area (i.e., network coinsurance levels will apply), except allowed charges will be limited to the recognized charge.

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

Your Share of Medical Service Cost

You share in the cost of your care by making monthly contributions, if applicable, for the cost of coverage and paying deductibles and coinsurance. These terms are explained below and specific deductibles and coinsurance percentages are shown in the chart in the **Benefits at a Glance.** In line with Oxy's cost-sharing philosophy and as a means of encouraging participants to use their Medical Plan benefits wisely, contributions, annual deductibles and coinsurance will increase as the annual Medical Plan costs increase over time.

Deductible

	AETNA RETIREE MEDICAL PLAN
Individual Deductible	The individual deductible is the part of the network and non-network covered expenses you pay each year before the Plan starts to pay benefits. Network expenses count toward the non-network deductible and vice versa. Prescription drug expenses do not count toward your medical deductible. Once you meet the individual deductible, the Plan starts to pay benefits. Each January 1, you start over with a new deductible.
Family Deductible	Once the total of covered expenses applied toward the individual deductibles for you and any covered dependents reaches the family deductible, you and your dependents will all be considered to have met the family deductible, and the Plan will pay benefits for you and your covered dependents.

The annual deductible for you and your dependents is based on your retirement date and when you become eligible for Medicare:

- Retirees who retired and were Medicare-eligible on or after January 1, 2000 will have deductibles as shown in the **Benefits at a Glance**.
- Retirees who retired after January 1, 1984, and were Medicare-eligible before January 1, 2000, currently do not pay monthly contributions for medical coverage. Instead, the deductible represents a combination of the deductible plus the annualized contribution. In 2019, this annual deductible for network services is $2,200 per individual ($400 plus the $150 retiree base rate times 12 months) with a maximum $4,400 per family. The 2019 non-network deductible for this group will be $2,600 per person and $5,200 for the family maximum.
- Certain Oxy retirees who retired before January 1, 1984 have an annual deductible for network services of $150 per person, with a maximum family deductible of $450.

Coinsurance

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

Out-of-Pocket Maximum

	AETNA RETIREE MEDICAL PLAN
Out-of-Pocket Maximum	The Plan puts a limit on the dollar amount you pay for covered network and non-network expenses out of your own pocket—called the out-of-pocket maximum. • Your out-of-pocket maximum is based on whether you receive network or non-network care. • **Once your share of covered expenses (including the deductible) reaches the individual out-of-pocket maximum, the Plan pays 100% of covered expenses for the rest of the calendar year.** Each January 1, you start over with a new out-of-pocket maximum**.** There is a separate individual out-of-pocket maximum for prescription drugs as described in *Prescription Drug Benefits*. • Your Medical Plan contributions and any precertification penalties as well as the prescription drug out-of-pocket limit do not apply toward the medical out-of-pocket maximum.
Family Out-of-Pocket Maximum	Once the total of amounts applied toward the individual out-of-pocket maximums for you and your covered dependents reaches the family out-of-pocket maximum, the Plan pays 100% of covered expenses for all covered family members for the rest of the calendar year.

You may access information about your current deductible and maximum benefits at OxyLink Online at **oxylink.oxy.com**.

Negotiated Fees vs. Recognized Charges

When you receive care from a network provider, your covered benefits are based on Aetna's negotiated fees. These are the fees that network providers agree to charge Aetna members for their services. Aetna's negotiated fees do not apply to care that is not covered under the Plan.

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

For prescription drugs, if you purchase prescriptions from an Express Scripts network retail or mail order pharmacy, your copay and coinsurance amount is based on Express Scripts discounted pricing. Reimbursement for prescriptions obtained through a non-network pharmacy is described in Prescription Drug Benefits.

Precertification for Non-Medicare Eligible Participants

To receive certain benefits from the Plan, non-Medicare eligible participants must follow the precertification rules described in this section. (Precertification does not apply to Medicare-eligible participants.)

Understanding Precertification

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

You do not need to precertify services provided by a network provider. Network providers obtain necessary precertification for you. Since precertification is the provider's responsibility, there is no additional out-of-pocket cost to you as a result of a network provider's failure to precertify services.

When you go to a non-network provider, it is **your responsibility** to obtain precertification from Aetna for any services or supplies on the precertification list on the next page. If you do not precertify, your benefits may be reduced, or the Plan may not pay any benefits.

Important

This section contains important information on the precertification process and any impact it may have on your coverage.

Precertification requirements do not apply to Medicare-eligible participants because Medicare is their primary coverage.

Precertification Process

Before being hospitalized or receiving certain other medical services or supplies, you must follow certain precertification procedures.

You, a member of your family, a hospital staff member, or the attending physician must notify Aetna to precertify the admission or medical services and expenses before receiving any of the services or supplies that require precertification, within the specified timeframes listed below. If you are using a network provider, generally, he or she is responsible for precertification.

To obtain precertification, you, your physician or the facility must call Aetna at the telephone number listed on your ID card. This call must be made as follows:

SERVICE	PRECERTIFY
For non-emergency admissions	At least five days before the date you are scheduled to be admitted.
For an emergency outpatient medical condition	Before the outpatient care, treatment or procedure if possible, or as soon as reasonably possible.
For an emergency admission	Within 48 hours or as soon as reasonably possible after you have been admitted.
For an urgent admission	Before you are scheduled to be admitted. An urgent admission is a hospital admission by a physician due to the onset of or change in an illness, the diagnosis of an illness or an injury.
For outpatient non-emergency medical services requiring precertification	At least five days before the outpatient care is provided or the treatment or procedure is scheduled.

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

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

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

Services and Supplies to Precertify

Precertification is required for the following types of inpatient and outpatient care medical expenses:

- Stays in a hospital
- Stays in a skilled nursing facility
- Stays in a rehabilitation facility
- Stays in a hospice facility
- Outpatient hospice care
- Stays in a residential treatment facility for treatment of mental disorders and substance abuse
- Partial hospitalization programs for mental disorders and substance abuse
- Home health care
- Private duty nursing care
- Intensive outpatient programs for mental disorders and substance abuse
- Applied behavioral analysis therapy
- Neuropsychological testing
- Outpatient detoxification
- Psychiatric home care services
- Psychological testing

If You Fail to Precertify

A precertification penalty of $500, or the cost of the treatment, if less, will be applied to the benefits paid if you do not obtain a required precertification before incurring medical expenses. You are responsible for obtaining the necessary precertification from Aetna before receiving services from a non-network provider. Your provider may precertify your treatment for you; however, you should verify with Aetna before the procedure that the provider has obtained precertification from Aetna.

If your treatment requires precertification and it isn't obtained, Aetna will reduce the amount paid toward your coverage, or your expenses may not be covered. You will be responsible for the unpaid balance of the bills.

Here's how your benefits are affected if the necessary precertification is not obtained.

IF PRECERTIFICATION IS:	THEN THE EXPENSES ARE:
Requested and approved by Aetna.	Covered.
Requested and denied.	Not covered; may be appealed.
Not requested, but would have been covered if requested.	Covered after a precertification penalty is applied.
Not requested, would not have been covered if requested.	Not covered; may be appealed.

Remember, any additional out-of-pocket expenses incurred because your precertification requirement was not met will ***not count*** toward your deductible, coinsurance or out-of-pocket maximum.

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

Covered Medical Expenses

This section describes the services and supplies covered under the Aetna Retiree Medical Plan. If you are not eligible for Medicare, unless otherwise noted in **Benefits at a Glance**, network charges are covered at 90% or 80% and non-network charges are covered at 70%. If you are Medicare-eligible, Medicare is your primary coverage and the Plan integrates benefits as described under **Integration with Medicare**. The deductible applies unless otherwise noted.

Although a service may be listed as a covered benefit, it will not be covered unless it is medically necessary for the diagnosis or treatment of your illness or injury. Also, regardless of whether you use a network or non-network provider, in most cases the Plan does not cover treatments, procedures or tests that are considered experimental or investigational as described in **What the Medical Plan Does Not Cover**. To find out if a service is considered experimental or investigational, you may contact Aetna Member Services or refer to Aetna's Clinical Policy Bulletins available online at **www.aetna.com.**

Acupuncture

The Plan covers up to 26 visits per calendar year for acupuncture therapy.

Eligible health services include the treatment by the use of acupuncture (manual or electroacupuncture) provided by your physician, if the service is performed:

- As a form of anesthesia in connection with a covered surgical procedure and
- To alleviate chronic pain or to treat:
  - Postoperative and chemotherapy-induced nausea and vomiting
  - Nausea of pregnancy
  - Postoperative dental pain
  - Temporomandibular disorders (TMD)
  - Migraine headache
  - Pain from osteoarthritis of the knee or hip (adjunctive therapy).

Ambulance Services

Ground Ambulance

The Plan covers charges for transportation:

- To the first hospital where treatment is given in a medical emergency;
- From one hospital to another hospital in a medical emergency when the first hospital does not have the required services or facilities to treat your condition;
- From hospital to home or to another facility when other means of transportation would be considered unsafe due to your medical condition;
- From home to hospital for covered inpatient or outpatient treatment when other means of transportation would be considered unsafe due to your medical condition (limited to 100 miles); and
- When during a covered inpatient stay at a hospital, skilled nursing facility or acute rehabilitation hospital, an ambulance is required to safely and adequately transport you to or from inpatient or outpatient medically necessary treatment.

Air or Water Ambulance

Covered expenses include charges for transportation to a hospital by air or water ambulance when:

- Ground ambulance transportation is not available;
- Your condition is unstable and requires medical supervision and rapid transport; and
- In a medical emergency, transportation from one hospital to another hospital when the first hospital does not have the required services or facilities to treat your condition and you need to be transported to another hospital (the two conditions above must be met).

Ambulance Services Limitations

The Plan does not cover charges incurred to transport you:

- If an ambulance service is not required by your physical condition;
- If the type of ambulance service provided is not required for your physical condition;
- By any form of transportation other than a professional ambulance service; or
- By fixed wing air ambulance from a non-network provider.

Clinical Trials

Covered expenses include charges made for experimental or investigational drugs, devices, treatments or procedures under an approved clinical trial only when you have cancer or a terminal illness, and *all* of the following conditions are met:

- Standard therapies have not been effective or are inappropriate;
- Aetna determines, based on published, peer-reviewed scientific evidence, that you may benefit from the treatment; and
- You are enrolled in an approved clinical trial that meets all of these criteria.

An “approved clinical trial” is a clinical trial that meets these criteria:

- The FDA has approved the drug, device, treatment or procedure to be investigated or has granted it investigational new drug (IND) or group c/treatment IND status. This requirement does not apply to procedures and treatments that do not require FDA approval.
- The clinical trial has been approved by an Institutional Review Board that will oversee the investigation.
- The clinical trial is sponsored by the National Cancer Institute (NCI) or similar federal organization.
- The trial conforms to standards of the NCI or other, applicable federal organization.
- The clinical trial takes place at an NCI-designated cancer center or takes place at more than one institution.
- You are treated in accordance with the protocols of that study.

Routine Patient Costs

Covered expenses include charges made by a provider for “routine patient costs” furnished in connection with your participation in an approved clinical trial for cancer or other life-threatening disease or condition, as those terms are defined in the federal Public Health Service Act, Section 2709.

Clinical Trials Limitations

The Plan does not cover:

- Services and supplies related to data collection and record-keeping that is solely needed due to the clinical trial (i.e. protocol-induced costs);
- Services and supplies provided by the trial sponsor without charge to you; and
- The experimental intervention itself (except medically necessary Category B investigational devices and promising experimental or investigational interventions for terminal illnesses in certain clinical trials in accordance with Aetna’s claim policies).

Dental Care

Oral and Maxillofacial Treatment (Mouth, Jaws and Teeth)

Covered expenses include charges made by a physician, a dentist or hospital for non-surgical treatment of infections or diseases of the mouth, jaw joints or supporting tissues as follows:

- Services and supplies for treatment of, or related conditions of, the teeth, mouth, jaws, jaw joints or supporting tissues (this includes bones, muscles and nerves) for surgery needed to:
  - Treat a fracture, dislocation or wound;
  - Cut out teeth that are partly or completely impacted in the bone of the jaw; teeth that will not erupt through the gum; other teeth that cannot be removed without cutting into bone; the roots of a tooth without removing the entire tooth; cysts, tumors or other diseased tissues;

  - Cut into gums and tissues of the mouth. This is only covered when not done in connection with the removal, replacement or repair of teeth; or
  - Alter the jaw, jaw joints or bite relationships by a cutting procedure when appliance therapy alone cannot result in functional improvement.
- Hospital services and supplies received for a stay required because of your condition.
- Dental work, surgery and orthodontic treatment needed to remove, repair, restore or reposition natural teeth damaged, lost or removed; or other body tissues of the mouth fractured or cut due to injury. Any such teeth must have been free from decay or in good repair and be firmly attached to the jaw bone at the time of the injury. Treatment must be completed in the calendar year of or calendar year following the accident.
- If crowns, dentures, bridges or in-mouth appliances are installed due to injury, covered expenses only include charges for:
  - The first denture or fixed bridgework to replace lost teeth;
  - The first crown needed to repair each damaged tooth; and
  - An in-mouth appliance used in the first course of orthodontic treatment after the injury.

Jaw Joint Disorders

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

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

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

Diagnostic and Preoperative Testing

Outpatient Complex Imaging Expenses

The Plan covers charges made on an outpatient basis by a physician, hospital or a licensed imaging or radiological facility for complex imaging services to diagnose an illness or injury, including:

- Computerized axial tomography (CAT or CT) scans;
- Magnetic resonance imaging (MRI);
- Positron emission tomography (PET) scans; and
- Any other outpatient diagnostic imaging service costing over $500.

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

Outpatient Diagnostic Lab Work and Radiological Services

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

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

Outpatient Preoperative Testing

Before a scheduled covered surgery, covered expenses include charges made for tests performed by a hospital, surgery center, physician or licensed diagnostic laboratory provided the charges for the surgery are covered expenses and the tests are:

- Related to your surgery, and the surgery takes place in a hospital or surgery center;
- Completed within 14 days before your surgery;
- Performed on an outpatient basis;
- Covered if you were an inpatient in a hospital; and
- Not repeated in or by the hospital or surgery center where the surgery will be performed.

Test results should appear in your medical record kept by the hospital or surgery center where the surgery is performed.

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

Durable Medical Equipment

The Plan covers durable medical equipment (such as wheelchairs, walkers, crutches) as follows:

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

Emergency and Urgent Care

Emergency Medical Conditions

Covered expenses include charges made by a hospital or a physician for services provided in an emergency room to evaluate and treat an emergency medical condition.

The emergency care benefit covers:

- Use of emergency room facilities;
- Emergency room physician services;
- Hospital nursing staff services; and
- Radiologist and pathologist services.

You should contact your physician after receiving treatment for an emergency medical condition.

Important

With the exception of urgent care, if you visit a hospital emergency room for a non-emergency condition, the Plan will not cover your expenses. No other Plan benefits will pay for non-emergency care in the emergency room.

Urgent Conditions

Covered expenses include charges made by a hospital or urgent care provider to evaluate and treat an urgent condition.

Urgent care coverage includes:

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

You should contact your physician after receiving treatment for an urgent condition.

Family Planning

For females with reproductive capacity, the Plan pays those charges incurred for services and supplies that are provided to prevent pregnancy. All contraceptive methods, services and supplies must be approved by the U.S. Food and Drug Administration (FDA).

Coverage includes counseling services on contraceptive methods provided by a physician, obstetrician or gynecologist in either a group or individual setting.

Covered expenses include charges made by a physician for:

- Services and supplies needed to administer or remove a covered contraceptive prescription drug or device;
- Female injectable contraceptives that are generic prescription drugs;
- Female contraceptives devices that are generic devices and brand name devices;
- Female voluntary sterilization, including charges billed separately by the provider for female voluntary sterilization procedures and related services and supplies including, but not limited to, tubal ligation and sterilization implants;
- Male voluntary sterilization; and
- Voluntary termination of pregnancy.

Pregnancy Coverage

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

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

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

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

Infertility Coverage

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

The Plan covers treatments for infertility up to a lifetime maximum of $20,000 (network and non-network combined limit) for medical related services. The services must be preauthorized by calling the National Infertility Unit at **800-575-5999** before the initiation of hormone treatment services. Failure to obtain preauthorization of services will result in a denial of benefits.

The following procedures are covered:

- Artificial insemination cycles (including intrauterine insemination) stimulated with ovulatory stimulants (e.g. Clomid) or aromatase inhibitors (e.g. Letrozole) or completed without stimulation medications.
- Advanced reproductive technologies (ART) such as: in-vitro fertilization (IVF), frozen embryo transfer (FET), zygote intrafallopian transfer (ZIFT), gamete intrafallopian transfer (GIFT), and intracytoplasmic sperm injection (ICSI). Call the National Infertility Unit at **800-575-5999** before treatment begins to confirm coverage.

Infertility medications necessary for the provision above, including parenteral injection and oral ovulation induction drugs will be subject to a $10,000 lifetime pharmacy limit.

All frozen embryos stored after a completed cycle with ovarian stimulation must be used before coverage availability for another ovarian stimulation cycle. Embryo transfer guidelines should be followed for all embryo transfers (fresh and frozen cycles) and elective single embryo transfer should be utilized when clinically appropriate.

The following services, expenses and fees are not covered:

- Donor-related for donated oocytes or sperm, including medical and travel expenses; agency, lab and donor fees; psychological screening; FDA testing for the donor and partner; genetics screening; and all medications for the donor;
- IUI cycle stimulated with gonadotropins or menotropins;
- Fallopian tube ligations and vasectomy reversals;
- Surrogacy and associated fees;
- Experimental or investigational medical and surgical procedures;
- Services not medically appropriate per Aetna's Clinical Policy Bulletin for Infertility Coverage; and
- Non-participating provider services, unless authorized by the NIU.

Hearing Aids

Hearing aids will be covered up to $2,500 every 3 years.

Eligible health services include hearing care that includes prescribed hearing aids and hearing aid services as described below.

Hearing aid means:

- Any wearable non-disposable instrument or device designed to aid or make up for impaired human hearing
- Parts, attachments, or accessories

Hearing aid services are:

- Audiometric hearing exam and evaluation for a hearing aid prescription performed by:
  - A physician certified as an otolaryngologist or otologist.
  - An audiologist who is legally qualified in audiology, or holds a certificate of Clinical Competence in Audiology from the American Speech and Hearing Association in the absence of any licensing requirements; and who performs the exam at the written direction of a legally qualified otolaryngologist or otologist.
- Electronic hearing aids, installed in accordance with a prescription written during a covered hearing exam.
- Any other related services necessary to access, select and adjust or fit a hearing aid.

