Summary Plan Description
of the
Occidental Petroleum Corporation
Welfare Plan

(Amended and Restated Effective as of January 1, 2021)

General Health & Welfare Benefit Component

Revision Date: January 1, 2021

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

TABLE OF CONTENTS

Page

ARTICLE I DEFINITIONS 3
1.1 Affiliate 3
1.2 Affordable Care Act 3
1.3 APC Ancillary Plan 3
1.4 APC Health Plan 3
1.5 APC Retiree Health Plan 3
1.6 Authorized Representative 3
1.7 Beneficiary 3
1.8 Benefit Program 3
1.9 Benefit Program Summary Plan Description 3
1.10 Board of Directors 4
1.11 Child 4
1.12 Claims Administrator 4
1.13 Claims Fiduciary 4
1.14 Claims Regulations 4
1.15 COBRA 4
1.16 COBRA Administrator 4
1.17 Code 4
1.18 Dependent 4
1.19 Disclosure Administrator 5
1.20 Domestic Partner 5
1.21 Effective Date 6
1.22 Employee 6
1.23 Employee Benefits Committee 6
1.24 Employer 7
1.25 ERISA 7
1.26 Fiduciary Appointment Officer 7
1.27 FMLA 7
1.28 Fully-Insured Program 7
1.29 HIPAA 7
1.30 Participant 7
1.31 Participant Contribution 8
1.32 Payee 8
1.33 Plan 8
1.34 Plan Administrator 8
1.35 Plan Sponsor 8
1.36 Plan Year 8
1.37 Policy(ies) 8
1.38 Retiree 8
1.39 Separate Coverage 9
1.40 Spouse 9
1.41 Summary Plan Description 9
1.42 Waiting Period 9

1.43 Wrap-Plan 9
1.44 Wrap-SPD 10

ARTICLE II INTERPRETATION 10

ARTICLE III ELIGIBILITY AND PARTICIPATION 10
3.1 Eligibility. 10
3.2 Enrollment. 11
3.3 Termination of Participation. 11

ARTICLE IV FUNDING 11

ARTICLE V BENEFITS 12
5.1 Terms and Conditions. 12
5.2 Charges by Network Providers. 13
5.3 Provider Non-Discrimination. 13

ARTICLE VI CLAIMS PROCEDURES 13
6.1 General 13
6.2 Definitions. 14
6.3 Initial Claim Procedure and Time Limits 17
6.4 Notification of Benefit Determination. 20
6.5 Appeal Procedures 22
6.6 Benefit Determination on Review. 26
6.7 Calculating Time Periods. 30
6.8 Relevance to Claim. 30
6.9 External Review 30
6.10 Exhaustion of Administrative Remedies. 34
6.11 Action for Recovery. 36
6.12 Participant's Responsibilities. 36
6.13 Unclaimed Benefits 37
6.14 Standards for Culturally and Linguistically Appropriate Notifications 37

ARTICLE VII COORDINATION OF BENEFITS 38
7.1 Coordinating Benefits with Coverage from Another Source. 38
7.2 Coverage from Another Source. 38
7.3 Construction. 38
7.4 Allowable Charge 38
7.5 Automobile Limitations. 39
7.6 Ordering of Benefits. 39
7.7 Reduction of Benefits Payable by the Plan. 40
7.8 Coordination of Benefits for Persons Eligible for Medicare. 41
7.9 Claims Determination Period. 41
7.10 Reduced Benefits when the Plan Pays Second. 41
7.11 Right to Receive or Release Necessary Information. 42
7.12 Facility of Payment to Other Plan. 42
7.13 Right of Recovery. 42

ARTICLE VIII RIGHT OF SUBROGATION AND REIMBURSEMENT 42
8.1 Benefits Subject to this Provision 43

8.2 When this Provision Applies.... 43
8.3 Amount Subject to Subrogation or Reimbursement.... 46
8.4 When Recovery Includes the Cost of Past or Future Expenses.... 46
8.5 When a Participant Retains an Attorney.... 46
8.6 When the Participant is a Minor, is Deceased, is a COBRA Qualified Beneficiary or is a Dependent.... 47
8.7 When a Participant Does Not Comply.... 47

ARTICLE IX AMENDMENT OR TERMINATION.... 47
9.1 Right to Amend.... 48
9.2 Right to Terminate.... 48

ARTICLE X ADMINISTRATION.... 48
10.1 Controlling Provisions.... 48
10.2 Employee Benefits Committee.... 48
10.3 Allocation of Authority.... 49
10.4 Powers and Duties of Plan Administrator.... 49
10.5 Delegation by the Plan Administrator.... 50
10.6 Disclosure Responsibility.... 50
10.7 Rules and Decisions.... 51
10.8 Facility of Payment for Incapacitated Participant.... 51
10.9 Assignment and Payment of Benefits.... 52
10.10 Overpayments.... 52

ARTICLE XI COBRA CONTINUATION COVERAGE.... 53
11.1 Continuation of Benefits under COBRA.... 53
11.2 Election of COBRA Coverage.... 53
11.3 Period of COBRA Coverage.... 54
11.4 Contribution Requirements for COBRA Coverage.... 55
11.5 Limitation on Qualified Beneficiary's Rights to COBRA Coverage.... 56
11.6 Extension of COBRA Coverage Period.... 57
11.7 Responses to Inquiry Regarding Qualified Beneficiary's Right to Coverage.... 58
11.8 Coordination of Benefits - Medicare and COBRA.... 58
11.9 Relocation and COBRA Coverage.... 59
11.10 COBRA Coverage and HIPAA Special Enrollment Rules.... 59
11.11 Definitions.... 59
11.12 Qualified Beneficiary Notice Procedures.... 61
11.13 Special Second Election Period for Certain Eligible Individuals Who Did Not Elect COBRA Continuation Coverage.... 62
11.14 Continuation of Benefits for Covered Domestic Partners and their Covered Children.... 62
11.15 Questions and Other Information Regarding COBRA Coverage.... 63

ARTICLE XII HIPAA PRIVACY AND SECURITY.... 63
12.1 HIPAA Privacy and Security in General.... 63
12.2 Designation of Health Care Components and Safeguards.... 63
12.3 Use and Disclosure of Protected Health Information.... 64
12.4 Certification of Amendment of Plan Documents by Plan Sponsor.... 66
12.5 Plan Sponsor Agrees to Certain Conditions for PHI.... 66
12.6 Adequate Separation Between the Plan and the Plan Sponsor.... 67
12.7 Limitations of PHI Access and Disclosure.... 67

12.8 Noncompliance Issues 67
12.9 Members of Organized Health Care Arrangement 67
12.10 Additional Requirements Imposed by HITECH 67
12.11 Limitation on the Use and Disclosure of Genetic Information 68
12.12 Notification in Case of a Breach of Unsecured PHI 68
12.13 Other Medical Privacy Laws. 69

ARTICLE XIII **MISCELLANEOUS LAW PROVISIONS** **69**
13.1 Qualified Medical Child Support Orders 69
13.2 Procedural Requirements 70
13.3 Actions Taken by Fiduciaries 71
13.4 National Medical Support as Qualified Medical Child Support Order 71
13.5 Rights of States for Group Health Plans where Participants are Eligible for Medical Benefits. 72
13.6 Health Program Coverage of Dependent Children in Adoption Cases. 73
13.7 Continued Coverage of Pediatric Vaccine under Group Health Plans. 73
13.8 Family and Medical Leave Act. 74
13.9 Uniformed Services Employment and Reemployment Rights Act 75
13.10 Health Insurance Portability and Accountability Act 77
13.11 Mental Health Parity and Addiction Equity Act. 80
13.12 Newborns' and Mothers' Health Protection Act. 81
13.13 Women's Health and Cancer Rights Act. 81
13.14 Genetic Information Nondiscrimination Act. 81
13.15 Affordable Care Act. 81
13.16 Other Laws 82
13.17 Governing Law; Jurisdiction. 82

ARTICLE XIV **IMPORTANT ERISA INFORMATION** **82**

ARTICLE XV **STATEMENT OF ERISA RIGHTS** **83**

APPENDIX A - Participating Employers **86**

APPENDIX B - Benefit Programs **87**

APPENDIX C - Claims Administrators and Fiduciaries **89**

APPENDIX D - HIPAA **95**

APPENDIX E - Medicare Notice of Creditable Coverage **96**

APPENDIX F - Benefit Program Summary Plan Descriptions **99**

APPENDIX G - Eligibility **102**

APPENDIX H - Provisions Related to COVID-19 ..... **115**

IMPORTANT NOTICE: The First and Second Summaries of Material Modifications are attached at the end of this Wrap-SPD.

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

Introduction

Occidental Petroleum Corporation (the *"Plan Sponsor")* maintains the Occidental Petroleum Corporation Welfare Plan" (the *"Plan")* for the benefit of the eligible Employees and Retirees (and their eligible Dependents) of the Plan Sponsor and the other adopting Employers of the Plan. The Plan Sponsor has amended and restated the Plan effective as of January 1, 2021.

The Plan is an "employee welfare benefit plan" as defined in the Employee Retirement Income Security Act of 1974, as amended *("ERISA")*. The Plan provides health and welfare benefits to Participants, in accordance with the terms, conditions and limitations of the Plan. Terms of the Plan pertaining to eligibility, coverage, exclusions and limitations on coverage, and other rules pertaining to the benefits available under the Plan, are set forth in this wrap-around summary plan description document *("Wrap-SPD")* and in the summary plan description documents for the Benefit Programs (each, a *"Benefit Program Summary Plan Description")* which are listed in Appendix F, incorporated hereunder in their entirety by reference, and, together with the Wrap-SPD, constitute the full *"Summary Plan Description"* of the Plan as required by ERISA.*

Please review the Wrap-SPD and the incorporated Benefit Program Summary Plan Description documents carefully, paying particular attention to the provisions in this Wrap-SPD and the Benefit Program Summary Plan Description documents concerning exclusions, limitations on coverage and precertification requirements.

The masculine gender of words used in this Wrap-SPD include the feminine gender, and words used in the singular include the plural, and vice-versa, when applicable. The capitalized terms used in this Wrap-SPD shall have the meanings set forth in Article I and as provided elsewhere herein; provided, however, the definitions of certain capitalized terms contained in this introduction are provided solely for convenience of reference within this introduction. Any reference to an "Appendix" in this Wrap-SPD shall mean an Appendix to this Wrap-SPD unless otherwise stated.

* Note: Additional benefits coverage separate from the General Health & Welfare Benefit Component described herein (i.e., "Separate Coverage", as defined in this Wrap-SPD) is provided under the Plan. Certain terms and conditions of the Separate Coverage are described in separate summary plan descriptions (and any other governing documents) which are attached to the wrap-around Plan document and incorporated therein by reference and thus constitute a part of the Plan. For convenience of reference, however, when used in this Wrap-SPD, the term "Plan" shall not include the Separate Coverage unless otherwise specified or appropriate in context.

FOREWORD

The benefits provided under the Plan are for the exclusive benefit of the eligible Employees and Retirees (and their eligible Dependents) of the Plan Sponsor and the other adopting Employers of the Plan. These benefits are intended to be continued indefinitely; however, the Plan Sponsor reserves the unilateral right and discretion to make any changes, without advance notice, to the Plan which it deems to be necessary or appropriate, in its discretion, to comply with applicable law, regulation or other authority issued by a governmental entity. The Plan Sponsor also reserves the unilateral right and discretion to amend, modify, or terminate, without advance notice, all or any part of the Plan and to make any other changes that it deems necessary or appropriate in its discretion. Changes in the Plan may occur in any or all parts of the Plan, including, but not limited to, benefit coverage, deductibles, maximums, copayments, exclusions, limitations, definitions, eligibility and the like, under any or all of the Benefit Programs identified in Appendix B. You should not, therefore, assume that the benefits which are provided under the Plan will continue to be available and remain unchanged, and you should disregard any information or communication (written or oral) that would seem to limit the Plan Sponsor's absolute right and discretion to terminate, suspend, discontinue or amend such benefits. Furthermore, the Plan Administrator and the Claims Fiduciary, as applicable, each reserve the absolute right, authority and discretion to interpret, construe, construct and administer the terms and provisions of the Plan, in their discretion, including correcting any error or defect, supplying any omission, reconciling any inconsistency, and making all findings of fact including, without limitation, any factual determination that may impact eligibility or a claim for benefits. Benefits under the Plan will be paid only if the Plan Administrator or Claims Fiduciary, as applicable, determines in its discretion that the Participant is entitled to them. All decisions, interpretations and other determinations of the Plan Administrator or Claims Fiduciary, as applicable, will be final, binding and conclusive on all persons and entities subject only to the claims appeal procedures of the Plan. There will be no *de novo* review of any such decision, interpretation or determination by any court. Any review of such decision, interpretation or determination will be limited to determining whether the decision, interpretation or determination was so arbitrary and capricious as to be an abuse of discretion under ERISA's standards.

IMPORTANT NOTICE: The First and Second Summaries of Material Modifications are attached at the end of this Wrap-SPD. These documents modify the terms of this Wrap SPD.

ARTICLE I
DEFINITIONS

The following terms, where capitalized, will have the meanings set forth below when used in this Wrap-SPD and thus supersede any other meanings for the same terms set forth in the Benefit Program Summary Plan Description documents, unless a different meaning is plainly required by the context:

1.1 Affiliate means a corporation or other entity which is controlled by the Plan Sponsor, or under common control with the Plan Sponsor, as determined by the Plan Sponsor after taking into consideration the common control rules under Section 3(40)(B) of ERISA (multiple employer welfare associations).

1.2 Affordable Care Act means the federal Patient Protection and Affordable Care Act of 2010, as amended by the federal Health Care and Education Reconciliation Act of 2010 and subsequent amendments, and the authoritative guidance issued thereunder by the appropriate governmental entities.

1.3 APC Ancillary Plan means the Anadarko Petroleum Corporation Ancillary Benefits Plan, as amended.

1.4 APC Health Plan means the Anadarko Petroleum Corporation Health Benefits Plan, as amended.

1.5 APC Retiree Health Plan means the Anadarko Petroleum Corporation Retiree Health Benefits Plan, as amended.

1.6 Authorized Representative means the person or entity designated by a Participant, in accordance with Section 6.1(d), to act on the Participant's behalf with respect to a benefit claim or appeal of an adverse benefit determination under a Benefit Program or another purpose permitted by ERISA. Except as otherwise specifically provided under a Fully-Insured Program, an "Authorized Representative" is not the legal assignee of any rights or benefits of the Participant under any Benefit Program or ERISA.

1.7 Beneficiary means a Beneficiary under the Plan as defined under the terms of the respective Benefit Program.

1.8 Benefit Program means a program of benefits that is offered by the Plan Sponsor (and/or another Employer) under the Plan to provide certain employee group health and/or welfare benefits coverage to eligible individuals which would be an "employee welfare benefit plan" under Section 3(1) of ERISA if offered separately. The Benefit Programs are incorporated into this Wrap-SPD, which is, in turn, incorporated into the Wrap-Plan. Each Benefit Program under the Plan is identified in Appendix B of this Wrap-SPD. The Plan Sponsor may add or delete a Benefit Program from the Plan by amending Appendix B of this Wrap-SPD.

1.9 Benefit Program Summary Plan Description means a written arrangement, including (a) a benefits booklet, summary of coverage, plan document or summary plan description, (b) a group insurance policy issued by an insurance carrier to the Plan Sponsor (or other Employer), or (c) a certificate of coverage, schedule of benefits, notice or other instrument, under which a Benefit Program

is established, operated or maintained. Each of the documents referenced in items (a), (b) and (c) (above) is incorporated into this Wrap-SPD as part of Appendix F. A Benefit Program Summary Plan Description (or any portion thereof) will not, in and of itself, constitute either the written "Plan document" or the official "Summary Plan Description" of the Plan, as required by ERISA, notwithstanding any references in any Benefit Program Summary Plan Description to the contrary. However, such Benefit Program Summary Plan Description does contain certain terms of the Plan. Any reference to a Benefit Program Summary Plan Description also refers to any amendment, rider, endorsement, exhibit or attachment thereto.

1.10 Board of Directors means the Board of Directors of the Plan Sponsor.

1.11 Child means (a) a biological child of an Employee or Domestic Partner, (ii) a legally adopted child or a child placed for adoption with the Employee, Spouse or Domestic Partner, (iii) a stepchild of an Employee, or (iv) a child for whom the Employee, Spouse or Domestic Partner has a court appointed guardianship or conservatorship, but only if such child primarily lives with the Employee and is a member of the Employee's household.

1.12 Claims Administrator means, as set forth in Appendix C, the Plan Administrator or the third party administrator, insurance company or other person or entity, as designated by the Plan Administrator to process claims and/or perform other administrative duties under the Plan or a Benefit Program.

1.13 Claims Fiduciary means the person or entity that serves as the named claims fiduciary with respect to reviewing and making final decisions regarding claims under a Benefit Program. The Plan Administrator shall be the "Claims Fiduciary" for each Benefit Program unless otherwise set forth in Appendix C.

1.14 Claims Regulations means the claims regulations issued by the U.S. Department of Labor under ERISA, as set forth at 29 CFR § 2560.503-1 and 29 CFR § 2590.715-2719, collectively, as may be amended from time to time. References herein to any section of the Claims Regulations will also refer to any successor provision thereof.

1.15 COBRA means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended. As appropriate in context, the term "COBRA" also includes the regulations and other authority issued under COBRA by the appropriate governmental authority.

1.16 COBRA Administrator means the Plan Administrator, or the third party or other person or entity designated by the Plan Administrator to perform COBRA administration under the Plan on behalf of the Plan Administrator, as set forth in Appendix C.

1.17 Code means the Internal Revenue Code of 1986, as amended, and the implementing regulations and other authority issued thereunder by the appropriate governmental authority. References herein to any section of the Code will also refer to any successor provision thereof.

1.18 Dependent means an individual who is one of the following:

(a) An eligible Employee's Spouse.

(b) An eligible Employee's Domestic Partner.

(c) A Child of an eligible Employee or an eligible Employee's Spouse or Domestic Partner, but only through the end of the month during which such Child attains age 26;

(d) A Child of an eligible Employee or an eligible Employee's Spouse or Domestic Partner, beginning with the first day of the first month next following the month during which such Child attains age 26, but only if such Child is dependent on the Employee or the Employee's Spouse or Domestic Partner because of a mental or physical handicap rendering the Child medically incapacitated and unable to be self-supportive ("***Disabled***"). The Child must satisfy either of the following requirements: (i) on or prior to the last day of the month during which such Child attains age 26, the Child is Disabled and covered as a Dependent under the Plan or (ii) the Child is Disabled and over age 26 prior to the Child's parent first becoming eligible for coverage under the Plan, either as an Employee or as the Spouse or Domestic Partner of an Employee, and the Employee enrolls the Child in the Plan when the Employee first becomes eligible to enroll in such coverage (*i.e.*, such Disabled Child cannot later be added to coverage under the Plan). In addition, the Child must reside with the Employee in his household for more than one-half of the year, and the Child must not provide more than one-half of his own support for the year. Periodic proof of incapacity may be required by the Plan Administrator to continue coverage for the Child.

Any Child who does not meet one of the definitions in subsections (c) or (d) (above) will not be eligible for coverage under the Plan.

Notwithstanding the foregoing provisions of this Section 1.18, if the Benefit Program Summary Plan Description for a Fully-Insured Program provides a definition of "Dependent" that conflicts with the definition in this Section 1.18, the definition in such Benefit Program Summary Plan Description will control for purposes of that Fully-Insured Program.

At any time, the Plan Administrator may require proof that is reasonably acceptable to the Plan Administrator to the effect that an individual qualifies or continues to qualify as a Dependent under the Plan.

1.19 Disclosure Administrator means the individual or entity, as designated in Article XIV, to whom the Plan Administrator has delegated the authority, duty and discretion to furnish, on its behalf, the disclosures that are required by Section 104(b)(4) of ERISA and which are requested in accordance with Section 10.6 of this Wrap-SPD.

1.20 Domestic Partner means an individual who:

(a) is at least 18 years of age;

(b) lives with the Employee or Retiree in a committed, monogamous relationship;

(c) has lived in such relationship with the Employee or Retiree at the same place of residence for at least six (6) months;

(d) is not legally married to the Employee or Retiree or legally married to, or in a domestic partnership with, any other person; and

(e) is not related to the Employee or Retiree by blood or adoption; provided that both such individual and the Employee or Retiree intend for their relationship to be continuous and of

an indefinite duration and that the Employee or Retiree is not married to, or in a domestic partnership with, any other person.

The Plan Administrator may require the Employee or Retiree to provide evidence that is satisfactory to the Plan Administrator in order to verify that all the requirements set forth in this paragraph have been met.

Notwithstanding the foregoing, if the Benefit Program Summary Plan Description for a Fully-Insured Program provides a definition of "Domestic Partner" (or similar term) that conflicts with the definition in this Section 1.20, the definition in such Benefit Program Summary Plan Description will control for purposes of that Fully-Insured Program.

The Plan Administrator shall have the sole and absolute discretion to determine whether an individual is a Domestic Partner for all purposes of the Plan, except as otherwise required under a Fully-Insured Program.

1.21 Effective Date means the effective date of this amendment and restatement of the Plan, *i.e.*, January 1, 2021.

1.22 Employee means, unless otherwise specified in the Benefit Program Summary Plan Description or Policy for a Fully-Insured Program, any individual who is (a) considered to be in an employer-employee relationship as a "common law" employee with the Employer and (b) on the U.S. payroll records of the Employer for purposes of federal income tax withholding. Except as may otherwise be specified in the Benefit Program Summary Plan Description or Policy for a Fully-Insured Program, the term "Employee" will not include any person during any period that such person was classified on the Employer's records as other than an Employee. For example, the term "Employee" will not include anyone classified on the Employer's records as an independent contractor, agent, leased employee, contract employee, temporary employee or similar classification, regardless of whether any agency (governmental or otherwise) or court determines that any such person is, or was, a common law employee of an Employer, even if such determination has a retroactive effect. For purposes of this definition, (a) a "leased employee" means any person, regardless of whether or not he is a "leased employee" as defined in Code Section 414(n)(2), whose services are supplied by an employment, leasing, or temporary service agency and who is paid by or through an agency or third-party, (b) an "independent contractor" means any person rendering service directly or indirectly to the Employer and whom the Employer treats as an independent contractor by reporting payments for the person's services on IRS Form 1099 (or its successor), and (c) a "contract employee" means a person who is employed by a third-party entity which is retained by the Employer through a contract for services, pursuant to which such person indirectly renders services to, or for the benefit of, the Employer.

Furthermore, employees who (i) are non-resident aliens and (ii) receive no earned income (within the meaning of Code Section 911(d)(2)) from an Employer which constitutes income from sources within the United States (within the meaning of Code Section 861(a)(3)) will not be considered Employees who are eligible to participate in the Plan.

1.23 Employee Benefits Committee means the Occidental Petroleum Corporation Employee Benefits Committee, which is a committee of one or more Employees appointed by the Fiduciary Appointment Officer to act as named fiduciary and Plan Administrator of the Plan. References herein to the Employee Benefits Committee or Plan Administrator shall include, when appropriate, any

Employee, Claims Administrator, Claims Fiduciary or other person or entity who has been delegated the appropriate authority by the Employee Benefits Committee as Plan Administrator in accordance with Section 10.5.

1.24 Employer means the Plan Sponsor, or any Affiliate of the Plan Sponsor which has adopted the Plan with the consent of the Plan Sponsor, provided such Affiliate has not terminated participation or withdrawn from the Plan. The adopting Employers of the Plan shall be listed in Appendix A, as such Appendix may be revised from time to time by the Plan Sponsor without the need for a formal amendment to the Plan.

1.25 ERISA means the Employee Retirement Income Security Act of 1974, as amended. References herein to any section of ERISA will also refer to any successor provision thereof.

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

1.27 FMLA means the Family and Medical Leave Act of 1993, as amended.

1.28 Fully-Insured Program means each of the following Benefit Programs that are fully-insured with an insurance carrier:

- BlueCross BlueShield of Western New York
- Independent Health (HMO) Medical Program
- Vision Insurance Program;
- Global Medical, Dental and Vision Insurance Program;
- Basic Life Insurance Program;
- Dependent Life Insurance Program;
- Optional Group Universal Life Insurance Program;
- Basic AD&D Insurance Program;
- Voluntary AD&D Insurance Program;
- Occupational AD&D Insurance Program;
- Long-Term Disability Insurance Program;
- Basic Life Insurance Program for Retirees of Occidental Petroleum Corporation and Adopting Affiliates;
- Legacy APC Basic, Supplemental and Dependent Life Insurance Program for APC, KM and UPR Retirees;
- Legacy APC Basic Life Insurance Program for Oryx Retirees;
- Legacy APC Basic Life Insurance Program for Certain Disabled Employees;
- Legacy APC Basic Life Insurance–Guaranteed Life Insurance Funding Account (GLIFA) Program; and
- Legacy APC LTD Employee Supplemental Life Program.

