SUMMARY PLAN DESCRIPTION

DENTAL PLAN

Effective January 1, 2021

Dental Insurance Program
Benefit Program Summary Plan Description
Effective as of January 1, 2021

The Dental Benefit Program ("Dental Program" or the "Program") promotes and encourages preventive dental care and provides benefits for services that are essential to the proper care of your teeth. How much you pay for your care out of your own pocket depends on whether the expense is covered by the Dental Program and whether you choose a Network Provider or a Non-Network Provider.

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

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

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

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

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Eligibility

All regular full-time and part-time Employees and their Spouses or Domestic Partners and Dependent Children are eligible to participate in the Dental Program as of the Employee's date of hire with Occidental Petroleum Corporation or one of its affiliated companies (i.e., referred to as an "Employer in the Wrap-SPD). However, no individual who meets any one of the following may be an eligible Employee with respect to the Dental Program:

- an Employee who is included in a unit of Employees that is covered by an agreement which the Secretary of the federal Department of Labor finds to be a collective bargaining agreement between Employee representatives and the Employer, if the Plan or the Dental Program in particular was the subject of good faith bargaining, unless such agreement provides for coverage of such Employees in the Plan or the Dental Program in particular; or

- an Employee who is employed by a division or operating unit of the Employer for which the Plan or the Dental Program in particular has not been adopted; or

- an individual who is not the Employee of an Employer.

For additional information regarding eligibility, please see the Wrap-SPD and its Appendix G.

Dental Program at a Glance

For updates to this information, go to My HR on oxynet.oxy.com or look for any Summaries of Material Modification that might accompany this document.

Annual Deductible	$50 individual/$150 family
Annual Maximum Applies to preventive and diagnostic, basic and major services	$2,000 per person per calendar year
Lifetime Maximum Does not include orthodontia	Unlimited
Orthodontia Lifetime Maximum	$2,500 per covered person
COVERED SERVICES	**YOU PAY (NETWORK OR NON-NETWORK)**
Preventive and Diagnostic Services • Routine oral exams—2 per year • Cleaning and scaling of teeth—3 per year • Bitewing and diagnostic x-rays • Fluoride application (dependents under age 16) • Sealants for permanent molars (dependents under age 16) • Space maintainers • Problem-based exams	Covered by Plan at 100% no deductible

Basic Restorative Services • Simple extractions • Oral surgery • Fillings, except gold • Repair or recementing of crowns, inlays, bridgework and dentures • Relining of dentures • Treatment of diseases of the gums and tissues of the mouth (periodontics) • Endodontic treatments such as root canals • General anesthesia, if Medically Necessary	20% after deductible
Major Restorative Services • Crowns, inlays or gold fillings • Dentures • Fixed bridgework (including inlays and crowns as abutments)	50% after deductible
Orthodontic Services • Braces and other orthodontic treatment	50%, not subject to deductible, up to lifetime maximum

Aetna Life Insurance Company is the Claims Fiduciary and Claims Administrator for the Dental Program.

For Help and Information

Contact Information		
Provider:	**Address:**	**Phone:**
Aetna	P.O. Box 14586 Lexington, KY 40512-4586 Website: https://aetna.com	800-334-0299 Outside U.S.: 817-417-2000 (ext. 4154016)
PayFlex (FSA and HSA Administration)	P.O. Box 4000 Richmond, KY 40476-4000 Website: https://www.payflex.com/	844-PAYFLEX (844-729-3539) Outside U.S.: 402-345-0666
OxyLink Employee Service Center (Eligibility, Life Events, Contributions)	4500 South 129th East Avenue Tulsa, OK 74134-5870 Email: oxylink@oxy.com Website: https://oxylink.oxy.com/	800-699-6903 Outside U.S: 918-610-1990

Dental Providers

Using Network and Non-Network Dental Providers

Under the Dental Program, you have the freedom to choose any licensed Dental Provider when you need dental care. You can select a Dental Provider that belongs to the Aetna network (a Network Provider) or one that does not (a Non-Network Provider).

When you use Network Providers:

- Your out-of-pocket expenses may be lower because network providers have agreed to provide covered services and supplies at a Negotiated Fee.
- You will not pay any amounts above the Negotiated Fee for a covered service or supply.
- Aetna's Negotiated Fees do not apply to care that is not covered under the Dental Program.
- You will not have to submit dental claims for treatment received, provided that your Network Provider takes care of filing claims for you.
- You receive notification of what the Dental Program has paid toward your Covered Expenses. (You are responsible for the deductible and your coinsurance amount shown on the explanation of benefits "EOB" form.)