Special coverage options after your Plan coverage ends

Continuation of coverage for other reasons
To request an extension of coverage, just call the toll-free Member Services number on your ID card.

How can you extend coverage for hearing services and supplies when coverage ends?
If your coverage ends while you are not totally disabled, your Plan will cover hearing services and supplies within 30 days after your coverage ends if:

- The prescription for the hearing aid is written in the 30 days before your coverage ended.
- The hearing aid is ordered during the 30 days before the date coverage ends.

Home Health Care

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

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

Covered expenses include only the following:

- Skilled nursing services that require medical training of, and are provided by, a licensed nursing professional within the scope of his or her license. These services need to be provided during intermittent visits of four hours or less, with a daily maximum of three visits. Intermittent visits are considered periodic and recurring visits that skilled nurses make to ensure your proper care, which means they are not on site for more than four hours at a time. If you are discharged from a hospital or skilled nursing facility after an inpatient stay, the intermittent requirement may be waived to allow coverage for up to 12 hours (three visits) of continuous skilled nursing services if these services are provided within 10 days of discharge.
- Home health aide services, when provided in conjunction with skilled nursing care, that directly support the care. These services need to be provided during intermittent visits of four hours or less, with a daily maximum of three visits.
- Medical social services by a qualified social worker, when provided in conjunction with skilled nursing care.
- Skilled behavioral health care services provided in the home by a behavioral health provider when ordered by a physician and directly related to an active treatment plan of care established by the physician as long as:

- The skilled behavioral health care is appropriate for the active treatment of a condition, illness or disease to avoid placing you at risk for serious complications;
- The services are in lieu of a continued confinement in a hospital or residential treatment facility, or receiving outpatient services outside of the home;
- The services provided are not primarily for comfort, convenience or custodial in nature;
- The services are intermittent or hourly in nature; and
- The services are not for applied behavioral analysis.

Benefits for home health care visits are payable up to the home health care plan maximum. **In calculating the calendar year maximum visits, each four-hour visit by a nurse or therapist is one visit, and each behavioral health provider visit of up to one hour is one visit.** This maximum will not apply to care given by an R.N. or L.P.N. when:

- Care is provided within 10 days of discharge from a hospital or skilled nursing facility as a full-time inpatient; and
- Care is needed to transition from the hospital or skilled nursing facility to home care.

When the above criteria are met, covered expenses include up to 12 hours of continuous care by an R.N. or L.P.N. per day.

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

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

- Services or supplies that are not a part of the home health care plan;
- Services of a person who usually lives with you, or who is a member of your or your spouse's family;
- Services of a certified or licensed social worker;
- Services for infusion therapy;
- Transportation;
- Services or supplies provided to a minor or dependent adult when a family member or caregiver is not present; and
- Services that are custodial care.

Important

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

Home health care needs to be precertified by Aetna. See **Precertification** for details.

Home health care plan maximum is 120 visits per calendar year (combination of network and non-network). See this *Home Health Care* section for definition of what constitutes a **visit**.

Hospice Care

The Plan covers hospice care that is provided as part of a hospice care program for a person with a prognosis of 12 months or less to live. The Plan covers charges made by a hospice facility, hospital or skilled nursing facility on its own behalf for:

- Inpatient care—Room and board charges, up to the semi-private room rate and other services and supplies provided to a person while a full-time inpatient for pain control, and other acute and chronic symptom management.
- Outpatient care—Those services and supplies furnished to a person while not confined as a full-time inpatient.

The Plan covers outpatient charges made by a hospice care agency for:

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

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

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

As part of hospice care coverage, the Plan covers home health care agency expenses for:

- Physical and occupational therapy;
- Part-time or intermittent home health aide services for up to eight hours in any one day, which consist mainly of caring for the person;
- Medical supplies;
- Drugs and medicines prescribed by a physician; and
- Psychological and dietary counseling.

The Plan's hospice care benefit *does not* include coverage for:

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

Important

Inpatient hospice care and home health care must be precertified by Aetna. See **Precertification** for details.

Hospital Services

Inpatient Hospital Expenses*

The Plan covers charges made by a hospital for room and board, and other hospital services and supplies for a person confined as an inpatient. Room and board charges are covered up to the hospital's semi-private rate.

Room and board charges include:

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

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

- Ambulance services;
- Physician and surgeon services;
- Operating and recovery rooms;
- Intensive or special care facilities;
- Administration of blood and blood products, but not the cost of the blood or blood products;
- Radiation therapy;
- Speech therapy, physical therapy and occupational therapy;
- Oxygen and oxygen therapy;
- Radiological services, laboratory testing and diagnostic services;
- Medications and intravenous (IV) preparations; and
- Discharge planning.

Important

Hospital admissions need to be precertified by Aetna. See **Precertification** for details.

Outpatient Hospital Expenses

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

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

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

Mental Disorders and Substance Abuse Treatment

Mental Disorders

Covered expenses include charges made for the treatment of mental disorders by behavioral health providers.

In addition to meeting all other conditions for coverage, the treatment plan must:

- Be written and prescribed and supervised by a behavioral health provider;
- Include follow-up treatment; and
- Be for a condition that can favorably be changed.

Benefits are payable for charges incurred in a hospital, psychiatric hospital, residential treatment facility or behavioral health provider's office for the treatment of mental disorders as follows:

- **Inpatient treatment:** Covered expenses include room and board charges at the semi-private room rate, and other services and supplies provided during your stay in a hospital, psychiatric hospital or residential treatment facility. Inpatient benefits are payable only if your condition requires services that are only available in an inpatient setting.
- **Partial confinement treatment:** Covered expenses include charges made for partial confinement treatment provided in a facility or program for the intermediate short-term or medically-directed intensive treatment of a mental disorder. Such benefits are payable if your condition requires services that are only available in a partial confinement treatment setting.
- **Outpatient treatment:** Covered expenses include charges for treatment received while not confined as a full-time inpatient in a hospital, psychiatric hospital or residential treatment facility. The Plan covers partial hospitalization services (more than four hours, but less than 24 hours per day) provided in a facility or program for the intermediate short-term or medically-directed intensive treatment. The partial hospitalization will only be covered if you would need inpatient care if you were not admitted to this type of facility. Outpatient mental health treatment also includes:
  - Electro-convulsive therapy (ECT); and
  - Substance use disorder injectables.

Substance Abuse

Covered expenses include charges made for the treatment of substance abuse by behavioral health providers. In addition to meeting all other conditions for coverage, the treatment must meet the following criteria:

- There is a program of therapy prescribed and supervised by a behavioral health provider; and
- The program of therapy includes either:
  - A follow-up program directed by a behavioral health provider on at least a monthly basis; or
  - Meetings at least twice a month with an organization devoted to the treatment of alcoholism or substance abuse.

Important

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

Inpatient care, partial hospitalizations and outpatient treatment must be precertified by Aetna. See **Precertification** for details.

The Plan covers:

- **Inpatient Treatment:** Covered expenses include room and board charges at the semi-private room rate, and other services and supplies provided during your stay in a psychiatric hospital or residential treatment facility, appropriately licensed by the state Department of Health or its equivalent. Coverage includes treatment in a hospital-when the hospital does not have a separate treatment facility section-for the medical complications of substance abuse. Medical complications include detoxification, electrolyte imbalances, malnutrition, cirrhosis of the liver, delirium tremens and hepatitis.
- **Partial Confinement Treatment:** Covered expenses include charges made for partial confinement treatment provided in a facility or program for the intermediate short-term or medically-directed intensive treatment of substance abuse. Such benefits are payable if your condition requires services that are only available in a partial confinement treatment setting.
- **Outpatient Treatment:** Outpatient treatment includes charges for treatment of substance abuse received while not confined as a full-time inpatient in a hospital, psychiatric hospital or residential treatment facility. The Plan covers partial hospitalization services (more than four hours, but less than 24 hours per day) provided in a facility or program for the intermediate short-term or medically-directed intensive treatment of alcohol or drug abuse. The partial hospitalization will only be covered if you would need inpatient treatment if you were not admitted to this type of facility.

Obesity Treatment

Covered expenses include one morbid obesity surgical procedure within a two-year period, beginning with the date of the first morbid obesity surgical procedure, unless a multi-stage procedure is planned. Covered expenses also include charges made by a physician, licensed or certified dietician, nutritionist or hospital for the non-surgical treatment of morbid obesity for the following outpatient weight management services:

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

Physician Services

Physician Visits

Covered expenses include charges made by a physician during a visit to treat an illness or injury. The visit may be at the physician's office, in your home, in a hospital or other facility during your stay, or in an outpatient facility. Covered expenses also include:

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

Surgery

Covered expenses include charges made by a physician for:

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

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

Anesthetics

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

Preventive Care

In compliance with health care reform, the Plan covers certain preventive services such as routine well woman, well man and well child exams that are submitted and billed by your provider as preventive care at 100% coverage with no deductible. The list of services is normally updated annually, so you should contact Aetna to determine if a service is considered preventive or to request a current list of covered preventive care services.

If an exam or service is given to diagnose or treat an illness or injury, it is not considered a physical exam or routine screening, so the exam and/or service ***would not*** be processed under preventive care. It would be processed as a regular medical claim subject to deductible and coinsurance.

Routine Physical Exams

Covered expenses include charges made by your primary care physician (PCP) for routine physical exams. This includes routine vision and hearing screenings given as part of the routine physical exam. A routine exam is a medical exam given by a physician for a reason other than to diagnose or treat a suspected or identified illness or injury, and also includes:

- Evidence-based items that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force.
- Services as recommended in the American Academy of Pediatrics/Bright Futures Guidelines for Children and Adolescents.
- Screenings and counseling services as provided for in the comprehensive guidelines recommended by the Health Resources and Services Administration. These services may include but are not limited to:
  - Screening and counseling services, such as:
    - Interpersonal and domestic violence;
    - Sexually transmitted diseases; and
    - Human immune deficiency virus (HIV) infections.
    - Screening for gestational diabetes for women.
    - High-risk human papillomavirus (HPV) DNA testing for women age 30 and older.
  - X-rays, lab and other tests given in connection with the exam.
  - For covered newborns, an initial hospital checkup.

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

- Services covered to any extent under any other part of the Plan;
- Services for diagnosis or treatment of a suspected or identified illness or injury;
- Exams during your stay for medical care;
- Services not given by a physician or under his or her direction; or
- Psychiatric, psychological, personality or emotional testing or exams.

Immunizations

Covered expenses include charges made by your physician or a facility that have been recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention for:

- Immunizations for infectious diseases; and
- Materials for administration of immunizations.

The Plan does not cover charges incurred for immunizations that are not considered preventive care such as those required due to your employment or travel.

Well Woman Preventive Visits

Covered expenses include charges made by your physician, obstetrician or gynecologist for:

- A routine well woman preventive exam office visit, including Pap smears. A routine well woman preventive exam is a medical exam given by a physician for a reason other than to diagnose or treat a suspected or identified illness or injury; and
- Routine preventive care breast cancer genetic counseling and breast cancer (BRCA) gene blood testing. Covered expenses include charges made by a physician and lab for the BRCA gene blood test and charges made by a genetic counselor to interpret the test results and evaluate treatment.

These benefits will be subject to any age, family history and frequency guidelines that are:

- Evidence-based items or services that have in effect a rating of A or B in the recommendations of the United States Preventive Services Task Force; and
- Evidence-informed items or services provided in the comprehensive guidelines supported by the Health Resources and Services Administration.

Unless specified above, the Plan will not cover charges for:

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

Routine Screenings for Cancer

Covered expenses include, but are not limited to, charges incurred for routine cancer screenings as follows:

- Mammograms;
- Fecal occult blood tests;
- Digital rectal exams;
- Prostate specific antigen (PSA) test;
- Sigmoidoscopies;
- Double contrast barium enemas (DCBE);
- Colonoscopies (removal of polyps performed during a screening procedure is a covered expense); and
- Lung cancer screening.

These benefits will be subject to any age, family history and frequency guidelines that are:

- Evidence-based items or services that have in effect a rating of A or B in the recommendations of the United States Preventive Services Task Force; and
- Evidence-informed items or services provided in the comprehensive guidelines supported by the Health Resources and Services Administration.

Unless specified above, this preventive care benefit does not cover charges incurred for services that are covered to any extent under any other part of this Plan.

Screening and Counseling Services

Covered expenses include charges made by your PCP in an individual or group setting for the following:

- **Obesity and/or Healthy Diet:** Screening and counseling services to aid in weight reduction due to obesity. Coverage is limited to 26 network and 10 non-network visits; however, of these only 26 visits will be allowed under the Plan for healthy diet counseling provided in connection with hyperlipidemia (high cholesterol) and other known risk factors for cardiovascular and diet-related chronic disease. Each session of up to 60 minutes is equal to one visit. Coverage includes:
  - Preventive counseling visits and/or risk factor reduction intervention;
  - Nutrition counseling; and
  - Healthy diet counseling visits provided in connection with hyperlipidemia (high cholesterol) and other known risk factors for cardiovascular and diet-related chronic disease.
- **Misuse of Alcohol and/or Drugs:** Screening and counseling services to aid in the prevention or reduction of the use of an alcohol agent or controlled substance. Coverage includes preventive counseling visits, risk factor reduction intervention and a structured assessment. Coverage is limited to five visits. Each session of up to 60 minutes is equal to one visit.
- **Use of Tobacco Products:** Screening and counseling services to aid in the cessation of the use of tobacco products. Tobacco product means a substance containing tobacco or nicotine including cigarettes, cigars, smoking tobacco, snuff, smokeless tobacco and candy-like products that contain tobacco. Coverage is limited to eight visits. Each session of up to 60 minutes is equal to one visit. Coverage includes, to aid in the cessation of the use of tobacco products:
  - Preventive counseling visits;
  - Treatment visits; and
  - Class visits.
- **Sexually Transmitted Infections:** Covered expenses include the counseling services to help you prevent or reduce sexually transmitted infections. Coverage is limited to two visits. Each session of up to 30 minutes is equal to one visit.
- **Genetic Risks for Breast and Ovarian Cancer:** Covered expenses include the counseling and evaluation services to help you assess your breast and ovarian cancer susceptibility.

Prenatal Care

Coverage for prenatal care is limited to pregnancy-related physician office visits, including the initial and subsequent history and physical exams of the pregnant woman (maternal weight, blood pressure, fetal heart rate check and fundal height).

Unless otherwise specified, the Plan does not cover charges for:

- Services that are covered to any extent under any other part of this Plan; and
- Pregnancy expenses (other than prenatal care as described above).

Comprehensive Lactation Support and Counseling Services

Covered expenses include comprehensive lactation support (assistance and training in breastfeeding) and counseling services provided to females during pregnancy, or at any time following delivery, for breastfeeding by a certified lactation support provider. Covered services include:

- **Lactation Support and Lactation Counseling Services:** Covered expense when provided in either a group or individual setting. Benefits for lactation counseling services are limited to six network visits in 12 months. Additional or non-network visits are covered as physician office visits.
- **Breastfeeding Durable Medical Equipment:** Coverage includes the rental or purchase of breastfeeding durable medical equipment for the purpose of lactation support (pumping and storage of breast milk) as follows:
  - Breast pump: Covered expenses include the following:
    - The rental of a hospital-grade electric pump for a newborn child when the newborn child is confined in a hospital.
    - The purchase of:
      - An electric breast pump (non-hospital grade). A purchase will be covered once every three years; or
      - A manual breast pump. A purchase will be covered once per pregnancy.

      If an electric breast pump was purchased within the previous three-year period, the purchase of another breast pump will not be covered until a three-year period has elapsed from the last purchase.
  - Breast pump supplies: Coverage is limited to only one purchase per pregnancy in any year where a covered female would not qualify for the purchase of a new pump.

  Coverage for the purchase of breast pump equipment is limited to one item of equipment, for the same or similar purpose, and the accessories and supplies needed to operate the item. You are responsible for the entire cost of any additional pieces of the same or similar equipment you purchase or rent for personal convenience or mobility.

Aetna reserves the right to limit the payment of charges up to the most cost-efficient and least restrictive level of service or item that can be safely and effectively provided. The decision to rent or purchase is at the discretion of Aetna.

Vision Care Services

Covered expenses include charges made by a legally qualified ophthalmologist or optometrist for a routine eye exam that includes refraction and glaucoma testing. A routine eye exam does not include a contact lens exam. The Plan covers charges for one routine eye exam in any calendar year.

Prosthetic Devices

Covered expenses include charges made for internal and external prosthetic devices and special appliances, if the device or appliance improves or restores body part function that has been lost or damaged by illness, injury or congenital defect. Covered expenses also include instruction and incidental supplies needed to use a covered prosthetic device. The Plan covers the first prosthesis for an internal body part or organ or external body part that you need that temporarily or permanently replaces all or part of a body part lost or impaired as a result of illness, injury or congenital defect as described in the list of covered devices below:

- An artificial arm, leg, hip, knee or eye;
- Eye lens;
- An external breast prosthesis and the first bra made solely for use with it after a mastectomy;
- A breast implant after a mastectomy;

- Ostomy supplies, urinary catheters and external urinary collection devices;
- Speech generating device;
- A cardiac pacemaker and pacemaker defibrillators; and
- A durable brace that is custom made and fitted for you.

Covered expenses also include replacement of a prosthetic device if:

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

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

- Orthopedic shoes, therapeutic shoes, foot orthotics or other devices to support the feet, unless required for the treatment of or to prevent complications of diabetes, or if the shoes are the first pair of corrective shoes for a child up to age two, or if an orthopedic shoe is an integral part of a covered leg brace;
- Trusses, corsets and other support items; or
- Any item listed in **What the Medical Plan Does Not Cover**.

Reconstructive or Cosmetic Surgery and Supplies

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

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

Reconstructive Breast Surgery

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

Sexual Health

The Plan covers charges for any treatment, drug, service or supply related to changing sex or sexual characteristics.

Short-Term Rehabilitation Therapy Services

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

- Licensed or certified physical, occupational or speech therapist;
- Hospital, skilled nursing facility or hospice facility;
- Behavioral health provider for autism spectrum disorder; or
- Physician.