1.29 HIPAA means the Health Insurance Portability and Accountability Act of 1996, as amended. References herein to any section of HIPAA will also refer to any successor provision thereof.

1.30 Participant means an Employee or Retiree of the Employer who meets the requirements for

eligibility as set forth in Article III and who is properly enrolled for coverage under the Plan. The term "Participant" also includes any eligible Dependent of a person specified in the previous sentence who is properly enrolled for coverage under the Plan. A person will cease to be a Participant when he no longer meets the requirements for eligibility as set forth in applicable provisions of the Plan.

1.31 Participant Contribution means the pre-tax or after-tax contribution required to be paid by a Participant, if any, for coverage under a Benefit Program, as determined under each Benefit Program. The term "Participant Contribution" thus includes, but is not limited to, contributions used for the provision of benefits under a self-funded arrangement of the Plan Sponsor or an Employer, as well as contributions used to purchase coverage that is provided under insurance contracts or policies, if any.

1.32 Payee means, apart from the Participant, a Beneficiary or other person or entity, including the Participant's estate, who is entitled to a benefit under the Plan pursuant to the terms of a Benefit Program.

1.33 Plan means the Occidental Petroleum Corporation Welfare Plan (which consists of (a) the Wrap-Plan, (b) the Policies set forth in the Policy Appendix to the Wrap-Plan and incorporated therein by reference, (c) the summary plan descriptions (and any other governing documentation) for the Separate Coverage, which documentation is attached to the Wrap-Plan and incorporated therein by reference, (d) this Wrap-SPD, and (e) each Benefit Program Summary Plan Description as incorporated hereunder by reference), as such Plan may be amended from time to time. The Wrap-Plan, Policies, governing documents for the Separate Coverage, Wrap-SPD and Benefit Program Summary Plan Description documents each contain certain terms of the Plan and together constitute the complete Plan.

1.34 Plan Administrator means the person or entity which has the authority and responsibility to manage and direct the operation of the Plan in its discretion and is the "plan administrator" for purposes of Section 3(16)(A) of ERISA. However, the Plan Administrator may assign or delegate duties to third parties or other persons or entities, such as the Claims Administrator or the Claims Fiduciary, under the terms of either the Plan or any Benefit Program, or by means of a separate written agreement. The Employee Benefits Committee shall be the "Plan Administrator". References herein to the "Plan Administrator" or "Employee Benefits Committee" shall include, when appropriate, any Employee, Claims Administrator, Claims Fiduciary or other person or entity who has been delegated the appropriate authority by the Plan Administrator in accordance with Section 10.5.

1.35 Plan Sponsor means Occidental Petroleum Corporation or its successor in interest.

1.36 Plan Year means each twelve (12) consecutive month period commencing January 1st and ending on December 31st.

1.37 Policy(ies) means a group insurance policy (or contract) issued by an insurance carrier (or service provider) to the Plan Sponsor (or other Employer), pursuant to which certain employee health or other welfare benefits under the Fully-Insured Programs are provided to Participants, including any amendments, endorsements or riders there to. The Policies, if any, are set forth in the Policy Appendix to the Wrap-Plan.

1.38 Retiree means a "retiree" as such term is defined under the terms of the applicable Benefit Program Summary Plan Description documents for the (a) Basic Life Insurance Program for Retirees of Occidental Petroleum Corporation and Adopting Affiliates, (b) Legacy APC Basic, Supplemental

and Dependent Life Insurance Program for APC, KM and UPR Retirees, (c) Legacy APC Basic Life Insurance Program for Oryx Retirees, (d) Legacy APC Basic Life Insurance Program for Certain Disabled Employees, and (e) Legacy APC Basic Life Insurance–Guaranteed Life Insurance Funding Account (GLIFA) Program.

1.39 Separate Coverage means the other benefits coverage provided under the Plan, as described in the Wrap-Plan, that is separate from the benefits coverage described in this Wrap-SPD and the Benefit Program Summary Plan Descriptions incorporated hereunder. Certain terms and conditions of the Separate Coverage are set forth in separate summary plan descriptions (and any other governing documents) which are attached to the Wrap-Plan and incorporated therein by reference and thus constitute a part of the Plan. For convenience of reference, however, when used in this Wrap-SPD, the term "Plan" shall not include the Separate Coverage unless otherwise specified or appropriate in context.

1.40 Spouse means a person to whom an Employee or Retiree is lawfully married, which marriage was solemnized, authenticated and recorded as required by the state or foreign jurisdiction in which the marriage took place, to the extent such marriage is legally recognized as valid for purposes of applicable Federal law (including, but not limited to, the Code, ERISA, and the Affordable Care Act) and any regulations promulgated under such applicable Federal law, but shall not include an individual separated from the Employee or Retiree under a legal separation or divorce decree. The term "Spouse" will also include a common law spouse if the Employee or Retiree and spouse became common law married in a state which recognizes common law marriages and meet all of the requirements for common law marriage in that state. The Employee or Retiree must provide proof of a ceremonial or common law marriage if and as requested by the Plan Administrator, such as, for example, an affidavit of marriage, or a marriage license or certificate of common law marriage issued by the applicable state.

Notwithstanding the foregoing, if the Benefit Program Summary Plan Description for a Fully-Insured Program provides a definition of "Spouse" (or similar term) that conflicts with the definition in this Section 1.40, the definition in such Benefit Program Summary Plan Description will control for purposes of that Fully-Insured Program.

The Plan Administrator shall have the sole and absolute discretion to determine whether an individual is a Spouse for all purposes of the Plan, except as otherwise required under a Fully-Insured Program.

1.41 Summary Plan Description means this Wrap-SPD and each Benefit Program Summary Plan Description as listed on Appendix F and incorporated into this Wrap-SPD by reference, as all such documents may be amended from time to time, and which, together, constitute the full "Summary Plan Description" of the Plan as required by ERISA. The Summary Plan Description is incorporated into the Wrap-Plan by reference and constitutes a part of the Plan.

1.42 Waiting Period means for a regular enrollee, the period of time (if any), not to exceed 90 days, that must pass before coverage for an Employee or Dependent who is otherwise eligible to enroll under the terms of the Plan can become effective, as determined in accordance with the Affordable Care Act. If an Employee or Dependent enrolls in the Plan as a late enrollee or special enrollee, any period before such late or special enrollment is not a Waiting Period.

1.43 Wrap-Plan means the wrap-around Plan document which is entitled "Occidental Petroleum

Corporation Welfare Plan (Amended and Restated Effective as of January 1, 2021)" (including the Policy Appendix and any other appendices as may be attached thereto), as amended from time to time.

1.44 Wrap-SPD means this wrap-around summary plan description document, including any appendices hereto, as amended from time to time.

ARTICLE II
INTERPRETATION

Notwithstanding any reference in a Benefit Program Summary Plan Description that such Benefit Program Summary Plan Description, in and of itself (or any portion thereof), constitutes the ERISA-required "summary plan description" of the Plan, the official Summary Plan Description of the Plan consists of this Wrap-SPD and the Benefit Program Summary Plan Description documents incorporated herein by reference.

With respect to a Fully-Insured Program, if a term or provision of this Wrap-SPD or the Wrap-Plan conflicts with a term or provision of the applicable Benefit Program Summary Plan Description or Policy, the term or provision of such Benefit Program Summary Plan Description or Policy will control unless specifically stated otherwise herein or in the Wrap-Plan. The terms and provisions of this Wrap-SPD or the Wrap-Plan shall not enlarge the rights of an Employee, Retiree, Participant, Dependent or Beneficiary to any benefit available under a Fully-Insured Program.

With respect to a Benefit Program other than a Fully-Insured Program, (1) if a term or provision of this Wrap-SPD conflicts with a term or provision of the applicable Benefit Program Summary Plan Description, the term or provision of this Wrap-SPD will control unless specifically stated otherwise herein, and (2) if a term or provision of this Wrap-SPD or the applicable Benefit Program Summary Plan Description conflicts with a term or provision of the Wrap-Plan, then the term or provision of the Wrap-Plan will control unless specifically stated otherwise in the Wrap-Plan.

Notwithstanding the foregoing, if there is a conflict between a term or provision of the Wrap-Plan, a Policy, this Wrap-SPD or a Benefit Program Summary Plan Description, and such conflict involves a term or provision required by ERISA, the Code or other controlling law, on the one hand, and a term or provision not so required on the other, the term or provision required by controlling law will control. This determination will be made by the Plan Administrator.

The terms and provisions of the Plan include the terms and provisions of the Wrap-Plan, the Policies listed in the Policy Appendix to the Wrap-Plan, the summary plan descriptions (and any other governing documentation) for the Separate Coverage, the Wrap-SPD, and the Benefit Program Summary Plan Description documents.

ARTICLE III
ELIGIBILITY AND PARTICIPATION

3.1 Eligibility.

An Employee or Retiree (and the Dependent of either) will be eligible to participate in a Benefit Program under the Plan in accordance with the eligibility provisions of Appendix G.

3.2 Enrollment.

An Employee's, Retiree's or Dependent's enrollment in a Benefit Program under the Plan shall become effective as specified in the applicable Benefit Program Summary Plan Description. The Plan Administrator or its designee may establish procedures in accordance with the Benefit Programs for the enrollment of Employees, Retirees and/or their Dependents thereunder. The Plan Administrator will provide enrollment forms or online enrollment procedures that must be completed by the prescribed deadline prior to commencement of coverage under the Benefit Programs.

3.3 Termination of Participation.

A Participant will cease being a Participant in the Plan and coverage under the Plan for the Participant (including any covered Dependents) shall terminate as described in Appendix G. Notwithstanding the foregoing, a termination of coverage under a Benefit Program that is subject to the Affordable Care Act may only be effective retroactively if the Participant or Dependent (a) performs an act, practice or omission that constitutes fraud, (b) makes an intentional misrepresentation of material fact, or (c) fails to make a required Participant Contribution when due, or as otherwise permitted under the Affordable Care Act and the authoritative guidance issued thereunder.

ARTICLE IV
FUNDING

Notwithstanding anything to the contrary contained herein or in a Benefit Program Summary Plan Description, participation in the Plan by a Participant and the payment of Plan benefits will be conditioned on such Participant Contributions towards the cost of coverage under the Plan at such time and in such amounts as the Plan Administrator will establish from time to time. To the extent that a Participant is required to make Participant Contributions toward the cost of coverage under the Plan, the Plan Administrator shall designate the applicable method by which the Participant must make such Participant Contributions, and the Participant must consent in writing (including electronically, as applicable), or as otherwise required under the Plan Administrator's procedures, to such payment method to remain covered under the Plan. Nothing herein requires an Employer or the Plan Administrator to contribute to or under the Plan, or to maintain any fund or segregate any amount for the benefit of any Participant, Employee, Dependent, Beneficiary or Payee, except to the extent specifically required under the terms of a Benefit Program. No Participant, Employee, Retiree, Dependent or Beneficiary will have any right to, or interest in, the assets of any Employer as the result of coverage under the Plan until actually paid. The Plan shall not be "funded" for purposes of ERISA.

Benefits or premiums for the Plan will be provided through insurance contracts or through the general assets of the Employer in accordance with the terms of the Plan, including the relevant Benefit Program. An Employer will have no obligation, but will have the right, to insure or reinsure or to purchase stop loss coverage, where applicable, with respect to any Benefit Program under the Plan. If, and to the extent that, the Plan is provided through an Employer's purchase of insurance, payment of any benefits under such Benefit Program will be the sole responsibility of the insurer, and the Employer will have no responsibility for any such payment.

ARTICLE V
BENEFITS

5.1 Terms and Conditions.

(a) *Generally.*

The actual terms and conditions of eligibility, coverage, exclusions and limitations on coverage, and the additional rules pertaining to the benefits of Participants under the Plan, are set forth in the Benefit Program Summary Plan Description documents and this Wrap-SPD. Any maximum benefit amounts, deductibles, copayments and out-of-pocket maximum amounts, as applicable, and the reimbursement percentages for eligible charges under the Plan, as applicable, are contained in the Benefit Program Summary Plan Description documents, as they may be amended from time to time, subject to subsection (b), below. The Benefit Program Summary Plan Description documents, as then currently in effect, are incorporated in their entirety by reference into this Wrap-SPD which, in turn, is incorporated by reference into the Wrap-Plan.

(b) *Exclusion Regarding Waived, Reduced or Forgiven Charges.*

In addition to any exclusions from coverage set out in the applicable Benefit Program Summary Plan Description, the Plan will exclude from coverage under any Benefit Program providing health care benefits that is not a Fully-Insured Program any charges incurred by a Participant with respect to which the Participant (i) is not obligated to pay, (ii) is not billed, or (iii) would not have been billed but for the coverage of such charges under the applicable terms of the Plan. Consequently, if the Claims Fiduciary for such Benefit Program determines that a health care provider is waiving, reducing or forgiving (or has waived, reduced, or forgiven) any portion of its charges for covered services or supplies provided to a Participant, or any portion of any copayment, deductible, or coinsurance amount that the Participant is required to pay for such provider's covered services or supplies under the applicable terms of the Plan, without the Claims Fiduciary's express written consent, then the Claims Fiduciary shall have the unilateral right and discretion to wholly or partially reduce the benefits paid under the terms of the Plan with respect to such services in proportion to the amount of such charges, copayments, deductibles, or coinsurance amounts waived, reduced or forgiven, regardless of whether such provider represents or affirms that the Participant remains financially responsible for such amount. Furthermore, the Claims Fiduciary reserves the unilateral right and discretion to require a Participant to provide satisfactory written proof that the Participant has paid the required copayment, deductible, or coinsurance amount attributable to any covered services or supplies received, whether prior to or subsequent to the payment by the Claims Fiduciary of any Plan benefits for such services or supplies; provided, however, that the Claims Fiduciary's failure to request any such proof in any one or more instance shall not constitute any waiver or limitation of this exclusion under the Plan.

For purposes of clarification, and not limitation, the exclusion set forth in this subsection (b) would apply, for example, to an out-of-network health care provider's charges for services or supplies provided to a Participant based on such provider's agreement to set those charges at the in-network benefits level under the Plan or at another level not otherwise applicable to such services or supplies under the terms of the Plan.

The Claims Fiduciary of the applicable Benefit Program shall have the sole discretion to (i) interpret, construe and apply the exclusion set out in this subsection (b), (ii) make any determinations and decisions deemed to be necessary or appropriate for such purpose, and (iii) otherwise effectuate the intent of such exclusion.

5.2 Charges by Network Providers.

To the extent that health care benefits under a Benefit Program are provided through a network provider organization, the Plan's reimbursement of charges by a participating network provider will be limited to the rates which have been negotiated between the Claims Administrator and the provider network. In addition, any amounts charged by network providers over the negotiated rate will not be covered and cannot be charged back to the Participant, that is, there will be no balance billing by network providers directly to Participants.

5.3 Provider Non-Discrimination.

To the extent required by the Affordable Care Act, the Plan will not discriminate with respect to participation under the Plan or coverage against any health care provider who is acting within the scope of that provider's license or certification under applicable State law. This provision will not require that the Plan contract with any health care provider willing to abide by the terms and conditions for participation established by the Plan. Further, this provision will not prevent the Plan from establishing varying reimbursement rates based on quality or performance measures.

ARTICLE VI
CLAIMS PROCEDURES

6.1 General.

(a) Except as provided in subsection (b) (below), an initial claim for benefits under a Benefit Program will be submitted in accordance with, and to the party designated under, the terms of such Benefit Program. Notwithstanding the foregoing, unless a Benefit Program specifically provides otherwise, a claim for benefits must be submitted not later than twelve (12) months after the date that the claim arises (for example, the date a medical service is provided and the charge is incurred). If a Benefit Program does provide otherwise, then the limitation under the Benefit Program will control. In the event that a claim, as originally submitted, is not complete, the Claimant will be notified and the Claimant will then have the responsibility for providing the missing information within the timeframe stated in such notification.

(b) To the extent that a Benefit Program does not prescribe a claims procedure for benefits that satisfies the applicable requirements of the Claims Regulations and the Affordable Care Act, as applicable, as determined by the Plan Administrator, the claims procedures set out below in Sections 6.2 through 6.9 will apply to a claim for benefits under such Benefit Program. Such procedures are intended to comply with the Claims Regulations and the Affordable Care Act, as applicable, and shall be construed and applied accordingly. However, to the extent that a particular Benefit Program is not an ACA Program, any provisions of this Article VI that apply only to plans which are subject to the Affordable Care Act shall not apply to such Benefit Program.

(c) A request for an eligibility or coverage determination which is not associated with a request for benefits under the Plan, or a casual or general inquiry regarding the Plan, shall not constitute a claim for benefits (or a related appeal) under ERISA or the Plan. Except as provided in Section 6.2(a)(iv) regarding a rescission of coverage, in order for such a request or inquiry to constitute a claim for benefits or an appeal of an Adverse Benefit Determination, it must be associated with a request for benefits that is or was made by a Claimant in accordance with the procedures for initially filing a claim under the applicable Benefit Program and this Article VI.

(d) A Participant or Beneficiary may designate an Authorized Representative to act as "claimant" on his behalf with respect to the Plan's claims procedures, as permitted by ERISA. The Claims Fiduciary for the applicable Benefit Program may require that any such designation be made in writing (including electronically), using a form prescribed by the Claims Fiduciary as consistent with ERISA and in accordance with the Claims Fiduciary's procedures for such purpose, in a manner that is sufficiently clear and conspicuous to enable the Claims Fiduciary to reasonably verify the status of the authorized representative and the scope of such authorization. Whether any such designation of an Authorized Representative meets such requirements shall be determined by the Plan Administrator or Claims Fiduciary, as applicable, in its discretion. The Plan Administrator or the Claims Fiduciary, as applicable, may disregard any designation of an Authorized Representative that it deems to be defective or otherwise improper or invalid hereunder. In particular, and without limitation, such entities reserve the right and discretion to refuse to honor a Participant's or Beneficiary's designation of an Authorized Representative if the Plan Administrator or Claims Fiduciary, as applicable, determines that such designation is fraudulent; such as, for example, when the Plan Administrator or Claims Fiduciary, as applicable, determines that the signature of approval on the designation does not belong to the Participant or Beneficiary.

(e) To the extent required by the Affordable Care Act with respect to a Health Care Claim or otherwise with respect to a Disability Claim filed after April 1, 2018, the Plan will ensure that any such claim and any appeal thereof are adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making the decision. Accordingly, decisions regarding hiring, compensation, termination, promotion, or other similar matters regarding any such person (such as a claims adjudicator or medical expert, or, with respect to a Disability Claim filed after April 1, 2018, a vocational expert) will not be made based upon the likelihood that such person will support the denial of benefits.

6.2 Definitions.

(a) *Adverse Benefit Determination* means any of the following:

(i) a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for a benefit under the Plan, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a Participant's eligibility to participate in the Plan;

(ii) a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit under the Plan, resulting from the application of precertification procedures or other utilization review procedures;

(iii) a failure to cover an item or service for which benefits under the Plan are otherwise provided because it is determined to be experimental and/or investigational or not medically necessary or appropriate, or because another exclusion applies under the Plan; or

(iv) with respect to a Health Care Claim under an ACA Program or a Disability Claim filed after April 1, 2018, a rescission of coverage, which is a cancellation or discontinuance of coverage that has a retroactive effect (except to the extent that such cancellation or discontinuance of coverage is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage), whether or not, in connection with the rescission, there is an adverse effect on any particular benefit at that time.

(b) *Adverse Benefit Determination on Review* means the upholding or affirmation of an appealed Adverse Benefit Determination.

(c) *Affordable Care Act Program* or *ACA Program* means each of the following (together, the "**ACA Programs**"), to the extent such program does not constitute an "excepted benefit" under the Affordable Care Act:

(i) BCBSTX HDHP Medical;

(ii) BCBSTX PPO Medical;

(iii) Express Scripts Prescription Drug Program;

(iv) BCBSWNY Medical *(New York Employees Only)*; and

(v) Independent Health (HMO) Medical *(New York Employees Only)*.

(d) *Benefit Determination* means a determination by the Claims Administrator on a claim for benefits under the Plan, whether or not an Adverse Benefit Determination.

(e) *Benefit Determination on Review* means a determination by the Claims Fiduciary (or if the applicable Benefit Program requires two levels of appeal, the Claims Administrator with respect to the first level appeal) on an appeal of an Adverse Benefit Determination, whether or not an Adverse Benefit Determination on Review.

(f) *Claimant* means a Participant or Beneficiary under the Plan, or his Authorized Representative who is designated by the Participant to act on his behalf. In the case of an Urgent Care Claim, a Health Care Professional with knowledge of the medical condition of the Participant to whom the Urgent Care Claim applies will be permitted to act as the Authorized Representative of such Participant.

(g) *Concurrent Care Decision* means, with respect to an ongoing course of treatment previously approved by the Plan which is to be provided over a period of time or number of treatments: (i) any reduction or termination by the Plan of such course of treatment (other than by Plan amendment or termination) before the end of such period of time or number of treatments; or (ii) any request by a Claimant to extend the ongoing course of treatment beyond the period of time or number of treatments. A Concurrent Care Decision described in clause

(i) will constitute an Adverse Benefit Determination.

(h) *Disability Claim* means a claim for benefits that is conditioned upon a showing of "disability" by the Claimant.

(i) *External Review* means a review of an Adverse Benefit Determination (including a Final Internal Adverse Benefit Determination) conducted pursuant to the external review process described in Section 6.9.

(j) *Final Internal Adverse Benefit Determination* means an Adverse Benefit Determination on Review that has been upheld by the Plan at the completion of the internal appeals process described in Sections 6.5 and 6.6 (or an Adverse Benefit Determination with respect to which the internal appeals process has been exhausted under the deemed exhaustion rules of Section 6.10).

(k) *Final External Review Decision* means a determination by an Independent Review Organization at the conclusion of an External Review.

(l) *Health Care Claim* means a Pre-Service Claim, a Post-Service Claim, a Concurrent Care Decision or an Urgent Care Claim.

(m) *Health Care Professional* means a physician or other health care service provider who is licensed, accredited, or certified to perform the specified health services consistent with state law.

(n) *Independent Review Organization* or *IRO* means an entity that is accredited by URAC or by similar nationally-recognized accrediting organization (and that otherwise meets the applicable requirements of Section 2590.714-2719 of the Claims Regulations) and conducts independent External Reviews of Adverse Benefit Determinations and Final Internal Adverse Benefit Determinations pursuant to Section 6.9.

(o) *Non-Health Claim* means a claim other than a Pre-Service Claim, Post-Service Claim, Concurrent Care Decision, Urgent Care Claim, or Disability Claim.

(p) *Pre-Service Claim* means a claim for a benefit under a group health plan that, under the terms of the applicable plan, conditions the receipt of the benefit, in whole or in part, on pre-approval of the benefit in advance of obtaining medical care.

(q) *Post-Service Claim* means a claim for a benefit under a group health plan for reimbursement or consideration of payment for the cost of medical care that has already been rendered. A Post-Service Claim is a claim that is neither a Pre-Service Claim nor an Urgent Care Claim.

(r) *Urgent Care Claim* means a claim for medical care or treatment that, if not received, (i) could seriously jeopardize the life or health of the Claimant or the ability of the Claimant to regain maximum function; or (ii) in the opinion of a health care provider with knowledge of the Claimant's medical condition, would subject the Claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the Claim. If a health care provider with knowledge of the Claimant's medical condition deems the medical care or

treatment urgent, then the claim is an Urgent Care Claim.

6.3 Initial Claim Procedure and Time Limits.

(a) *Initial Claim Process.*

A claim and all required documentation will be filed in writing with the applicable Claims Administrator and decided within the applicable timeframes set forth herein, regardless of whether all information required to perfect the claim is included. The timeframe for decision begins upon receipt by the Claims Administrator of a claim submitted by the Claimant in accordance with the Plan's claims procedures, and is contingent upon the type of claim that is submitted, whether the claim submitted is a complete claim or incomplete claim, whether additional information is required and whether an extension is required to make a decision on the claim.