If you receive care from a Non-Network Provider:

- Your benefits are limited to the Recognized Charge and your expenses will generally be higher.
- If the charge is more than the Recognized Charge, you pay the difference. This excess amount will not apply toward your deductible.
- You must file a claim to receive reimbursement from the Dental Program.

Get the most value out of your benefits. Use the cost estimator on the Aetna member website at aetna.com to help decide whether to get care in-network or out-of-network. Aetna's member website may contain additional information that can help you determine the cost of a service or supply.

Aetna Provider Network

To participate in Aetna's network, a Dentist must meet certain standards through a process called credentialing—which looks at factors such as education and licensing. To find a Dentist in your area that is a Network Provider:

- **Go to aetna.com and click on *Find a Doctor* to search for a Network Provider.**
  - If you log in to the member website, your network is automatically selected.
  - To search for a Dentist who is a Network Provider without logging in, select the type of search you want (e.g., dentist) and enter your zip code. When asked to select a plan, choose Dental PPO/PDN with PPO II Network.
  - You can search the online Directory for a specific Dentist or all Dentists in a given zip code. You can also get information about a Dentist's practice, such as address, phone numbers and access for the disabled.
- **Contact Aetna Member Services.**
  - A representative can also help you find a **Network Provider Dentist** in your area. The Aetna Member Services toll-free number is shown on your ID card.
  - You also may email Aetna Member Services from Aetna's secure member website. Just go to aetna.com and select *Member Log In*.

Your Share of Dental Service Costs

You can find information about current deductibles and maximum benefits on “My HR” on OxyNet.

Deductible

When you receive dental care, you pay a calendar year deductible on Covered Expenses before the Dental Program starts to pay benefits for certain services. There are two types of deductible: individual and family.

The individual calendar year deductible is the part of Covered Expenses you and each covered dependent pays each year (January 1 to December 31) before the Dental Program starts to pay benefits.

If the covered dental expenses of all family members reach the family deductible (for example, if you have four covered family members and three family members meet their individual deductibles), no other deductible is required for the rest of the calendar year.

Important
The deductible does not apply to diagnostic and preventive services.

Coinsurance

After you meet the deductible, the Dental Program pays a percentage of the covered dental expenses and you pay the rest. The portion of Covered Expenses you pay is called your coinsurance.

Annual and Lifetime Maximums

The Dental Program will pay a set amount for diagnostic and preventive, basic and major services in a calendar year—the annual maximum. There is no separate lifetime maximum for these services; however, there is a separate lifetime maximum benefit for Orthodontic Treatment.

Dental Treatment Estimate and Advance Claim Review

If your Dentist recommends a Course of Treatment expected to cost $350 or more, it is requested that you have your Dentist submit a request for an Advance Claim Review (pre-treatment estimate) with Aetna.

Ask your Dentist to provide a full description of the treatment you need, using a Dental Benefits Request form available on **My HR** on oxynet.oxy.com under My HR Home > I’m looking for > Forms/Documents or on OxyLink Online at **oxylink.oxy.com** under Plan Documents and Information. Your Dentist should send the form to Aetna before treatment begins. Aetna may ask for supporting x-rays and other diagnostic records. In determining the amount of benefits payable, Aetna will take into account alternate procedures, services or courses of treatment needed to accomplish the appropriate result.

After review of the treatment plan, Aetna will provide you and your Dentist with a statement of the benefits payable by the Dental Program. You can use this information to decide how to proceed.

Advance Claim Review is a service that gives you information that you and your Dentist can consider when deciding on a course of treatment. It is not necessary for a Dental Emergency or routine care such as cleanings or check-ups.

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

Covered Dental Program Expenses

The Dental Program covers only Medically Necessary dental care expenses incurred while your coverage is in effect. An expense is incurred on the day you receive a dental service or supply. Aetna will pay for the least expensive service or supply that treats the condition (see the Alternate Treatment section that follows). In addition, please see below the section entitled "What the Dental Program Does Not Cover".