Charges for the following short-term rehabilitation expenses are covered:

Autism Spectrum Disorder Benefits

Covered expenses for autism spectrum disorder (as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association) include charges made for the services and supplies for the diagnosis and treatment (including routine behavioral health services such as office visits or therapy) of autism spectrum disorder when ordered by a physician, licensed psychologist, or licensed clinical social worker, as part of a treatment plan, when the covered child is diagnosed with autism spectrum disorder.

Cardiac and Pulmonary Rehabilitation Benefits

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

Pulmonary rehabilitation benefits are available as part of an inpatient hospital stay. A limited course of outpatient pulmonary rehabilitation is covered for the treatment of a reversible pulmonary disease state. This course of treatment is limited to a maximum of 36 hours or a six-week period.

Therapy

The Plan covers outpatient cognitive therapy, physical therapy, occupational therapy and speech therapy rehabilitation. Inpatient rehabilitation benefits for the services listed will be paid as part of your inpatient hospital and skilled nursing facility benefits provision in this SPD:

- **Applied behavioral analysis (ABA) therapy** for individuals diagnosed with an Autism Spectrum Disorder. Specific criteria must be met to be eligible for this benefit. Treatment is based on medical necessity and requires precertification. This program also requires ongoing reviews for continuation of therapy.
- **Cognitive therapy** associated with physical rehabilitation is covered when the cognitive deficits have been acquired as a result of neurologic impairment due to trauma, stroke or encephalopathy, and when the therapy is part of a treatment plan intended to restore previous cognitive function.
- **Occupational therapy** (except for vocational rehabilitation or employment counseling) is covered for non-chronic conditions and acute illnesses and injuries, provided the therapy is expected to significantly improve, develop or restore physical functions lost or impaired as a result of an acute illness, injury or surgical procedure, or to relearn skills to significantly improve independence in the activities of daily living. Occupational therapy does not include educational training or services designed to develop physical function.

- **Physical therapy** is covered for non-chronic conditions and acute illnesses and injuries, provided the therapy is expected to significantly improve, develop or restore physical functions lost or impaired as a result of an acute illness, injury or surgical procedure. Physical therapy does not include educational training or services designed to develop physical function.
- **Speech therapy** is covered for non-chronic conditions and acute illnesses and injuries if expected to restore the speech function or correct a speech impairment resulting from illness or injury; or for delays in speech function development as a result of a gross anatomical defect present at birth. Speech function is the ability to express thoughts, speak words and form sentences. Speech impairment is difficulty with expressing one's thoughts with spoken words.

Coverage for physical, occupational and speech therapy is also available for the treatment of developmental delays (as an exception to the non-chronic condition criteria described in the bullets above).

A visit consists of no more than one hour of therapy. Covered expenses include charges for two therapy visits of no more than one hour in a 24-hour period. The therapy should follow a specific treatment plan that details the treatment, specifies frequency and duration, and provides for ongoing reviews; and is renewed only if continued therapy is appropriate.

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

- Therapies for the treatment of delays in development, unless resulting from acute illness or injury, or congenital defects amenable to surgical repair (such as cleft lip/palate). Examples of non-covered diagnoses include pervasive development disorders, Down syndrome and cerebral palsy, as they are considered both developmental and/or chronic in nature. This does not apply to physical therapy, occupational therapy or speech therapy provided for the treatment of autism spectrum disorders;
- Any services that are covered expenses in whole or in part under any other group plan sponsored by an employer;
- Any services unless provided in accordance with a specific treatment plan;
- Services provided during a stay in a hospital, skilled nursing facility, or hospice facility except as stated above;
- Services not performed by a physician or under the direct supervision of a physician;
- Treatment covered as part of the spinal manipulation treatment. This applies whether or not benefits have been paid under that section;
- Services provided by a physician or physical, occupational or speech therapist who resides in your home or who is a member of your or your spouse's family; or
- Special education to instruct a person whose speech has been lost or impaired to function without that ability, including lessons in sign language.

Skilled Nursing Care

The Plan covers charges by an R.N., L.P.N., or nursing agency for outpatient skilled nursing care. This is care by a visiting R.N. or L.P.N. to perform specific skilled nursing tasks.

Covered expenses also include private duty nursing provided by a R.N. or L.P.N. if the person's condition requires skilled nursing care and visiting nursing care is not adequate. However, covered expenses will not include private duty nursing for any shifts during a calendar year in excess of the Private Duty Nursing Care maximum shifts. Each period of private duty nursing of up to eight hours is considered one private duty nursing shift.

Limitations

Unless specified above, the Plan does not cover charges for:

- Nursing care that does not require the education, training and technical skills of a R.N. or L.P.N.
- Nursing care assistance for daily life activities, such as:
  - Transportation;
  - Meal preparation;
  - Vital sign charting;
  - Companionship activities;
  - Bathing;
  - Feeding;
  - Personal grooming;
  - Dressing;
  - Toileting; and
  - Getting in/out of bed or a chair.
- Nursing care provided for skilled observation.
- Nursing care provided while you are an inpatient in a hospital or health care facility.
- A service provided solely to administer oral medicine, except where law requires a R.N. or L.P.N. to administer medicines.

Skilled Nursing Facility Care

The Plan covers charges made by a skilled nursing facility for the services and supplies listed below. These must be provided to a person while confined to convalescent care from an illness or injury.

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

Skilled nursing facility care *does not* include charges for treatment of:

- Drug addiction;
- Chronic brain syndrome;
- Alcoholism;
- Mental retardation; and
- Any other mental disorder.

Important

Admission to a skilled nursing facility must be precertified by Aetna. See **Precertification** for details.

The Plan pays for a maximum of 120 days for skilled nursing services per calendar year, combined for network and non-network care.

Specialized Care

Chemotherapy

Covered expenses include charges for chemotherapy treatment. Coverage levels depend on where treatment is received. In most cases, chemotherapy is covered as outpatient care. Inpatient hospitalization for chemotherapy is limited to the initial dose while hospitalized for the diagnosis of cancer and when a hospital stay is otherwise medically necessary based on your health status.

Radiation Therapy Benefits

Covered expenses include charges for the treatment of illness by x-ray, gamma ray, accelerated particles, mesons, neutrons, radium or radioactive isotopes.

Outpatient Infusion Therapy Benefits

Covered expenses include infusion therapy received from an outpatient setting including but not limited to:

- A free-standing outpatient facility;
- The outpatient department of a hospital; or
- A physician in his/her office or in your home.

The list of preferred infusion locations can be found by contacting Member Services by logging onto the Aetna member website at **www.aetna.com** or calling the number on the back of your ID card.

Infusion therapy is the intravenous or continuous administration of medications or solutions that are a part of your course of treatment. Charges for the following outpatient Infusion Therapy services and supplies are covered expenses:

- The pharmaceutical when administered in connection with infusion therapy and any medical supplies, equipment and nursing services required to support the infusion therapy;
- Professional services;
- Total parenteral nutrition (TPN);
- Chemotherapy;
- Drug therapy (includes antibiotic and antivirals);
- Pain management (narcotics); and
- Hydration therapy (includes fluids, electrolytes and other additives).

Not included under this infusion therapy benefit are charges incurred for:

- Enteral nutrition;
- Blood transfusions and blood products;
- Dialysis; and
- Insulin.

Coverage for inpatient infusion therapy is provided under inpatient hospital and skilled nursing facility. Benefits payable for infusion therapy will not count toward any applicable home health care maximums.

Spinal Manipulation Benefit

The Plan covers expenses for chiropractic therapy services such as manipulative (adjustive) treatment or other physical treatment for conditions caused by (or related to) biomechanical or nerve conduction disorders of the spine. Benefits are paid for up to 26 visits per calendar year.

The maximum does not apply to expenses incurred:

- While the person is a full-time inpatient in a hospital;
- For treatment of scoliosis;
- For fracture care; or
- For surgery, including pre- and post-surgical care provided or ordered by the operating physician.

Special Programs

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

24/7 Telemedicine Services

Teladoc gives you access 24/7 to a U.S. board-certified doctor for non-emergency medical conditions through the convenience of phone, video or mobile app visits. Set up your account by visiting Teladoc.com/Aetna, download the app from your mobile store or call 1-855-Teladoc (835-2362). You will need to provide a medical history and request a consult. You pay the applicable cost up front.

Transplants—National Medical Excellence Program®

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

Transplant Services

Eligible health services include organ transplant services provided by a physician and hospital.
Organ means:

- Solid organ
- Hematopoietic stem cell
- Bone marrow
- CAR-T and T-cell receptor therapy for FDA-approved treatments

Network of transplant specialist facilities

The amount you will pay for covered transplant services is determined by where you get transplant services. You can get transplant services from:

- An Institutes of Excellence™ (IOE) facility we designate to perform the transplant you need, or
- A Non-IOE facility.

Your cost share will be lower when you get transplant services from the IOE facility we designate to perform the transplant you need. You may also get transplant services at a non-IOE facility, but your cost share will be higher.

The National Medical Excellence (NME) Program® will coordinate all solid organ, bone marrow and CAR-T and T-cell therapy services, and other specialized care you need.

Many pre- and post-transplant medical services, even routine ones, are related to and may affect the success of your transplant. While your transplant care is being coordinated by the NME Program, all medical services must be managed through NME so that you receive the highest level of benefits at the appropriate facility. This is true even if the covered service is not directly related to your transplant.

Important

To ensure coverage, all transplant procedures need to be precertified by Aetna. See **Precertification** for details.

Expenses Not Covered

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

- Services and supplies furnished to a donor when the recipient is not a covered person
- Harvesting and storage of organs, without intending to use them for immediate transplantation for your existing illness
- Harvesting and/or storage of bone marrow, hematopoietic stem cells or other blood cells without intending to use them for transplantation within 12 months from harvesting, for an existing illness

Network of Transplant Specialist Facilities

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

You can obtain a list of IOE facilities on the provider search (**www.aetna.com**) or by contacting Aetna Member Services at **800-334-0299.**

Travel and Lodging

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

Other Health Management Programs

Special programs are available to provide you with education, guidance and tools to better handle certain conditions and health care events. Discount programs are also available to give you access to savings on weight management, fitness, vision and hearing products and services, and alternative therapies.

For more details, log on to the member website at **aetna.com** and select *Health Programs* for links to health management and family health program information and resources.

In Touch Care

When you're facing a chronic or acute health challenge, Aetna In Touch Care, a voluntary, confidential program, provides the resources you need, when you need them at no cost to you.

One-on-One Nurse Support

For urgent circumstances, an In Touch Care nurse provides one-on-one phone support for you and your family. The nurse can help you:

- Customize action plans that fit your life;
- Navigate the health care system;
- Coordinate your care; and
- Prepare for a hospital stay or plan for recovery.

Virtual Care

For less urgent, less immediate health needs, use online tools to help you:

- Track your health progress through an online health assessment, or track your health statistics and physical activity;
- Choose from several online coaching programs that provide customized tools and guidance; and
- Call an In Touch Care nurse if you need extra help along the way.

Aetna may contact you directly to notify you about this program. You can also learn more at **aetna.com**.

Compassionate Care℠ Program

The Aetna **Compassionate Care Program** can help you and your family when facing the advanced stages of an illness. You may have questions and difficult decisions to make. You don't have to do it alone. Nurse case managers and helpful resources are here to help. Call the Member Services toll-free phone number on your Aetna ID card to talk with a nurse case manager about the program.

Beginning Right℠ Maternity Program

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

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

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

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

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

Informed Health® Line

You and your family have around-the-clock access to an Aetna team of nurses experienced in providing information on a variety of health topics. Aetna's Informed Health® Line (IHL) nurses help you communicate more effectively with your physicians and provide you with information about:

- Health issues;
- Medical procedures; and
- Treatment options.

To reach the Informed Health® Line day or night, call **800-556-1555,** which is also listed on your Aetna ID card. You may also access the member website to review comprehensive and unbiased evidence-based information for help in making decisions about your health.

What the Medical Plan Does Not Cover

Not every medical service or supply is covered by the Plan, even if prescribed, recommended or approved by your physician or dentist. The Plan covers only those services and supplies that are medically necessary and included in **Covered Medical Expenses**. Charges made for the following are not covered except to the extent listed under *Covered Medical Expenses.*

This section contains a general list of charges *not covered* under the medical portion of the Aetna medical options. Excluded charges are not used when calculating benefits and do not count toward your deductible, coinsurance or out-of-pocket maximum.

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

General Exclusions

The Plan *does not* cover:

- Non-medically necessary services, including but not limited to, those treatments, services, prescription drugs and supplies that are not medically necessary, as determined by Aetna, for the diagnosis and treatment of illness, injury, restoration of physiological functions or covered preventive services. This applies even if they are prescribed, recommended or approved by your physician or dentist.
- Services provided where there is no evidence of pathology, dysfunction, or disease; except as specifically provided in connection with covered routine care and cancer screenings.
- Services, including those related to pregnancy, rendered before the effective date or after the termination of coverage, unless coverage is continued under **Continuation of Coverage**.
- Care, treatment, services or supplies not prescribed, recommended or approved by a physician or dentist.
- Services of a resident physician or intern rendered in that capacity.
- Charges made only because you have health coverage.
- Charges you are not legally obligated to pay.
- Services provided by a spouse, domestic partner, parent, child, stepchild, brother, sister, in-law or any household member.
- Charges not recognized by the claims administrator.
- Charges for a service or supply furnished by a non-network provider in excess of the recognized charge.
- Charges submitted for services that are not rendered, or rendered to a person not eligible for coverage under the Plan.

- Charges submitted for services by an unlicensed hospital, physician or other provider or not within the scope of the provider's license.
- Charges in excess of the negotiated fee for a given service or supply given by a network provider.
- Unauthorized services, including any service obtained by or on behalf of a covered person without precertification by Aetna when required. This exclusion does not apply in a medical emergency or in an urgent care situation.
- Any illness or injury related to employment or self-employment including any illness or injury that arises out of (or in the course of) any work for pay or profit, unless no other source of coverage or reimbursement is available to you for the services or supplies. Sources of coverage or reimbursement may include your employer, Workers' Compensation, or an occupational illness or similar program under local, state or federal law. A source of coverage or reimbursement will be considered available to you even if you waived your right to payment from that source. If you are also covered under a Workers' Compensation law or similar law, and submit proof that you are not covered for a particular illness or injury under such law, that illness or injury will be considered "non-occupational" regardless of cause.

Behavioral Health Services

The Plan *does not* cover charges for:

- Alcoholism or substance abuse rehabilitation treatment on an inpatient or outpatient basis, except to the extent coverage for detoxification or treatment of alcoholism or substance abuse is specifically provided in **Covered Medical Expenses**;
- Treatment of a covered health care provider who specializes in the mental health care field and who receives treatment as a part of their training in that field;
- Treatment of impulse control disorders such as pathological gambling, kleptomania, pedophilia, caffeine use or nicotine use;
- Treatment of antisocial personality disorder;
- Counseling services and treatment for marriage, religious, family, career, social adjustment, pastoral or financial counselor, except as specifically provided in **Covered Medical Expenses**;
- Wilderness treatment programs (whether or not the program is part of a licensed **residential treatment facility**, or otherwise licensed institution), educational services, schooling or any such related or similar program, including therapeutic programs within a school setting; or
- Treatment of mental retardation, defects and deficiencies. This exclusion does not apply to mental health services or to medical treatment of the mentally retarded in accordance with the benefits provided in **Covered Medical Expenses**.

Cosmetic Services and Plastic Surgery

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

- Face lifts; body lifts; tummy tucks; liposuctions; removal of excess skin; removal or reduction of non-malignant moles, blemishes or varicose veins; cosmetic eyelid surgery and other surgical procedures;
- Procedures to remove healthy cartilage or bone from the nose (even if the surgery may enhance breathing) or other part of the body;
- Chemical peels, dermabrasion, laser or light treatments, bleaching, creams, ointments or other treatments or supplies to alter the appearance or texture of the skin;
- Insertion or removal of any implant that alters the appearance of the body (such as breast or chin implants), except removal of an implant will be covered when medically necessary;

- Removal of tattoos (except for tattoos applied to assist in covered medical treatments such as markers for radiation therapy);
- Repair of piercings and other voluntary body modifications, including removal of injected or implanted substances or devices;
- Surgery to correct gynecomastia;
- Breast augmentation; and
- Otoplasty.

Custodial Care and Maintenance Care

The Plan *does not* cover charges for custodial care or maintenance care, as defined, without regard to who prescribes, recommends or performs these services.

Educational Services

The Plan *does not* cover charges for:

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

Experimental or Investigational

The Plan *does not* cover charges for experimental or investigational drugs, devices, treatment or procedures except as described in **Covered Medical Expenses**.

Facility Charges

The Plan *does not cover* facility charges for care services or supplies provided in:

- Rest homes;
- Assisted living facilities;
- Similar institutions serving as an individual's primary residence or providing primarily custodial or rest care;
- Health resorts;
- Spas, sanitariums; or
- Infirmaries at schools, colleges, or camps.

Home and Mobility

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

- Purchase or rental of exercise equipment, air purifiers, central or unit air conditioners, water purifiers, waterbeds and swimming pools;
- Exercise and training devices, whirlpools, portable whirlpool pumps, sauna baths or massage devices;
- Equipment or supplies to aid sleeping or sitting, including non-hospital electric and air beds, water beds, pillows, sheets, blankets, warming or cooling devices, bed tables and reclining chairs;
- Equipment installed in your home, workplace or other environment, including stair-glides, elevators, wheelchair ramps, or equipment to alter air quality, humidity or temperature;

- Other additions or alterations to your home, workplace or other environment, including room additions, changes in cabinets, countertops, doorways, lighting, wiring, furniture, communication aids, wireless alert systems or home monitoring;
- Services and supplies furnished mainly to provide a surrounding free from exposure that can worsen your illness or injury;
- Removal from your home, worksite or other environment of carpeting, hypo-allergenic pillows, mattresses, paint, mold, asbestos, fiberglass, dust, pet dander, pests or other potential sources of allergies or illness; and
- Transportation devices, including stair-climbing wheelchairs, personal transporters, bicycles, automobiles, vans or trucks, or alterations to any vehicle or transportation device.

Motor Vehicle Accidents

The Plan *does not* cover charges incurred due to injuries received in an accident involving any motor vehicle for which no-fault insurance is available, regardless of whether any such policy is designated as secondary to health coverage.