(b) *Urgent Care Claim:*

(i) If an Urgent Care Claim is submitted, the Claims Administrator will render a Benefit Determination and provide notice to the Claimant of such Benefit Determination as soon as possible, taking into account the medical exigencies, but not later than seventy-two (72) hours after the Urgent Care Claim is received, subject to subsection (b)(ii).

(ii) If an Urgent Care Claim as submitted is incomplete, the Claims Administrator will notify the Claimant as soon as possible, but not later than twenty-four (24) hours after receiving the incomplete claim. Such notice will request the additional information required to render a decision on the claim and explain why such information is necessary. The Claimant will be afforded a reasonable amount of time, taking into account the circumstances, but not less than forty-eight (48) hours, to provide the requested information. Regardless of whether the Claimant provides the Claims Administrator with the requested information, the Claims Administrator will render a Benefit Determination on the claim and provide notice to the Claimant of such Benefit Determination as soon as possible, but not later than forty-eight (48) hours after the earlier of (A) receipt of the requested information or (B) the end of the period afforded the Claimant to provide the requested information.

(iii) In the event that the Claimant fails to follow the Plan's procedures for filing an Urgent Care Claim, the Claimant will be notified of such failure and of the proper procedures to be followed in filing such a Claim. The notification will be provided to the Claimant as soon as possible, but not later than twenty-four (24) hours following the failure. Notification may be oral, unless written notification is requested by the Claimant. For the purposes of this Section 6.3(b)(iii), a failure to follow the Plan's procedures for filing will mean only such a failure that is (A) a communication by Claimant that is received by a person or organizational unit customarily responsible for handling benefit matters under the Plan; and (B) a communication that names a specific Claimant, a specific medical condition or symptom, and a specific treatment, service, or product for which approval is requested.

(iv) Notification of any Adverse Benefit Determination with respect to an Urgent

Care Claim will be made in accordance with Section 6.4.

(c) *Concurrent Care Decisions.*

(i) As to a Concurrent Care Decision which is an Adverse Benefit Determination, the Claims Administrator will notify the Claimant, in accordance with Section 6.4, of the Adverse Benefit Determination at a time sufficiently in advance of the reduction or termination to allow the Claimant to appeal and obtain a Benefit Determination on Review of that Adverse Benefit Determination before the benefit is reduced or terminated.

(ii) In the event of a Concurrent Care Decision which is a request by a Claimant to extend the course of treatment beyond the period of time or number of treatments and is an Urgent Care Claim, such Concurrent Care Decision will be decided as soon as possible, taking into account the medical exigencies. The Claims Administrator will notify the Claimant of the Benefit Determination, whether or not adverse, within twenty-four (24) hours after receipt of the Claim by the Plan, provided that any such Claim is made to the Plan at least twenty-four (24) hours prior to the expiration of the prescribed period of time or number of treatments. Notification of any Adverse Benefit Determination concerning a request to extend the course of treatment, whether or not involving an Urgent Care Claim, will be made in accordance with Section 6.4, and appeal of the same will be governed by Sections 6.6(a)(i), (ii) or (iii), as appropriate.

(d) *Other Health Care Claims*. In the case of a Health Care Claim that is neither an Urgent Care Claim nor a claim involving a Concurrent Care Decision as described in subsection (c), the Claims Administrator will notify the Claimant of the Plan's Benefit Determination, as follows:

(i) Pre-Service Claim:

(A) The Claims Administrator will render a Benefit Determination and provide notice to the Claimant of such Benefit Determination (whether or not adverse) within a reasonable period of time appropriate to the medical circumstances, but not later than fifteen (15) days after receipt of the Pre-Service Claim by the Plan. This period may be extended one time by the Plan for up to fifteen (15) days, provided that the Claims Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the Claimant, prior to the expiration of the initial fifteen (15) day period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision. If such an extension is necessary due to a failure of the Claimant to submit the information necessary to decide the Claim, the notice of extension will specifically describe the required information, and the Claimant will be afforded at least forty-five (45) days from the receipt of the notice within which to provide the specified information.

(B) In the event that the Claimant fails to follow the Plan's procedures for filing a Pre-Service Claim, the Claimant will be notified of such failure and of

the proper procedures to be followed in filing such a claim. The notification will be provided to the Claimant as soon as possible, but not later than five (5) days following the failure. Notification may be oral, unless written notification is requested by the Claimant. For the purposes of this Section 6.3(d)(i)(B), a failure to follow the Plan's procedures for filing will mean only such a failure that is (i) a communication by Claimant that is received by a person or organizational unit customarily responsible for handling benefit matters under the Plan; and (ii) a communication that names a specific Claimant, a specific medical condition or symptom, and a specific treatment, service, or product for which approval is requested.

(C) Notification of an Adverse Benefit Determination made hereunder will be made in accordance with Section 6.4

(ii) Post-Service Claim:

(A) The Claims Administrator will render a Benefit Determination and provide notice to the Claimant of any such Adverse Benefit Determination within a reasonable period of time, but not later than thirty (30) days after receipt of the Post-Service Claim. This period may be extended one time by the Plan for up to fifteen (15) days, provided that the Claims Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the Claimant, prior to the expiration of the initial thirty (30) day period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision. If such an extension is necessary due to a failure of the Claimant to submit the information necessary to decide the Post-Service Claim, the notice of extension will specifically describe the required information, and the Claimant will be afforded at least forty-five (45) days from receipt of the notice within which to provide the specified information.

(B) Notification of an Adverse Benefit Determination made hereunder will be made in accordance with Section 6.4.

(e) *Disability Claims.*

(i) If a Disability Claim is submitted, the Claims Administrator will render a Benefit Determination and provide notice to the Claimant of any such Adverse Benefit Determination within a reasonable period of time, but not later than forty-five (45) days after receipt of the Disability Claim (the "***Initial Period***"). The Initial Period may be extended by the Plan for up to thirty (30) days (the "***First Extension***"), provided that the Claims Administrator both (A) determines that such an extension is necessary due to matters beyond the control of the Plan, and (B) notifies the Claimant, prior to the expiration of the Initial Period, of the circumstances requiring the First Extension and the date by which the Plan expects to render a decision.

(ii) If, prior to the end of the First Extension, the Claims Administrator determines that, due to matters beyond the control of the Plan, a decision cannot be rendered within the First Extension, the period for making the determination may be extended

for up to an additional thirty (30) days (the "***Second Extension***"), provided that the Claims Administrator notifies the Claimant, prior to the expiration of the First Extension, of the circumstances requiring the Second Extension and the date as of which the Plan expects to render a decision.

(iii) In the case of any extension under this subsection (e), the notice of extension will specifically explain (A) the standards on which entitlement to a benefit is based, (B) the unresolved issues that prevent a decision on the claim, and (C) the additional information needed to resolve those issues, and the Claimant will be afforded at least forty-five (45) days within which to provide the specified information.

(iv) Notification of any Adverse Benefit Determination with respect to a Disability Claim will be made in accordance with Section 6.4.

(f) *Non-Health Claims*.

(i) If a Non-Health Claim is submitted, the Claims Administrator will render a Benefit Determination and provide notice to the Claimant of any denial, in whole or in part, of such Non-Health Claim within a reasonable period of time, but not later than ninety (90) days after receipt of the Non-Health Claim, unless the Claims Administrator determines that special circumstances require an extension of time for processing the Non-Health Claim. If the Claims Administrator determines that an extension of time for processing is required, written notice of the extension will be furnished to the Claimant prior to the termination of the initial ninety (90) day period. In no event shall such extension exceed a period of ninety (90) days from the end of such initial period. The extension notice will indicate the special circumstances requiring an extension of time and the date by which the Plan expects to render the Benefit Determination.

(ii) Notification of any Adverse Benefit Determination with respect to a Non-Health Claim will be made in accordance with Section 6.4 (below).

6.4 Notification of Benefit Determination.

(a) Except as provided in Section 6.4(b), the Claims Administrator will provide a Claimant with written or electronic notification of any Adverse Benefit Determination. The notification will set forth in a manner calculated to be understood by the Claimant:

(i) the specific reason or reasons for the Adverse Benefit Determination;

(ii) reference to the specific Plan provisions upon which the determination is based;

(iii) a description of additional material or information necessary for the Claimant to perfect the claim and an explanation of why such material or information is necessary;

(iv) a description of the Plan's appeal procedures and time limits applicable to such procedures, including, in the case of an Urgent Care Claim, a description of the

expedited review process applicable to such claims, along with a statement of the Claimant's right to bring a civil action under Section 502(a) of ERISA following an Adverse Benefit Determination on Review (or, if a Benefit Program requires two levels of appeal, following an Adverse Benefit Determination on Review with respect to the second appeal);

(v) with respect to Health Care Claims, or Disability Claims filed on or prior to April 1, 2018:

(A) if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the Adverse Benefit Determination, either the specific rule, guideline, protocol, or other similar criterion, or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the Adverse Benefit Determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to the Claimant upon request; or

(B) if the Adverse Benefit Determination is based on a medical necessity or experimental and/or investigational treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Claimant's medical circumstances, or a statement that such explanation will be provided free of charge to the Claimant upon request;

(vi) with respect to Health Care Claims under an ACA Program:

(A) information sufficient to identify the claim involved (including the date of service, the health care provider, and the claim amount (if applicable));

(B) the reason or reasons for the Adverse Benefit Determination, including the denial code and its corresponding meaning, as well as a description of the ACA Program's standard, if any, that was used in denying the claim;

(C) a description of available internal appeals and External Review processes, including information regarding how to initiate an appeal;

(D) the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman established to assist individuals with the internal claims and appeals and External Review processes; and

(E) a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning (and, in the case of such request, the Claimant shall be provided with such information as soon as practicable, and such request shall not be considered a request for internal appeal or External Review with respect to the claim);

(vii) with respect to a Disability Claim filed after April 1, 2018:

(A) A discussion of the decision regarding the Disability Claim, including an explanation of the basis for disagreeing with (or not following):

(1) The views of any Health Care Professionals treating the Claimant and any vocational professionals who evaluated the Claimant, as presented to the Claims Administrator by the Claimant;

(2) The views of any medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a Claimant's Adverse Benefit Determination, without regard to whether such advice was relied upon in making the Adverse Benefit Determination; and

(3) Any disability determination regarding the Claimant that was made by the Social Security Administration, as presented to the Claims Administrator by the Claimant;

(B) If the Adverse Benefit Determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for such determination, applying the terms of the Plan to the Claimant's medical circumstances, or a statement that such explanation will be provided free of charge to the Claimant upon request;

(C) Either the specific internal rules, guidelines, protocols, standards or other similar criteria of the Plan relied upon in making the Adverse Benefit Determination or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the Plan do not exist; and

(D) A statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claimant's Disability Claim; whether a document, record, or other information is "relevant" to a Disability Claim will be determined by reference to Section 6.8.

(b) In the case of an Adverse Benefit Determination involving an Urgent Care Claim, the information described in Section 6.4(a) may be provided to the Claimant orally within the time frame prescribed in Section 6.3(b), provided that a written or electronic notification is furnished to the Claimant not later than three (3) days after the oral notification.

(c) Any notification of an Adverse Benefit Determination with respect to either a Health Care Claim under an ACA Program or a Disability Claim filed after April 1, 2018, shall be provided in a culturally and linguistically appropriate manner, as described in Section 6.13.

6.5 Appeal Procedures.

(a) Each Claimant will have a reasonable opportunity to appeal an Adverse Benefit Determination to the Claims Fiduciary (or, if the applicable Benefit Program requires two levels of appeal, to the Claims Administrator with respect to the first level appeal) as set forth hereafter. The Claimant must complete all of the administrative review steps available through the Claims Administrator before an appeal to the Claims Fiduciary, if any, is

permitted under the Plan.

(b) Each Claimant will have the opportunity to submit written comments, documents, records, and other information relating to the claim appealed. With respect to a Health Care Claim under an ACA Program, a Claimant is allowed to review the claim file and to present evidence and testimony as part of the internal claims and appeals process.

(c) Each Claimant will be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claimant's claim for benefits under the Plan. Whether a document, record, or other information is "relevant" to a claim for benefits under the Plan will be determined by reference to Section 6.8.

(d) The appeal will take into account all comments, documents, records, and other information submitted by the Claimant relating to the claim, without regard to whether such information was submitted or considered in the initial Benefit Determination.

(e) The Claimant will have one-hundred eighty (180) days (sixty (60) days with respect to a Non-Health Claim) following receipt of notification of an Adverse Benefit Determination within which to appeal said Determination. If the applicable Benefit Program requires two levels of appeal, the Claimant will have sixty (60) days following receipt of notification of an Adverse Benefit Determination on review of the first appeal within which to file a second appeal of the Adverse Benefit Determination.

Except with respect to a Non-Health Claim:

(f) The appeal will not afford deference to the initial Adverse Benefit Determination and will be conducted by a decision maker who is neither the individual who made the Adverse Benefit Determination that is on appeal, nor the subordinate of such decision maker.

(g) In deciding an appeal of an Adverse Benefit Determination that is based in whole or in part on a medical judgment, the decision maker will consult with a Health Care Professional who has appropriate training and experience in the field of medicine involving the medical judgment.

(h) All medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the Adverse Benefit Determination on appeal will be identified without regard to whether the advice was relied upon in making the Adverse Benefit Determination.

(i) All Health Care Professionals engaged for purposes of consultation under Section 6.5(g) will be an individual who is neither an individual who was consulted in connection with the Adverse Benefit Determination that is on appeal, nor the subordinate of such individual.

(j) In the case of an Urgent Care Claim, a request for an expedited appeal of an Adverse Benefit Determination may be submitted orally or in writing by the Claimant, and all necessary information, including the Plan's Benefit Determination on Review, will be transmitted between the Plan and the Claimant by telephone, facsimile, or other available similarly expeditious method.

(k) A Claimant will not be required to file more than two appeals of an Adverse Benefit Determination prior to bringing a civil action under Section 502(a) of ERISA. To the extent that the claims procedures set forth in any Benefit Program provide for more than two levels of appeal of an Adverse Benefit Determination, any level of appeal beyond the second level of appeal will be "voluntary".

(l) To the extent that any Benefit Program offers a voluntary level of appeal ("***Voluntary Appeal***") (except to the extent the Plan is required to do so by State law), including voluntary arbitration or any other form of dispute resolution, and notwithstanding anything in such Benefit Program to the contrary:

(i) The Plan waives any right to assert that a Claimant has failed to exhaust administrative remedies because the Claimant did not elect to submit a benefit dispute to a Voluntary Appeal;

(ii) Any statute of limitations or other defense based on timeliness is tolled during the time that a Voluntary Appeal is pending;

(iii) A Claimant may elect to submit a benefit dispute to a Voluntary Appeal only after exhaustion of the appeals permitted by the Benefit Program under which the benefit dispute arose, subject to Section 6.5(k);

(iv) A Claimant will be provided, upon request, sufficient information relating to the Voluntary Appeal to enable the Claimant to make an informed judgment about whether to submit a benefit dispute to Voluntary Appeal, including a statement that the decision of a Claimant as to whether or not to submit a benefit dispute to Voluntary Appeal will have no effect on the Claimant's rights to any other benefits under the Plan, and information about the applicable rules, the Claimant's right to representation, the process for selecting the decision maker, and the circumstances, if any, that may affect the impartiality of the decision maker, such as any financial or personal interests in the result or any past or present relationship with any party to the review process; and

(v) No fees or costs will be imposed on the Claimant as part of the Voluntary Appeal.

(m) Notwithstanding anything in a Benefit Program to the contrary, a Claimant will not be subject to mandatory arbitration of an Adverse Benefit Determination, except to the extent that:

(i) The arbitration is counted as one of the two appeals described in Section 6.5(k) and is conducted in accordance with the requirements applicable to such appeals; and

(ii) The Claimant is not precluded from challenging the decision resulting from such arbitration under section 502(a) of ERISA or other applicable law.

(n) With respect to a Health Care Claim under an ACA Program:

(i) If the Claims Fiduciary has made a Final Internal Adverse Benefit

Determination regarding such claim, the Claims Fiduciary shall, as soon as possible and sufficiently in advance of the required date for issuing the notice regarding its determination under Section 6.6(a), provide the Claimant, free of charge, with any new or additional evidence considered, relied upon, or generated by the Claims Fiduciary, or at the direction of the Claims Fiduciary, in connection with such claim, in order to give the Claimant a reasonable opportunity to respond prior to that date;

(ii) Before the Claims Fiduciary issues any Final Internal Adverse Benefit Determination with respect to such claim based on a new or additional rationale, the Claims Fiduciary will, as soon as possible and sufficiently in advance of the required date for issuing the notice regarding its determination under Section 6.6, provide the Claimant, free of charge, with the rationale, in order to give the Claimant a reasonable opportunity to respond prior to that date;

(iii) Notwithstanding the provisions of Section 6.6(a), if such new or additional evidence is received by the Claims Fiduciary so late that it would be impossible to provide it to the Claimant in time for the Claimant to have a reasonable opportunity to respond, the period for providing the notice of any Final Internal Adverse Benefit Determination is tolled until such time as the Claimant has a reasonable opportunity to respond; after the Claimant responds, or has a reasonable opportunity to respond but fails to do so, the Claims Fiduciary shall notify the Claimant of its final Benefit Determination on Review as soon as the Claims Fiduciary, acting in a reasonable and prompt fashion, can provide the notice, taking into account the medical exigencies; and

(iv) The coverage which is the subject of the Adverse Benefit Determination on appeal will be continued pending the outcome of the appeal; for this purpose, the Plan will comply with the requirements of Section 2560.503-1(f)(2)(ii) of the Claims Regulations, which generally provides that benefits for an ongoing course of treatment cannot be reduced or terminated without providing advance notice and an opportunity for advance review.

(o) With respect to a Disability Claim filed after April 1, 2018:

(i) Prior to the issuance of an Adverse Benefit Determination on Review regarding the Disability Claim, the Claimant will be provided, free of charge, with any new or additional evidence considered, relied upon, or generated by the Claims Fiduciary (or, if the applicable Benefit Program requires two levels of appeal, by the Claims Administrator with respect to the first level appeal), or at the direction of such decision maker, in connection with such claim;

(ii) Prior to the issuance of an Adverse Benefit Determination on Review regarding the Disability Claim that is based on a new or additional rationale, the Claims Fiduciary (or, if the applicable Benefit Program requires two levels of appeal, the Claims Administrator with respect to the first level appeal) will provide the Claimant, free of charge, with such rationale; and

(iii) In the case of either subsection (i) or (ii), such evidence or rationale will be provided to the Claimant as soon as possible and sufficiently in advance of the date

on which the notice of an Adverse Benefit Determination on Review is required to be provided under Section 6.6(a), in order to give the Claimant a reasonable opportunity to respond prior to that date.

6.6 Benefit Determination on Review.

(a) *Timing of Notification.*

(i) Urgent Care Claim. In the case of an Urgent Care Claim, the Claims Fiduciary (or, if the applicable Benefit Program requires two levels of appeal, the Claims Administrator with respect to the first level appeal) will notify the Claimant, in accordance with Section 6.6(b), of the Plan's Benefit Determination on Review as soon as possible, taking into account the medical exigencies, but not later than seventy-two (72) hours after receipt of the Claimant's appeal of an Adverse Benefit Determination by the Plan; provided that the Claims Fiduciary (or Claims Administrator, as applicable) defers to the attending health care provider with respect to the decision as to whether a claim constitutes "urgent care".

(ii) Pre-service Claims. In the case of a Pre-Service Claim, the Claims Fiduciary (or, if the applicable Benefit Program requires two levels of appeal, the Claims Administrator with respect to the first level appeal) will notify the Claimant, in accordance with Section 6.6(b), of the Plan's Benefit Determination on Review within a reasonable period of time appropriate to the medical circumstances. Such notification will be provided not later than thirty (30) days after receipt by the Plan of the Claimant's appeal of an Adverse Benefit Determination, unless the applicable Benefit Program requires two appeals of an Adverse Benefit Determination, in which case such notification will be provided not later than fifteen (15) days after receipt by the Plan of the Claimant's appeal of an Adverse Benefit Determination.

(iii) Post-Service Claims. In the case of a Post-Service Claim, the Claims Fiduciary (or, if the applicable Benefit Program requires two levels of appeal, the Claims Administrator with respect to the first level appeal) will notify the Claimant, in accordance with Section 6.6(b), of the Plan's Benefit Determination on Review within a reasonable period of time, but not later than sixty (60) days after receipt by the Plan of the Claimant's appeal of an Adverse Benefit Determination, unless the applicable Benefit Program requires two appeals of an Adverse Benefit Determination, in which case such notification will be provided not later than thirty (30) days after receipt by the Plan of the Claimant's appeal of an Adverse Benefit Determination.

(iv) Disability Claims. In the case of a Disability Claim, the Claims Fiduciary (or, if the applicable Benefit Program requires two levels of appeal, the Claims Administrator with respect to the first level appeal) will notify the Claimant, in accordance with Section 6.6(b), of the Plan's Benefit Determination on Review within a reasonable period of time, but not later than forty-five (45) days after receipt by the Plan of the Claimant's appeal of an Adverse Benefit Determination, unless the Claims Fiduciary determines that special circumstances require an extension of time for processing the claim. If the Claims Fiduciary determines that an extension of time for processing is required, written notice of the extension will be furnished to the Claimant prior to the termination of the initial forty-five (45) day period. In no event

will such extension exceed a period of forty-five (45) days from the end of the initial period. The extension notice will indicate the special circumstances requiring an extension of time and the date by which the Plan expects to render the Benefit Determination on Review.

(v) Non-Health Claims. In the case of a Non-Health Claim, the Claims Fiduciary (or, if the applicable Benefit Program requires two levels of appeal, the Claims Administrator with respect to the first level appeal) shall notify the Claimant in accordance with Section 6.6(b) of the Plan's Benefit Determination on Review within a reasonable period of time, but not later than sixty (60) days after receipt by the Plan of the Claimant's appeal of an Adverse Benefit Determination, unless the Claims Fiduciary determines that special circumstances require an extension of time for processing the claim. If the Claims Fiduciary determines that an extension of time for processing is required, written notice of the extension shall be furnished to the Claimant prior to the termination of the initial sixty (60) day period. In no event shall such extension exceed a period of sixty (60) days from the end of the initial period. The extension notice shall indicate the special circumstances requiring an extension of time and the date by which the Plan expects to render the Benefit Determination on Review.

(vi) In the case of an Adverse Benefit Determination on Review, the Claims Fiduciary (or, if the applicable Benefit Program requires two levels of appeal, the Claims Administrator with respect to the first level appeal) will provide access to, and copies of, documents, records, and other information described in Sections 6.6(b)(iii), (iv), (v) and (vi), as appropriate.