Alternate Treatment

Sometimes there are several ways to treat a dental problem, all of which provide acceptable results. When alternate services or supplies can be used, the Dental Program's coverage will be limited to the cost of the least expensive service or supply that is:

- Customarily used nationwide for treatment; and
- Viewed by the dental profession as appropriate for treatment of the condition. The service or supply must meet broadly accepted standards of dental practice, taking into account your current oral condition.

You should review the differences in the cost of alternate treatment with your dental provider. Of course, you can still choose the more costly treatment method, but you are responsible for any charges in excess of what the Dental Program covers.

Diagnostic and Preventive Services

Diagnostic and preventive services include:

- Routine oral exams—twice per calendar year
- Cleaning and scaling of teeth—three times per calendar year
- Problem-focused exams
- Topical application of fluoride—one per calendar year for dependents under age 16
- Diagnostic and other x-rays—one full mouth or panoramic series every three years
- Bitewing x-rays:
  - Two sets in a calendar year for dependents under age 14
  - One set in a calendar year for individuals age 14 and older
- Sealants only for permanent molars—once every three rolling years, for dependents under age 16
- Treatment to relieve pain in a Dental Emergency
- Space maintainers for premature loss of primary teeth only

Basic Restorative Services

Basic restorative services include:

- Simple extractions
- Oral surgery:
  - For non-impacted wisdom teeth extractions
  - If the procedure is not covered under your medical plan (including extraction of impacted teeth)
- Fillings, except gold
- General anesthetics, if medically necessary
- Treatment of diseased periodontal structures

- Endodontic treatment, such as pulp capping and root canals
- Repair or recementing of crowns, inlays, bridgework or dentures
- Addition of teeth to an existing partial removable denture or existing fixed bridgework (see the section on the Replacement Rule which follows)
- Relining/rebasing of dentures

Major Restorative Services

Major restorative services include:

- Inlays, gold fillings or crowns, including precision attachments for dentures
- First installation of removable dentures and partial dentures to replace one or more natural teeth, including adjustments for the six-month period after they were installed
- First installation of fixed bridgework to replace one or more natural teeth, including inlays and crowns as abutments
- Occlusal adjustment for a Jaw Joint Disorder. Covered services include night guards for grinding the teeth or equilibration, capping the teeth, and fixed or partial bridgework
- Dental implants and related services
- Replacement of an existing removable denture or fixed bridgework with a new denture or fixed bridgework (see the section on the Replacement Rule which follows)

Replacement Rule

Certain replacements of veneers, complete dentures, removable partial dentures, fixed partial dentures (bridges) and other prosthetic services are covered only when you give satisfactory proof to Aetna that:

- You had a tooth (or teeth) extracted after the existing denture or bridge was installed. As a result, you need to replace or add teeth to your denture or bridge.
- The present veneer, complete denture, removable partial denture, fixed partial denture (bridge) or other prosthetic service was installed at least five years before its replacement and cannot be made serviceable.
- Your present denture is an immediate temporary one that replaces an extracted tooth (or teeth). A permanent denture is needed, and the temporary denture cannot be used as a permanent denture. Replacement must occur within 12 months from the date that the temporary denture was installed.

Dental Work Completed After Coverage Ends

Your dental coverage may end while you or your covered dependent are in the middle of treatment. The Dental Program does not cover dental services that are given after your coverage ends. However, the Dental Program will cover the following services if they are ordered while you were covered by the Dental Program, and installed within 30 days after your coverage ends:

- Inlays
- Onlays
- Crowns
- Removable bridges
- Cast or processed restorations
- Dentures

- Fixed partial dentures (bridges)
- Root canals

For purposes of this section “ordered” means:

- For a denture: the impressions from which the denture will be made were taken.
- For a root canal: the pulp chamber was opened.
- For any other item: the teeth that will serve as retainers or supports, or the teeth that are being restored:
  - Have been fully prepared to receive the item; and
  - Impressions have been taken from which the item will be prepared.

Orthodontic Treatment

The Dental Program covers Orthodontic Treatment for you and your covered dependents (including your legal spouse or Domestic Partner). However, the Dental Program does not cover the following orthodontic services and supplies:

- Replacement of broken appliances
- Retreatment of orthodontic cases
- Changes in treatment necessitated by an accident
- Maxillofacial surgery
- Myofunctional therapy
- Treatment of cleft palate
- Treatment of micrognathia
- Treatment of macroglossia
- Treatment of primary dentition
- Treatment of transitional dentition
- Lingually placed direct bonded appliances and arch wires (i.e., invisible braces) (see the Alternate Treatment section above)
- Removable acrylic aligners or “invisible aligners” (see the Alternate Treatment section above)

What the Dental Program Does Not Cover

Not every dental care service or supply is covered by the Dental Program, even if prescribed, recommended or approved by your Physician or Dentist. The Dental Program covers only those services and supplies that are Medically Necessary. Some services are specifically limited or excluded. Charges made for the following are not covered except to the extent listed in the Covered Dental Program Expenses section above.