Other Services and Supplies

The Plan also *does not* cover:

- Annual or other charges to be in a physician's practice;
- Charges to have preferred access to a physician's services such as boutique or concierge physician practice;
- Charges in excess of the benefit, dollar, day, visit or supply limits stated in this SPD;
- Specific non-standard allergy services and supplies, including but not limited to, skin titration (Rinkel method), cytotoxicity testing (Bryan's Test) treatment of non-specific candida sensitivity and urine auto-injections;
- Non-emergency charges incurred outside of the United States if you traveled to such location to obtain prescription drugs or supplies, even if otherwise covered under the Plan. This also includes prescription drugs or supplies if:
  - Such prescription drugs or supplies are unavailable or illegal in the United States; or
  - The purchase of such prescription drugs or supplies outside the United States is considered illegal;
- Charges for the LEAP, TEACCH, Denver and Rutgers programs;
- Dental services (except as provided in Dental Care) for any treatment, services or supplies related to the care, filling, removal or replacement of teeth and the treatment of injuries and diseases of the teeth, gums, and other structures supporting the teeth. This includes but is not limited to:
  - Services of dentists, oral surgeons, dental hygienists, and orthodontists including apicoectomy (dental root resection), root canal treatment, soft tissue impactions, treatment of periodontal disease, alveolectomy, augmentation and vestibuloplasty and fluoride and other substances to protect, clean or alter the appearance of teeth;
  - Dental implants, false teeth, prosthetic restoration of dental implants, plates, dentures, braces, mouth guards, and other devices to protect, replace or reposition teeth; and
  - Non-surgical treatments to alter bite or the alignment or operation of the jaw, including treatment of malocclusion or devices to alter bite or alignment.

  This exclusion does not include removal of bony impacted teeth, bone fractures, removal of tumors and orthodontogenic cysts;

- Disposable outpatient supplies, including sheaths, bags, elastic garments, support hose, bandages, bedpans, syringes, blood or urine testing supplies, and other home test kits; and splints, neck braces, compresses and other devices not intended for reuse by another patient, except as specifically provided as covered;
- Drugs, medications and supplies that are excluded under the Oxy Retiree Medical Plan option, however, may be covered under **Prescription Drug Benefits**:
  - Over-the-counter drugs, biological or chemical preparations, and supplies that may be obtained without a prescription including vitamins;
  - Any services related to the dispensing, injection or application of a drug;
  - Any prescription drug purchased illegally outside the United States, even if otherwise covered under this Plan within the United States;
  - Immunizations related to work;
  - Needles, syringes and other injectable aids, except as covered for diabetic supplies;
  - Drugs related to the treatment of non-covered expenses;
  - Performance enhancing steroids;
  - Injectable drugs if an alternative oral drug is available;
  - Outpatient prescription drugs;
  - Self-injectable prescription drugs and medications;
  - Any prescription drugs, injectibles, or medications or supplies provided by the customer or through a third-party vendor contract with the customer; and
  - Charges for any prescription drug for the treatment of erectile dysfunction, impotence, or sexual dysfunction or inadequacy.
- Private duty nursing during your stay in a hospital, and outpatient private duty nursing services, except as specifically described in **Skilled Nursing Care**;
- Personal comfort or convenience items: any service or supply primarily for your convenience and personal comfort or that of a third party, including telephone, television, internet, barber or beauty service or other guest services; housekeeping, cooking, cleaning, shopping, monitoring, security or other home services; and travel, transportation, or living expenses, rest cures, recreational or diversional therapy;
- Expenses for preparing or copying medical reports, itemized bills or claim forms; mailing and/or shipping and handling; broken or cancelled appointments; sales tax; or interest charges;
- Travel expenses of a physician or covered person, except as specified in **Special Programs**;
- Food items, including infant formulas, nutritional supplements, vitamins (including prescription vitamins), medical foods and other nutritional items, even if they are the sole source of nutrition (this exclusion does not apply to specialized medical foods delivered parenterally);
- Foot care except as provided in **Covered Medical Expenses** and any services, supplies or devices to improve comfort or appearance of toes, feet or ankles, including but not limited to:
  - Treatment of calluses, bunions, toenails, hammer-toes, subluxations, fallen arches, weak feet, chronic foot pain or conditions caused by routine activities such as walking, running, working or wearing shoes; and
  - Shoes (including orthopedic shoes), arch supports, shoe inserts, ankle braces, guards, protectors, creams, ointments and other equipment, devices and supplies, even if required following a covered treatment of an illness or injury;
- Hospital, inpatient or residential cognitive therapy, or educational therapy or retraining unless part of a neurological rehabilitation program for an acute organic brain condition;

- Treatment for developmental deficits, learning disability, pervasive development disorders and chronic organic brain syndrome; except as specifically provided in **Short-Term Rehabilitation Therapy Services**;
- Non-medical services in the treatment of mental disability (except initial diagnosis);
- Services and supplies provided for personal comfort or convenience, or for the convenience of any other person, including a provider;
- Drugs, medicines or supplies while not confined as an inpatient that do not require a physician's prescription;
- Any treatment, drug, service or supply to stop or reduce smoking or the use of other tobacco products or to treat or reduce nicotine addiction, dependence or cravings, including counseling, hypnosis and other therapies, medications, nicotine patches and gum except as specifically provided in the **Preventive Care**; however, the prescription drug benefits cover certain prescribed smoking cessation products;
- Performance, athletic performance or lifestyle enhancement drugs or supplies;
- Routine physical exams, routine vision exams, routine dental exams, routine hearing exams, immunizations, or other preventive services and supplies, except to the extent coverage for such exams, immunizations, services or supplies is provided for in this SPD;
- Dental procedures, except the procedures described in **Covered Medical Expenses**;
- Durable medical equipment charges for more than one item for the same or similar purposes;
- Blood, blood plasma, synthetic blood, blood products or substitutes, including but not limited to, the provision of blood, other than blood derived clotting factors. Any related services including processing, storage or replacement costs, and the services of blood donors, apheresis or plasmapheresis are not covered. For autologous blood donations, only administration and processing costs are covered;
- Court ordered services, including those required as a condition of parole or release;
- Any health exams required:
  - By a third party, including examinations and treatments required to obtain or maintain employment, or which an employer is required to provide under a labor agreement;
  - By any law of a government;
  - For securing insurance, school admissions, or professional or other licenses;
  - To travel; and
  - To attend a school, camp, or sporting event or participate in a sport or other recreational activity;
- Any special medical reports not directly related to treatment except when provided as part of a covered service;
- Any growth/height treatment, device, drug, service or supply (including surgical procedures, devices to stimulate growth and growth hormones), solely to increase or decrease height or alter the rate of growth;
- Hearing:
  - Any hearing service or supply that does not meet professionally accepted standards; and
  - Hearing exams given during a stay in a hospital or other facility; and
  - Any tests, appliances and devices for the improvement of hearing, or to enhance other forms of communication to compensate for hearing loss or devices that simulate speech except to the extent coverage for such tests, appliances and devices is provided for in this SPD;
- Any services and supplies related to births occurring in the home or in a place not licensed to perform deliveries;

- Nursing and home health aide services provided outside of the home (such as in conjunction with school, vacation, work or recreational activities);
- Transportation costs, including ambulance services for routine transportation to receive outpatient or inpatient services except as described in **Covered Medical Expenses**;
- Payment for that portion of the charge for which Medicare or another party is the primary payer; or
- Charges the recipient has no legal obligation to pay; or the charges would not be made if the recipient did not have coverage (to the extent exclusion is permitted by law), including:
  - Care in charitable institutions;
  - Care for conditions related to current or previous military service;
  - Care while in the custody of a governmental authority;
  - Any care a public hospital or other facility is required to provide; or
  - Any care in a hospital or other facility owned or operated by any federal, state or other governmental entity, except to the extent coverage is required by applicable laws.

Other Therapies and Tests

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

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

The Plan *does not* cover charges for therapies for the treatment of congenital defects amenable to surgical repair (such as cleft lip/palate), except as specifically provided in **Covered Medical Expenses**.

Reproductive and Sexual Health

The Plan *does not* cover charges for:

- Contraception, except as specifically described in **Family Planning.** Not covered supplies include over-the-counter contraceptive supplies including but not limited to condoms, contraceptive foams, jellies and ointments.
- Sexual dysfunction/enhancement: Any treatment, drug, service or supply to treat sexual dysfunction, enhance sexual performance or increase sexual desire, including:
  - Surgery, drugs, implants, devices or preparations to correct or enhance erectile function, enhance sensitivity, or alter the shape or appearance of a sex organ; and
  - Sex therapy, sex counseling, marriage counseling, or other counseling or advisory services.
- Infertility: Except as specifically described in **Covered Medical Expenses**

Vision and Speech

The Plan *does not* cover charges for:

- Special supplies such as non-prescription sunglasses and subnormal vision aids;
- Vision services or supplies that do not meet professionally accepted standards;
- Eye exams during your stay in a hospital or other facility for health care;
- Contact lenses evaluation and fitting exam;
- Eyeglasses or duplicate or spare eyeglasses or lenses or frames;
- Replacement of lenses or frames that are lost, stolen or broken;
- Acuity tests;
- Eye surgery for the correction of vision, including radial keratotomy, LASIK and similar procedures;
- Services to treat errors of refraction; and
- Speech therapy for treatment of delays in speech development, except as specifically provided in **Covered Medical Expenses**.

Weight Management

Except as provided in **Obesity Treatment**, the Plan *does not* cover charges for treatments, prescription drugs, services, or supplies intended to decrease or increase body weight, control weight or treat obesity, including morbid obesity, regardless of the existence of comorbid conditions.

Requesting Medical Benefits

In general, if you use a network provider, the provider will submit the claim for you. You must submit the claim if you use a non-network provider within 90 days after the date you incur 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.

Filing Medical Claims

Claim forms are available on:

- OxyLink Online at **oxylink.oxy.com**
- **Aetna.com** or by calling Aetna Member Services at **800-334-0299**

The claim form contains instructions on how and when to file a claim, as well as the address to which you should send your completed form. When filing a claim for benefits, you must provide:

- Names and addresses of physicians or providers;
- The dates on which expenses are incurred; and
- Copies of all bills and receipts.

Claims should be submitted to:

Aetna Life Insurance Company
P.O. Box 14079
Lexington, KY 40512-4079
Fax: **859-455-8650**

You should always submit claims to the primary plan first. When filing a claim for **coordination of benefits**, you must submit the explanation of benefits (EOB) statement received from the primary plan and all associated bills to the secondary plan.

You can file claims for benefits and appeal adverse claim decisions yourself or through an authorized representative—a person you authorize, in writing, to act on your behalf. You need to tell Aetna if you choose to have someone else appeal for you (even if it is your provider). You should fill out an authorized representative form telling Aetna that you are allowing someone to appeal for you. You can get this form by contacting Aetna. You can use an authorized representative at any level of appeal. The Plan will also recognize a court order giving a person authority to submit claims on your behalf, except in the case of a claim involving urgent care, a health care professional with knowledge of your condition may always act as your authorized representative.

Important

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

Payment of Medical Benefits

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

Prescription Drug Benefits

Prescription drug coverage is provided through Express Scripts, Inc. (Express Scripts) for the Aetna Retiree Medical Plan.

This benefit has two components 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.
- The mail order pharmacy is designed for a longer-term prescription.

The amount you pay for your prescription depends on whether it is a generic, preferred or non-preferred brand name drug. Refer to the **Benefits at a Glance** chart for prescription drug **copay** and **coinsurance** information.

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

Retail Pharmacy

You should use a participating retail pharmacy for your short-term prescriptions (up to a 30-day supply). For maintenance prescription drugs, you can obtain your initial prescription plus two refills at a participating retail pharmacy and then a penalty will apply for any additional retail fills—see **Mail Order Pharmacy** for obtaining maintenance drugs. When you show your Express Scripts ID card to the pharmacist, you pay your retail copay or 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 **express-scripts.com** and under Manage Prescriptions, select Locate a Pharmacy.
- Ask your retail pharmacy whether it participates in the Express Scripts network.

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

For claims: Return the completed form and receipts to:

Express Scripts
ATTN: Commercial Claims
P.O. Box 14711
Lexington, KY 40512-4711

You may also fax your claim form to: **608-741-5475**.

Mail Order Pharmacy

If you take maintenance prescription drugs or other medications for long-term treatment, you may order up to a 90-day supply through the Express Scripts mail-order drug service. Mail order can also be used to fill non-urgent, short-term prescriptions. The retail pharmacy coinsurance will apply to mail order prescriptions of 30 days or less.

Typically, the mail-order service provides significant cost savings on medications that are dispensed by Express Scripts.

To order by mail, send your original prescription, completed order form and payment of the applicable copay or coinsurance amount to Express Scripts. If you choose not to provide debit or credit card information and prefer to pay by check, you can estimate your copay or coinsurance by contacting Express Scripts. Order forms are available on **oxylink.oxy.com, express-scripts.com**, or by contacting Express Scripts Member Services. Mail your order forms to:

Express Scripts
P.O. Box 747000
Cincinnati, OH 45274-7000

You may also have your doctor fax your prescriptions. Ask your doctor to call **800-551-7680** for faxing instructions.

Refills can be ordered by mail, online at **express-scripts.com**, or by phone any time day or night. Refills are usually delivered within three to five 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 the Express Scripts Specialty Pharmacy, Accredo, which provides enhanced clinical benefits as well as cost benefits to you and the Plan.

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

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

EXAMPLES OF SPECIALTY DRUG CATEGORIES	SPECIALTY DRUG EXAMPLES
Self-administered drugs	Growth hormones
Anemia	Procrit, aranesp
Rare disease	Immune Globulin
Administered injectable	Synagis
Administered infused	Remicade, orencia

Precertification

The Plan requires precertification (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 the Express Scripts mail order 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.

Express Scripts 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

Express Scripts' 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 Express Scripts 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 Express Scripts ID card to begin the certification process. Benefits may not be payable unless the required procedures are followed and certification approved.

Coordination of Pharmacy Benefits

Express Scripts does not coordinate benefits. If your dependent's primary coverage is provided by another plan and the Oxy Retiree Medical Plan is secondary, you should submit prescription drug claims to Aetna for secondary benefits. Secondary benefits are provided by the Plan and will be subject to the medical deductible and 80% coinsurance. See **Coordination of Benefits (COB)** for more information.

Covered Prescription Drug Benefits

The prescription drug benefit covers:

- Federal legend drugs—drugs that require a label stating: "Caution: Federal law prohibits dispensing without a prescription" (Age restrictions apply to coverage for certain prescription drugs.);
- Compound medications if they are medically necessary, not experimental or investigative, do not contain any excluded ingredients, and determined by Express Scripts to be reasonably priced (This list may be obtained from Express Scripts.);
- 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;
- Infertility prescription drugs up to a $10,000 lifetime maximum benefit;
- Legend contraceptive devices;
- Legend prenatal vitamins for females only;
- Legend pediatric fluoride vitamin drops up to a 50-day supply; and
- Legend smoking deterrents.

What the Prescription Drug Benefit Does Not Cover

The prescription drug benefit *does not* cover the following prescription drug expenses:

- Any drug that does not, by federal law, require a prescription, such as an over-the-counter (OTC) drug or drugs with an equivalent OTC product, even when a prescription is written for it; however, some OTC preventive medications will be covered if obtained with a prescription;
- Compound medications that are experimental or investigative or contain an excluded ingredient;
- Therapeutic devices and appliances;
- Any drug entirely consumed when and where it is prescribed;
- Medication which is to be taken by or administered to an individual, in whole or in part, while he or she is a patient in a licensed hospital, rest home, sanitarium extended care facility, skilled nursing facility, convalescent hospital, nursing home or similar institution which operates on its premises or allows to be operated on its premises, a facility for dispensing pharmaceuticals;
- Any refill of a drug dispensed more than one year after prescribed, or as permitted by law where the drug is dispensed;
- Drugs labeled "Caution-Limited by Federal Law to investigational use," or experimental drugs, even though a charge is made to the individual;
- Drugs to treat impotency or sexual dysfunction;
- Drugs whose sole purpose is to stimulate or promote hair growth (e.g., Rogaine, Propecia);
- Drugs prescribed for cosmetic purposes (e.g., Renova, Vaniqa, Botox, Solage);
- Allergy sera;
- Immunization agents;
- Biologicals, blood and blood plasma;
- Performance, athletic performance or lifestyle enhancement drugs or supplies;
- Fertility agents once the $10,000 lifetime maximum benefit has been exhausted; or
- Nutritional supplements, appetite suppressants and antiobesity preparations.

Information for Medicare-Eligible Participants who are not deemed eligible for the Medicare Advantage PPO Plan

In some cases, a Medicare Part D plan may provide a better benefit than this Plan. You can, but do not have to, enroll in Medicare Part D because the Oxy Plan is considered "creditable." That is, the Oxy Retiree Medical Plan provides coverage that is expected to be as good as or better than the lowest level of drug coverage authorized under a Medicare Part D plan.

If you decide to enroll in a Part D plan, please use your Part D coverage to obtain your prescription drug benefits since the Plan is not eligible to receive the federal subsidy for your drug costs if you are enrolled in Medicare Part D. This will ultimately impact the Plan's ability to control costs and, therefore, your contributions.

If you are enrolled in the Oxy Retiree Medical Plan and decide to enroll in a Medicare Part D plan at a later date, you may do so without incurring a late enrollment penalty provided the Plan is considered creditable.

Coordination of Benefits (COB)

When you and your eligible dependents are covered by more than one health plan (e.g., medical, dental, vision), your benefits are coordinated with benefits from your other coverage to prevent duplicate payments for the same services.

The Plan coordinates coverage with any of the following plans:

- Group insurance;
- Other prepaid coverage under service plan contracts, or under group or individual practice;
- No-fault auto insurance required by law and provided on other than a group basis;
- Other governmental benefits other than Medicare; and
- Any other type of coverage for groups, including plans that are insured and those that are not.

This feature can result in your receiving greater benefits from this Plan in combination with another plan and Medicare than you would have received if you were covered only by Medicare and this Plan. This is likely whenever this Plan is third in line to pay, after another plan and Medicare.

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

This Plan always pays secondary to:

- Any medical payment, personal insurance plan or no-fault coverage under any automobile policy available to you; and
- Any plan or program that is required by law.

All covered persons should review their automobile insurance policy to ensure that uncoordinated medical benefits have been chosen so that the automobile insurance policy is the primary payer.

How COB Works

When you have a claim for expenses that is covered by two or more plans, one plan—known as the primary plan—pays benefits first. The other plan, the secondary plan, adjusts payments so the total benefit paid does not exceed 100% of the total **allowable expense**.