(b) *Manner and Content of Notification of Benefit Determination on Review.*

The Claims Fiduciary (or, if the applicable Benefit Program requires two levels of appeal, the Claims Administrator with respect to the first level appeal) will provide a Claimant with written or electronic notification of the Plan's Benefit Determination on Review. In the case of an Adverse Benefit Determination on Review, the notification will set forth in a manner calculated to be understood by the Claimant:

(i) The specific reason or reasons for the Adverse Benefit Determination on Review;

(ii) Reference to the specific Plan provisions upon which the Adverse Benefit Determination on Review is based;

(iii) A statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claimant's claim for benefits under the Plan. Whether a document, record, or other information is "relevant" to a claim for benefits will be determined by reference to Section 6.8;

(iv) A statement describing any Voluntary Appeal procedures offered by the Plan and the Claimant's right to obtain the information about such procedures described in Section 6.5(l)(iv);

(v) A statement of the Claimant's right to bring an action under Section 502(a) of ERISA (or, if a Benefit Program requires two levels of appeal, the Claimant's right to bring an action under Section 502(a) of ERISA following an Adverse Benefit Determination on Review with respect to the second appeal), and, if the Adverse Benefit Determination on Review is regarding a Disability Claim which is filed after April 1, 2018, a description of any contractual limitations period under the applicable Benefit Program that applies to the Claimant's right to bring such an action, as described in Section 6.11, including the calendar date on which such contractual limitations period expires for such claim;

(vi) With respect to an appeal of either a Health Care Claim or a Disability Claim filed on or prior to April 1, 2018:

(A) the following statement: "You and your Plan may have other voluntary alternative dispute resolution options, such as mediation; one way to find out what may be available is to contact your local U.S. Department of Labor office and your state insurance regulatory agency";

(B) if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the Adverse Benefit Determination on Review, either (1) the specific rule, guideline, protocol, or other similar criterion, or (2) a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the Adverse Benefit Determination on Review and that a copy of the rule, guideline, protocol, or other similar criterion will be provided, free of charge, to the Claimant upon request; and

(C) if the Adverse Benefit Determination on Review is based on a medical necessity or experimental and/or investigational treatment or similar exclusion or limit, either (1) an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Claimant's medical circumstances, or (2) a statement that such explanation will be provided, free of charge, upon request;

(vii) With respect to an appeal of a Health Care Claim under an ACA Program:

(A) information sufficient to identify the claim involved (including the date of service, the health care provider, and the claim amount (if applicable));

(B) the reason or reasons for the Adverse Benefit Determination or Final Internal Adverse Benefit Determination, including the denial code and its corresponding meaning, as well as a description of the ACA Program's standard, if any, that was used in denying the claim; in the case of a notice of Final Internal Adverse Benefit Determination, this description must include a discussion of the decision;

(C) a description of any additional available internal appeals processes and External Review processes, including information regarding how to initiate an appeal;

(D) the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman established to assist individuals with the internal claims and appeals and External Review processes; and

(E) a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning (and, in the case of such request, the Claimant shall be provided with such information as soon as practicable, and such request shall not be considered a request for internal appeal or External Review with respect to the claim); and

(viii) With respect to an appeal of a Disability Claim that is filed after April 1, 2018:

(A) A discussion of the Adverse Benefit Determination on Review, including an explanation of the basis for disagreeing with (or not following):

(1) The views of any Health Care Professionals treating the Claimant and any vocational professionals who evaluated the Claimant, as presented to the Claims Fiduciary (or, if the applicable Benefit Program requires two levels of appeal, the Claims Administrator with respect to the first level appeal) by the Claimant;

(2) The views of any medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the Adverse Benefit Determination on Review, without regard to whether such advice was relied upon in making the Adverse Benefit Determination on Review; and

(3) Any disability determination regarding the Claimant that was made by the Social Security Administration, as presented to the Claims Fiduciary (or, if the applicable Benefit Program requires two levels of appeal, the Claims Administrator with respect to the first level appeal) by the Claimant;

(B) If the Adverse Benefit Determination on Review is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for such determination, applying the terms of the Plan to the Claimant's medical circumstances, or a statement that such explanation will be provided free of charge to the Claimant upon request; and

(C) Either the specific internal rules, guidelines, protocols, standards or other similar criteria of the Plan relied upon in making the Adverse Benefit Determination on Review or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the Plan do not exist.

(c) Any notification of an Adverse Benefit Determination on Review with respect to an

appeal of either a Health Care Claim under an ACA Program or a Disability Claim that is filed after April 1, 2018 shall be provided in a culturally and linguistically appropriate manner, as described in Section 6.13.

6.7 Calculating Time Periods.

For the purposes of Sections 6.3 and 6.6(a), the period of time within which a Benefit Determination or a Benefit Determination on Review is required to be made will begin at the time a claim or appeal, as the case may be, is filed in accordance with the procedures of the Plan, without regard to whether all information necessary to make a Benefit Determination or a Benefit Determination on Review, as the case may be, accompanies the filing.

In the event that a period of time is extended as permitted under Section 6.3 or 6.6(a) due to a Claimant's failure to submit information necessary to decide a claim or the appeal, the period for making the Benefit Determination or the Benefit Determination on Review will be tolled from the date on which the notification of the extension is sent to the Claimant until the date on which the Claimant responds to the request for additional information.

The period for making a Benefit Determination on Review under Section 6.6(a) will also be tolled under the circumstances described, and as provided, in Section 6.5(n)(iii).

6.8 Relevance to Claim.

For the purposes of Sections 6.5(c) and 6.6(b)(iii), a document, record, or other information will be considered "relevant" to a Claimant's claim if such document, record, or other information:

(a) was relied upon in making the Benefit Determination;

(b) was submitted, considered, or generated in the course of making the Benefit Determination, without regard to whether such document, record, or other information was relied upon in making the Benefit Determination;

(c) demonstrates compliance with any administrative processes and safeguards in making the Benefit Determination; or

(d) except with respect to a Non-Health Claim, constitutes a statement of policy or guidance with respect to the Plan concerning the denied treatment option or benefit for the Claimant's diagnosis, without regard to whether such advice or statement was relied upon in making the Benefit Determination.

6.9 External Review.

External Review will only be available with respect to Health Care Claims that are incurred under an ACA Program. If an ACA Program is fully-insured, External Review thereunder will be provided in accordance with the State external review process or Federally-administered external review process that is applicable to the health insurance issuer of the ACA Program under the Affordable Care Act. If an ACA Program is self-funded, External Review thereunder will be provided in accordance with subsections (a) through (e) below, which subsections are intended to comply with

the Federal external review process set forth in Section 2590.715-2719(d) of the Claims Regulations and shall be construed and applied accordingly.

(a) *Claims Eligible for External Review*. External Review applies only to the following under an ACA Program:

(i) An Adverse Benefit Determination, including a Final Internal Adverse Benefit Determination, that involves medical judgment (including, but not limited to, (A) a determination based medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit, (B) a determination that a treatment is experimental or investigational, (C) a determination regarding whether the Claimant is entitled to a reasonable alternative standard for a reward under a wellness program, or (D) a determination based on the Plan's compliance with the nonquantitative treatment limitation provisions of the Mental Health Parity and Addiction Equity Act of 2008 and its implementing regulations), as determined by the external reviewer; and

(ii) A rescission of coverage (whether or not the rescission has any effect on any particular benefit at that time).

A denial, reduction, termination, or a failure to provide payment for a benefit based on a determination that the Claimant fails to meet the requirements for eligibility under the terms of the Plan is not eligible for External Review.

(b) *Request for External Review*. A Claimant may file a written request for External Review with the Claims Fiduciary if such request is filed by the date that is four months after the date of receipt a notice of the Adverse Benefit Determination or Final Internal Adverse Benefit Determination ("Last Filing Date") or, if there is no such date in the fourth month following receipt of the notice, then the Last Filing Date will be the first day of the fifth month following receipt of the notice. If the Last Filing Date would fall on a Saturday, Sunday, or Federal holiday, the Last Filing Date is extended to the next day that is not a Saturday, Sunday, or Federal holiday.

(c) *Preliminary Review and Notice*. Within five business days following receipt of a request for an External Review, the Claims Fiduciary shall complete a preliminary review of the request to determine whether:

(i) The Claimant is or was covered by the ACA Program at the time the health care item or service in question was requested, or, in the case of a retrospective review, whether the Claimant was covered by the ACA Program at the time the health care item or service was provided;

(ii) The Adverse Benefit Determination or Final Internal Adverse Benefit Determination does not relate to the Claimant's failure to meet the eligibility requirements of the ACA Program;

(iii) The Claimant has exhausted the Plan's internal appeal process applicable to the ACA Program, unless the Claimant is not required to exhaust the internal appeals process as provided in Section 6.10; and

(iv) The Claimant has provided all the information and forms required to process an External Review.

Within one business day after completion of the preliminary review, the Claims Fiduciary will issue a written notice to the Claimant. If the Claimant's request for External Review is complete, but not eligible for External Review, the notice will include the reasons for the request's ineligibility and current contact information, including telephone number, for the Employee Benefit Security Administration. If the request is not complete, the notice will include a description of the information or materials necessary to complete the request, and the Claimant shall be permitted to perfect the request for External Review by the later of (A) 48 hours after the Claimant receives the notice, or (B) the Last Filing Date.

(d) *Referral to Independent Review Organization*. If a Claimant's request is eligible for External Review, the Claims Fiduciary will assign the request to an Independent Review Organization to conduct the External Review in accordance with an independent and unbiased process that meets the requirements of Section 2590.713-2719(d)(2)(iii) of the Claims Regulations. No costs, including filing fees, will be imposed on a Claimant who requests External Review.

The assigned IRO will provide timely written notice to the Claimant, confirming whether the request is eligible for External Review and including a statement that the Claimant may, within ten business days following the date of receipt of the notice, submit additional information to the IRO in writing. Any such additional information will be considered by the IRO when conducting the External Review. The IRO is not required to, but may in its discretion, accept and consider additional information submitted in writing after ten business days.

Within five business days after the date that a request for External Review is assigned to the IRO, the Claims Fiduciary will provide the IRO with the documents and information that were considered in making the Adverse Benefit Determination or Final Internal Adverse Benefit Determination, provided however, any failure by the Claims Fiduciary to timely provide such documents and information will not delay the conduct of the External Review. If the Claims Fiduciary fails to timely provide the documents and information, the IRO may terminate the External Review and make a decision to reverse the Adverse Benefit Determination or Final Internal Adverse Benefit Determination, in which case the IRO will notify the Claimant and the Claims Fiduciary of its decision within one business day after such decision is made.

Upon receipt of any information submitted by the Claimant, the IRO will, within one business day thereafter, forward such information to the Claims Fiduciary. Upon its receipt of any such information, the Claims Fiduciary may reconsider its Adverse Benefit Determination or Final Internal Adverse Benefit Determination that is the subject of the External Review. Reconsideration by the Claims Fiduciary will not delay the External Review. The External Review may be terminated as a result of the Claims Fiduciary's reconsideration only if the Claims Fiduciary decides, upon completion of its reconsideration, to reverse its Adverse Benefit Determination or Final Internal Adverse Benefit Determination and provide coverage or payment with respect to the claim. In that case, within one business day after making such a decision, the Claims Fiduciary will provide written notice of its decision to the Claimant and the IRO. The IRO will terminate the External Review upon receipt of such notice

from the Claims Fiduciary.

If the External Review is not terminated based on the Claims Fiduciary's reconsideration, the IRO will review and consider all of the information and documents timely provided to the IRO, as well as the following, to the extent such information or documents are available and the IRO considers them appropriate:

(i) The Claimant's medical records;

(ii) The attending Health Care Professional's recommendation;

(iii) Reports from appropriate Health Care Professionals and other documents submitted by the Claims Fiduciary, Claimant, or the Claimant's treating provider;

(iv) The terms of the Plan, as applicable to the claim;

(v) Appropriate practice guidelines;

(vi) Any applicable clinical review criteria developed and used by Claims Fiduciary, unless the criteria are inconsistent with the applicable terms of the Plan or with applicable law; and

(vii) To the extent the final IRO decision maker is different from the IRO's clinical reviewer, the opinion of such clinical reviewer, after considering information described in this notice, to the extent the information or documents are available and the clinical reviewer or reviewers consider such information or documents appropriate.

In reaching its Final External Review Decision, the IRO will review the claim *de novo* and will not be bound by any decisions or conclusions reached during the Plan's internal claims and appeals process applicable to the claim. The IRO will provide written notice of its Final External Review Decision to both the Claimant and the Claims Fiduciary within 45 days after its receipt of the request for the External Review. Such notice will contain a general description of the reason for the request for External Review (including information sufficient to identify the claim), references to the evidence or documentation considered by the IRO in reaching its decision, and the other information required by the Claims Regulations.

After a Final External Review Decision, the IRO will maintain records of all claims and notices associated with the External Review process for six years and will make such records available for examination as required by the Claims Regulations or other applicable law.

The IRO's Final External Review Decision will be binding except to the extent that (i) other remedies are available under State or Federal law to either the Plan or to the Claimant or (ii) the Plan voluntarily makes payment on the claim or otherwise provides benefits at any time, including after a Final External Review Decision that denies the claim or otherwise fails to require such payment or benefits.

Upon receipt of a notice of a Final External Review Decision reversing the Adverse Benefit Determination or Final Adverse Benefit determination, the Plan will immediately

provide coverage or payment for the claim.

(e) *Expedited External Review*. An expedited External Review shall be provided:

(i) If the Claimant received an Adverse Benefit Determination that involves a medical condition of the Claimant for which the timeframe for completion of an expedited internal appeal would seriously jeopardize the life or health of the Claimant or would jeopardize the Claimant's ability to regain maximum function and the Claimant has filed a request for an expedited internal appeal;

(ii) If the Claimant received a Final Internal Adverse Benefit Determination and the Claimant has a medical condition where the timeframe for completion of a standard External Review would seriously jeopardize the life or health of the Claimant or would jeopardize the Claimant's ability to regain maximum function; or

(iii) If the Claimant received a Final Internal Adverse Benefit Determination which concerns an admission, availability of care, continued stay, or health care item or service for which the Claimant received emergency services, but has not been discharged from the facility.

Immediately upon receipt of a request for an expedited External Review, the Claims Fiduciary will determine if the request meets the eligibility requirements set forth in Section 6.9(c). The Claims Fiduciary will immediately send a notice to the Claimant that meets the requirements described in Section 6.9(c) to communicate its eligibility determination.

If the Claimant's request is eligible for expedited External Review, the Claims Fiduciary will assign the request to an IRO pursuant to the requirements in Section 6.9(d). The Claims Fiduciary will provide or transmit all necessary documents and information considered in making the Adverse Benefit Determination or Final Internal Adverse Benefit Determination to the assigned IRO electronically or by telephone or facsimile or any other available expeditious method. The IRO, to the extent such information or documents are available and the IRO considers them appropriate, will consider such information or documents as described in Section 6.9(d). In reaching its decision, the IRO will review the claim *de novo* and will not be bound by any decisions or conclusions reached during the Plan's internal claims and appeals process.

The IRO will provide the Claimant and the Plan with a notice of its Final External Review Decision, in accordance with the requirements set forth in Section 6.9(d), as expeditiously as the Claimant's medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited External Review. If such notice is not in writing, then within 48 hours after the date such notice is provided, the IRO will provide a written confirmation of its decision to the Claimant and the Claims Fiduciary.

6.10 Exhaustion of Administrative Remedies.

(a) *Exhaustion Required Prior to Action for Recovery*. Notwithstanding anything to the contrary in a Benefit Program, no action at law or in equity may be brought to recover under the Plan until all administrative remedies have been exhausted (including two internal

appeals of an Adverse Benefit Determination if required by the applicable Benefit Program). If a Claimant fails to file a timely claim, or if the Claimant fails to request a review in accordance with the Plan's claim procedures outlined herein, such Claimant will have no right of review and will have no right to bring any action in any court. The denial of the claim will become final and binding on all persons for all purposes.

(b) *Deemed Exhaustion – Health Care Claim under an ACA Program*. If the Plan fails to strictly adhere to all of the applicable requirements of Sections 6.3 through 6.8 with respect to a Health Care Claim under an ACA Program, the Claimant is deemed to have exhausted the internal claims and appeals process of the Plan (except as provided in subsection (d), below) with respect to such claim. In such case, the Claimant may initiate an External Review under Section 6.9, as applicable, and is also entitled to pursue any available remedies under Section 502(a) of ERISA or under State law, as applicable, on the basis that the Plan has failed to provide a reasonable internal claims and appeals process that would yield a decision on the merits of the claim. If the Claimant chooses to pursue remedies under Section 502(a) of ERISA under such circumstances, the claim or appeal is deemed denied on review without the exercise of discretion by an appropriate fiduciary.

(c) *Deemed Exhaustion – Disability Claim Filed After April 1, 2018*. If the Plan fails to strictly adhere to all of the applicable requirements of Sections 6.3 through 6.8 with respect to a Disability Claim filed after April 1, 2018, the Claimant is deemed to have exhausted the administrative remedies available under the Plan (except as provided in subsection (d), below) with respect to such claim. Accordingly, the Claimant is entitled to pursue any available remedies under Section 502(a) of ERISA on the basis that the Plan has failed to provide a reasonable claims procedure that would yield a decision on the merits of the claim. If the Claimant chooses to pursue remedies under Section 502(a) of ERISA under such circumstances, the claim or appeal is deemed denied on review without the exercise of discretion by an appropriate fiduciary.

(d) *De Minimis Violations*. Notwithstanding subsections (b) and (c), above, the internal claims and appeals process with respect to a Health Care Claim under an ACA Program and the administrative remedies under the Plan with respect to a Disability Claim filed after April 1, 2018, will not be deemed exhausted based on de minimis violations that do not cause, and are not likely to cause, prejudice or harm to the Claimant, so long as the Plan demonstrates that the violation (i) was for good cause or due to matters beyond the control of the Plan and (ii) occurred in the context of an ongoing, good faith exchange of information between the Plan and the Claimant (provided, however, this exception shall not be applicable if the violation is part of a pattern or practice of violations by the Plan). The Claimant may request a written explanation of the de minimis violation from the Plan, and the Plan will provide such explanation within 10 days, including a specific description of the Plan's basis, if any, for asserting that the violation should not cause the internal claims and appeals process of the Plan with respect to a Health Care Claim under an ACA Program or the administrative remedies of the Plan with respect to a Disability Claim filed after April 1, 2018, to be deemed exhausted. If a court (or, with respect to a Health Care Claim under an ACA Program, an external reviewer) rejects the Claimant's request for immediate review on the basis that the Plan met the standards for the exception, then:

(i) with respect to a Health Care Claim under an ACA Program, the Claimant has the right to resubmit and pursue the internal appeal of the Claim, in which case, within

a reasonable time after the external reviewer or court rejects the claim for immediate review (not to exceed 10 days), the Plan shall provide the Claimant with notice of the opportunity to resubmit and pursue the internal appeal of the claim, and time periods for re-filing the claim shall begin to run upon Claimant's receipt of such notice; and

(ii) with respect to a Disability Claim filed after April 1, 2018, the claim shall be considered as re-filed on appeal upon the Plan's receipt of the decision of the court, and, within a reasonable time after such receipt, the Plan shall provide the Claimant with notice of the resubmission.

6.11 Action for Recovery.

Unless otherwise expressly stated in a Benefit Program, and subject to Section 6.10, any action at law or in equity with respect to any and all claims relating to the Plan must be brought for recovery within one year from the earlier of (1) the date of a Final Internal Adverse Benefit Determination, if applicable, or (2) the accrual of any claim under or relating to the Plan that does not result in a Final Internal Adverse Benefit Determination. If the Benefit Program Summary Plan Description for a particular Fully-Insured Program expressly states a limitations period for bringing an action thereunder, then such Benefit Program Summary Plan Description will control with respect to that Fully-Insured Program.

6.12 Participant's Responsibilities.

Each Participant will be responsible for providing the Claims Administrator, the Claims Fiduciary, the Plan Administrator and/or the Employer with the Participant's and each Beneficiary's current U.S. mailing address and electronic address, as specified in the Benefit Programs. Accordingly, any notices required or permitted to be given by the Claims Administrator, the Claims Fiduciary, the Plan Administrator or the Employer hereunder will be deemed given if directed to such address furnished by the Participant and mailed by regular United States mail, delivered by messenger or other professional delivery service, or provided by electronic means as specified in Section 2520.104b-l(c) of ERISA. The Claims Administrator, Claims Fiduciary, Plan Administrator and the Employer will not have any obligation or duty to locate a Participant, Dependent or Beneficiary.

In the event that a Participant, Dependent or Beneficiary becomes entitled to a payment under a Benefit Program that is not a Fully-Insured Program, and such payment is delayed or cannot be made:

(a) because the current address according to the Claims Fiduciary's records is incorrect;

(b) because the Participant, Dependent or Beneficiary fails to respond to the notice sent to the current address according to the Claims Fiduciary's records,

(c) because of conflicting claims to such payments; or

(d) for any other reason;

the amount of such payment, if and when made, will be determined under the provisions of the Plan without payment of any interest or earnings.

In the event that a Participant or Beneficiary becomes entitled to a payment under a Fully-Insured Program, the amount of such payment, if and when made, shall be determined under the provisions of the applicable Benefit Program.

To the extent that the entitlement of a Participant, Dependent, Beneficiary or other individual to a benefit under the Plan is the subject of an interpleader action in a court of competent jurisdiction, the Plan Administrator, Plan Sponsor and any other Plan fiduciary may act in reliance upon any order issued by such court regarding any individual's entitlement to benefits under the Plan, which action shall satisfy its fiduciary and other duties under the Plan.

6.13 Unclaimed Benefits.

If, within twelve (12) months after any amount becomes payable under the Plan to a Participant or Beneficiary with respect to a Benefit Program other than a Fully-Insured Program, and the same will not have been claimed or any check issued under the Plan remains uncashed, provided reasonable care will have been exercised in attempting to make such payments, the amount thereof will be forfeited and will cease to be a liability of the Plan.

6.14 Standards for Culturally and Linguistically Appropriate Notifications.

The notifications described in Sections 6.4(c) and 6.6(c), with respect to Health Care Claims under an ACA Program and Disability Claims filed after April 1, 2018 (for purposes of this Section 6.13, each a "***Determination Notice***", and, collectively, "***Determination Notices***"), shall be administered in accordance with the requirements set forth in subsection (a), below, for the applicable non-English languages described in subsection (b), below.

(a) *Requirements.*

(i) The Plan shall provide oral language services to a Claimant that include (A) answering questions in any applicable non-English language and (B) providing assistance with filing claims and appeals of any Adverse Benefit Determinations (including, with respect to a Health Care Claim under an ACA Program, External Review) in any applicable non-English language;

(ii) The Plan shall provide, upon request by a Claimant, a Determination Notice in any applicable non-English language; and

(iii) The Plan shall include in the English versions of all Determination Notices a statement, prominently displayed in any applicable non-English language, which clearly indicates the Plan's procedures by which a Claimant may access the language services provided by the Plan.

(b) *Applicable Non-English Language.*

With respect to an address in any United States county to which a Determination Notice is sent, a non-English language is an "applicable non-English language" if ten percent or more of the population residing in such county is literate only in the same non-English language, as determined in guidance published by the U.S. Department of Labor.

ARTICLE VII
COORDINATION OF BENEFITS

7.1 Coordinating Benefits with Coverage from Another Source.

The coordination of benefits ("**COB**") provisions in this Article VII will apply to all health benefits provided under the Plan, but only to the extent that the applicable Benefit Program Summary Plan Description does not contain its own COB provisions. In the event that the Benefit Program Summary Plan Description contains its own COB provisions, such provisions will govern and control the coordination of benefits under that Benefit Program.

If a Participant has coverage under the Plan as well as coverage from another source (or sources), benefits that are received through the Plan will be coordinated with the benefits available under the plan(s) containing the Participant's other source of benefits.

7.2 Coverage from Another Source.

For purposes of this Article VII, "coverage from another source" will mean any other plan, policy or contract (individually and collectively, a "***plan***") providing benefits or services for medical care, prescription drug coverage, dental care or vision care, including but not limited to, one of the following:

(a) group insurance, or any other arrangement of coverage for individuals in a group health maintenance organization (HMO) or other group on an insured, self-insured or uninsured basis, or state or federal programs providing health coverage other than a state plan under Medicaid or TRICARE (*i.e.*, the U.S. Department of Defense's worldwide health care program for active duty and retired uniformed services members and their families);

(b) group coverage sponsored through a school or other educational institution, for a student;

(c) coverage under a service plan contract or prepayment plan or program;

(d) group coverage under franchise organizations; or

(e) no-fault insurance required under any law of a government and provided on other than a group basis, but only to the extent the benefits are required under such no-fault law.

7.3 Construction.

Coverage from another source will be construed separately with respect to each policy, contract or other arrangement for benefits or services, and separately with respect to that portion of any such policy, contract, or other arrangement which reserves the right to take the benefits or services of other plans into consideration in determining its benefits and that portion which does not.

7.4 Allowable Charge.

For a charge to be allowable it must be a usual and reasonable charge and at least part of it must be covered under the Plan.

When benefits are reduced under a primary plan because a Participant does not comply with the other plan's provisions, the amount of such reduction will not be considered an allowable charge. Examples of such provisions are those related to second surgical opinions, precertification of admissions or services, and preferred or direct provider arrangements.

In the case of HMO (Health Maintenance Organization) or other in-network only plans: the Plan will not consider any charges in excess of what an HMO or network provider has agreed to accept as payment in full. Also, when an HMO or network plan is primary and the Participant does not use an HMO or network provider, the Plan will not consider as an allowable charge any charge that would have been covered by the HMO or network plan had the Participant used the services of an HMO or network provider.

When a plan provides benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered will, for purposes of this Article VII, be considered to be the allowable charge.