- Any instruction for diet, plaque control and oral hygiene.
- Cosmetic services and supplies, including plastic, reconstructive and cosmetic surgery; personalization or characterization of dentures; other services and supplies that improve, alter or enhance appearance, augmentation and vestibuloplasty; and other substances to protect, clean, whiten, bleach or alter the appearance of teeth; whether or not for psychological or emotional reasons, except to the extent listed as covered in the Covered Dental Program Expenses section above.
- Crown, inlays and onlays, and veneers unless:
  - Treatment is for decay or traumatic Injury and teeth cannot be restored with a filling material; or

  - The tooth is an abutment to a covered partial denture or fixed bridge.
- Dental services and supplies that are covered in whole or in part under any other:
  - Part of this Dental Program; or
  - Plan of group benefits provided by the Plan Sponsor or Employer.
- Dentures, crowns, inlays, onlays, bridges, or other appliances or services used to splint; alter vertical dimension; restore occlusion; or correct attrition, abrasion or erosion
- Treatment of any Jaw Joint Disorder and treatments to alter bite or the alignment or operation of the jaw, including temporomandibular joint treatment, orthognathic surgery, and treatment of malocclusion or devices to alter bite or alignment, except to the extent listed as covered in the Covered Dental Program Expenses section above.
- General anesthesia and intravenous sedation, unless specifically covered and only when done in connection with another necessary covered service or supply
- Pontics, crowns, cast or processed restorations made with high noble metals (gold or titanium)
- Prescribed drugs, pre-medication or analgesia
- Replacement of a device or appliance that is lost, missing or stolen; replacement of appliances that have been damaged due to abuse, misuse or neglect; and for an extra set of dentures
- Services and supplies where there is no evidence of pathology, dysfunction or disease other than covered preventive services
- Services and supplies for the patient's personal comfort or convenience, or the convenience of any other person, including a provider
- Services and supplies in connection with treatment or care that is not covered under the Dental Program
- Space maintainers except when needed to preserve space resulting from the premature loss of deciduous teeth
- Surgical removal of impacted wisdom teeth only for orthodontic reasons
- Treatment by other than a Dentist. The Dental Program will cover the following services provided by a licensed dental hygienist under the supervision and guidance of a Dentist:
  - Scaling of teeth
  - Cleaning of teeth
  - Topical application of fluoride
- Acupuncture, acupressure and acupuncture therapy, except to the extent listed as covered in the Covered Dental Program Expenses section above.
- Any charges in excess of the benefit, dollar, day, visit or supply limits stated in this SPD
- Charges submitted for services by an unlicensed Hospital, Physician or other provider or not within the scope of the provider's license
- Charges submitted for services that are not rendered, or not rendered to a person not eligible for coverage under the Dental Program
- Court ordered services, including those required as a condition of parole or release
- Any dental exams:
  - Required by a third party, including exams and treatments to obtain or maintain employment, or which an employer is required to provide under a labor agreement
  - Required by any law of a government, securing insurance or school admissions, or professional or other licenses
  - Required to travel, attend a school, camp or sporting event, or participate in a sport or

other recreational activity

- Any special medical reports not directly related to treatment except when provided as part of a covered service
- Experimental or Investigational drugs, devices, treatments or procedures, except to the extent listed as covered in the Covered Dental Program Expenses section above. A drug, device, procedure or treatment will be considered 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.
- Payment for that portion of the charge for which Medicare or another party is the primary payer
- Miscellaneous charges for services, supplies, or otherwise, including:
  - Cancelled or missed appointment charges;
  - Charges to complete claim forms;
  - Charges the recipient has no legal obligation to pay; or
  - Charges that would not be made if the recipient did not have coverage (to the extent exclusion is permitted by law), including care:
    - In charitable institutions;
    - For conditions related to current or previous military service; or
    - While in the custody of a governmental authority.
  - Services that are not Medically Necessary 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.
- Routine dental exams and other preventive services and supplies, except to the extent listed as covered in the Covered Dental Program Expenses section above.
- Services rendered before the effective date or after coverage ends, unless coverage is continued as provided for in the Wrap-SPD.
- Work related: Occupational Injuries and Occupational Illnesses are not covered if you have coverage elsewhere such as workers compensation benefits.