When the Oxy Plan is **primary,** it pays the allowable amount for the treatment you received.

When the Oxy Plan is **secondary,** it pays the amount necessary so the total amount you receive from the Oxy Plan and the other plans combined is not greater than the amount you would have received under the Oxy Plan alone (100% of the total allowable expense under the Oxy Plan). In determining that amount, the Plan calculates the benefits it would have paid in the absence of other coverage. Then the Plan applies that amount to any allowable expense under the Plan that was unpaid by the primary plan. The amount will be reduced so that when combined, the total benefits paid by all plans for the claim do not exceed 100% of the total allowable expense. In addition, as the secondary plan, the Plan will credit to its deductible any amounts that would have been credited in the absence of other coverage.

Order of Benefit Determination

In general, the rules used to determine which plan pays benefits first are:

- The plan with no coordination provision is primary. (Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits may provide that the supplementary coverage is excess to any other parts of the plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan hospital and surgical benefits, and insurance-type coverages that are written in connection with a closed panel plan to provide non-network benefits.)
- The plan that covers the person other than as a dependent pays before the plan that covers that person as a dependent. (If the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the plan covering the person as a dependent and primary to the plan covering the person as other than a dependent [e.g., a retired employee], then the order of benefits between the two plans is reversed so that the plan covering the person as an employee, member, subscriber or retiree is secondary and the other plan is primary.)
- For a dependent child who has coverage under both parents' plans (when the parents are married or living together), the plan that covers the parent with the earlier birth date (month and day) in the year is primary (no matter what the year). If the month and day of birth of both parents is the same, then the plan that has covered the parent for a longer time pays first. If the other plan has a rule based on gender of the parent, the rule in the other plan determines order of payment.
- For dependent children whose parents are legally separated or divorced, plan payments are determined in this order:
  - If there is a court decree which states that the parents shall share joint custody of a dependent child, without stating that one of the parents is responsible for the health care expense of the child, the order of benefit determination rules specified in the bullet above will apply (earlier birth date rule).
  - If there is a court decree (Qualified Medical Child Support Order, or QMCSO) for the child, the plan that covers the child as a dependent of the parent who is responsible pays before any other plan that covers the child as a dependent child. If the parent with responsibility has no health coverage but his or her spouse does, the plan of that parent's spouse is the primary plan.
  - If there is no QMCSO:
    - The plan of the custodial parent (the parent awarded custody by a court decree or, if there is no court decree, the parent with whom the child resides more than one half of the calendar year without regard to any temporary visitation);
    - The plan (if any) of the spouse of the custodial parent;
    - The plan of the parent not having custody; and then
    - The spouse's plan of the parent not having custody.

  A dependent child covered under more than one plan of individuals who are not the parents of the child, the order of benefits is determined as outlined above as if the individuals were the parents.
- The plan that covers a person as an employee who is neither laid-off nor retired (or as that employee's dependent) pays before the plan that covers that person as a laid-off or retired employee (or as that employee's dependent). If the other plan does not have this rule, then this rule is ignored.
- If a person whose coverage is provided under a right of continuation provided by federal or state law also is covered under another plan, the plan covering the person as an employee, member, subscriber or retiree (or as that person's dependent) is primary, and the continuation coverage is secondary. If the other plan does not have this rule, then this rule is ignored.
- The plan that has covered the person as an employee, member or subscriber for a longer time pays before the plan that has covered the person a shorter time.
- When the rules above do not apply, the allowable expenses are shared equally between the plans. In addition, the Plan will not pay more than it would have paid had it been primary.

COB with Medicare

Once you become **Medicare-eligible**, how your health care claims are processed will change. If it's determined you are not eligible to participate in the Oxy Medicare Advantage PPO Plan and you are eligible to remain in the Oxy Retiree Medical Plan, Medicare will provide your primary coverage and be the primary payer for your health care expenses effective the first of the month you become eligible for Medicare. The Oxy Retiree Medical Plan will generally be the secondary payer. When processing claims for each Medicare-eligible participant, the Oxy Retiree Medical Plan will reduce its payment by the amount Medicare paid—or would have paid if you were enrolled in Medicare Parts A and B. **This means Medicare benefits will be taken into account for any participant while he or she is eligible for Medicare, whether or not you choose to enroll in Medicare Part A and/or Part B.**

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

- Covered under it;
- Not covered under Medicare because he or she:
  - Refused it;
  - Dropped it; or
  - Failed to make proper request for it.

These are the changes:

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

For more information on Medicare, visit **medicare.gov**.

Right to Receive and Release Necessary Information

The claims administrators may receive or release, from any other organization or person, any information necessary to decide whether coordination applies and to determine benefits payable under the Plan. This may be done without your consent. Any person claiming benefits under the Plan is required to give information necessary to coordinate benefits.

Facility of Payment

Any payment made under another plan may include an amount that should have been paid under the Plan. If it does, the claims administrator may pay that amount to the organization that made that payment. That amount is then to be treated as though it were paid under the Oxy Plan. The claims administrator will not have to pay that amount again. The term *payment made* means reasonable cash value of the benefits provided in the form of services.

Right of Recovery

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

Claims and Appeals Procedures

This section explains the rules and provisions that affect claim denial and appeals of benefits.

The Plan Administrator is responsible for claims and appeals procedures. However, the Plan Administrator has delegated authority to handle claims and appeals to the claims administrators. See **Administrative Information** for contact information.

Filing an Initial Claim

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

When you file a claim, the claims administrator reviews the claim and makes a decision to either approve or deny the claim. The claims administrator has the full discretionary authority to:

- Interpret the provisions of the Plan—such interpretation will be final and conclusive on all persons;
- Determine eligibility for benefits;
- Provide participants with a reasonable notification of their benefits available under the Plan; and
- Approve reimbursement requests and authorize the payment of benefits.

If your benefit claim is denied, in whole or in part, you will receive notification by mail or electronically from the claims administrator within the time frames noted in the following table. The notice provides important information to assist you in making an appeal of the denied claim (or adverse benefit determination), if you wish to do so. Refer to **When You Disagree with a Claim Decision** for more information about appeals.

You can file claims for benefits and appeal adverse claim decisions yourself or through an authorized representative (that is, a person you authorize in writing to act on your behalf, including your provider). The Plan will also recognize as your authorized representative:

- A court order giving a person (an authorized representative) authority to make the appeal on your behalf by providing written consent to Aetna; and
- In the case of an urgent care claim or a pre-service claim, a physician familiar with the case may represent you in the appeal.

You need to tell us if you choose to have someone else appeal for you (even if it is your provider). You should fill out an authorized representative form telling us that you are allowing someone to appeal for you. You can get this form by contacting Aetna. You can use an authorized representative at any level of appeal.

Adverse Benefit Determination

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

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

Time Frames for Claim Processing

TYPE OF CLAIM	CLAIMS ADMINISTRATOR RESPONSE TIME	EXTENSION
Urgent care claim (including urgent care that is concurrent care involving the extension of a course of treatment or number of treatments); a claim for medical care or treatment where delay could: • Seriously jeopardize your life or health, or your ability to regain maximum function; • Subject you to severe pain that cannot be adequately managed without the requested care or treatment; or • In the case of a pregnant woman, cause serious jeopardy to the health of the fetus.	As soon as possible, taking into account the medical demands, but no later than 72 hours (24 hours for a concurrent care claim extension if the claim is at least 24 hours before the expiration of the prescribed course of treatment or number of treatments) after the Plan receives your claim. If you fail to provide sufficient information with the claim to determine whether, or to what extent, benefits are payable from the Plan, you are notified no later than 24 hours after the Plan receives your claim about the specific information you need to submit. You will have at least 48 hours to provide this information. You will be notified of the claim decision as soon as possible, but no later than 48 hours after the earlier of the Plan's receipt of the specified information or the end of the period during which you may provide the specified information.	NA
Concurrent care claim reduction or termination: a decision to reduce or terminate a course of treatment that was previously approved.	With enough advance notice to allow you to appeal	NA

TYPE OF CLAIM	CLAIMS ADMINISTRATOR RESPONSE TIME	EXTENSION
Pre-service claim: a claim for a benefit that requires approval of the benefit in advance of receiving care (**precertification**).	Within a reasonable time, but no later than 15 days after the Plan receives your claim.	These time periods may be extended up to an additional 15 days due to circumstances outside Aetna's control. In that case, you will be notified of the extension before the end of the initial 15 or 30-day period. For example, they may be extended because you have not submitted sufficient information, in which case you will be notified of the specific information necessary and given an additional period of at least 45 days after receiving the notice to furnish that information. You will be notified of Aetna's claim decision no later than 15 days after the end of that additional period (or after receipt of the information, if earlier). For pre-service claims which name a specific claimant, medical condition, and service or supply for which approval is requested, and which are submitted to an Aetna representative responsible for handling benefit matters, but which otherwise fail to follow the Plan's procedures for filing pre-service claims, you will be notified of the failure within 5 days (within 24 hours in the case of an urgent care claim) and of the proper procedures to be followed. The notice may be oral unless you request written notification
Post-service claims: a claim for care or treatment that has been rendered.	Within a reasonable time, but no later than 30 days after the Plan receives your claim.	

Medicare Direct Program

The Medicare Direct Program is a computerized claim-paying service that automatically forwards information directly from Medicare to Aetna about your medical claims paid under Medicare Part B. The Medicare Direct Program does not apply to claims paid under Medicare Part A.

If you participate in the program, you can easily and conveniently coordinate your Medicare payments with the Medical Plan. Any of your medical claims paid under Medicare Part B are forwarded directly to Aetna, who is then able to process your claim without you having to mail the claim or the Explanation of Medicare Benefits (EOMB) to Aetna. This service is free of charge and offers you less paperwork, faster turnaround time on your claim, and reduced postage costs.

Eligibility

Retirees are eligible to participate in the Medicare Direct Program if:

- Medicare is your primary coverage;
- You are enrolled in Medicare Part B;
- You are covered by the Medical Plan;
- Your only two sources of medical coverage are Medicare and the Oxy Retiree Medical Plan; and
- You have received medical care in a Medicare Direct-participating state.

Dependents are also eligible if they meet the above criteria and have Medicare and the Medical Plan as their only two sources of medical coverage. Your dependents may participate in Medicare Direct even if you choose not to enroll. Surviving spouses of deceased retirees also are eligible to participate in Medicare Direct if they meet the requirements as outlined above.

How to Enroll

To enroll in the Medicare Direct Program, you may complete a Medicare Direct form, available by contacting Aetna Member Services at 800-334-0299. If your spouse is not eligible for Medicare Direct when you enroll, you can request a new form for your spouse to complete when he/she becomes eligible for Medicare Part B. If you meet the eligibility rules above, Medicare Direct will begin six to eight weeks after you sign up.

Terminating Participation

You can terminate your participation at any time by calling Aetna Member Services or writing to:

Aetna, Inc. – Medicare Direct
151 Farmington Avenue
Hartford CT 06156-5605

Claim Denial

If your claim is denied, in whole or in part, you will receive a notice by mail or electronically that contains all of the following:

- A reference to the specific reasons for the denial;
- The specific Plan provisions on which the denial is based;
- If an internal rule, guideline, protocol or other similar criterion was relied on to determine a claim, you will receive either a copy of the actual rule, guideline, protocol or other criterion, or a statement that the rule, guideline, protocol or other criterion was used and how you can request a copy free of charge. If the denial is based on medical necessity, experimental treatment or a similar exclusion or limit, you will receive either an explanation of the scientific or clinical judgment for the determination based on the Plan terms and your medical circumstances, or a statement that you can receive the explanation free of charge upon request;
- A description of any additional material or information needed to perfect the claim and an explanation of why it's necessary;
- An explanation of the Plan's claim review procedures, applicable time limits and your rights to bring a civil action under ERISA section 502(a) following any denial on review; and
- An explanation of the expedited claim review procedure for an urgent care claim. In the case of an urgent care claim, the Plan may notify you by phone or fax and follow up with a notice by mail or electronically no later than three days after the notification.

If your Medical Plan or Prescription Drug Program claim is denied, in whole or in part, your notice will also include:

- Information to confirm the identity of the claim, including the date of service, provider's name and claim amount.
- A statement describing the availability of, on request, the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning.
- The denial code, its meaning and a description of any standard used in denying the claim.
- Details about any available internal appeals and external review processes, including information about how to initiate an appeal.
- A statement about the availability of, and contact information for, any applicable office of health insurance consumer assistance or other entity established by federal law to assist individuals with the claims and appeals process.

The following special rules apply to any disability claim only if the Plan Administrator determines you are disabled for purposes of such benefit. If your disability claim is denied, in whole or in part, your notice will also include:

- A discussion of the decision, including an explanation of the basis for disagreeing with or not following: (1) the views presented to the Plan Administrator by health care professionals treating the you and vocational professionals who evaluated you, (2) the views of medical or vocational experts obtained by the Plan Administrator, without regarding to whether the advice was relied upon in making the benefit determination, and (3) a disability determination made by the Social Security Administration;
- If the claim denial was based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the denial, applying the terms of the Plan to your circumstances, or a statement that such an explanation will be provided free of charge upon request;
- The internal rules, guidelines, protocols, standards or other similar criteria relied upon in denying the claim, or a statement that such rules, guidelines, protocols, standards or other similar criteria do not exist; and
- A statement of your right to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits.

When You Disagree with a Claim Decision

Appeal Process

Requests for appeal submitted verbally for urgent care claims or in writing for all claims must be made within 180 days from the receipt of the notice of an adverse benefit determination to the claims administrator. However, appeals of adverse benefit determinations involving urgent care may be made to Aetna Member Services at **800-334-0299**.

Your appeal should include:

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

Written requests for claim appeals may be sent to:

CLAIMS ADMINISTRATOR	APPEALS ADDRESS
Aetna	Aetna Attn: National Account CRT P.O. Box 14463 Lexington, KY 40512
Express Scripts, Inc.	Express Scripts Attn: Clinical Appeals Department P.O. Box 66588 St Louis, MO 63166-6588 Fax: **877- 852-4070**

The Plan provides either one or two levels of appeal depending on the type of coverage. If you have two levels of appeal and you are dissatisfied with the outcome of your level one appeal, you can request a level two appeal, to be filed no later than 60 days following receipt of the level one notice of adverse benefit determination (90 days for non-urgent prescription drug claims). Appeals are reviewed by personnel not involved in making the adverse benefit determination (except for concurrent care claim reduction or termination). The following chart summarizes how appeals are handled for different types of claims.

TYPE OF APPEAL	LEVEL ONE APPEAL RESPONSE	LEVEL TWO APPEAL RESPONSE
Urgent care medical claims (including urgent care that is concurrent care)	36 hours	36 hours
Concurrent care claim reduction or termination	With enough advance notice to allow you to appeal	NA
Pre-service claim	15 calendar days	15 calendar days
Post-service claims	30 calendar days (15 days for provider submitted prescription drug claims)	30 calendar days (15 days for provider submitted prescription drug claims)

External Review for Medical Claims

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

To request an external review, you must meet the following requirements:

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

The claim denial letter you receive from the claims administrator will describe the process to follow if you wish to pursue an external review, including a copy of the Request for External Review Form. You will not be charged for an external review.

You must submit the Request for External Review Form to the claims administrator within 123 calendar days (4 months) of the date you received the final claim denial letter. You also must include a copy of the final claim denial letter and all other pertinent information that supports your request.

The claims administrator will contact the External Review Organization and they will select an independent clinical reviewer with appropriate expertise to perform the review. In making a decision, the external reviewer may consider any appropriate credible information you send with the Request for External Review Form, and will follow the claims administrator's contractual documents and Plan criteria governing the benefits. You will be notified of the decision of the External Review Organization usually within 45 calendar days of the claims administrator's receipt of your request form and all necessary information. A quicker review is possible if your clinical reviewer certifies (by telephone or on a separate Request for External Review Form) that a delay in receiving the service would endanger your health. Expedited reviews are decided within three to five calendar days after the claims administrator receives the request.

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

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

For more information about the claims administrator's external review process, call the customer service telephone number shown on your ID card.

Appealing a Denied Disability Claim

The following special rules apply to the appeal of a denied disability claim only if the Plan Administrator determines you are disabled for purposes of such benefit. You are entitled, upon request, to review and receive a free copy of any Plan policy statement or guideline that relates to the denied benefit, even if the policy statement or guideline was not relied on in denying the claim.

When the Plan Administrator reviews a denied disability claim on appeal, the following additional requirements apply:

- The review will not give deference to the claim denial and will not be made by the person who made the original claim denial, or a subordinate of that person.
- In deciding an appeal of any disability claim denial that is based in any way on a medical judgment, the Plan Administrator must get advice from a health care professional who has training and experience in the area of medicine.
- Upon request, you will be provided the names of any medical or vocational experts who were consulted in connection with your disability claim denial, even if the advice was not relied upon in making the denial.
- The health care professional consulted by the Plan Administrator cannot be a person who was consulted by the Plan Administrator in connection with the claim denial (or a subordinate of the person who was consulted in the original claim).
- The Plan Administrator must disclose, free of charge, any new or additional evidence considered, relied upon, or generated by or at the direction of the Plan Administrator in connection with the disability claim, and any new or additional rationale upon which such adverse benefit determination may be based. The Plan Administrator will disclose this information to you before the Plan Administrator issues an adverse benefit determination and will give you a reasonable opportunity to respond prior to that date.

If any part of your disability claim is denied on appeal, the Plan Administrator's denial shall also set forth:

- A discussion of the decision, including an explanation of the basis for disagreeing with or not following: (1) the views presented to the Plan Administrator by health care professionals treating the you and vocational professionals who evaluated you, (2) the views of medical or vocational experts obtained by the Plan Administrator, without regarding to whether the advice was relied upon in making the benefit determination, and (3) a disability determination made by the Social Security Administration;
- If the claim denial was based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the denial, applying the terms of the Plan to your circumstances, or a statement that such an explanation will be provided free of charge upon request;
- The internal rules, guidelines, protocols, standards or other similar criteria relied upon in denying the claim, or a statement that such rules, guidelines, protocols, standards or other similar criteria do not exist;
- A statement of your right to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits; and
- Any applicable contractual limitations period that applies to the claimant's right to bring suit under Section 502(a) of ERISA, including the calendar date on which the contractual limitations period expires.

Assignment of Coverage

Your benefit under the Plan belongs to you and generally may not be sold, assigned, transferred, pledged or garnished under most circumstances. The Plan Administrator may accept elections or make payments to someone who is legally authorized to conduct your affairs. This may be a relative, a court-appointed guardian or some other person.