7.5 Automobile Limitations.

When medical payments are available under vehicle insurance, the Plan will pay excess benefits only, without reimbursement for vehicle plan deductibles. Except as required by law, the Plan will always be considered the secondary carrier regardless of the individual's election under PIP (personal injury protection) coverage with the auto carrier.

7.6 Ordering of Benefits.

When coverage is provided by two or more sources for the same allowable charge as stated above, whether the Plan or the other plan (either, a "plan") is primary is established in the following order:

(a) The plan that has no COB provision will be considered primary to a plan that has COB provisions;

(b) The plan covering the person as an employee will be primary to the plan covering the person as a dependent;

(c) The plan covering a person in his own capacity will be primary to the plan covering a person as a dependent; however, if the person is a Medicare beneficiary, and Medicare is secondary to the plan covering the person as a dependent and primary to the plan covering the person as a non-dependent, then the plan covering the person as a dependent is primary, Medicare is secondary and the plan covering the person as a non-dependent is the tertiary plan (that is, in this specific situation, the plan covering the person as a non-dependent pays only after the plan covering the person as a dependent and after Medicare);

(d) The plan covering a person as an active employee will be primary to the plan covering the person as a retired, terminated, inactive, suspended or laid-off employee, except that if the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule does not apply;

(e) The plan covering a person as an employee will be primary to the plan covering the person as a COBRA participant or a beneficiary under any other federal or state continuation

coverage, except that if the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule does not apply;

(f) The plan covering a dependent as a dependent of an active employee is primary to the plan covering the dependent as the dependent of a former employee or as a COBRA participant or a beneficiary under any other federal or state continuation coverage;

(g) For the purposes of a dependent covered under the plans of both of his non-divorced parents (or parents who never married, but who live together) the plan covering the parent whose birthday falls first in the year will be primary to the plan covering the parent whose birthday falls later in the year. If both parents have the same birthday, then the plan covering the parent for the longest period of time will be primary, except that if the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule does not apply;

(h) For a dependent whose parents are divorced or legally separated (or if the parents never married and do not live together), and the dependent is covered by the plans of both parents, the plan covering the parent who is responsible for the dependent's health care under the terms of a court decree or state agency order will be the primary payor for any period after the plan has actual knowledge of those terms. If the specific terms of the court decree state that the parents will share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the plans covering the child will follow the order of benefit determination rules outlined above when a child is covered as a dependent and the parents are not divorced. In the absence of such court decree or state agency order, payment will be made in the order as follows:

(i) the plan of the natural parent with custody;

(ii) the plan of the step-parent with custody; and

(iii) the plan of the natural parent without custody;

(i) If (a), (b), (c), (d), (e), (f), (g) or (h) do not apply, then the plan covering the person for the longest period of time will be primary; and

(j) Notwithstanding any provision to the contrary, to the extent required by applicable law, the Plan shall be primary with respect to items or services for which a State provides child health assistance under the State's child health plan. This provision will be interpreted in accordance with the Children's Health Insurance Program Reauthorization Act of 2009, and the authoritative guidance thereunder.

7.7 Reduction of Benefits Payable by the Plan.

Whenever the Plan is considered secondary to another plan, benefits will be payable by the primary plan to the extent that the expense is an incurred charge, and the Plan will be liable for the remainder of the eligible expenses that would be payable in the absence of dual coverage up to the amount that would otherwise be payable to the extent payable in total under the Plan.

7.8 Coordination of Benefits for Persons Eligible for Medicare.

The above provisions of this Article VII will apply to all Participants who are entitled to Medicare, subject to the following provisions. For purposes of this Section, "entitled to Medicare" means that an individual either is receiving Medicare benefits or would receive such benefits if he made application to the Social Security Administration.

(a) The Plan is a primary plan with regard to the following Participants eligible for Medicare:

(i) any Participant (or Participant's Spouse) who is covered under the Plan by reason of current employment status with an Employer and who is also entitled to Medicare benefits, for as long as such employment status continues; provided that this rule will not apply if the Employer has fewer than twenty (20) Employees in current employment status for each working day in each of twenty (20) or more calendar weeks in the current calendar year and the preceding calendar year;

(ii) any Participant who is entitled to Medicare benefits solely on the basis of having end-stage renal disease ("***ESRD***"); provided that Medicare will be considered to be the primary payer of benefits on behalf of an insured individual with ESRD after expiration of the period that begins on the date the individual first becomes entitled to Medicare Part A benefits under Social Security Act Section 226A and ends 30 months later; and

(iii) any disabled Participant who is entitled to Medicare but still participates in the Plan on the basis of current employment status, for as long as such employment status continues; provided that this rule will not apply unless the Employer had at least one hundred (100) individuals in current employment status on a typical business day during the previous calendar year.

(b) The Plan is a secondary plan with regard to all other Participants eligible for Medicare to the full extent permitted by Medicare or other applicable federal law.

(c) When a Participant is eligible for, or would have been eligible for with proper request enrollment in Parts A and B of Medicare, but is not enrolled in Parts A and B of Medicare, benefits payable under the Plan will be reduced by the benefits that would have been payable had the Participant been properly enrolled in Parts A and B of Medicare.

7.9 Claims Determination Period.

Benefits will be coordinated on a calendar year basis. This is called the "claims determination period." However, the claims determination period does not include any part of a year during which a person has no coverage under the Plan, or any part of a year before the date this COB provision or a similar provision takes effect.

7.10 Reduced Benefits when the Plan Pays Second.

When the Plan pays first, the benefits of the Plan are determined before those of another plan and without considering the benefits of the other plan. When the Plan pays second, the benefits of the Plan may be reduced or denied as herein described. The benefits of the Plan will be reduced when

the sum of:

(a) The benefits that would be payable for the allowable charges under the Plan in the absence of this COB provision, and

(b) The benefits that would be payable for the allowable charges under the other benefit plans, in the absence of provisions with a purpose like that of this COB provision, whether or not claim is made,

exceeds those allowable charges in a claims determination period. In that case, the benefits of the Plan will be reduced so that the Plan's benefits and the benefits payable under the other benefit plans do not total more than those allowable charges that would be available under the Plan in the absence of this COB provision.

When the benefits of the Plan are reduced as described above, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of the Plan.

7.11 Right to Receive or Release Necessary Information.

To make this provision work, the Plan may give or obtain needed information from another insurer or any other organization or person. This information may be given or obtained without the consent of or notice to any other person; provided however, any disclosure of "protected health information", as that term is defined in Section 12.1, by the Plan will be made in accordance with Article XII herein and the requirements of HIPAA. A Participant must provide the Plan with the information it requests about other plans and their payment of allowable charges in order to be eligible for benefits (or continued benefits) under the Plan.

7.12 Facility of Payment to Other Plan.

The Plan may repay other plans for benefits paid that the Claims Fiduciary determines, in its discretion, should have been paid under the Plan. Any such repayment by the Plan will count as a valid payment under the Plan.

7.13 Right of Recovery.

The Plan may pay benefits that should be paid by another benefit plan. In this case the Plan may recover the amount paid from the other benefit plan or the Participant. That repayment will count as a valid payment under the other benefit plan. Further, the Plan may pay benefits that are later found to be greater than the allowable charge. In this case, the Plan may recover the amount of the overpayment from the source to which it was paid.

ARTICLE VIII
RIGHT OF SUBROGATION AND REIMBURSEMENT

The provisions of this Article VIII will govern and control the Plan's rights to subrogation and reimbursement with respect to a Benefit Program other than a Fully-Insured Program, and will supersede any subrogation and reimbursement provisions set forth in any Benefit Program Summary Plan Description for such Benefit Program to the extent that such other provisions are more restrictive or limited regarding the rights of the Plan than are these provisions. The Plan reserves all its

subrogation and reimbursement rights, at law and in equity, to the full extent not contrary to applicable law as determined by the Plan Administrator.

The Plan Administrator may, in its discretion, designate a third party service provider or other person or entity to exercise the rights described in this Article VIII on behalf of the Plan. In addition, the Plan Administrator may, in its discretion and on a case-by-case basis, waive or limit any of the subrogation and reimbursement rights set forth in this Article VIII on behalf of the Plan to the extent deemed appropriate. Any such waiver or limitation in a particular case will not limit or diminish in any way the Plan's rights in any other instance or at any other time.

8.1 Benefits Subject to this Provision

This Article VIII will apply to all health benefits provided under the Plan.

For purposes of this Article, certain terms are defined as follows:

(a) "**Recovery**" means any and all monies and property paid by a Third Party to (i) the Participant, (ii) the Participant's attorney, assign, legal representative, or Beneficiary, (iii) a trust of which the Participant is a beneficiary, or (iv) any other person or entity on behalf of the Participant, by way of judgment, settlement, compromise or otherwise (no matter how those monies or property may be characterized, designated or allocated and irrespective of whether a finding of fault is made as to the Third Party) to compensate for any losses or damages caused by, resulting from, or in connection with, the injury or illness.

(b) "**Reimbursement**" means repayment to the Plan for medical or other benefits that it has paid to or on behalf of the Participant toward care and treatment of the injury or illness and for the expenses incurred by the Plan in collecting this amount, including the Plan's equitable rights to recovery.

(c) "**Subrogation**" means the Plan's right to pursue the Participant's claims against a Third Party for any or all medical or other benefits or charges paid by the Plan.

(d) "**Third Party**" means any individual or entity, other than the Plan, who is or may be liable, or legally or equitably responsible, to pay expenses, compensation or damages in connection with a Participant's injury or illness.

The term "Third Party" will include the party or parties who caused the injury or illness; the insurer, guarantor or other indemnifier or indemnitor of the party or parties who caused the injury or illness; a Participant's own insurer, such as an uninsured, underinsured, medical payments, no-fault, homeowner's, renter's or any other liability insurer; a workers' compensation insurer; and any other individual or entity that is or may be liable or legally or equitably responsible for Reimbursement or payment in connection with the injury or illness.

8.2 When this Provision Applies

A Participant may incur medical or other charges related to any injury or illness caused by the act or omission of a Third Party. Consequently, such Third Party may be liable, or legally or equitably responsible, for payment of charges incurred in connection with the injury or illness. If so, the Participant may have a claim against that Third Party for payment of the medical or other charges. In that event, the Plan will be secondary payer, not primary, and the Plan will be Subrogated to all rights

the Participant may have against that Third Party.

Furthermore, the Plan will have a right of first and primary Reimbursement enforceable by an equitable lien against any Recovery paid by the Third Party. The equitable lien will be equal to 100% of the amount of benefits paid by the Plan for the Participant's injury or illness and expenses incurred by the Plan in enforcing the provisions of this Article VIII (including, without limitation, attorneys' fees and costs of suit, and without regard to the outcome of such an action), regardless of whether or not the Participant has been made whole by the Third Party. This equitable lien will attach to the Recovery regardless of whether (a) the Participant receives the Recovery or (b) the Participant's attorney, a trust of which the Participant is a beneficiary, or other person or entity receives the Recovery on behalf of the Participant. This right of Reimbursement enforceable by an equitable lien is intended to entitle the Plan to equitable relief under Section 502(a)(3) of ERISA, and will be construed accordingly.

As a condition to receiving benefits under the Plan, the Participant hereby agrees to immediately notify the Plan Administrator, in writing, of whatever benefits are payable under the Plan that arise out of any injury or illness that provides, or may provide, the Plan with Subrogation and/or Reimbursement rights under this Article VIII.

The Plan's equitable lien supersedes any right that the Participant may have to be "made whole." In other words, the Plan is entitled to the right of first Reimbursement out of any Recovery the Participant procures, or may be entitled to procure, regardless of whether the Participant has received compensation for any or all of his damages or expenses, including any of his attorneys' fees or costs. Additionally, the Plan's right of first and primary Reimbursement will not be reduced for any reason, including attorneys' fees, costs, comparative negligence, limits of collectability or responsibility, or otherwise. The Plan is not responsible for a Participant's legal fees and costs, is not required to share in any way for any payment of such fees and costs, and its equitable lien will not be reduced by any such fees and costs. As a condition to coverage and receiving benefits under the Plan, the Participant agrees that acceptance of benefits, as well as participation in the Plan, is constructive notice of the provisions of this Article VIII, and Participant hereby automatically grants an equitable lien to the Plan to be imposed upon and against all rights of Recovery with respect to Third Parties, as described above.

In addition to the foregoing, the Participant:

(a) Authorizes the Plan to sue, compromise and settle in the Participant's name to the extent of the amount of medical or other benefits paid for the injury or illness under the Plan and the expenses incurred by the Plan in collecting this amount, and assigns to the Plan the Participant's rights to Recovery when the provisions of this Article VIII apply;

(b) Must notify the Plan in writing of any proposed settlement and obtain the Plan's written consent before signing any release or agreeing to any settlement;

(c) Must cooperate fully with the Plan in its exercise of its rights under this Article VIII, do nothing that would interfere with or diminish those rights, and furnish any information as required by the Plan to exercise or enforce its rights hereunder;

(d) Authorizes the Plan to join or intervene into any action by Participant against a Third Party; and

(e) Authorizes the Plan to Bring an action to set aside any settlement agreement entered into without the written consent of the Plan Administrator.

Furthermore, the Plan Administrator reserves the absolute right and discretion to require a Participant who may have a claim against a Third Party for payment of medical or other charges that were paid, or are payable, by the Plan to execute and deliver a Subrogation and Reimbursement agreement acceptable to the Plan Administrator (including execution and delivery of a Subrogation and Reimbursement agreement by any parent or guardian on behalf of a covered Dependent, even if such Dependent is of majority age) and, subject to Section 8.5, that acknowledges and affirms: (i) the conditional nature of medical or other benefits payments which are subject to Reimbursement and (ii) the Plan's rights of full Subrogation and Reimbursement, as provided in this Article VIII ("**S&R Agreement**").

When a right of Recovery exists, and as a condition to any payment by the Plan (including payment of future benefits for the same or other illnesses or injuries), the Participant will execute and deliver all required instruments and papers, including any S&R Agreement provided by the Plan, as well as doing and providing whatever else is needed, to secure the Plan's rights of Subrogation and Reimbursement, before any medical or other benefits will be paid by the Plan for the injury or illness. The Plan may file a copy of an S&R Agreement signed by the Participant and his attorney (and if applicable, signed by the parent or guardian on behalf of the covered Dependent) with such other entities, or the Plan may notify any other parties of the existence of Plan's equitable lien; provided, the Plan's rights will not be diminished if it fails to do so.

To the extent the Plan requires execution of an S&R Agreement by a Participant (and his attorney, as applicable), a Participant's claim for any medical or other benefits for any injury or illness will be incomplete until an executed S&R Agreement is submitted to the Plan Administrator. Such S&R Agreement must be submitted to the Plan Administrator within the timeframe applicable to the particular type of benefits claimed by the Participant, as specified in the Plan's claims procedures. Any failure to timely submit the required S&R Agreement in accordance with the Plan's claims procedures will constitute the basis for denial of the Participant's claim for benefits for the injury or illness, and will be subject to the Plan's claims appeal procedures.

The Plan Administrator may determine, in its sole discretion, that it is in the Plan's best interests to pay medical or other benefits for the injury or illness before an S&R Agreement and other papers are signed and actions taken (for example, to obtain a prompt payment discount); however, in that event, any payment by the Plan of such benefits prior to or without obtaining a signed S&R Agreement or other papers will not operate as a waiver of any of the Plan's Subrogation and Reimbursement rights and the Plan still will be entitled to Subrogation and Reimbursement. In addition, the Participant will do nothing to prejudice the Plan's right to Subrogation and Reimbursement, and hereby acknowledges that participation in the Plan precludes operation of the "made-whole" and "common-fund" doctrines. A Participant who receives any Recovery has an absolute obligation to immediately tender the Recovery (to the extent of 100% of the amount of benefits paid by the Plan for the Participant's injury or illness and expenses incurred by the Plan in enforcing the provisions of this Article VIII, including attorneys' fees and costs of suit, regardless of an action's outcome) to the Plan under the terms of this Article VIII. A Participant who receives any such Recovery and does not immediately tender the Recovery to the Plan will be deemed to hold such Recovery in constructive trust for the Plan because the Participant is not the rightful owner of such Recovery to the extent the Plan has not been fully reimbursed. By participating in the Plan, or

receiving benefits under the Plan, the Participant automatically agrees, without further notice, to all the terms and conditions of this Article VIII and any S&R Agreement.

The Plan Administrator has maximum discretion to interpret the terms of this Article VIII and to make changes in its interpretation as it deems necessary or appropriate.

8.3 Amount Subject to Subrogation or Reimbursement

Any amounts Recovered will be subject to Subrogation or Reimbursement, even if the payment the Participant receives is for, or is described as being for, damages other than medical expenses or other benefits paid, provided or covered by the Plan. This means that any Recovery will be automatically deemed to first cover the Reimbursement, and will not be allocated to or designated as reimbursement for any other costs or damages the Participant may have incurred, until the Plan is reimbursed in full and otherwise made whole. In no case will the amount subject to Subrogation or Reimbursement exceed the amount of medical or other benefits paid for the injury or illness under the Plan and the expenses incurred by the Plan in collecting this amount. The Plan has a right to recover in full, without reduction for attorneys' fees, costs, comparative negligence, limits of collectability or responsibility, or otherwise, even if the Participant does not receive full compensation for all of his charges and expenses.

8.4 When Recovery Includes the Cost of Past or Future Expenses

In certain circumstances, a Participant may receive a Recovery that includes amounts intended to be compensation for past and/or future expenses for treatment of the illness or injury that is the subject of the Recovery. The Plan will not cover any expenses for which compensation was provided through a previous Recovery. This exclusion will apply to the full extent of such Recovery or the amount of the expenses submitted to the Plan for payment, whichever is less. Participation in the Plan also precludes operation of the "made-whole" and "common-fund" doctrines in applying the provisions of this Article VIII.

It is the responsibility of the Participant to inform the Plan Administrator when expenses incurred are related to an illness or injury for which a Recovery has been made. Acceptance of benefits under the Plan for which the Participant has already received a Recovery will be considered fraud, and the Participant will be subject to any sanctions determined by the Plan Administrator, in its sole discretion, to be appropriate. The Participant is required to submit full and complete documentation of any such Recovery in order for the Plan to consider eligible expenses that exceed the Recovery.

8.5 When a Participant Retains an Attorney

If the Participant retains an attorney, the Plan will not pay any portion of the Participant's attorneys' fees and costs associated with the Recovery, nor will it reduce its Reimbursement pro-rata for the payment of the Participant's attorneys' fees and costs. Attorneys' fees will be payable from the Recovery only after the Plan has received full Reimbursement.

The Plan Administrator reserves the absolute right and discretion to require the Participant's attorney to sign an S&R Agreement as a condition to any payment of benefits under the Plan and as a condition to any payment of future Plan benefits for the same or other illnesses or injuries. Additionally, pursuant to such S&R Agreement, the Participant's attorney must acknowledge and consent to the fact that the "made-whole" and "common fund" doctrines are inoperable under the

Plan, and the attorney must agree not to assert either doctrine in his pursuit of Recovery.

Any Recovery paid to the Participant's attorney will be subject to the Plan's equitable lien, and thus an attorney who receives any Recovery has an absolute obligation to immediately tender the Recovery (to the extent of 100% of the amount paid by the Plan for the Participant's injury or illness and expenses incurred by the Plan in enforcing the provisions of this Article VIII, including attorneys' fees and costs of suit regardless of an action's outcome) to the Plan under the terms of this Article VIII. A Participant's attorney who receives any such Recovery and does not immediately tender the recovery to the Plan will be deemed to hold the Recovery in constructive trust for the Plan because neither the Participant nor his attorney is the rightful owner of the Recovery to the extent the Plan has not received full Reimbursement.

8.6 When the Participant is a Minor, is Deceased, is a COBRA Qualified Beneficiary or is a Dependent

The provisions of this Article VIII apply to the parents, trustee, guardian or other representatives of a minor Participant and to the heirs or personal representatives of the estate of a deceased Participant, regardless of applicable law and whether or not the representative has access to or control of the Recovery. For purposes of this Article VIII, the term "Participant" will also include a COBRA Qualified Beneficiary (as defined in Section 11.11) who has elected COBRA Continuation Coverage under the Plan and a Domestic Partner or Domestic Partner's child who has elected Partner Continuation Coverage, pursuant to Section 11.14, under the Plan. If a covered Dependent is the Participant whose benefits under the Plan are subject to the Plan's Subrogation and Reimbursement rights, the covered Employee who enrolled such Dependent under the Plan will also be required to execute the S&R Agreement, upon request, even if the Dependent is not a minor, and, in such event, the Employee will be liable for any breach of this Article VIII by the Employee or such Dependent.

8.7 When a Participant Does Not Comply

When a Participant does not comply with the provisions of this Article VIII, the Plan Administrator will have the power and authority, in its sole discretion, to (i) deny payment of any claims for benefits by or on behalf of the Participant and (ii) deny or reduce future benefits payable (including payment of future benefits for the same or other injuries or illnesses) under the Plan by the amount due as Reimbursement to the Plan. The Plan Administrator may also, in its sole discretion, deny or reduce future benefits (including future benefits for the same or other injuries or illnesses) under any other group benefits plan maintained by the Plan Sponsor. The reductions will equal the amount of the required Reimbursement. If the Plan must bring an action against a Participant to enforce the provisions of this Article VIII, the Participant will be obligated to pay the Plan's attorneys' fees and costs regardless of the action's outcome.

ARTICLE IX
AMENDMENT OR TERMINATION

The provisions of this Article IX will govern and control amendment and termination of the Plan, and will supersede any conflicting or inconsistent provisions set forth in a Benefit Program Summary Plan Description.

9.1 Right to Amend.

The Board of Directors, the Executive Vice President, Human Resources, of the Plan Sponsor ("***EVPHR***") (or the successor to such position) and any officer of the Plan Sponsor who is duly authorized by the Board of Directors for this purpose will each have the right, authority and power to make, at any time, any amendment to the Plan. Notwithstanding the previous sentence, the Employee Benefits Committee shall have the right, authority and power to approve, adopt, and execute any amendment to the Plan that (i) is required by applicable law, or (ii) does not have a significant impact on the cost of the Plan or significantly decrease benefits provided under the Plan, as determined in good faith and with the certification of an actuary if necessary.

No amendment will retroactively prejudice any claim for benefits under the Plan that was incurred but not paid prior to the date of the amendment, unless the person or entity responsible for the amendment, as applicable, determines that such amendment is necessary or desirable to comply with applicable law or is required under the particular Benefit Program. Moreover, if the Plan is amended, a Participant's right to receive coverage for expenses incurred for supplies or services that were actually received or actually rendered on his behalf before the date of such amendment will not be reduced or eliminated. However, an amendment may reduce or eliminate a Participant's right to receive coverage for expenses that are or will be incurred for supplies or services that are received or rendered on or after the date of the amendment, even if such supplies or services were approved or are part of a series of treatments or services that began prior to such date.

9.2 Right to Terminate.

The Board of Directors and the EVPHR (or the successor to such position) will each have the right, authority, power, and discretion to terminate the Plan at any time, in whole or in part, without prior notice, to the extent deemed advisable in its or his discretion; provided, however, such termination will not prejudice any claim under the Plan that was incurred but not paid prior to the termination date unless the Board of Directors or EVPHR, as applicable, determines it is necessary or desirable to comply with applicable law.

The Board of Directors or the EVPHR may, in its or his discretion, terminate the participation of any Employer, with respect to its Employees and Retirees only, in the Plan, effective as of any date such person or entity deems advisable. The Plan Sponsor may revise Appendix A, as needed, to reflect the termination of an Employer from participation in the Plan, without regard to the formal amendment provisions of the Plan.

ARTICLE X
ADMINISTRATION

10.1 Controlling Provisions.

The provisions of this Article X will govern and control with respect to the subject matter herein, and will supersede any conflicting or inconsistent provisions set forth in a Benefit Program Summary Plan Description regarding such subject matter, except as specifically stated otherwise in this Article X. This determination will be made by the Plan Administrator.

10.2 Employee Benefits Committee.

The Employee Benefits Committee shall be the "Plan Administrator". Subject to Section 10.5,

the day-to-day administration of the Plan shall be the responsibility of the Employee Benefits Committee. The Employee Benefits Committee may be reimbursed for proper expenditures incurred during the course of performance of duties hereunder in accordance with applicable law. The Employee Benefits Committee shall be subject to such duties and procedures as may be designated by the Plan Sponsor pursuant to a separate instrument.