Requesting Dental Benefits

In general, if you use a Network Provider, the provider will submit the claim for you. If you use a Non-Network Provider, you must submit the claim 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 Dental Claims and Appeals

Claim forms are available on:

- **My HR** on oxynet.oxy.com
- OxyLink Online at **oxylink.oxy.com**
- **Aetna.com** or by calling Aetna Member Services at **800-334-0299 or outside the U.S.: 817-417-2000 ext. 4154016**

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 the Dentist(s) and or Dental Provider;
- The dates on which expenses are incurred; and
- Copies of all bills and receipts.

Claims should be submitted to Aetna, which serves as the claims review fiduciary, at:

Aetna
P.O. Box 14094
Lexington, KY 40512-4094
Fax: 859-455-8650

If the Dental Program is secondary to another plan, you must submit claims to the primary plan first. When filing a secondary claim with the Dental Program, 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. The Dental Program will also recognize a court order giving a person authority to submit claims on your behalf. 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.

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. To file a claim for benefits and/or for rights to appeal a denial, please the Claims Procedures section in the Wrap-SPD. Appeals should be sent to:

Aetna
Attn: Dental Resolution Team
P.O. Box 14597
Lexington, KY 40512

Payment of Dental 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.

Funding

The dental benefits are not insured with Aetna or any of its affiliates. They are paid from employee contributions and Occidental Petroleum Corporation's general assets.

Glossary

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—Dental services and supplies shown as covered under this Plan.

Course of Treatment—A planned program of one or more services or supplies to treat a dental condition. The condition must be diagnosed by the attending Dentist as a result of an oral exam, and treatment may be given by one or more Dentists. The course of treatment starts on the date a Dentist first gives a service to correct or treat the dental condition.

Covered Dental Program Expenses – This term has the meaning provided for in the section entitled "Covered Dental Program Expenses".

Deductible—The part of your Covered Expenses you pay before the Dental Program starts to pay benefits.

Dental Provider—The following entities legally qualified to furnish dental services or supplies:

- Any Dentist;
- Group;
- Organization;
- Dental facility; or
- Other institution or person.

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.

Directory—A listing of all network providers serving the class of employees to which you belong. Network provider information is also available online for Aetna at http://www.Aetna.com.

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

- There are insufficient outcomes data available from controlled clinical trials published in the peer-reviewed literature to substantiate its safety and effectiveness for the Illness or Injury involved; or
- Approval required by the U. S. Food and Drug Administration (FDA) has not been granted for marketing; or
- A recognized national medical or dental society or regulatory agency has determined, in writing, that it is experimental or investigational, or for research purposes; or
- It is a type of drug, device, procedure 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.

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 register nurse 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.

Jaw Joint Disorder—This is:

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

Lifetime Maximum – This is the most the Dental Program will pay for Covered Expenses incurred by any one covered person in their lifetime.

Medically Necessary—Dental service, supplies, or prescription drugs that a dental provider, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an Illness, Injury, disease or its symptoms, and that provision of the service, supply or prescription drug is:

- In accordance with generally accepted standards of 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 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 dental specialty society recommendations and the views of dental providers practicing in relevant clinical areas and any other relevant factors.

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 Dental Program.

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.

Non-Network Care (out-of-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 occurs due to, any activity in connection with employment or self-employment whether or not on a full-time basis.

Occurrence (dental) —A period of disease or Injury that ends when 60 consecutive days have passed during which you:

- Receive no medical treatment, services or supplies for the disease or Injury; and
- Neither take any medication nor has any medication prescribed for the 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.

Plan Administrator—Occidental Petroleum Corporation Employee Benefits Committee.

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 Welfare Plan.

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.

Recognized Charge – The fee or payment that Aetna has determined its discretion as appropriate for the service provided by a Non-Network Provider. You may contact Aetna in advance of receiving service from a Dental Provider to learn of the Recognized Charge for the service to be received. The approved claim for the service performed by the Non-Network will depend upon other factors including whether the service performed is covered by the Dental Program.

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

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