Medical, prescription, dental and vision benefits provided under the Plan may not be assigned, transferred or in any way made over to another party by you or your dependents. Nothing in the Plan will be construed to make the Plan or Oxy liable to any third party to whom you or your dependents may be liable for medical, prescription, dental or vision care treatment or services. If any person attempts to take any action contrary to this assignment prohibition, such action shall be void and Oxy and the Plan Administrator may disregard such action, will not be bound by it in any manner and will suffer no liability for any such disregard.

In addition, the Plan is required to comply with federal laws, such as IRS tax levies and court-issued Qualified Domestic Relations Orders (QDROs). The Plan Administrator will hold or pay your benefit as it finds appropriate in case of your bankruptcy or other assignment of your benefits under the Plan whether voluntary or involuntary.

However, the Plan may make payments to physicians, other health care professionals or institutions who provide health care services or supplies to participants in the normal course of administration of the Plan. Payments to a state providing Medicaid benefits in accordance with ERISA Section 609 are allowed. Similarly, Oxy's subrogation and reimbursement rights are not limited by this provision.

A direction to pay a provider is not an assignment of any right under this Plan or of any legal or equitable right to institute any court proceeding.

Recovery of Overpayment

If a benefit payment is made by the Plan, to you or on your behalf, which exceeds the benefit amount that you are entitled to receive, the Plan has the right to require the return of the overpayment. The claims administrator has the right to:

- Reduce by the amount of the overpayment, any future benefit payment made to or on behalf of a participant in the Plan; or
- Reduce any future benefit payment to the network provider by the amount of the overpayment.

These future payments may involve the Plan or other health plans that are administered by the Plan's third-party administrator— Aetna. Under this process, Aetna reduces future payments to providers by the amount of the overpayments they receive, and then credits the recovered amount to the plan that overpaid the network provider. Payments to network providers under this Plan are subject to this same process when Aetna recovers overpayments for other plans administered by Aetna.

These rights do not affect any other right of overpayment recovery the claims administrator may have.

Incorrect Information, Fraud, Concealment or Error

The Plan has the right to seek repayment by whatever means permitted by law if due to an error (whether human or systems) or incorrect information (whether provided by fraud, misrepresentation or concealment):

- You or your dependents are provided coverage under the Plan;
- Continuation coverage is provided;
- Claims are paid;
- Liability for failure to enroll, provide continuation coverage, pay benefits or terminating coverage arises; or
- An overpayment or erroneous payment is made.

Likewise, a human or systems error will not deprive you or your dependents of coverage or impact the payment of benefits under the Plan to which you or your dependents are otherwise entitled.

Except as otherwise required by law, if you or your dependents fail to provide requested information, make a false statement, or furnish fraudulent or incorrect information, the Plan reserves the right to terminate your and your dependents' coverage under the Plan either retroactively or prospectively, seek repayment for any payments made on your or your dependents' behalf, and refuse to offer continuation coverage.

Legal Action

You must exhaust all appeal levels and procedures before you initiate any litigation, arbitration or administrative proceeding regarding an alleged breach of the contract terms by the claims administrator or any matter within the scope of the appeals procedure.

If your claim for benefits is not approved in whole or in part, and you disagree with the outcome, you have the right to bring a civil action when **all available levels of reviews, including all appeal processes, have been completed.**

In addition, no legal action can be brought after the later of (i) 180 days after receiving a response to your appeal of an adverse benefit determination or (ii) two years after the earliest date services or benefits were sought.

Unclaimed Funds

In the event any reimbursement check issued under a program funded using Oxy's general assets remains uncashed after a period of time determined by the Plan Administrator, the check will be voided, and the funds returned applied to payment of current benefits under the applicable program. If you or your dependent subsequently request repayment, the Plan Administrator will make payment pursuant to the terms and conditions of the program in effect at the time the original claim was presented.

Subrogation and Right of Recovery Provision

The provisions of this section apply to all current or former Plan participants and also to the parents, guardian or other representative of a dependent child who incurs claims and is or has been covered by the Plan. The Plan's right to recover (whether by subrogation or reimbursement) applies to the personal representative of your estate, your decedents, minors, and incompetent or disabled persons. "You" or "your" includes anyone on whose behalf the Plan pays benefits. No adult covered person hereunder may assign any rights that it may have to recover medical expenses from any tortfeasor or other person or entity to any minor child or children of said adult covered person without the prior express written consent of the Plan.

The Plan's right of subrogation or reimbursement, as set forth below, extends to all insurance coverage available to you due to an injury, illness or condition for which the Plan has paid medical claims (including, but not limited to, liability coverage, uninsured motorist coverage, underinsured motorist coverage, personal umbrella coverage, medical payments coverage, workers compensation coverage, no fault automobile coverage or any first-party insurance coverage).

Your health Plan is always secondary to automobile no-fault coverage, personal injury protection coverage or medical payments coverage.

No disbursement of any settlement proceeds or other recovery funds from any insurance coverage or other source will be made until the health Plan's subrogation and reimbursement interests are fully satisfied.

Subrogation

The right of subrogation means the Plan is entitled to pursue any claims that you may have to recover the benefits paid by the Plan. Immediately on paying or providing any benefit under the Plan, the Plan shall be subrogated to (stand in the place of) all rights of recovery you have against any responsible party with respect to any payment made by the responsible party to you due to your illness or injury to the full extent of benefits provided or to be provided by the Plan. The Plan may assert a claim or file suit in your name and take appropriate action to assert its subrogation claim, with or without your consent. The Plan is not required to pay you part of any recovery it may obtain, even if it files suit in your name.

Reimbursement

If you receive any payment from any responsible party or insurance coverage as a result of an illness or injury, the Plan has the right to recover from, and be reimbursed by, you for all amounts the Plan has paid and will pay as a result of that illness or injury, up to and including the full amount of your recovery.

Constructive Trust

By accepting benefits (whether the payment of such benefits is made to you or on your behalf to any provider) from the Plan, you agree that if you receive any payment as a result of an illness or injury, you will serve as a constructive trustee over the funds that constitute such payment. Failure to hold such funds in trust will be deemed a breach of your fiduciary duty to the Plan. No disbursement of any settlement proceeds or other recovery funds from any insurance coverage or other source will be made until the health Plan's subrogation and reimbursement interest are fully satisfied.

Lien Rights

Further, the Plan will automatically have a lien to the extent of benefits paid by the Plan for the treatment of the illness, injury or condition upon any recovery whether by settlement, judgment or otherwise, related to treatment for any illness or injury for which the Plan paid benefits. The lien may be enforced against any party who possesses funds or proceeds representing the amount of benefits paid by the Plan including, but not limited to, you, your representative or agent, and/or any other source that possessed or will possess funds representing the amount of benefits paid by the Plan or Oxy.

Assignment for Subrogation

To secure the Plan's recovery rights, you agree to assign to the Plan any benefits or claims or rights of recovery you have under any automobile policy or other coverage, to the full extent of the Plan's subrogation and reimbursement claims. This assignment allows the Plan to pursue any claim you may have, whether or not you choose to pursue the claim.

First-Priority Claim

By accepting benefits (whether the payment of such benefits is made to you or on your behalf to any provider) from the Plan, you acknowledge that the Plan's recovery rights are a first-priority claim against all responsible parties and are to be repaid to the Plan before you receive any recovery for your damages. The Plan is entitled to full reimbursement on a first-dollar basis from any payments, even if such payment to the Plan will result in a recovery to you that is insufficient to make you whole or to compensate you in part or in whole for the damages sustained. The Plan is not required to participate in or pay court costs or attorney fees to any attorney you hire to pursue your damage claim.

Applicability to All Settlements and Judgments

The terms of this entire subrogation and right of recovery provision apply and the Plan is entitled to full recovery regardless of whether any liability for payment is admitted by any responsible party and regardless of whether the settlement or judgment identifies the medical benefits the Plan provided or purports to allocate any portion of such settlement or judgment to payment of expenses other than medical expenses. The Plan is entitled to recover from any and all settlements or judgments, even those designated as pain and suffering, non-economic damages and/or general damages only. The Plan's claim will not be reduced due to your own negligence. The Plan's reimbursement will not be limited or reduced because any responsible party is liable only in part, its resources are limited or you have not been fully compensated. Any portion of the recovery used to pay fees and costs including attorneys' fees will not be allocated against the Plan's recovery (i.e., the "common fund doctrine").

Cooperation

You shall fully cooperate with the Plan's efforts to recover its benefits paid. It is your duty to notify the Plan within 30 days of the date when any notice is given to a party, including an insurance company or attorney, of your intention to pursue or investigate a claim to recover damages or obtain compensation due to illness or injury sustained by you. You and your agents agree to provide the Plan or its representatives notice of any recovery you or your agents obtain before receipt of such recovery funds or within five days if no notice was given before receipt. Further, you and your agents agree to provide notice before any disbursement of settlement or any other recovery funds obtained. You and your agents shall provide all information requested by the Plan, the claims administrator or its representative including, but not limited to, completing and submitting any applications or other forms or statements as the Plan may reasonably request and all documents related to or filed in personal injury litigation. Failure to provide this information, failure to assist the Plan in pursuit of its subrogation rights or failure to reimburse the Plan from any settlement or recovery you receive may result in:

- The denial of any future benefit payments or claim until the Plan is reimbursed in full;
- Termination of your health benefits; or
- The institution of court proceedings against you.

You shall do nothing to prejudice the Plan's subrogation or recovery interest or to prejudice the Plan's ability to enforce the terms of this Plan provision. This includes, but is not limited to, refraining from making any settlement or recovery that attempts to reduce or exclude the full cost of all benefits provided by the Plan or disbursement of any settlement proceeds or other recovery before fully satisfying the health Plan's subrogation and reimbursement interest.

You acknowledge that the Plan has the right to conduct an investigation regarding the illness or injury to identify any responsible party. The Plan reserves the right to notify a responsible party and his/her agents of its lien. Agents include, but are not limited to, insurance companies and attorneys.

You acknowledge that the Plan has notified you that it has the right pursuant to the Health Insurance Portability & Accountability Act (HIPAA), 42 U.S.C. Section 1301 *et seq*, to share your personal health information in exercising its subrogation and reimbursement rights.

Interpretation

In the event that any claim is made that any part of this subrogation and right of recovery provision is ambiguous or questions arise concerning the meaning or intent of any of its terms, the claims administrator for the Plan has the sole authority and discretion to resolve all disputes regarding the interpretation of this provision. The Plan Administrator may in its sole and absolute discretion waive or modify any of the subrogation and right of recovery provisions whenever it deems appropriate under the facts and circumstances of a particular case.

Jurisdiction

By accepting benefits from the Plan, you agree that any court proceeding with respect to this provision may be brought in any court of competent jurisdiction as the Plan may elect. By accepting such benefits, you hereby submit to each such jurisdiction, waiving whatever rights may correspond to you by reason of your present or future domicile. By accepting such benefits, you also agree to pay all attorneys' fees the Plan incurs in successful attempts to recover amounts the Plan is entitled to under this section.

Continuation of Coverage

Under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), you and your eligible dependents have the right to continue group health plan coverage if it ends for the reasons under **Qualifying Events**. If you pay the required premiums, you and your eligible dependents may continue participation in the Plan option in which you or your dependents are enrolled at the time of your qualifying event.

Instead of enrolling in COBRA coverage, there may be other coverage options for you and your family through:

- The Health Insurance Marketplace;
- Medicaid; or
- Other group health plan coverage options (such as a spouse's plan). You must enroll through a special enrollment period, generally within 30 days of losing coverage.

Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at **healthcare.gov**.

Qualifying Events

You and your qualified beneficiaries have a right to choose COBRA coverage if coverage is lost because of any of these qualifying events:

COVERAGE IS LOST BECAUSE…	CAN CONTINUE COVERAGE …	FOR UP TO…	TAKE ACTION
• You die • You become entitled to benefits under Medicare	• Your spouse • Your dependent children	36 months	You and your qualified beneficiaries are notified of the right to continue coverage. To continue coverage, enroll within 60 days of the later of the COBRA notification date or the date regular benefits end.
• Your surviving spouse dies	• Your dependent children	36 months	
• You divorce, legally separate or your marriage is annulled	• Your ex-spouse • Your dependent children	36 months	You or your qualified beneficiaries must notify the OxyLink Employee Service Center within 60 days of the event by the approved method, or your dependents lose their right to COBRA coverage. After receiving notice of the qualifying event from you, your qualified beneficiaries are notified of their right to continue coverage. To continue coverage, enroll within 60 days of the later of the COBRA notification date or the date regular benefits end.
• Your dependent child is no longer eligible for coverage under the Plan (for example, your child reaches the age limit)	• Your dependent child	36 months	

Qualified Beneficiary

A qualified beneficiary under COBRA includes you, your covered spouse and your covered dependent children at the time a coverage-ending event occurs. If you or your spouse gives birth to or adopts a child after the qualifying COBRA event, the child is also a qualified beneficiary. If you marry while continuing coverage under COBRA, your new spouse and any other dependents you add to your family are also considered qualified beneficiaries. You must enroll new beneficiaries in the Plan within 31 days of the event.

Disability Extension

An 11-month extension of coverage may be available for all qualified beneficiaries if one of the qualified beneficiaries is determined by the Social Security Administration (SSA) to be disabled. The disability must start before the 60th day of COBRA coverage and last until the end of the 18-month period of COBRA coverage. To qualify for this disability extension, you must notify the COBRA administrator (PayFlex) and provide a copy of the SSA determination within 60 days after the date of the SSA disability determination and before the end of the original 18-month COBRA period. Notify the COBRA administrator within 30 days after the SSA's determination that the qualified beneficiary is no longer disabled.

Second Qualifying Event

An extension of coverage is available to spouses and dependent children if a second qualifying event occurs during the first 18- or 29-month continuation period. You must notify the COBRA administrator (PayFlex) in writing within 60 days after a secondary qualifying event if you want to extend your COBRA coverage. COBRA coverage will not last beyond 36 months from the date of the original qualifying event.

Enrolling in COBRA Coverage

COBRA coverage is provided under the same plan option in which you are enrolled at the time of the qualifying event. When plan coverage changes, it also changes for COBRA coverage.

Each qualified beneficiary has an independent right to elect COBRA coverage. You can elect coverage for your spouse. You or your spouse can elect coverage for your children. You elect coverage by enrolling within 60 days from the date of the qualifying event—or the date you receive the form, if later.

You must pay your premiums for the first month of continuation coverage within 45 days of the date you elect COBRA. Make all future payments on the first day of each month (subject to a 30-day grace period) while coverage continues.

If you do not pay your premium within the initial 45-day period (30 days of the due date for future payments), your coverage will end retroactive to the last day for which timely payment was made. You will lose all continuation rights under the Plan.

Cost of COBRA Coverage

Your cost for COBRA coverage is the full cost of coverage to the Plan—that is, the amount you pay for coverage plus the company's contribution to the cost—with a 2% administrative fee added. You pay 150% of the full premium cost for the additional 11 months of disability coverage.

Your cost will change if the cost of group coverage for the company's retirees changes. You pay the cost of COBRA coverage with after-tax dollars.

When COBRA Coverage Ends

Continued coverage ends on the first of the following events:

- The end of the maximum COBRA continuation period;
- Failure to pay required premiums;
- Coverage under another group plan that does not restrict coverage for preexisting conditions;
- Oxy no longer offers a group health plan;
- A qualified beneficiary is on extended coverage for up to 29 months due to disability and a final determination is made that the beneficiary is no longer disabled; or
- Your dependents die.

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

Contact and Address Information

To protect your family's rights, you should keep the Plan informed in writing of any changes in your address and any changes in your marital status. You should also keep a copy, for your records, of any notices you provide. You may provide such notices to the OxyLink Employee Service Center via electronic mail to **oxylink@oxy.com** or mail to:

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

Plan materials are available on **oxylink.oxy.com** or contact the OxyLink Employee Service Center at **800-699-6903.**

If you have questions about COBRA, contact the OxyLink Employee Service Center. For more information about your rights under **ERISA**, including COBRA, HIPAA and other laws affecting group health plans, contact the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) website at **dol.gov/ebsa** or call their toll-free number at **888-444-3272**. For more information about health insurance options available through a Health Insurance Marketplace, visit **healthcare.gov**.

Additional Information

Administrative Information

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

Plan Name	Occidental Petroleum Corporation Retiree Medical Plan, also known as the Plan.
Plan Sponsor's Employer Identification Number	95-4035997
Plan Number	651
Plan Year Ends	December 31
Plan Administrative Services	Administrative services contracts with Aetna Life Insurance Company and Express Scripts, Inc.
Plan Administrator	Occidental Petroleum Corporation Employee Benefits Committee 5 Greenway Plaza, Suite 110 Houston, TX 77046 713-215-7000
Claims Administrators	**For Aetna:** Aetna Life Insurance Company 151 Farmington Avenue Hartford, CT 06156 **For Express Scripts, Inc.:** Express Scripts, Inc. 1 Express Way St. Louis, MO 63121
Plan Sponsor	Occidental Petroleum Corporation 5 Greenway Plaza, Suite 110 Houston, TX 77046 713-215-7000
Named Fiduciary	• Aetna Life Insurance Company for Aetna medical claims • Express Scripts, Inc. for prescription drug claims
Plan Type	An ERISA welfare plan
Address for Legal Process	Service for legal process related to the Plan may be made upon the Plan Administrator or claims administrators at the addresses listed above.
Funding	The medical benefits are not insured with Aetna or Express Scripts, Inc. They are paid from participant contributions and OPC's general assets.

Plan Continuation

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

Discretionary Authority

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.

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

Plan Documents

This benefit plan description summarizes the main features of the Plan, and is not intended to amend, modify or expand the Plan provisions. In all cases, the provisions of the Plan document and any applicable contracts control the administration and operation of the Plan. If a conflict exists between a statement in this summary and the provisions of the Plan document or any applicable contracts, the Plan document will govern. You may request a copy of all the Plan documents by writing to the Plan Administrator at the address shown in **Additional Information**. Copies of requested documents will be furnished within 30 days at a reasonable charge.

No Implied Promises

By adopting and maintaining the Occidental Petroleum Corporation Retiree Medical Plans for certain eligible participants, 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, the 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.

Oral representations or promises will not be binding on the Plan. Participants and beneficiaries should not rely on any oral description of the Plan because the written terms of the Plan document will always govern.