10.3 Allocation of Authority.

The Plan Administrator will control and manage the operation and administration of the Plan, except to the extent such duties have been delegated to other persons or entities as provided in the Wrap-Plan, this Wrap-SPD or a Benefit Program Summary Plan Description. Any decisions made by the Plan Administrator or Claims Fiduciary (or any other person or entity delegated authority by the Plan Administrator or Claims Fiduciary, as applicable, to determine benefits in accordance with the Plan) will be final and conclusive on all Participants, Payees and all other persons and entities, subject only to the claims appeal procedures of the Plan. Neither the Plan Administrator nor any Employee will receive any compensation with respect to services provided under the Plan, except as an Employee may be entitled to benefits hereunder.

10.4 Powers and Duties of Plan Administrator.

The Plan Administrator (and the Claims Fiduciary, but only with respect to reviewing and making decisions regarding claims under a Benefit Program) will each have such powers as may be necessary to discharge its duties hereunder, including, but not by way of limitation, the following:

(a) to have final discretionary authority to (i) administer, enforce, construe, and construct the Plan, including the Benefit Program Summary Plan Description documents, (ii) make decisions relating to all questions of eligibility to participate, (iii) make determinations of benefits, and (iv) reconcile any inconsistency, correct any defect, supply any omission and make all findings of fact, including, without limitation, in cases where such the exercise of such authority may impact eligibility or a claim for benefits;

(b) to prescribe procedures to be followed by Participants filing application for benefits;

(c) to prepare and distribute, in such manner as the Plan Administrator determines to be appropriate, any information that explains the Plan and benefits thereunder;

(d) to receive from the Employer and from Participants such information as necessary for the proper administration of the Plan;

(e) to furnish the Employer and the Participants such annual reports with respect to the administration of the Plan as necessary;

(f) to receive, review and keep on file (as it deems necessary) reports of benefit payments by the Employer and reports of disbursements for expenses;

(g) to exercise such authority and responsibility as it deems appropriate in order to comply with the terms of the Plan relating to the records of Participants, including an examination at the Employer's expense of the records of the Plan to be made by such attorneys, accountants, auditors or other agents as it may select, in its discretion, for that purpose; and

(h) to appoint persons or entities to assist in the administration as it deems advisable; and the Plan Administrator may delegate thereto any power or duty imposed upon or granted to it under the Plan.

If, due to errors in drafting, any Plan provision does not accurately reflect its intended meaning, as demonstrated by prior interpretations or other evidence of intent, or as determined by the Plan Administrator in its sole and exclusive judgment, the provision will be considered ambiguous and will be interpreted by the Plan Administrator (or the Claims Fiduciary) in a fashion consistent with its intent, as determined by the Plan Administrator (or the Claims Fiduciary). The Plan may be amended retroactively to cure any such ambiguity, notwithstanding anything in the Plan to the contrary.

The Plan Administrator (or Claims Fiduciary) may rely upon the direction or information from a Participant relating to such Participant's entitlement to benefits hereunder as being proper under the Plan, and will not be responsible for any act or failure to act. Neither the Plan Administrator nor the Employer makes any guarantee to any Employee or Retiree in any manner for any loss that may result because of the Employee's or Retiree's participation in the Plan.

All decisions, interpretations, determinations and actions in the exercise of the powers, authority and duties described in this Section will be final and conclusive on all persons and entities subject only to the claims appeal procedures of the Plan. Benefits under the Plan will be paid only if the Plan Administrator (or Claims Fiduciary) determines in its discretion that the Participant is entitled to them. There will be no *de novo* review of any such decision, interpretation, determination, finding or action by any court. Any review of any such decision, interpretation, determination, finding or action will be limited to determining whether the decision, interpretation, determination, finding or action in question was so arbitrary and capricious as to be an abuse of discretion under ERISA standards.

10.5 Delegation by the Plan Administrator.

The Plan Administrator may delegate to other persons or entities any of the administrative functions relating to the Plan, together with all powers necessary to enable its designee(s) to properly carry out such duties hereunder, including, without limitation, delegation to the Claims Administrator, the Claims Fiduciary and the Disclosure Administrator. The Plan Administrator may employ such counsel, accountants, Claims Administrators, Claims Fiduciaries, consultants, actuaries and such other persons or entities as it deems advisable in its discretion. The Plan Administrator, as well as any person to whom any duty or power in connection with the operation of the Plan is delegated, may rely upon all valuations, reports, and opinions furnished by any accountant, consultant, third-party administration service provider, legal counsel, or other specialist. Moreover, the Plan Administrator or such delegate who is also an Employee will be fully protected in respect to any action taken or permitted in good faith in reliance on such information.

10.6 Disclosure Responsibility.

(a) *General.* The Disclosure Administrator shall, in response to a written request by a Participant or Beneficiary, furnish a copy of the documents and instruments specified in Section 104(b)(4) of ERISA ("***Plan Disclosures***") as required by ERISA. A Participant's or Beneficiary's request for Plan Disclosures must be submitted to the Disclosure Administrator in writing, at the

address listed in Article XIV, and must identify the particular Plan Disclosures that are being requested. The Disclosure Administrator may, in its discretion, impose a reasonable charge to cover the cost of copying and furnishing the requested Plan Disclosures to the extent permitted by ERISA.

(b) *Requests by an Authorized Representative*. A request for Plan Disclosures may be submitted to the Disclosure Administrator by an authorized representative of the Participant or Beneficiary, provided that (i) the authorization of such representative is designated in writing by the Participant or Beneficiary in a manner that is sufficiently clear and conspicuous, as determined by the Disclosure Administrator in its discretion, to enable the Disclosure Administrator to reasonably verify the status of the authorized representative and the scope of such authorization, and (ii) a copy of the signed authorization is submitted to the Disclosure Administrator with the request for Plan Disclosures. The Disclosure Administrator will not make any Plan Disclosures to a person or entity claiming to be an authorized representative prior to receipt of an authorization that meets the criteria in clauses (i) and (ii), as determined by the Disclosure Administrator. The Disclosure Administrator may disregard any designation of an authorized representative that it deems to be defective or otherwise improper or invalid hereunder. In particular, and without limitation, the Disclosure Administrator reserves the right and discretion to refuse to honor a Participant's or Beneficiary's designation of an authorized representative if the Disclosure Administrator determines that such designation is fraudulent; such as, for example, when the Disclosure Administrator determines that the signature of approval on the designation does not belong to the Participant or Beneficiary.

(c) *Examination of Records*. Participants and Beneficiaries shall have the right to examine such records, documents and other data as required by ERISA at reasonable times during regular business hours. Nothing contained in the Plan shall give any Participant the right to examine any data or records with respect to any other Participant except as required by applicable law which cannot be waived.

10.7 Rules and Decisions.

The Plan Administrator may adopt such rules and procedures, as it deems necessary or appropriate for the proper administration of the Plan. The Plan Administrator will be entitled to rely upon information furnished to it which appears proper without the necessity of any independent verification or investigation.

10.8 Facility of Payment for Incapacitated Participant.

Except as otherwise provided under the terms of a Fully-Insured Program, whenever, in the Claims Fiduciary's opinion, a Participant is entitled to receive any payment of a benefit hereunder and is under a legal disability or is incapacitated in any way so as to be unable to manage his own financial affairs (including physical and mental incompetence or status as a minor), the Claims Fiduciary may direct payments to such person or to the person's legal representative (such as a guardian or conservator, upon proper proof of appointment furnished to the Claims Fiduciary), Dependent, or relative of such person for such person's benefit, or the Claims Fiduciary may direct payment for the benefit of such person in such manner as the Claims Fiduciary considers advisable in its discretion. Any payment of a benefit, to the full extent thereof, in accordance with the provisions of this Section 10.7 will be a complete discharge of any liability for the making of such payment under the

Plan.

10.9 Assignment and Payment of Benefits.

Except with respect to a Fully-Insured Program, the provisions of this Section 10.9 shall supersede any provisions of a Benefit Program Summary Plan Description regarding the subject matter hereof and shall govern and control.

Except as otherwise expressly provided under the terms of a written agreement with a provider of healthcare services or supplies to which the Plan Administrator, the Claims Fiduciary, or other delegate of the Plan Administrator is a named party (a "***Plan Agreement***"), no rights, causes of action and benefits under the Plan can be assigned or transferred to any person or entity, including, but not limited to, an out-of-network healthcare provider (or any representative or agent with respect to such provider), either before or after healthcare services or supplies are provided to, or on behalf of, a Participant. For purposes of clarification and not limitation, such rights and causes of action shall include any administrative, statutory, or legal right or cause of action that a Participant or other individual may have under ERISA, including, but not limited to, any right to (a) make a claim for Plan benefits, (b) request the Plan document or other documents related to the Plan or a claim for benefits, (c) file an appeal of a denied claim for Plan benefits, or (d) file a lawsuit under ERISA or other applicable law.

In the absence of a Plan Agreement which specifically provides for assignment of the Participant's benefits and/or rights under the Plan (*i.e.*, is not merely an agreement between the Participant and the health care provider or its representative or agent), the Plan Administrator and Claims Fiduciary, as applicable, each reserve the unilateral right and discretion to elect to make any benefit payment under the Plan directly to the health care provider, the Participant, or to another designated person or entity, with or without the Participant's authorization, with each such payment being made on behalf of the Participant, and not to such payment recipient in its, his or her own right. Moreover, if the Plan Administrator or Claims Fiduciary, as applicable, elects to make any such direct payment, it shall not constitute a waiver by the Plan Administrator or Claims Fiduciary of the anti-assignment provisions of this Section 10.9. In addition, any payment made under the Plan to any such person or entity discharges the Plan's responsibility to the Participant for benefits under the Plan to the full extent of such payment. Accordingly, if a provider is overpaid as the result of accepting a payment for the same covered service from the Participant and from the Plan, the provider, and not the Plan, shall be responsible for reimbursing the Participant for such overpayment.

Disclosures of information about the Participant can only be made to a Participant or a Participant's authorized representative in accordance with applicable law and the terms of the Plan.

10.10 Overpayments.

If, for any reason, any benefit, premium or fee under the Plan is erroneously paid or reimbursed by the Plan Administrator, Claims Fiduciary or other person or entity to a Participant or to an insurance company, a healthcare or other services provider (including an assignee of the Participant as described in Section 10.9), or other person or entity for the benefit of a Participant (collectively, a "***Third-Party Payee***"), such erroneously-paid amount shall constitute an "***Overpayment***" under the Plan, with respect to which the Plan shall have a right of first and primary reimbursement from such Participant or Third-Party Payee that is enforceable by an equitable lien equal to 100% of the Overpayment amount ("***Overpayment Reimbursement***"). Without limitation, the

Plan's right to Overpayment Reimbursement is intended to entitle the Plan to equitable relief under Section 502(a)(3) of ERISA and shall be construed accordingly. By accepting a benefit, premium or fee under the Plan, each Participant and Third-Party Payee automatically acknowledges and agrees that the Plan has the right to pursue Overpayment Reimbursement from the general assets of the Participant or Third-Party Payee to whom the Overpayment was made, to the full extent permitted by ERISA.

If such Overpayment is not refunded to the Plan within a reasonable time period as determined by the Plan Administrator or Claims Fiduciary, the Overpayment shall be (a) charged directly to the Participant (including, without limitation, to a covered Employee on behalf of any of his or her Dependents or Beneficiaries) or to a Third-Party Payee as a reduction of the amount of future benefits otherwise payable by the Plan on behalf of the Participant, or (b) recouped by any other method which the Plan Administrator or Claims Fiduciary, as applicable, deems to be appropriate in its discretion, to the extent permitted by applicable law. For example, the selected repayment method may include, without limitation, (i) payroll deduction in the case of an Employee or his Dependent or Beneficiary (in which case the Employee must execute such forms authorizing payroll deduction as the Plan Administrator shall require as a mandatory condition of his participation, or continued participation, in the Plan), or (ii) offsetting other payments made by the Plan to the Participant or to the same Third-Party Payee on the Participant's behalf, as permitted by applicable law (in which case, such payment offset to a Third-Party Payee shall not constitute an adverse benefit determination that is subject to the ERISA claims and appeals procedures of the Plan). For purposes of clarity and not limitation, in the event of the application of any Overpayment Reimbursement to a Third-Party Payee pursuant to the foregoing provisions of this Section 10.10, the offset of the Overpayment hereunder is simply an adjustment to the amount payable to the Third-Party Payee to reflect the Overpayment and shall not be considered to be the denial or partial denial of any benefit claim under the Plan.

ARTICLE XI
COBRA CONTINUATION COVERAGE

11.1 Continuation of Benefits under COBRA.

Qualified Beneficiaries will have all continuation rights required by COBRA for group health plan benefits offered under the Benefit Programs within the Plan. To the extent a Benefit Program offering health benefits does not specify COBRA rights in accordance with Code Section 4980B, the Plan will be administered in accordance with Code Section 4980B and as set forth in this Article XI. In addition, the Plan Administrator will adopt such policies and provide such forms, as it deems advisable to implement the rights contemplated by this Section 11.1.

11.2 Election of COBRA Coverage.

(a) *COBRA Continuation Coverage for Terminated Employees.*

A Qualified Beneficiary who is a Covered Employee may elect COBRA Continuation Coverage, at his own expense, if his participation under the Plan would terminate as a result of either of the following Qualifying Events: termination of employment (other than for gross misconduct) or reduction of hours of employment with the Employer.

(b) *COBRA Continuation Coverage for Qualifying Dependent.*

Subject to Section 11.5, a Qualified Beneficiary who is a Qualifying Dependent of a Covered Employee may elect COBRA Continuation Coverage, at his own expense, if:

(i) his participation under the Plan would terminate as a result of a Qualifying Event; or

(ii) the Qualifying Dependent is a child born to, adopted or placed for adoption with the Covered Employee during the Covered Employee's period of COBRA Continuation Coverage.

(c) *Enrollment for COBRA Continuation Coverage.*

A Qualified Beneficiary (or a third party on behalf of the Qualified Beneficiary) must complete and return the required enrollment materials within a maximum of sixty (60) days from the later of:

(i) loss of coverage; or

(ii) the date the Plan Administrator sends notice of eligibility for COBRA Continuation Coverage.

Failure to enroll for COBRA Continuation Coverage during this maximum sixty (60) day period will terminate all rights to COBRA Continuation Coverage under this Article XI. A separate election as to what health coverage, if any, is desired may be made by or on behalf of each Qualified Beneficiary. However, an affirmative election of COBRA Continuation Coverage by a Covered Employee or his Spouse will be deemed to be an election for that Covered Employee's Qualifying Dependents who would otherwise lose coverage under the Plan, unless the election specifically provides to the contrary. Elections for COBRA Continuation Coverage may be made by the Qualified Beneficiary or on his behalf by a third party (including a third party that is not a Qualified Beneficiary).

COBRA Continuation Coverage for a Qualified Beneficiary that is a child who is born to, adopted by or placed for adoption with a Covered Employee begins when the child is enrolled in the Plan, whether through special enrollment or open enrollment.

If, during the election period, a Qualified Beneficiary waives COBRA Continuation Coverage, the waiver can be revoked at any time before the end of the election period. Revocation of the waiver is an election of COBRA Continuation Coverage. However, if a waiver is later revoked, coverage will not be provided retroactively (that is, from the date of the loss of coverage until the waiver is revoked). Waivers and revocations of waivers are considered made on the date they are sent to the third-party administrator that performs services on behalf of the Plan Administrator as the Plan's "COBRA Administrator", at the address listed in Section 11.12.

11.3 Period of COBRA Coverage.

A Qualified Beneficiary who qualifies for COBRA Continuation Coverage as a result of termination of employment (other than for gross misconduct) or reduction in hours of employment, may elect COBRA Continuation Coverage for up to eighteen (18) months measured from the date of the Qualifying Event. A Qualified Beneficiary who is a Covered Employee who is eligible for COBRA

Continuation Coverage due to the bankruptcy of the Employer may continue COBRA Continuation Coverage until the date of the Covered Employee's death. A Qualified Beneficiary who is a Qualifying Dependent may continue COBRA Continuation Coverage (a) for up to thirty-six (36) months from the date of the Qualifying Event, or (b) if the Qualifying Event is the bankruptcy of the Employer, until the earlier of (i) the date of the Qualified Beneficiary's death or (ii) thirty-six (36) months from the date of the Covered Employee's death.

Coverage under this Section 11.3 may not continue beyond:

(a) the date on which the Employer ceases to maintain a group health plan within its controlled group;

(b) the last day of the month for which premium payments have been made, if the individual fails to make premium payments on time, in accordance with Section 11.4;

(c) the date the Qualified Beneficiary, after the date he or she elects COBRA Continuation Coverage, first becomes enrolled in Medicare;

(d) the date the Qualified Beneficiary, after the date he or she elects COBRA Continuation Coverage, first becomes covered under another group health plan and is no longer subjected, due to changes in the law or otherwise, to a pre-existing condition exclusion or limitation under the Qualified Beneficiary's other coverage or new employer plan; or

(e) in the case of a disabled Qualified Beneficiary (and his disabled or non-disabled family members) receiving COBRA Continuation Coverage under the eleven (11) month extended coverage described in Section 11.6, and with respect to such extended coverage, the first day of the month that begins more than thirty (30) days after the date the Qualified Beneficiary is determined by the Social Security Administration to no longer be "disabled" within the meaning of the Social Security Act.

The Plan can terminate for cause the coverage of a Qualified Beneficiary on the same basis that the Plan terminates for cause the coverage of Similarly Situated Beneficiaries, for example, for the submission of a fraudulent claim.

In the case of a Qualified Beneficiary who is a child born to, adopted by or placed for adoption with a Covered Employee during a period of COBRA Continuation Coverage, the maximum period of COBRA Continuation Coverage is the maximum period applicable to the Qualifying Event giving rise to the period of COBRA Continuation Coverage during which the child was born or placed for adoption.

In the case of an individual who is not a Qualified Beneficiary and who is receiving coverage under the Plan solely because of the individual's relationship to a Qualified Beneficiary, if the Plan's obligation to make COBRA Continuation Coverage available to the Qualified Beneficiary ceases, the Plan is not obligated to make coverage available to the individual who is not a Qualified Beneficiary.

11.4 Contribution Requirements for COBRA Coverage.

Qualified Beneficiaries who elect COBRA Continuation Coverage as a result of a Qualifying Event (or third parties on behalf of a Qualified Beneficiary) will be required to pay Continuation Coverage Contributions. Qualified Beneficiaries (or third parties on behalf of a Qualified Beneficiary)

must make the Continuation Coverage Contributions monthly on or prior to the first day of the month of such coverage. However, a Qualified Beneficiary has forty-five (45) days from the date of an affirmative election to pay the Continuation Coverage Contributions for the first month plus the cost for the period between the date health coverage would otherwise have terminated due to the Qualifying Event and the date the Qualified Beneficiary actually elects COBRA Continuation Coverage. If the Qualified Beneficiary fails to make the Continuation Coverage Contribution for the first month's premium, coverage will either terminate or will be retroactively cancelled.

The Qualified Beneficiary will have a thirty (30) day grace period from the due date (the first of each month) to make the Continuation Coverage Contributions due for such month. Continuation Coverage Contributions must be postmarked on or before the end of the thirty (30) day grace period.

If Continuation Coverage Contributions are not made on a timely basis, COBRA Continuation Coverage will terminate as of the last day of the month for which such premiums were made on a timely basis. The thirty (30) day grace period will not apply to the forty-five (45) day period for payment of COBRA premiums as applicable to initial elections.

Except as provided in Section 11.6, the Continuation Coverage Contribution will be one hundred percent (100%) of the cost of coverage plus a two percent (2%) administrative fee for a total contribution of one hundred two percent (102%) of the cost of coverage.

If timely payment of the Continuation Coverage Contribution is made to the Plan in an amount that is not significantly less than the amount due for a period of coverage, then the amount paid is deemed to satisfy the Plan's requirement for the amount that must be paid for Continuation Coverage Contribution, unless the Plan notifies the Qualified Beneficiary of the amount of the deficiency and grants a reasonable period of time (thirty (30) days) for payment of the deficiency to be made. For purposes of this Section 11.4, an amount not significantly less than the amount the Plan requires to be paid will be defined as the lesser of fifty dollars ($50) or ten percent (10%) of the required payment amount.

11.5 Limitation on Qualified Beneficiary's Rights to COBRA Coverage.

If a Qualified Beneficiary loses, or will lose, health coverage under the Plan as a result of a Qualifying Event that is a divorce, legal separation or ceasing to be a Dependent, such Qualified Beneficiary or the Covered Employee (or a representative of either) must notify the Plan Administrator, as described in Section 11.12, within a maximum of sixty (60) days after the latest of (a) the Qualifying Event, (b) the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event, or (c) the date on which the Qualified Beneficiary is informed, including through the Summary Plan Description or a COBRA general notice, of his responsibility to provide a Qualifying Event notice as described in this Section 11.5 and the Plan's procedures for providing such notice. Failure to make timely notification will result in a termination of the Qualified Beneficiary's rights to COBRA Continuation Coverage under this Article XI.

A Qualified Beneficiary must notify the Plan Administrator, as described in Section 11.12, of the birth to, adoption by or placement for adoption of a child with a Covered Employee receiving COBRA Continuation Coverage.

For all other Qualifying Events (including when the Qualifying Event is the end of employment, the death of a Covered Employee, commencement of a proceeding in bankruptcy with

respect to the Employer, a Covered Employee's entitlement to Medicare (Part A, Part B, or both)), the Employer must notify the Plan Administrator of the Qualifying Event. The notice must be provided within a maximum of thirty (30) days after the Qualifying Event.

11.6 Extension of COBRA Coverage Period.

A Qualified Beneficiary or the Covered Employee (or a representative of either) must notify the Plan Administrator, as described in Section 11.12, if a second Qualifying Event occurs while the Qualified Beneficiary is receiving COBRA Continuation Coverage. The Qualified Beneficiary must notify the Plan Administrator within a maximum of sixty (60) days after the latest of (a) the second Qualifying Event, (b) the date the Qualified Beneficiary would lose coverage on account of the second Qualifying Event, or (c) the date on which the Qualified Beneficiary is informed, including through the Summary Plan Description or a COBRA general notice, of his responsibility to provide a notice of a second Qualifying Event and the Plan's procedures for providing such notice.

If a second Qualifying Event that is not a termination of employment or reduction in hours occurs during an eighteen (18) month period of COBRA Continuation Coverage explained in Section 11.3 (or twenty-nine (29) month period, if extended due to disability), coverage may be extended to a maximum of thirty-six (36) months from the date of the first Qualifying Event for the affected Qualifying Dependent. Coverage will be extended, however, only if the second Qualifying Event would have caused the Qualifying Dependent to lose coverage under the Plan in the absence of the first Qualifying Event. Any such extension of COBRA Continuation Coverage applies only to Qualifying Dependents. Therefore, such extension would apply to a child adopted or placed for adoption with a Qualified Beneficiary, but would not apply to a spouse who was added to a Qualified Beneficiary's COBRA Continuation Coverage as a result of the Qualified Beneficiary's becoming married after commencement of the initial eighteen (18) month continuation period.

The maximum COBRA Continuation Coverage Period is extended up to eleven (11) months for Qualified Beneficiaries (and their disabled or non-disabled family members receiving COBRA Continuation Coverage due to the same Qualifying Event) for up to twenty-nine (29) months in total (measured from the date of the Qualifying Event), provided the following requirements are met:

(a) the Social Security Administration ("***SSA***") determines that the Qualified Beneficiary was "disabled" on the date of the Qualifying Event or within the first sixty (60) days of COBRA Continuation Coverage following the Qualifying Event, and

(b) the Qualified Beneficiary or the Covered Employee (or a representative of either) provides notice to the Plan Administrator, as described in Section 11.12, of such SSA determination:

(i) within sixty (60) days after the latest of (A) the date of the SSA determination, (B) the date on which the Qualifying Event occurred, (C) the date on which the Qualified Beneficiary loses coverage due to the Qualifying Event, or (D) the date on which the Qualified Beneficiary is informed, including through the Summary Plan Description or a COBRA general notice, of the obligation to provide the disability notice and the Plan's procedures for providing such notice; but

(ii) not later than the last day of the initial eighteen (18) month period of COBRA Continuation Coverage.

In such event, the Continuation Coverage Contribution will be one hundred fifty percent (150%) of the cost of coverage for the nineteenth (19th) through twenty-ninth (29th) months of COBRA Continuation Coverage.

However, if a Qualified Beneficiary who meets the above requirements receives a final determination from the SSA that he is no longer disabled, said beneficiary or the Covered Employee (or a representative of either) must notify the Plan Administrator, as described in Section 11.12, within thirty (30) days after the later of (a) the date of that determination or (b) the date on which the Qualified Beneficiary is informed, including through the Summary Plan Description or a COBRA general notice, of the obligation to provide the end-of-disability notice and the Plan's procedures for providing such notice. Such a final determination by the SSA will end the disability extension of COBRA Continuation Coverage for all Qualified Beneficiaries as of the later of either: (i) the first day of the month following thirty days (30) from the final determination date; or (ii) the end of the COBRA Continuation Coverage period without regard to the disability extension.

11.7 Responses to Inquiry Regarding Qualified Beneficiary's Right to Coverage.

If a provider of health care (such as a physician, hospital, or pharmacy) contacts the Plan to confirm coverage of a Qualified Beneficiary during the election period, the Plan will give a complete response to the health care provider about the Qualified Beneficiary's COBRA Continuation Coverage rights during the election period, and his right to retroactive coverage if COBRA is elected. If a provider of health care (such as a physician, a hospital or pharmacy) contacts the Plan to confirm coverage of a Qualified Beneficiary with respect to whom the required payment has not been made for the current period, but for whom any applicable grace period has not expired, the Plan will inform the health care provider of all of the details of the Qualified Beneficiary's right to pay for such coverage during the applicable grace period.

11.8 Coordination of Benefits - Medicare and COBRA.

For purposes of this Article XI, "Medicare Entitlement" means being entitled to Medicare due to either (a) enrollment (automatically or otherwise) in Medicare Parts A or B, or (b) being medically determined to have end-stage renal disease ("**ESRD**") and (i) having applied for Medicare Part A, (ii) having satisfied any waiting period requirement and (iii) being either (A) insured under Social Security, (B) entitled to retirement benefits under Social Security or (C) a spouse or dependent of a person satisfying either (A) or (B). Such Medicare Entitlement is a COBRA terminating event.

If a Covered Employee has a Qualifying Event due to his termination of employment or reduction in work hours, and such Qualifying Event occurs less than eighteen (18) months after the date the Covered Employee became entitled to Medicare, the maximum period of COBRA Continuation Coverage for the Covered Employee's Qualifying Dependents will be extended to the last day of the thirty-six (36) month period measured from the date the Covered Employee became entitled to Medicare, while the maximum period of COBRA Continuation Coverage for the Covered Employee is eighteen (18) months from the Qualifying Event.

If a Covered Employee has a Qualifying Event due to his termination of employment or reduction in work hours and, after the Covered Employee has elected COBRA Continuation Coverage and during the first eighteen (18) months of COBRA Continuation Coverage (or twenty-nine (29) months if extended due to disability), the Covered Employee first becomes entitled to Medicare, the Covered Employee's COBRA Continuation Coverage will end, and the maximum period of COBRA

Continuation Coverage for his Qualified Dependents who were Qualified Beneficiaries and elected COBRA Continuation Coverage will be extended to the last day of the thirty-six (36) month period measured from the date of the Qualifying Event. Coverage will be extended, however, only if the Covered Employee's Medicare entitlement would have caused such Qualifying Dependents to lose coverage under the Plan in the absence of the Qualifying Event. The Covered Employee or Qualifying Dependent (or a representative of either) must provide notice to the Plan Administrator, as described in Section 11.12, of the Covered Employee's Medicare entitlement within a maximum of sixty (60) days after the latest of (a) the date of Medicare entitlement, (b) the date the Qualified Beneficiary would lose coverage on account of the Medicare Entitlement, or (c) the date on which the Qualified Beneficiary is informed, including through the Summary Plan Description or a COBRA general notice, of the responsibility to provide a notice of Medicare entitlement and the Plan's procedures for providing such notice.

11.9 Relocation and COBRA Coverage.

If a Qualified Beneficiary moves outside the service area of a region-specific benefit package, alternative coverage, if available to active employees, will be made available to the Qualified Beneficiary no sooner than the date of the Qualified Beneficiary's relocation, or if later, the first day of the month following the month in which the Qualified Beneficiary requests the alternative coverage. A Qualified Beneficiary has thirty (30) days from the date of the Qualified Beneficiary's relocation to request the alternative coverage.

11.10 COBRA Coverage and HIPAA Special Enrollment Rules.

Once a Qualified Beneficiary is receiving COBRA Continuation Coverage, the Qualified Beneficiary has the same right to enroll family members under the HIPAA rules as if the Qualified Beneficiary were an Employee or Participant in the Plan, provided that such family members do not become Qualified Beneficiaries, pursuant to Section 11.2, and are therefore not eligible to elect COBRA Continuation Coverage in their own right.

Election of COBRA Continuation Coverage by a Qualified Beneficiary may serve to bridge coverage between the Plan and any future coverage under another plan.

11.11 Definitions.

For purposes of this Article XI only, the following definitions will apply:

(a) *COBRA* means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

(b) *Continuation Coverage* means the coverage elected by a Qualified Beneficiary as of the date of a Qualifying Event. This coverage will be the same as the health coverage provided to Similarly Situated Beneficiaries who have not experienced a Qualifying Event as of the date the Qualified Beneficiary experiences a Qualifying Event. If the provisions of the Plan are modified for Similarly Situated Beneficiaries, such coverage will also be modified in the same manner for all Qualified Beneficiaries as of the same date. Open enrollment rights extended to active Employees will also be extended to similarly situated Qualified Beneficiaries.

(c) *Continuation Coverage Contribution* means the amount of premium contribution

required to be paid by or on behalf of a Qualified Beneficiary for Continuation Coverage.

(d) *Continuation Coverage Period* means the applicable time period for which Continuation Coverage may be elected.

(e) *Covered Employee* means an individual who was covered under the Plan on the day prior to the Qualifying Event and who is or was provided such coverage by virtue of the individual's performance of services for one or more entities maintaining the Plan. If an individual who otherwise would be a Covered Employee is denied coverage under the Plan in violation of applicable law, including HIPAA, the individual is considered a Covered Employee.

(f) *Open Enrollment Period* means a period during which an Employee covered under the Plan can choose to be covered under another plan or under another benefit option within the same plan, or add or eliminate coverage of family members.

(g) *Qualified Beneficiary* means a Covered Employee or Qualifying Dependent.

(h) *Qualifying Dependent* means:

(i) a Dependent covered under the Plan on the day prior to the Qualifying Event (except that such term shall not include the covered Domestic Partner of a covered Employee, or the covered child of such Domestic Partner, unless such Domestic Partner and/or child, as applicable, otherwise constitutes a "qualified beneficiary" under Code Section 4980B(g)(1)); or

(ii) a Dependent child who is born to, adopted or placed for adoption with a Covered Employee during the Covered Employee's period of COBRA Continuation Coverage; or

(iii) a child who is covered under the Plan on the day prior to the Qualifying Event pursuant to the terms of a qualified medical child support order.

(i) *Qualifying Event* means any of the following events which would otherwise result in a Covered Employee's or a Qualifying Dependent's loss of health coverage under the Plan in the absence of this provision:

(i) a Covered Employee's termination of employment, for any reason other than gross misconduct;

(ii) a Covered Employee's reduction in work hours resulting in a change of status such that the Covered Employee is no longer eligible to be a Covered Employee;

(iii) a Covered Employee's divorce or legal separation;

(iv) a Qualified Dependent ceasing to qualify as a Dependent under the provisions of the Plan;

(v) a Covered Employee's entitlement to benefits under Medicare;

(vi) the death of a Covered Employee;

(vii) the failure of a Covered Employee to return from FMLA leave (Note: the Covered Employee and family members will be entitled to COBRA Continuation Coverage even if they failed to pay the employee portion of premiums for coverage under the Plan during the FMLA leave); or

(viii) a proceeding in bankruptcy under Title 11 of the U.S. Code with respect to an Employer from whose employment a Covered Employee retired at any time.

Note: A loss of health coverage under the Plan includes any increase in the premium or contribution that must be paid by the Covered Employee (or Spouse or Dependent) for coverage under the Plan that results from the occurrence of one of the events listed above in subsections (i)(i) – (i)(viii). The loss of coverage need not occur immediately after the event, so long as the loss of coverage occurs before the end of the maximum COBRA Continuation Coverage Period. If coverage is reduced or eliminated in anticipation of an event, such reduction or elimination is disregarded in determining whether the event causes a loss of coverage.

(j) *Similarly Situated Beneficiaries* means Employees or their Dependents, as applicable, who are Participants in the Plan.

11.12 Qualified Beneficiary Notice Procedures.

Any notice that a Qualified Beneficiary is required to provide under this Article XI must be in writing. The Plan Administrator has contracted with a third-party administrator to perform services as the Plan's "COBRA Administrator." A Qualified Beneficiary must provide his written notice ("***Notice***") to the COBRA Administrator, on behalf of the Plan Administrator, at the address listed in Appendix C. Any Notice that is mailed must be postmarked no later than the last day of the applicable required notice period.

The required procedures for providing Notices under the Plan, including the form and content of Notices, are specified in the applicable Benefit Program Summary Plan Description document(s). To the extent that a Benefit Program does not prescribe required procedures for providing Notices under the Plan, the procedures set out in this Section 11.12 will apply.

The information that must be provided in the Notice is based on the purpose of the Notice, as follows:

- Qualifying Event Notice. The Notice to inform the Plan Administrator of a Qualifying Event (including a Covered Employee's entitlement to Medicare) must contain (1) the name of the Qualified Beneficiary; (2) the name of the Plan to which the Notice applies; (3) a description of the Qualifying Event; and (4) the date on which the Qualifying Event occurred.

- Disability Determination Notice. The Notice to inform the Plan Administrator of a Qualified Beneficiary's disability determination by the SSA must contain (1) the name of the Qualified Beneficiary, (2) the name of the Plan to which the Notice applies, and (3) a copy of the SSA's disability determination letter.

- Determination of End of Disability Notice. The Notice to inform the Plan Administrator of the SSA's determination that a disabled Qualified Beneficiary is no longer disabled must contain (1) the name of the Qualified Beneficiary, (2) the name of the Plan to which the Notice applies, and (3) a copy of the SSA's determination letter that a disability no longer exists.

- Birth, Adoption or Placement Notice. The Notice to inform the Plan Administrator of the birth, adoption or placement for adoption of a child with a Covered Employee receiving COBRA Continuation Coverage must contain (1) the name of the Covered Employee, (2) the name of the Plan to which the Notice applies, (3) the reason for the Notice (*i.e.*, the birth, adoption or placement for adoption of a child, as applicable), and (4) the date of such child's birth, adoption or placement for adoption.

A separate Notice must be provided for each event set out above. In addition, evidence that the event has occurred, acceptable to the COBRA Administrator, must be provided with the Notice. The following evidence shall be deemed "acceptable":

(a) For all such events except an SSA disability (or non-disability) determination, the Qualified Beneficiary's signed certification;

(b) For an SSA disability determination, a copy of the SSA Disability Award letter; and

(c) For an SSA non-disability determination, a copy of the SSA's determination that the Qualified Beneficiary is no longer disabled.

11.13 Special Second Election Period for Certain Eligible Individuals Who Did Not Elect COBRA Continuation Coverage.

Special COBRA rights may apply to certain Covered Employees who are eligible for trade adjustment assistance under the Trade Act of 2002 ("***TAA Employees***"). These TAA Employees may be entitled to a second opportunity to elect COBRA Continuation Coverage for themselves and certain family members (if they did not already elect COBRA Continuation Coverage) during a special second election period. This special second election period lasts for sixty (60) days or less. It is the 60-day period beginning on the first day of the month in which the TAA Employee becomes eligible for certain benefits under the Trade Act of 2002 and during the six (6) month period immediately after the TAA Employee's coverage under the Plan ends. A Covered Employee who qualifies or may qualify for this special election period should contact the COBRA Administrator at the address and telephone number listed in Appendix C for additional information.

11.14 Continuation of Benefits for Covered Domestic Partners and their Covered Children.

Neither the covered Domestic Partner of a covered Employee nor a covered child of such Domestic Partner shall be a Qualifying Dependent who is entitled to continuation of coverage rights under COBRA, except to the extent such Domestic Partner or child otherwise constitutes a "qualified beneficiary" under Code Section 4980B(g)(1).

However, if a Domestic Partner's coverage, or his child's coverage, under a Welfare Program that provides group health benefits terminates due to the occurrence an event specified in Section

11.11(i), the Domestic Partner and/or his child, as applicable, shall be entitled to elect "COBRA-like" coverage ("***Partner Continuation Coverage***") based on the same COBRA Continuation Coverage Periods, form and level of benefits, requirements for contributions by the Domestic Partner and/or his child, and other rules and administrative procedures as are applicable to COBRA Continuation Coverage provided under the Plan.

11.15 Questions and Other Information Regarding COBRA Coverage.

The Covered Employee will be responsible for keeping the Plan Administrator informed of any changes in his address and the addresses of his Spouse, Domestic Partner and Dependents. Questions concerning a Participant's COBRA coverage rights should be directed to the COBRA Administrator at the address and/or telephone number listed in Appendix C.

In the event that the Plan Administrator changes COBRA Administrators and the Participant is unable to reach the above-referenced COBRA Administrator, the Participant should direct questions to the Plan Administrator's Benefits Department at the address and telephone number listed in Article XIV.

ARTICLE XII
HIPAA PRIVACY AND SECURITY

12.1 HIPAA Privacy and Security in General.

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

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

12.2 Designation of Health Care Components and Safeguards.

To the extent the Plan is a hybrid entity (as defined by 45 CFR § 164.103 of the Privacy

Standards), the provisions of this Article XII will only apply to the health care components of the Plan (collectively referred to as the "***Health Care Components***"). All references to Protected Health Information (PHI) or Electronic Protected Health Information (ePHI) in this Article XII refer to PHI or ePHI that is created or received by or on behalf of the Health Care Components. The Health Care Components will thus comply with the following requirements:

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

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

Note: For purposes of this Section 12.2, the portions of the Plan which provide medical care benefits, prescription drug benefits, dental benefits, and vision care benefits constitute the Health Care Components.

12.3 Use and Disclosure of Protected Health Information.

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

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

(a) Determination of eligibility, coverage and cost sharing amounts (for example, cost of a benefit, Plan maximums and copayments as determined for an individual's claim);

(b) Coordination of benefits or non-duplication of benefits;

(c) Adjudication of health benefit claims (including appeals and other payment disputes);

(d) Subrogation of health benefit claims;

(e) Establishing employee contributions;

(f) Risk adjusting amounts due based on enrollee health status and demographic characteristics;

(g) Billing, collection activities and related health care data processing;

(h) Claims management and related health care data processing, including auditing payments, investigating and resolving payment disputes and responding to Participant inquiries about payments;

(i) Obtaining payment under a contract for reinsurance (including stop-loss and excess of loss insurance);

(j) Medical necessity reviews or reviews of appropriateness of care or justification of charges;

(k) Utilization review, including precertification, preauthorization, concurrent review and retrospective review;

(l) Disclosure to consumer reporting agencies related to the collection of premiums or reimbursement (the following PHI may be disclosed for payment purposes: name and address, date of birth, Social Security number, payment history, account number and name and address of the provider and/or health plan); and

(m) Obtaining reimbursements due to the Plan.

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

(a) Quality assessment;

(b) Population-based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination, disease management, contacting health care providers and patients with information about treatment alternatives and related functions;

(c) Rating provider and Plan performance, including accreditation, certification, licensing or credentialing activities;

(d) Enrollment, premium rating and other activities relating to the creation, renewal or replacement of a contract of health insurance or health benefits, and ceding, securing or placing a contract for reinsurance of risk relating to health care claims (including stop-loss insurance and excess loss insurance);

(e) Conducting or arranging for medical review, legal services and auditing functions, including fraud and abuse detection and compliance programs;

(f) Business planning and development, such as conducting cost-management and planning-related analyses related to managing and operating the Plan, including formulary development and administration, development or improvement of payment methods or coverage policies; and

(g) Business management and general administrative activities of the Plan, including, but not limited to:

(i) Management activities relating to the implementation of, and compliance with, HIPAA's administrative simplification requirements;

(ii) Customer service, including the provision of data analyses for policyholders, plan sponsors or other customers;

(iii) Resolution of internal grievances; and

(iv) Due diligence in connection with the sale or transfer of assets to a potential successor in interest, if the potential successor in interest is a "covered entity" under HIPAA or, following completion of the sale or transfer, will become a covered entity.

12.4 Certification of Amendment of Plan Documents by Plan Sponsor.

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

12.5 Plan Sponsor Agrees to Certain Conditions for PHI.

The Plan Sponsor agrees to:

(a) Not use or further disclose PHI other than as permitted or required by the Plan document or as required by law;

(b) Ensure that any agents, including a subcontractor, to whom the Plan Sponsor provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such PHI;

(c) Not use or disclose PHI for employment-related actions and decisions unless the use or disclosure is made pursuant to an authorization in compliance with HIPAA;

(d) Not use or disclose PHI in connection with any other benefit or employee benefit plan of the Plan Sponsor unless the use or disclosure is made pursuant to an authorization in compliance with HIPAA;

(e) Report to the Plan any PHI use or disclosure that is inconsistent with the uses or disclosures provided for of which it becomes aware;

(f) Make PHI available to an individual in accordance with HIPAA's access requirements;

(g) Make PHI available for amendment and incorporate any amendments to PHI in accordance with HIPAA;

(h) Make available the information required to provide an accounting of disclosures;

(i) Make internal practices, books and records relating to the use and disclosure of PHI received from Plan available to the HHS Secretary for the purposes of determining the Plan's compliance with HIPAA;

(j) If feasible, return or destroy all PHI received from the Plan that the Plan Sponsor still maintains in any form, and retain no copies of such PHI when no longer needed for the purpose for which disclosure was made (or if return or destruction is not feasible, limit further

uses and disclosures to those purposes that make the return or destruction infeasible); and

(k) Establish separation between the Plan and the Plan Sponsor in accordance with 45 CFR § 164.504(f)(2)(iii).

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

(1) Implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the ePHI that it creates, receives, maintains, or transmits on behalf of the Plan;

(2) Ensure that adequate separation required by 45 CFR §164.504(f)(2)(iii) under the Privacy Standards is supported by reasonable and appropriate security measures;

(3) Ensure that any agent, including a subcontractor, to whom it provides this information or who receives this information on behalf of the Plan agrees to implement reasonable and appropriate security measures to protect the information; and

(4) Report to the Plan any security incident of which it becomes aware, in accordance with the administrative procedures adopted by the Plan for compliance with the Security Standards.

12.6 Adequate Separation Between the Plan and the Plan Sponsor.

In accordance with the Privacy Standards, only the employees or classes of employees designated in Appendix D may be given access to PHI.

12.7 Limitations of PHI Access and Disclosure.

The persons described in Appendix D may only have access to and use and disclose PHI for Plan administration functions that the Plan Sponsor performs for the Plan.

12.8 Noncompliance Issues.

If the persons described in Appendix D do not comply with the Plan document, the Plan Sponsor will provide a mechanism for resolving issues of noncompliance, including disciplinary sanctions.

12.9 Members of Organized Health Care Arrangement.

To the extent that any Health Care Component is fully-insured, the Plan and the health insurance issuer or HMO with respect to such Health Care Component are an organized health care arrangement (as defined in § 160.103 of the Privacy Standards), but only with respect to PHI created or received by the health insurance issuer or HMO that relates to the individuals who are Participants or Beneficiaries in such Health Care Component.

12.10 Additional Requirements Imposed by HITECH.

The provisions of this Section 12.10 will apply to the Plan to the extent the Plan is a "covered entity" as defined in 45 CFR § 160.103. In accordance with, and to the extent required by, HITECH

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

12.11 Limitation on the Use and Disclosure of Genetic Information.

Notwithstanding anything herein to the contrary, no "genetic information" (as defined by Section 105 of the Genetic Information Nondiscrimination Act of 2008) shall be used or disclosed for underwriting, premium rating and other activities relating to the creation, renewal or replacement of a contract of health insurance or health benefits, or ceding, securing or placing a contract for reinsurance of risk relating to health care claims (including stop-loss insurance and excess loss insurance).

12.12 Notification in Case of a Breach of Unsecured PHI.

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

- A brief description of what happened, including the date of the Breach and the date of its discovery, if known;
- A description of the type of PHI involved, such as name, social security number, date of birth, address, account number, diagnosis, disability code, or other type of information involved;
- Any steps the individual should take to protect himself from potential harm resulting from the Breach;
- A brief description of what the Plan or its business associate is doing to investigate the Breach, mitigate harm to individuals, and to protect against further Breaches; and
- Contact procedures for individuals to ask questions or learn additional information, including a toll-free telephone number, e-mail address, web site, or postal address.

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

12.13 Other Medical Privacy Laws.

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

ARTICLE XIII
MISCELLANEOUS LAW PROVISIONS

13.1 Qualified Medical Child Support Orders.

Rules relating to Qualified Medical Child Support Orders ("***QMCSO***") – Any health plan offered under the Plan will provide benefits in accordance with the applicable requirements of any QMCSO.

(a) *Definitions*.

For purposes of Section 13.1, 13.2, 13.3 and 13.4, the following definitions apply:

(i) The term "Qualified Medical Child Support Order" will be defined for purposes of Sections 13.1, 13.2, 13.3 and 13.4 as follows: A Medical Child Support Order:

(A) which creates or recognizes the existence of an Alternate Recipient's right to, or assigns to an Alternate Recipient the right to, receive benefits for which a Participant or Beneficiary is eligible under a group health plan; and

(B) with respect to which the requirements of this Section 13.1 under "Information to be Included in a QMCSO" and "Restriction on New Types or Forms of Benefits" are met.

(ii) The term "Medical Child Support Order" will be defined in Sections 13.1, 13.2 and 13.3 as follows: Any judgment, decree, or order (including approval of a settlement agreement) issued by a court of competent jurisdiction which:

(A) provides for child support with respect to a child of a Participant under a health plan offered under the Plan or provides for health benefit coverage to such a child pursuant to a state domestic relations law (including a community property law), and relates to benefits under the health plan offered under the Plan; or

(B) enforces a law relating to medical child support described in Section 1908 of the Social Security Act (as added by Section 13822 of the Omnibus Budget Reconciliation Act of 1993) with respect to a health plan offered under the Plan.

(iii) For purposes of Sections 13.1, 13.2, 13.3 and 13.4, the term "Alternate Recipient" will be defined as follows: Any child of a Participant who is recognized under a Medical Child Support Order as having the right to enrollment under a health plan provided within the Plan with respect to such Participant.

(b) *Information to be Included in a QMCSO*.

A Medical Child Support Order meets the requirements of this paragraph only if such order clearly specifies:

(i) the name and the last known mailing address (if any) of the Participant and the name and mailing address of each Alternate Recipient covered by the order, except that, to the extent provided in the order, the name and mailing address of an official of a state or political subdivision thereof may be substituted for the mailing address of any such Alternate Recipient;

(ii) a reasonable description of the type of coverage to be provided by the Plan to each such Alternate Recipient, or the manner in which such type of coverage is to be determined; and

(iii) the time period to which such order applies.

(c) *Restriction on New Types or Forms of Benefits*.

A Medical Child Support Order meets the requirements of this paragraph only if such order does not require a health plan to provide any type or form of benefit, or any option, not otherwise provided under the health plan, except to the extent necessary to meet the requirements of a law relating to medical child support described in Section 1908 of the Social Security Act (as added by Section 13822 of the Omnibus Budget Reconciliation Act of 1993).

(d) *QMCSO Coverage Ends*.

A child who is covered pursuant to a QMCSO will have coverage end on the date the QMCSO expires.

13.2 Procedural Requirements.

(a) *Timely Notifications and Determinations*.

In the case of any Medical Child Support Order received by the Plan Administrator for a health plan offered under the Plan:

(i) the Plan Administrator will promptly notify the Participant and each Alternate Recipient of the receipt of such order and the Plan's procedures for determining whether a Medical Child Support Order is a QMCSO, and

(ii) within a reasonable period of time after receipt of such order, the Plan Administrator will determine whether such order is a QMCSO and notify the Participant and each Alternate Recipient of such determination.

(b) *Establishment of Reasonable Procedures*.