Multiple Employers and Misstatement of Fact

You cannot be covered under the Plan multiple times because you are connected with more than one employer.

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

Outcome of Covered Services and Supplies

The claims administrators and Oxy are not responsible for, and they do not make any guarantees concerning, the outcome of the covered services and supplies you receive.

Additional Provisions

The following additional provisions apply to your coverage:

- This SPD applies to coverage only, and does not restrict your ability to receive health care services that are not, or might not be, covered.
- This document describes the main features of the Plan. If you have any questions about the terms of the Plan or about the proper payment of benefits, contact your employer or Aetna.
- Sutter Health and Affiliates, the dominant health system in much of northern California, uses its bargaining power to insist on unique requirements to participate in the Aetna network. Aetna's contract with Sutter requires payment of claims that would otherwise be denied, such as those not medically necessary or experimental or investigational (but does not require payment for services the Plan expressly excludes from coverage, such as for cosmetic surgery). Aetna will charge the Plan for these claims in order to be able to continue providing Plan participants with access to Sutter's services on a network basis.

Financial Sanctions Exclusions

If any benefit provided by this Plan violates or will violate any economic or trade sanctions, the coverage is immediately considered invalid. For example, Aetna companies cannot make payments for health care or other claims or services if it violates a financial sanction regulation. This includes sanctions related to a blocked person or a country under sanction by the United States, unless permitted under a valid written Office of Foreign Assets Control (OFAC) license. For more information, visit **http://www.treasury.gov/resource-center/sanctions/Pages/default.aspx**.

Misstatements

Aetna's failure to implement or insist upon compliance with any provision of this Plan at any given time or times will not constitute a waiver of Aetna's right to implement or insist upon compliance with that provision at any other time or times.

Fraudulent misstatements in connection with any claim or application for coverage may result in termination of all coverage under this Plan.

Rescission of Coverage

Your coverage may be rescinded if you or the person seeking coverage on your behalf:

- Performs an act, practice or omission that constitutes fraud; or
- Makes an intentional misrepresentation of material fact.

You will be given 30 days advance written notice of any rescission of coverage.

As to medical and prescription drug coverage only, you have the right to an internal appeal with Aetna and/or the right to a third-party review conducted by an independent external review organization if your coverage under this SPD is rescinded retroactive to its effective date.

Required Notices

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

The Newborns' and Mothers' Health Protection Act

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

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

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

The Women's Health and Cancer Rights Act

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

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

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

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

New Health Insurance Marketplace Coverage Options and Your Health Coverage

Part A: General Information

To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Health Insurance Marketplace and employment-based health coverage offered by your employer.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a tax credit that lowers your monthly premium right away. The Marketplace will also direct you to Medicaid and Medicare if you are eligible. Open enrollment for health insurance coverage through the Marketplace generally begins in the fall for coverage as early as January 1.

Can I save money on my health insurance premiums in the Marketplace?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you may be eligible for depends on your household income.

Does employer health coverage affect eligibility for premium savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and instead may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a medical plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit. An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60% of such costs.

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you will lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution was well as your employee contribution to employer-offered coverages often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How can I get more information?

For more information about your coverage offered by your employer, please Contact OxyLink at 800-699-6903 or check your summary plan description on OxyLink Online at **oxylink.oxy.com**.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit healthcare.gov for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

Part B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information.

This information is numbered to correspond to the Marketplace application.

3. Employer name: Occidental Petroleum Corporation
4. Employer Identification Number (EIN): 95-4035997
5. Employer address: 5 Greenway Plaza, Suite 110
6. Employer phone number: 1-713-215-7000
7. City: Houston
8. State: Texas
9. Zip code: 77046

Here is some basic information about health coverage offered by this employer:

As your employer, we offer a health plan to:

- □ All employees.
- ✓ Some employees. Eligible employees are: regular, full-time hourly or salaried non-represented employees regularly scheduled to work at least 30 hours per week.

With respect to dependents:

- ✓ We do offer coverage. Eligible dependents are: Your Spouse, your domestic partner and his or her dependent children up to age 26, and your dependent children up to age 26.
- □ We do not offer coverage.

- ✓ If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, healthcare.gov will guide you through the process.

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage under this Plan, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **www.healthcare.gov**.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are **NOT** currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** (1-877-543-7669) or visit **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under the Plan, the company must allow you to enroll in the Plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance.** If you have questions about enrolling in the Plan, contact the Department of Labor at **www.askebsa.dol.gov** or call **1-866-444-EBSA** (1-866-444-3272).

If you live in one of the following states, you may be eligible for assistance paying your Plan premiums. The following list of states is current as of January 31, 2019. Contact your State for more information on eligibility:

STATE	CONTACT INFORMATION
ALABAMA—Medicaid	Website: www.myalhipp.com Phone: 1-855-692-5447
ALASKA—Medicaid	The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx
ARKANSAS – Medicaid	Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)
FLORIDA—Medicaid	Website: http://flmedicaidtplrecovery.com/hipp/ Phone: 1-877-357-3268
GEORGIA—Medicaid	Website: www.medicaid.georgia.gov – Click on Health Insurance Premium Payment (HIPP) Phone: 404-656-4507
INDIANA—Medicaid	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: http://www.indianamedicaid.com Phone 1-800-403-0864
IOWA—Medicaid	Website: http://dhs.iowa.gov/hawk-i Phone: 1-800-257-8563
KANSAS—Medicaid	Website: http://www.kdheks.gov/hcf/ Phone: 1-785-296-3512
KENTUCKY—Medicaid	Website: http://chfs.ky.gov Phone: 1-800-635-2570
LOUISIANA—Medicaid	Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331 Phone: 1-888-695-2447
MAINE—Medicaid	Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-442-6003 TTY: Maine relay 711
MASSACHUSETTS—Medicaid and CHIP	Website: http://www.mass.gov/eohhs/gov/departments/masshealth/ Phone: 1-800-862-4840
MINNESOTA—Medicaid	Website: http://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739 or 651-431-2670
MISSOURI—Medicaid	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
MONTANA—Medicaid	Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084

STATE	CONTACT INFORMATION
NEBRASKA—Medicaid	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
NEVADA—Medicaid	Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900
NEW HAMPSHIRE—Medicaid	Website: https://www.dhhs.nh.gov/oii/hipp.htm Phone: 1-800-852-3345 ext. 5218 or 603-271-5218
NEW JERSEY—Medicaid and CHIP	Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
NEW YORK—Medicaid	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA—Medicaid	Website: https://dma.ncdhhs.gov/ Phone: 919-855-4100
NORTH DAKOTA—Medicaid	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
OKLAHOMA—Medicaid and CHIP	Website: http://www.insureoklahoma.org Phone: 1-888-365-3742
OREGON—Medicaid and CHIP	Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075
PENNSYLVANIA—Medicaid	Website: http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm Phone: 1-800-692-7462
RHODE ISLAND—Medicaid	Website: http://www.eohhs.ri.gov/ Phone: 855-697-4347
SOUTH CAROLINA—Medicaid	Website: https://www.scdhhs.gov Phone: 1-888-549-0820
SOUTH DAKOTA—Medicaid	Website: http://dss.sd.gov Phone: 1-888-828-0059
TEXAS—Medicaid	Website: http://gethipptexas.com/ Phone: 1-800-440-0493
UTAH—Medicaid and CHIP	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
VERMONT—Medicaid	Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427

STATE	CONTACT INFORMATION
VIRGINIA—Medicaid and CHIP	Medicaid Website: http://www.coverva.org/programs_premium_assistance.cfm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm CHIP Phone: 1-855-242-8282
WASHINGTON—Medicaid	Website: http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/premium-payment-program Phone: 1-800-562-3022 ext. 15473
WEST VIRGINIA—Medicaid	Website: http://mywvhipp.com/ Phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN—Medicaid and CHIP	Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf Phone: 1-800-362-3002
WYOMING—Medicaid	Website: https://health.wyo.gov/healthcarefin/medicaid/ Phone: 307-777-7531

To see if any other states have added a premium assistance program since January 31, 2019, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (1-866-444-3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

Important Notice About Your Prescription Drug Coverage and Medicare

Please read the Creditable Coverage notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Occidental Petroleum Corporation and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

- Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
- Oxy has determined that the prescription drug coverage offered by the Occidental Petroleum Corporation Retiree Medical Plan is, on average for all Plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When can you join a Medicare drug plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15 to December 7 (provided you have been deemed not eligible to participate in the Oxy Medicare Advantage PPO Plan). However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two-month Special Enrollment Period (SEP) to join a Medicare drug plan.

What happens to your current coverage if you decide to join a Medicare drug plan?

If you decide to enroll in a Medicare prescription drug plan (provided you have been deemed not eligible to participate in the Oxy Medicare Advantage PPO Plan) and drop your prescription drug coverage through the Occidental Petroleum Corporation Retiree Medical Plan, be aware that you and your dependents may not be able to get this coverage back. You should compare your current coverage, including which drugs are covered, with the coverage and cost of the plans available in your area beginning this fall. Your current coverage through the Occidental Petroleum Corporation Retiree Medical Plan pays for other health and wellness expenses in addition to prescription drugs.

When will you pay a higher premium (penalty) to join a Medicare drug plan?

You should also know that if you drop or lose your current coverage with Occidental Petroleum Corporation and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About this Notice or Your Current Prescription Drug Coverage…

Contact OxyLink at 800-699-6903. Note: You'll receive the Creditable Coverage notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Occidental Petroleum Corporation changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans. For more information about Medicare prescription drug coverage:

- Visit **www.medicare.gov**
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call **800-MEDICARE** (800-633-4227). TTY users should call 877-486-2048

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at **www.socialsecurity.gov**, or call them at **800-772-1213** (TTY 800-325-0778).

Privacy Notice for Health Plans

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

The Plan and Oxy will not use or further disclose information that is protected by HIPAA (protected health information) except as necessary for treatment, payment, Plan operations and Plan administration, or as permitted or required by law. By law, the 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 call the OxyLink Employee Service Center at **800-699-6903,** go to **oxylink.oxy.com** and select *Required Notices,* then print the *HIPAA Privacy Notice.* If you have questions about the privacy of your health information or if you wish to file a complaint under HIPAA, contact the OxyLink Employee Service Center.

Nondiscrimination Notice—It's important we treat you fairly

That's why we follow federal civil rights laws in our health programs and activities. We don't discriminate, exclude people, or treat them differently on the basis of race, color, national origin, sex, age or disability. For people with disabilities, our medical providers offer free aids and services. For people whose primary language isn't English, our medical providers offer free language assistance services through interpreters and other written languages. Interested in these services? Call the Member Services number on your medical (Aetna or Anthem BlueCross BlueShield) and/or prescription drug (Express Scripts/Medco) ID card(s). If you think we failed to offer these services or discriminated based on race, color, national origin, age, disability or sex, you can file a complaint, also known as a grievance.

You can file a complaint with the Health and Welfare Team, Occidental Petroleum Corporation, 4500 S. 129th East Avenue, Tulsa, OK 74134-5801, 800-699-6903, fax: **800-610-1944**, oxylink@oxy.com. Or you can file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights at 200 Independence Avenue, SW; Room 509F, HHH Building; Washington, D.C. 20201 or by calling **800-368-1019** (TDD: 800-537-7697) or online at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf. Complaint forms are available at **http://www.hhs.gov/ocr/office/file/index.html**.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al Aetna (800) 334-0299 / (800) 628-3323 TDD; Express Scripts (800) 551-7680 / (800) 759-1089 TDD.

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電Aetna (800) 334-0299 / (800) 628-3323 TDD; Express Scripts (800) 551-7680 / (800) 759-1089 TDD.

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số Aetna (800) 334-0299 / (800) 628-3323 TDD; Express Scripts (800) 551-7680 / (800) 759-1089 TDD.

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. Aetna (800) 334-0299 / (800) 628-3323 TDD; Express Scripts (800) 551-7680 / (800) 759-1089 TDD 번으로 전화해 주십시오.

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa Aetna (800) 334-0299 / (800) 628-3323 TDD; Express Scripts (800) 551-7680 / (800) 759-1089 TDD.

ملحوظة: إذا كنت تتحدث اذكر تتوافر المساعدة اللغوية بالمجان لك تصل برقم اتصل بـ Aetna 800-334-0299-1 Express Scripts 855-547-8390-1

ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le Aetna (800) 334-0299 / (800) 628-3323 TDD; Express Scripts (800) 551-7680 / (800) 759 1089 TDD.

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните Aetna (800) 334-0299 / (800) 628-3323 TDD; Express Scripts (800) 551-7680 / (800) 759 1089 TDD.

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: Aetna (800) 334-0299 / (800) 628-3323 TDD; Express Scripts (800) 551-7680 / (800) 759-1089 TDD.

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。Aetna (800) 334-0299 / (800) 628-3323 TDD; Express Scripts (800) 551-7680 / (800) 759-1089 TDD まで、お電話にてご連絡ください。

સુચના: જો તમે ગુજરાતી બોલતા હો, તો નન:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો Aetna (800) 334-0299 / (800) 628-3323 TDD; Express Scripts (800) 551-7680 / (800) 759-1089 TDD.

ध्यान दें: यदद आप ह दिी बोलते हैं तो आपके ललए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। Aetna (800) 334-0299 / (800) 628-3323 TDD; Express Scripts (800) 551-7680 / (800) 759-1089 TDD पर कॉल करें।

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero Aetna (800) 334-0299 / (800) 628-3323 TDD; Express Scripts (800) 551-7680 / (800) 759-1089 TDD.

ໂປດຊາບ: ຖ້ າວ່ າ ທ່ ານເວ້ າພາສາ ລາວ, ການບ ໍ ລ ິ ການຊ່ ວຍເຫ ຼ ືອດ້ ານພາສາ, ໂດຍບ ໍ ່ ເສ ັ ຽຄ ່ າ, ແມ ່ ນມ ີ ພ ້ ອມໃຫ ້ ທ ່ ານ. ໂທຣ Aetna (800) 334-0299 / (800) 628-3323 TDD; Express Scripts (800) 551-7680 / (800) 759-1089 TDD.

شما می را رایگان به صورت زبان لاتین سه دهی کنید گفتگو فارسی زبان به این وجه:
Aetna (800) 334 0299, فراهم می شود با.
Express Scripts (800) 551-7680. تماس گیرید.

Your ERISA Rights

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

Receive Information About Your Plan and Benefits

- Examine, without charge, at the Plan Administrator's office and at other specified locations, all documents governing the Plan, including insurance contracts and a copy of the latest annual report (Form 5500 Series) that is filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain, upon written request to the Plan Administrator, copies of all documents governing the operation of the Plan, including insurance contracts and the latest annual report (Form 5500 Series), and an updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.
- Receive a copy of the procedures used by the Plan for determining a qualified medical child support order (QMCSO).

Continue Group Health Plan Coverage

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

Prudent Action by Plan Fiduciaries

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

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

Enforce Your Rights

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

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

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

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

Help with Your Questions

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

- The nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory; or
- The Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

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

Glossary

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

Aetna—Aetna Life Insurance Company, an affiliate, or a third party vendor under contract with Aetna.

Affiliate—Any business entity that is more than 80% owned, directly or indirectly by OPC, or is in an affiliated service group with OPC, as defined under the Code.

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

- If a covered person is confined in a private hospital room, the difference between the cost of a semi-private room in the hospital and the private room is not an allowable expense. This does not apply if one of the health plans provides coverage for a private room.
- If a person is covered by two or more health plans that compute their benefit payments on the basis of reasonable or **recognized charges**, any amount in excess of the highest of the reasonable or recognized charges for a specific benefit is not an allowable expense.
- If a person is covered by two or more health plans that provide benefits or services on the basis of negotiated charges, an amount in excess of the highest of the negotiated charges is not an allowable expense.
- The amount a benefit is reduced or not reimbursed by the primary health plan because a covered person does not comply with the health plan provisions is not an allowable expense. Examples of these provisions are second surgical opinions, precertification of admissions and preferred provider arrangements.
- If all health plans are high deductible health plans and the person intends to contribute to an HSA, the deductible for the primary high deductible health plan is not an allowable expense, except for any health expense not subject to the deductible per the Code.

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

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

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

Code—The Internal Revenue Code of 1986, as amended.

Coinsurance—The portion of your covered expenses that you pay.

Copay—A flat dollar amount you pay before receiving services. Copays apply before the deductible amount and apply to the out-of-pocket maximum limit.

Cosmetic—Services or supplies that alter, improve or enhance appearance.

Covered Expenses—Medical, dental, vision or hearing services and supplies shown as covered under this Plan.

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

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

Day care treatment—A partial confinement treatment program to provide treatment for you during the day. The hospital, psychiatric hospital or residential treatment facility does not make a room charge for day care treatment. Such treatment must be available for at least 4 hours, but not more than 12 hours in any 24-hour period.

Deductible—The part of your covered expenses you pay before the Plan starts to pay benefits. Additional information regarding deductibles and deductible amounts can be found in the *Benefits at a Glance* on page 3 and the *Deductible* section on page 18.

Dentist—A legally qualified dentist, or a physician licensed to do the dental work he or she performs.

Dental Emergency—Any dental condition that:

- Occurs unexpectedly;
- Requires immediate diagnosis and treatment in order to stabilize the condition; and
- Is characterized by symptoms such as severe pain and bleeding.

Dependent—Generally, your:

- Legal spouse (unless legally separated), and
- Children under age 26, and your disabled children may qualify as eligible dependents under the Plan.

Your eligible spouse is your spouse to whom you are legally married. All legal marriages will be recognized for purposes of benefit eligibility, regardless of the state in which you reside. This includes a spouse through common law marriage in applicable states. This does not include a spouse from whom you are legally separated.

Your eligible 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.

Unless otherwise noted in a specific coverage section, your children must be under the age of 26 to be eligible for coverage under the Plan regardless of their marital, student, financial or residency status. However, a child who has reached the upper age limit (age 26) and who is mentally or physically incapable of self-sustaining employment may continue to be eligible.

A dependent also includes a child for whom health care coverage is required through **Qualified Medical Child** Support Order (QMCSO). A QMCSO is any judgment, decree or order issued by a court of competent jurisdiction, or other court or administrative order, requiring you to provide health care benefits for a child.

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's age limit; and
- Depends mainly on you for support and maintenance.

You must provide proof of your child's disability to the claims administrator no later than 31 days after your child reaches the dependent age limit for review and determination of eligibility of continuation of coverage. The claims administrator may continue to ask you for proof that the child continues to meet conditions of incapacity and dependency.

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

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

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

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

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

Directory—A listing of all network providers serving the class of employees to which you belong. The contractholder will give you a copy of this directory. Network provider information is also available through Aetna's online provider directory, DocFind®.

Durable medical and surgical equipment (DME)—Equipment, and the accessories needed to operate it, that is:

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

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

Emergency admission—A hospital admission where the physician admits the person to the hospital right after the sudden and, at that time, unexpected onset of a change in the person's physical or mental condition:

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

Emergency care—The treatment given in a hospital's emergency room to evaluate and treat an emergency medical condition.

Emergency condition—A recent and severe medical condition—including but not limited to severe pain—that would lead a prudent layperson, possessing an average knowledge of medicine and health, to believe that his or her condition, illness, or injury is of such a nature that failure to get immediate medical care could result in:

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

Some examples of emergency conditions include:

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

ERISA—The Employee Retirement Income Security Act of 1974, as amended.

Experimental and investigational—A drug, device, a procedure or treatment will be determined to be experimental or investigational if:

- There are insufficient outcomes data available from controlled clinical trials published in the peer-reviewed literature to substantiate its safety and effectiveness for the illness or injury involved;
- Approval required by the FDA has not been granted for marketing;
- A recognized national medical or dental society or regulatory agency has determined, in writing, that it is experimental or investigational, or for research purposes;
- It is a type of drug, device or treatment that is the subject of a Phase I or Phase II clinical trial or the experimental or research arm of a Phase III clinical trial, using the definition of "phases" indicated in regulations and other official actions and publications of the FDA and Department of Health and Human Services; or
- The written protocol or protocols used by the treating facility, or the protocol or protocols of any other facility studying substantially the same drug, device, procedure or treatment, or the written informed consent used by the treating facility or by another facility studying the same drug, device, procedure or treatment states that it is experimental or investigational, or for research purposes.

Home health care agency—An agency that:

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

Home health care plan—A plan that provides for care and treatment in a person's home. It must be:

- Prescribed in writing by the attending physician; and
- An alternative to confinement in a hospital or skilled nursing facility.

Homebound—Means you are confined to your place of residence:

- Due to an illness or injury that makes leaving the home medically contraindicated; or
- Because the act of transport would be a serious risk to your life or health.

Situations where you would not be considered to be homebound include (but are not limited to):

- You do not often travel from home because of feebleness or insecurity brought on by advanced age (or otherwise); or
- You are wheelchair bound but could safely be transported via wheelchair accessible transportation.

Hospice care—Care provided to a terminally ill person by or under arrangements with a hospice care agency. The care must be part of a hospice care program.

Hospice care agency—An agency or organization that:

- Has hospice care available 24 hours a day.
- Meets any licensing or certification standards established by the jurisdiction where it is located.
- Provides:
  - Skilled nursing services;
  - Medical social services; and
  - Psychological and dietary counseling.
- Provides, or arranges for, other services which include:
  - Physician services;
  - Physical and occupational therapy;
  - Part-time home health aide services which mainly consist of caring for terminally ill people; and
  - Inpatient care in a facility when needed for pain control and acute and chronic symptom management.
- Has at least one physician, one R.N. and one licensed or certified social worker employed by the agency.
- Establishes policies about how hospice care is provided.
- Assesses the patient's medical and social needs.
- Develops a hospice care program to meet those needs.

- Provides an ongoing quality assurance program. This includes reviews by physicians, other than those who own or direct the agency.
- Permits all area medical personnel to utilize its services for their patients.
- Keeps a medical record on each patient.
- Uses volunteers trained in providing services for non-medical needs.
- Has a full-time administrator.

Hospice care facility—A facility, or distinct part of one, which:

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

Hospice care program—A written plan of hospice care that:

- Is established by and reviewed from time to time by the person's attending physician and appropriate hospice care agency personnel.
- Is designed to provide palliative (pain relief) and supportive care to terminally ill people and supportive care to their families.
- Includes an assessment of the person's medical and social needs, and a description of the care to be given to meet those needs.

Hospital—An institution that:

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

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

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

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

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

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

Institutes of Excellence (IOE)— A hospital or other facility that has contracted with Aetna to give services or supplies to an IOE patient in connection with specific transplants, procedures at a negotiated charge. A facility is an IOE facility only for those types of transplants, procedures for which it has signed a contract.

Jaw joint disorder—

- A temporomandibular joint (TMJ) dysfunction or any alike disorder of the jaw joint;
- A myofacial pain dysfunction (MPD); or
- Any alike disorder in the relationship of the jaw joint and the related muscles and nerves.

L.P.N.—A licensed practical nurse.

Lifetime Maximum—This is the most the Plan will pay for covered expenses incurred by any one covered person in their lifetime.

Maintenance care—Care made up of services and supplies that:

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

Medically necessary—Health care, dental or vision services, and supplies or prescription drugs that a physician, other health care provider, dental provider or vision provider, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that provision of the service, supply or prescription drug is:

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

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

Mental disorder—An illness commonly understood to be a mental disorder, whether or not it has a physiological basis, and for which treatment is generally provided by or under the direction of a behavioral health provider such as a psychiatric physician, a psychologist or a psychiatric social worker.

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

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

Morbid obesity—This means a Body Mass Index (BMI) that is greater than 40 kilograms per meter squared or equal to or greater than 35 kilograms per meter squared with a comorbid medical condition, including hypertension, a cardiopulmonary condition, sleep apnea or diabetes.

Negotiated fee (charge or rate)—The maximum charge a network provider has agreed to make for any service or supply for the purpose of benefits under the Plan.

Network provider—A health care provider who belongs to the claims administrator’s network and has contracted to furnish services or supplies for a negotiated charge.

Network services or supplies—Health care service or supply that is furnished by a network provider.

Night care treatment—A partial confinement treatment program provided when you need to be confined during the night. A room charge is made by the hospital, psychiatric hospital or residential treatment facility. Such treatment must be available at least:

- Eight hours in a row a night; and
- Five nights a week.

Non-network care—A health care service or supply provided by a non-network provider (one who does not belong to the claims administrator’s network).

Non-network provider—A health care provider who does not belong to the claims administrator's network and has not contracted with the claims administrator to furnish services or supplies at a negotiated fee.

Occupational Injury or Occupational Illness—An injury or illness that:

- Arises out of (or in the course of) any activity in connection with employment or self-employment whether or not on a full time basis; or
- Results in any way from an injury or illness.

OPC—Occidental Petroleum Corporation, a Delaware corporation.

Occurrence—This means a period of disease or injury. An occurrence ends when 60 consecutive days have passed during which the covered person:

- Receives no medical treatment; services; or supplies; for a disease or injury; and
- Neither takes any medication, nor has any medication prescribed, for a disease or injury.

Orthodontic treatment—Any medical or dental service or supply that is furnished to prevent or diagnose or correct a misalignment (whether or not for the purpose of relieving pain):

- Of the teeth;
- Of the bite; or
- Of the jaws or jaw joint relationship.

The following are not considered orthodontic treatment:

- The installation of a space maintainer; and
- A surgical procedure to correct malocclusion.

Oxy—Occidental Petroleum Corporation or an affiliated company.

Partial confinement treatment—A plan of medical, psychiatric, nursing, counseling, or therapeutic services to treat substance abuse or mental disorders. The plan must meet these tests:

- It is carried out in a hospital, psychiatric hospital or residential treatment facility on less than a full-time inpatient basis;
- It is in accord with accepted medical practice for the condition of the person;
- It does not require full-time confinement; and
- It is supervised by a psychiatric physician who weekly reviews and evaluates its effect.

Day care treatment and night care treatment are considered partial confinement treatment.

Physician—A duly licensed member of a medical profession who:

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

This also includes a health professional who:

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

Plan—The Occidental Petroleum Corporation Retiree Medical Plan. Unless the context otherwise requires in this SPD, the Plan means the retiree medical benefits described here.

Plan Administrator—Occidental Petroleum Corporation Employee Benefits Committee.

Precertification—A review of inpatient admissions and other care to determine whether the requested care is covered under your Plan. This review should take place before the admission and before the care is provided and is only required for non-Medicare eligible participants.

Prescription—A drug, biological, or compounded prescription drug by a prescriber. If it is an oral order, it must be promptly put in writing by the pharmacy.

Prescription Drug—A drug, biological, or compounded prescription which, by State and Federal Law, may be dispensed only by prescription and which is required to be labeled "Caution Federal Law prohibits dispensing without prescription." This includes:

- An injectable drug prescribed to be self-administered or administered by any other person except one who is acting within his or her capacity as a paid healthcare professional. Covered injectable drugs include injectable insulin.

Primary care physician (PCP)—A network provider who is:

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

Psychiatric hospital—An institution that meets all of the following requirements:

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

Psychiatric physician—A physician who:

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

R.N.—A registered nurse.

Recognized charge—The amount of a non-network provider's charge that is eligible for coverage. You are responsible for all amounts above what is eligible for coverage.

If your ID card displays the National Advantage Program (NAP) logo, your cost may be lower when you get care from a NAP provider. Through NAP, the recognized charge is determined as follows:

- If your service was received from a NAP provider, a pre-negotiated charge will be paid. NAP providers are non-network providers that have contracts with Aetna, directly or through third-party vendors, that include a pre-negotiated charge for services. NAP providers are not network providers.
- If your service was not received from a NAP provider, a claim specific rate or discount may be negotiated by Aetna or a third-party vendor.

If your claim is not paid as outlined above, the recognized charge for specific services or supplies will be the non-network Plan rate, calculated in accordance with the following:

Service or Supply	Non-Network Plan Rate
Professional services	An amount determined by Aetna, or its third-party vendors, based on data resources selected by Aetna, reflecting typical competitive charges and/or payments for a service, adjusted for the geographic area in which the service was provided.
Inpatient and outpatient charges of hospitals	**FCR** rate
Inpatient and outpatient charges of facilities other than hospitals	**FCR** rate
Prescription drugs	**AWP** rate

Important note: If the provider bills less than the amount calculated using the non-network Plan rate described above, the recognized charge is what the provider bills.

In the event you receive a balance bill from a provider for your non-network service, Patient Advocacy Services may be available to assist you in certain circumstances.

If NAP does not apply to you, the recognized charge for specific services or supplies will be the non-network Plan rate set forth in the above chart.

The non-network Plan rate does not apply to involuntary services. Involuntary services are services or supplies that are one of the following:

- Performed at a network facility by a non-network provider, unless that non-network provider is an assistant surgeon for your surgery;
- Not available from a network provider; or
- Emergency services.

Aetna will calculate your cost share for involuntary services in the same way as it would if you received the services from a network provider.

Special terms used

- **Average wholesale price (AWP**): The AWP is the current average wholesale price of a prescription drug listed in the Facts and Comparisons, Medi-span weekly price updates (or any other similar publication chosen by Aetna).
- **Geographic area:** The Geographic area is normally based on the first three digits of the U.S. Postal Service zip codes. If Aetna determines it needs more data for a particular service or supply, Aetna may base rates on a wider geographic area such as an entire state.
- **Facility charge review (FCR) rate:** The FCR rate is an amount that Aetna determines is enough to cover the facility provider's estimated costs for the service and leave the facility provider with a reasonable profit. For hospitals and other facilities that report costs (or cost-to-charge ratios) to CMS, the FCR rate is based on what the facilities report to CMS. For facilities that do not report costs (or cost-to-charge ratios) to CMS, the FCR rate is based on statewide averages of the facilities that do report to CMS. Aetna may adjust the formula, as needed, to maintain the reasonableness of the recognized charge. For example, Aetna may make an adjustment if it determines that in a particular state the charges of ambulatory surgery centers (or another class of facility) are much higher than charges of facilities that report costs (or cost-to-charge ratios) to CMS.

Aetna reserves the right to apply its reimbursement policies to all non-network services including involuntary services. Our reimbursement policies may affect the recognized charge.

These policies consider:

- The duration and complexity of a service
- When multiple procedures are billed at the same time, whether additional overhead is required
- Whether an assistant surgeon is necessary for the service
- If follow-up care is included
- Whether other characteristics modify or make a particular service unique
- When a charge includes more than one claim line, whether any services described by a claim line are part of or related to the primary service provided
- The educational level, licensure or length of training of the provider.

The Aetna reimbursement policies may consider:

- The Centers for Medicare and Medicaid Services' (CMS) National Correct Coding Initiative (NCCI) and other external materials that say what billing and coding practices are and are not appropriate
- Generally accepted standards of medical and dental practice
- The views of physicians and dentists practicing in the relevant clinical areas
- Aetna's own data and/or databases and methodologies maintained by third parties.

Aetna uses commercial software to administer some of these policies. The policies may be different for professional services and facility services.

Rehabilitation facility—A facility, or a distinct part of a facility, that provides rehabilitative services, meets any licensing or certification standards established by the jurisdiction where it is located, and makes charges for its services.

Rehabilitative services—The combined and coordinated use of medical, social, educational and vocational measures for training or retraining if you are disabled by illness or injury.

Residential treatment facility (mental disorders)—An institution that meets all of the following requirements:

- Is accredited by one of the following agencies, commissions or committees for the services being provided: The Joint Commission (TJC), Committee on Accreditation of Rehabilitation Facilities (CARF), American Osteopathic Association's Healthcare Facilities Accreditation Program (HFAP) or the Council on Accreditation (COA); or is credentialed by Aetna;
- Meets all applicable licensing standards established by the jurisdiction in which it is located;
- Performs a comprehensive patient assessment preferably before admission, but at least upon admission;
- Creates individualized active treatment plans directed toward the alleviation of the impairment that caused the admission;
- Has the ability to involve family/support systems in the therapeutic process;
- Has the level of skilled intervention and provision of care that is consistent with the patient's illness and risk;
- Provides access to psychiatric care by a psychiatrist as necessary for the provision of such care;

- Provides treatment services that are managed by a behavioral health provider who functions under the direction/supervision of a medical director; and
- Is not a wilderness treatment program (whether or not the program is part of a licensed residential treatment facility, or otherwise licensed institution), educational services, schooling or any such related or similar program, including therapeutic programs within a school setting.

In addition to the above requirements, for mental health residential treatment programs:

- A behavioral health provider must be actively on duty 24 hours per day for 7 days a week;
- The patient is treated by a psychiatrist at least once per week; and
- The medical director must be a psychiatrist.

Residential treatment facility (substance abuse)—An institution that meets all of the following requirements:

- Is accredited by one of the following agencies, commissions or committees for the services being provided: The Joint Commission (TJC), Committee on Accreditation of Rehabilitation Facilities (CARF), American Osteopathic Association's Healthcare Facilities Accreditation Program (HFAP), or the Council on Accreditation (COA); or is credentialed by Aetna;
- Meets all applicable licensing standards established by the jurisdiction in which it is located;
- Performs a comprehensive patient assessment preferably before admission, but at least upon admission;
- Creates individualized active treatment plans directed toward the alleviation of the impairment that caused the admission;
- Has the ability to involve family and/or support systems in the therapeutic process;
- Has the level of skilled intervention and provision of care that is consistent with the patient's illness and risk;
- Provides access to psychiatric care by a psychiatrist as necessary for the provision of such care;
- Provides treatment services that are managed by a behavioral health provider who functions under the direction/supervision of a medical director; and
- Is not a wilderness treatment program (whether or not the program is part of a licensed residential treatment facility, or otherwise licensed institution), educational services, schooling or any such related or similar program, including therapeutic programs within a school setting.

In addition to the above requirements, for chemical dependence residential treatment programs:

- Is a behavioral health provider or an appropriately state certified professional (for example, CADC, CAC);
- Is actively on duty during the day and evening therapeutic programming; and
- The medical director must be a physician who is an addiction specialist.

In addition to the above requirements, for chemical dependence detoxification programs within a residential setting:

- An R.N. is onsite 24 hours per day for seven days a week; and
- The care must be provided under the direct supervision of a physician.

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

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

Semi-private room rate—The room and board charge that an institution applies to the most beds in its semi-private rooms with two or more beds. If there are no such rooms, Aetna will figure the rate. It will be the rate most commonly charged by similar institutions in the same geographic area.

Skilled nursing facility—An institution that meets all of the following requirements:

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

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

Skilled nursing facility does not include:

- Institutions which provide only:
  – Minimal care;
  – Custodial care services;
  – Ambulatory; or
  – Part-time care services.
- Institutions which primarily provide for the care and treatment of alcoholism, substance abuse or mental disorders.

Skilled nursing services—Services that meet all of the following requirements:

- The services require medical or paramedical training.
- The services are rendered by an R.N. or L.P.N. within the scope of his or her license.
- The services are not custodial.

Specialist—A physician who practices in any generally accepted medical or surgical subspecialty, and provides care that is not considered routine medical care.

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

Surgery center—A freestanding ambulatory surgical facility that meets all of the following requirements:

- Meets licensing standards.
- Is set up, equipped and run to provide general surgery.
- Charges for its services.
- Is directed by a staff of physicians. At least one of them must be on the premises when surgery is performed and during the recovery period.
- Has at least one certified anesthesiologist at the site when surgery requiring general or spinal anesthesia is performed and during the recovery period.
- Extends surgical staff privileges to:
  - Physicians who practice surgery in an area hospital; and
  - Dentists who perform oral surgery.
- Has at least two operating rooms and one recovery room.
- Provides, or arranges with a medical facility in the area for, diagnostic x-ray and lab services needed in connection with surgery.
- Does not have a place for patients to stay overnight.
- Provides, in the operating and recovery rooms, full-time skilled nursing services directed by an R.N.
- Is equipped and has trained staff to handle emergency medical conditions.

It must have all of the following:

- A physician trained in cardiopulmonary resuscitation;
- A defibrillator;
- A tracheotomy set;
- A blood volume expander;
- A written agreement with a hospital in the area for immediate emergency transfer of patients; (Written procedures for such a transfer must be displayed and the staff must be aware of them.); and
- An ongoing quality assurance program, that includes reviews by physicians who do not own or direct the facility.

The facility must keep a medical record on each patient.

Terminally ill—A medical prognosis of 12 months or less to live.

Urgent admission—An admission where the physician admits the person to the hospital due to:

- The onset of or change in an illness; or
- The diagnosis of an illness; or
- An injury caused by an accident; which, while not needing an emergency admission, is severe enough to require confinement as an inpatient in a hospital within two weeks from the date the need for the confinement becomes apparent.

Urgent care provider—

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

Urgent condition—A sudden illness, injury or condition that:

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