The Plan Administrator will establish reasonable procedures to determine whether a Medical Child Support Order is a QMCSO and to administer the provisions of benefits under such QMCSO. Such procedures:

(i) will be in writing;

(ii) will provide for the notification of each person specified in a Medical Child Support Order who is named as eligible to receive benefits under the Plan (at the address included in the Medical Child Support Order) of such procedures promptly upon receipt by the Plan Administrator of the Medical Child Support Order; and

(iii) will permit an Alternate Recipient to designate a representative for receipt of copies of notices that are sent to the Alternate Recipient with respect to a QMCSO.

A Participant may obtain a copy of the QMCSO procedures, without charge, upon request to the OxyLink Employee Service Center, on behalf of the Plan Administrator, at the address and/or telephone number listed in Article XIV.

13.3 Actions Taken by Fiduciaries.

(a) *General Requirement.*

If the Plan Administrator acts in accordance with Sections 13.1, 13.2 and 13.3 in treating a Medical Child Support Order as being (or not being) a Qualified Medical Child Support Order, then the Plan's obligation to the Participant and each Alternate Recipient will be discharged.

(b) *Treatment of Alternate Recipients.*

(i) An individual who is an Alternate Recipient under a QMCSO will be considered a Beneficiary under the Plan for purposes of any provision of ERISA.

(ii) An individual who is an Alternate Recipient under any Medical Child Support Order will be considered a Participant under the specific health plan for purposes of the reporting and disclosure requirements of Title I of ERISA.

(c) *Direct Provision of Benefits Provided to an Alternate Recipient.*

Any payment for reimbursement of expenses paid by an Alternate Recipient or an Alternate Recipient's custodial parent or legal guardian will be made to the Alternate Recipient or the Alternate Recipient's custodial parent or legal guardian.

(d) *Payment to State Official Treated as Satisfaction of Plan's Obligation to Make Payment to Alternate Recipient.*

Payment of benefits by the Plan to an official of a state or a political subdivision thereof, whose name and address have been substituted for the name and address of an Alternate Recipient in a QMCSO, will be treated as payment of benefits to the Alternate Recipient.

13.4 National Medical Support as Qualified Medical Child Support Order.

(a) An appropriately completed National Medical Support Notice ("**Notice**") promulgated pursuant to Section 401(b) of the Child Support Performance and Incentive Act of 1998 will be deemed to be a QMCSO if the Notice does not require the Plan to provide any

type of form of benefit, or any option, not otherwise provided under the Plan, except to the extent necessary to meet the requirements of a law relating to medical child support described in Section 1908 of the Social Security Act (as added by Section 13822 of the Omnibus Budget Reconciliation Act of 1993), and the Notice clearly specifies the following:

(i) the name and the last known mailing address (if any) of the Participant and the name and mailing address of each Alternate Recipient (an official of a state or political subdivision may be substituted for the mailing address of any Alternate Recipient, if provided for in the Notice);

(ii) a reasonable description of the type of coverage to be provided to each Alternate Recipient, or the manner in which such type of coverage is to be determined; and

(iii) the period to which the Notice applies.

(b) If a Notice which satisfies Section 13.4(a) is issued for a child of a Participant under the Plan who is a noncustodial parent of the child, the Plan Administrator, within forty (40) business days after the date of the Notice, will:

(i) notify the state agency issuing the Notice with respect to such child whether coverage of the child is available under the terms of the Plan and, if so, whether such child is covered under the Plan and either the effective date of the coverage or, if necessary, any steps to be taken by the custodial parent (or by the official of a state or political subdivision thereof substituted for the name of such child pursuant to Section 13.4(a)(i) to effectuate the coverage; and

(ii) provide to the custodial parent (or such substituted official) a description of the coverage available and any forms or documents necessary to effectuate such coverage.

(c) Nothing in this Section 13.4 will be construed as requiring the Plan, upon receipt of Notice, to provide benefits under the Plan (or eligibility for such benefits) in addition to benefits (or eligibility for benefits) provided under the terms of the Plan as of immediately before the receipt of such Notice.

13.5 Rights of States for Group Health Plans where Participants are Eligible for Medical Benefits.

(a) *Compliance by Plans with Assignment of Rights.*

A Benefit Program offered under the Plan that provides health benefits will comply with any assignment of rights made by or on behalf of such Participant or a Beneficiary of the Participant as required by a state plan for medical assistance approved under Title XIX of the Social Security Act pursuant to Section 1912(a)(l)(A) of such Act (as in effect on the date of the enactment of the Omnibus Budget Reconciliation Act of 1993).

(b) *Enrollment and Provision of Benefits Without Regard to Medicaid Eligibility.*

In determining or making any payments for benefits of an individual as a Participant

or Beneficiary, the fact that the individual is eligible for or is provided medical assistance under a state plan for medical assistance approved under Title XIX of the Social Security Act will not be taken into account.

(c) *Acquisition by States of Rights of Third Parties.*

If payment has been made under a state plan for medical assistance approved under Title XIX of the Social Security Act offered under the Plan in any case in which a group health plan has a legal liability to make payment for items or services constituting such assistance, payment for benefits under the Plan will be made in accordance with any state law which provides that the state has acquired the rights with respect to a Participant to such payment for such items or services; provided, however that in no event will such a state law be applied to the extent it attempts to create rights for the state plan which are greater than those of the Participant under the Plan, specifically including any state law which provides that a state plan can make a claim for benefits or recover benefits beyond the period permitted under the Plan.

13.6 Health Program Coverage of Dependent Children in Adoption Cases.

(a) *Coverage Effective Upon Placement For Adoption.*

Notwithstanding anything in the Benefit Program Summary Plan Description documents to the contrary, if a Benefit Program offered under the Plan provides health coverage for Dependent children of Participants or Beneficiaries, such Benefit Program will provide benefits to Dependent children Placed For Adoption with Participants or Beneficiaries under the same terms and conditions as apply in case of Dependent children who are natural children of Participants or Beneficiaries under the Plan, irrespective of whether the adoption has become final.

(b) *Definitions.*

For purposes of this Section 13.6, the following definitions apply:

(i) "Child" means, in connection with any adoption or Placement For Adoption of the Child, an individual who has not attained age eighteen (18) as of the date of such adoption or Placement For Adoption.

(ii) "Placement, Placement For Adoption, or being Placed For Adoption", in connection with any Placement For Adoption of a Child with any person, means the assumption and retention by such person of a legal obligation for total or partial support of such Child in anticipation of adoption of such Child. The Child's Placement with such person terminates upon the termination of such legal obligation.

13.7 Continued Coverage of Pediatric Vaccine under Group Health Plans.

A Benefit Program offered under the Plan that is a health plan may not reduce its coverage of the costs of pediatric vaccines (as defined under Section 1928(h)(6) of the Social Security Act as amended by Section 13830 of the Omnibus Budget Reconciliation Act of 1993) below the coverage it provided as of May 1, 1993.

13.8 Family and Medical Leave Act.

(a) *Health Benefits.*

This subsection (a) shall apply to a Benefit Program to the extent it provides health benefits.

(i) General.

If an Employee Participant takes a leave pursuant to the FMLA, health benefits coverage for such Participant may continue, subject to the Participant's continued participation in the Plan, on the same basis as for active Participants for the first day on which such approved leave began until the end of the FMLA leave, pursuant to the requirements of the FMLA. The Employee may continue his coverage for the period of the leave of absence, but not to exceed the period prescribed by the FMLA, provided that he pays any required Participant Contributions under the Plan in accordance with Section 13.8(a)(iv). If the Employee fails to return to work on expiration of the leave period or notifies the Employer during the leave that he will not be returning to work due to reasons within his control, his coverage under the Plan will be terminated on the date he fails to return to work or the date following the date he gives such notice to the Employer.

(ii) Re-enrollment.

An Employee Participant who elects to revoke coverage under the Section 125 cafeteria plan sponsored by the Plan Sponsor ("***Flex Plan***") or whose coverage terminates during a leave granted pursuant to FMLA for failure to make any required Participant Contribution, will be eligible to re-enroll in the Plan immediately upon returning from the FMLA leave subject to payment of applicable Participant Contributions. Coverage will commence on the day of his return to employment to active service subject to administrative policies for election of coverage established by the Plan Administrator and payment of any required Participant Contributions. However, coverage will be reinstated only if the person(s) had coverage under the Plan when the FMLA leave started, and will be reinstated to the same extent that it was in force when that coverage terminated, subject to any changes that affect the work force as a whole.

(iii) COBRA.

An approved leave of absence, which may include a leave pursuant to FMLA, does not constitute a Qualifying Event under COBRA within the meaning of Section 11.11. The failure of the Employee Participant to return to work following the FMLA leave is a COBRA Qualifying Event. Notification by the Participant of the Participant's intent not to return from FMLA leave is a COBRA Qualifying Event if such failure to return results in a termination of employment. The last day of such leave will be deemed the date the Qualifying Event occurred.

(iv) Contributions.

An Employee Participant in the Plan who takes an FMLA leave is entitled to continue to participate in the Benefit Programs provided under the Plan during such leave. However, if the Participant is also a participant in the Flex Plan, the Participant may revoke his election to participate in the Flex Plan. If the Participant does not revoke his Flex Plan election, or if he does not participate in the Flex Plan, he must continue to make Participant Contributions to the Plan on a pay-as-you-go basis, unless the Participant makes advance payments or, if permitted under administrative policies adopted by the Plan Administrator, subsequent payments following the Participant's return from leave, provided that such administration has been previously approved by the Plan Administrator. Deductions for coverage or participation while on a paid leave will be withheld from the Participant's paychecks during the leave.

If any required Participant Contribution for a period of coverage has not been made, then coverage may be retroactively terminated effective as of the last day of the period for which the last required Participant Contribution was made.

If the Participant revokes his election to participate in the Flex Plan, then the Participant may, upon timely return from FMLA leave, elect to reinstate his election to participate in the Flex Plan. Such benefits provided under the Flex Plan will be reinstated upon the Participant's re-election.

(v) Termination of Benefits while on FMLA Leave.

If a Participant's coverage under the Plan has been terminated while on FMLA leave, such coverage will be reinstated upon timely return from FMLA leave. A Participant who elected to cease participation in the Flex Plan while on FMLA leave may elect to commence participation upon timely return from FMLA leave.

(b) *Non-Health Benefits.*

This subsection (b) shall apply to a Benefit Program to the extent it provides non-health benefits.

An Employee Participant shall be entitled to benefits under the Plan during a period of leave pursuant to the FMLA, at a minimum, to the same extent that similarly-situated Employees on other forms of leave (paid or unpaid, as appropriate) are entitled to benefits under the Plan during such other forms of leave, as determined by the Employer's established leave of absence policy. Upon timely return to active employment at the end of an Employee's FMLA leave, benefits under the Plan shall be resumed in the same manner and at the same levels as provided to the Employee when the leave began (and subject to any changes in benefit levels that may have taken place during the period of FMLA leave affecting all Participants), unless otherwise elected by the Employee. Upon return from FMLA leave, an Employee shall not be required to re-qualify for any Plan benefits the Employee was entitled to receive as a Participant before his FMLA leave began.

13.9 Uniformed Services Employment and Reemployment Rights Act.

The Plan will comply with the Uniformed Services Employment and Reemployment Rights

Act of 1994 ("***USERRA***") with regard to continuation rights during an approved military leave of absence and reenrollment rights on return from such military leave of absence. The Plan's continuation rights provided in connection with military leaves of absence will, at a minimum, be as follows:

(a) *Health Benefits.*

This subsection (a) shall apply to a Benefit Program to the extent it provides health benefits.

(i) An Employee who is not at work because of a period of duty in the Uniformed Services (as defined in USERRA), may, at the Employee's election, continue coverage in any or all Benefit Programs under the Plan during the period of absence, so long as the Employee satisfies the necessary provisions and makes any required Participant Contribution as provided under USERRA.

(ii) The maximum period of coverage for an Employee, an Employee's Spouse and/or Dependents, if any, under a Benefit Program during a period of duty in the Uniformed Services will be governed by the applicable limitations and provisions contained in USERRA unless more generous limitations are provided under the Employer's leave of absence policy.

(iii) An Employee who elects to continue coverage in one or more Benefit Programs under the Plan will pay:

(A) the Employee's share, if any, for coverage under the Plan if the Employee performs service in the Uniformed Services for up to thirty-one (31) days; or

(B) one hundred two percent (102%) of the full premium or cost under the Plan (determined in the same manner as the applicable COBRA Continuation Coverage premium under Section 4980B(f)(4) of the Code) if the Employee performs service in the Uniformed Services for thirty-one (31) days or more.

(iv) During the period of service in the Uniformed Services, the Employee may pay the necessary costs associated with coverage under the Plan, if any, by:

(A) remitting payment to the Employer on or before each pay period for which the Participant Contributions would have been deducted from the Employee's paycheck had the Employee not been absent serving in the Uniformed Services, provided that any delinquent payments must be made within thirty (30) days after their due date;

(B) at the Employee's request, prepaying the amounts that will become due during the period of service in the Uniformed Services out of one or more of the Employee's paychecks preceding such period of service in the Uniformed Services; or

(C) pre-approved arrangement with the Plan Administrator and in

accordance with administrative policies adopted by the Plan Administrator wherein the Employer pays the Employee's Participant Contributions during the Employee's period of service in the Uniformed Services. Upon return from such service, the Employee will reimburse the Employer for such previous payments.

Any Employee who is a Participant, who is not at work because of service in the Uniformed Services and who returns to active employment within the relevant time period determined under USERRA, will be eligible to return to work and immediately participate in the same Benefit Programs which the Participant had elected to participate in prior to serving in the Uniformed Services, subject to any changes in the Benefit Programs that affect the workforce as a whole, provided that the Participant returns to employment with the same benefit eligibility status that he held prior to serving in the Uniformed Services, and provided further, that the Participant makes all required elections to participate in the Plan on a timely basis. Except to the extent provided in administrative policies adopted by the Plan Administrator (or the Employer, if applicable), the maximum period of health care coverage available to a Participant (and his Dependents) while on a USERRA leave of absence will end on the earlier of (i) the last day of the maximum coverage period prescribed under USERRA (or if required by USERRA's discrimination rules, the last day of the longest period that the Employer's leave of absence policy permits Benefit Program coverage to continue) or (ii) the day after the date upon which the person fails to apply for a return to a position of employment within the time required under Section 4312(a) of USERRA. For purposes of determining eligibility for health benefits (and only if the Participant pays the full amount which the Employer is permitted to charge the Participant for health coverage under USERRA), a Participant who experiences a reduction in hours or termination of employment solely due to a USERRA leave will continue to be considered qualified as a Participant under the Plan until the earliest date that the termination of his health benefits is permitted under USERRA.

(b) *Non-Health Benefits.*

This subsection (b) shall apply to a Benefit Program to the extent it provides non-health benefits.

During a period of duty in the "Uniformed Services" (as defined in USERRA), the Employee shall be deemed to be "on furlough" or "leave of absence" from the Employer. The Employee shall be entitled to benefits under the Plan in accordance with the Employer's administrative policies and procedures regarding leaves of absence for military service under USERRA, but at a minimum, to the same extent as similarly-situated Employees who are on non-USERRA leave of absence from the Employer. If Plan benefits to which Employees on non-USERRA leave of absence are entitled vary according to the type of leave, the Employee on leave under USERRA must be given at least the most favorable benefits under the Plan accorded to any comparable form of leave.

13.10 Health Insurance Portability and Accountability Act.

The Plan will comply with HIPAA with respect to a Benefit Program offered under the Plan that provides health benefits, except to the extent that such health benefits are "excepted benefits" which are not subject to HIPAA's portability provisions.

(a) *Eligibility.*

The Plan will not base eligibility rules or Waiting Periods on any of the following: health status, mental or physical medical condition, genetic information or evidence of insurability or disability. However, the Plan may continue to provide for the exclusion of specified health conditions or lifetime maximums on certain specific benefits provided under the Plan. These restrictions do not preclude the Plan from applying differing benefit levels, benefit schedules or premium rates in certain situations as provided under HIPAA.

(b) *Enrollment.*

(i) Loss of coverage. Special enrollment periods will generally be provided for eligible Employees and their eligible Dependents (including their eligible Spouses and eligible Domestic Partners) whose other health coverage terminates due to (A) exhaustion of COBRA continuation coverage, or (B) if the other coverage is not COBRA continuation coverage, "loss of eligibility" for the other health coverage (for reasons other than the individual's failure to pay premiums or for cause) or termination of employer contributions toward the cost of the other coverage, if the Employee had previously declined coverage under the Plan or a particular Benefit Program for himself and/or his Dependents because he or they had other coverage under a group health plan or health insurance.

For this purpose, "loss of eligibility" includes, but is not limited to:

(A) A loss of eligibility for the other coverage resulting from legal separation, divorce, cessation of dependent status (such as attaining the maximum age for eligibility as a dependent child under the other coverage), death of the Employee, termination of employment, a reduction in the number of hours of employment, or any loss of eligibility for coverage after a period that is measured based on any of those events;

(B) In the case of other coverage offered through an HMO, or other arrangement, in the individual market that does not provide benefits to individuals who no longer reside, live, or work in a service area, loss of coverage because an individual no longer resides, lives, or works in the service area (whether or not within the choice of the individual);

(C) In the case of other coverage offered through an HMO, or other arrangement, in the group market that does not provide benefits to individuals who no longer reside, live, or work in a service area, loss of coverage because an individual no longer resides, lives, or works in the service area (whether or not within the choice of the individual), and no other benefit package is available to the individual;

(D) A situation in which an individual incurs a claim under the other coverage that would meet or exceed a lifetime maximum benefit limit on all benefits; and

(E) A situation in which the other coverage no longer offers any benefits

to the class of similarly situated individuals that includes the individual.

If the other coverage is COBRA Continuation Coverage, the coverage must be exhausted. A loss of COBRA Coverage resulting from the individual's failure to pay premiums is not considered exhaustion of COBRA Coverage for purposes of permitting special enrollment.

To be eligible for special enrollment, the Employee must request enrollment no more than thirty-one (31) days after the termination of the other coverage (or after the employer stops contributing toward the other coverage), or for purposes of subsection (D) above, after a claim is denied under the other coverage due to the operation of the lifetime maximum benefit limit on all benefits. The Employee must also have met any requirements under the Plan for stating in writing that coverage was previously declined due to other health coverage.

(ii) Acquisition of New Dependent. Special enrollment periods will be available for the following individuals, in the event the eligible Employee (or Participant) acquires a new Spouse, Domestic Partner or Dependent as a result of marriage or establishment of a domestic partnership, birth, adoption or placement for adoption, if enrollment is requested no more than thirty (30) days following the applicable event:

(A) The eligible Employee, if the Employee acquires a new Dependent as described in this subsection (b)(ii) above;

(B) The eligible Spouse or eligible Domestic Partner of the Participant, if either (1) the Spouse or Domestic Partner becomes the Participant's newly-acquired Dependent through marriage or establishment of a domestic partnership, or (2) the Participant acquires a new Dependent child as described in this subsection (b)(ii) above;

(C) The eligible Employee and his eligible Spouse or eligible Domestic Partner, if either (1) the Spouse or Domestic Partner becomes the Employee's newly-acquired Dependent through marriage or establishment of a Domestic Partnership, or (2) the Employee acquires a new Dependent child as described in this subsection (b)(ii) above;

(D) The eligible Dependents of the Participant, if the Participant acquires a new Dependent as described in this subsection (b)(ii) above;

(E) The eligible Employee and his eligible Dependents, if the Employee acquires a new Dependent as described in this subsection (b)(ii) above; and

(F) The eligible Employee, his eligible Spouse or eligible Domestic Partner and his eligible Dependents, if the Employee acquires a new Dependent as described in this subsection (b)(ii) above.

In the event of an acquisition of a new Dependent due to birth, adoption or placement for adoption, coverage may be effective retroactively to the date of such birth, adoption or placement for adoption. All other enrollments pursuant to a HIPAA

special enrollment right will be effective no sooner than the date the Plan Administrator receives the completed enrollment form and no later than the first day of the month following the date the Plan Administrator receives the completed enrollment form.

(iii) Medicaid/CHIP Special Enrollment Period. Notwithstanding any provision of the Plan to the contrary, the Plan shall permit an eligible Employee or an eligible Employee's Dependent who is eligible for, but not enrolled in, coverage under the Plan to elect to enroll in the Plan if either of the following conditions is met:

(A) *Termination of Medicaid or CHIP coverage*. The eligible Employee or the eligible Employee's Dependent is (i) covered under a Medicaid plan under Title XIX of the Social Security Act ("**Medicaid**") or under a State child health plan under Title XXI of such Act ("**CHIP**"), and (ii) coverage of the eligible Employee or the eligible Employee's Dependent under such a plan is terminated as a result of loss of eligibility for such coverage; or

(B) *Eligibility for Premium Assistance under Medicaid or CHIP*. The eligible Employee or the eligible Employee's Dependent becomes eligible for assistance under Medicaid or CHIP.

In order to enroll in the Plan due to an event described in clause (A) or (B) above, the eligible Employee must request coverage under the Plan not later than sixty (60) days after the date: (a) of termination of coverage under Medicaid or CHIP or (b) the eligible Employee or his eligible Dependent is determined to be eligible for assistance under Medicaid or CHIP. The request for coverage must be made in writing to the Plan Administrator.

With respect to an eligible Employee or eligible Employee's Dependent who elects coverage in accordance with this Section 13.10(b)(iii), coverage under the Plan shall be effective as of the first day of the month following the date the completed request for enrollment is received and accepted by the Plan Administrator.

(c) *HIPAA and COBRA Continuation Coverage.*

COBRA Continuation Coverage, as amended by HIPAA, will be provided in accordance with Article XI herein.

13.11 Mental Health Parity and Addiction Equity Act.

The Plan will comply with the Mental Health Parity and Addiction Equity Act of 2008 ("***MHPAEA***") with respect to health benefits provided under a Benefit Program, except to the extent that such health benefits are "excepted benefits" that are not subject to the MHPAEA provisions in Part 7 of ERISA. If a Benefit Program offered under the Plan provides medical and surgical benefits and mental health benefits or substance use disorder benefits, then the Benefit Program shall be construed and administered in accordance with Section 712 of ERISA and the regulations and other authority promulgated thereunder by the appropriate governmental authority.

13.12 Newborns' and Mothers' Health Protection Act.

The Plan will comply with the Newborns' and Mothers' Health Protection Act ("***NMHPA***") with respect to health benefits provided under a Benefit Program, except to the extent that such health benefits are "excepted benefits" which are not subject to the NMHPA provisions in Part 7 of ERISA. Under NMHPA, the Plan and health insurance issuers offering group health insurance generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or the newborn child to less than forty-eight (48) hours following a vaginal delivery or ninety-six (96) hours following a cesarean section delivery. However, the Plan or the issuer may pay for a shorter stay if the attending provider, after consultation with the mother, discharges the mother or newborn earlier. The Plan and the insurers may not set the level of benefits or out-of-pocket costs so that any later portion of the forty-eight (48) hour (or ninety-six (96) hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay. The Plan or insurers may not require that a physician or other health care provider obtain authorization for prescribing a length of stay of up to forty-eight (48) hours or ninety-six (96) hours, as applicable.

13.13 Women's Health and Cancer Rights Act.

The Plan will comply with the Women's Health and Cancer Rights Act ("***WHCRA***") with respect to health benefits provided under a Benefit Program, except to the extent that such health benefits are "excepted benefits" which are not subject to the WHCRA provisions in Part 7 of ERISA. A Benefit Program offered under the Plan that provides health coverage will provide coverage for the following medical and surgical benefits for an individual who is receiving health plan benefits in connection with a mastectomy and who has elected breast reconstruction:

(a) reconstruction of the breast on which the mastectomy has been performed;

(b) surgery and reconstruction of the other breast to produce a symmetrical appearance; and

(c) prosthesis and treatment of physical complications for all stages of a mastectomy, including lymphedemas (swelling associated with the removal of lymph nodes).

The manner of coverage will be determined in consultation with the attending health care provider and patient. Coverage for breast reconstruction and related services associated with a mastectomy will be subject to deductibles, co-payments, coinsurance amounts, pre-certification and utilization review requirements that are consistent with those that apply to other benefits under the Benefit Program.

13.14 Genetic Information Nondiscrimination Act.

The Plan will comply with the Genetic Information Nondiscrimination Act of 2008 as provided in Section 702 of ERISA and the regulations and other authority promulgated thereunder by the appropriate governmental authority.

13.15 Affordable Care Act.

The Plan will comply with the Affordable Care Act, and the regulations and other authority promulgated thereunder by the appropriate governmental authority, with respect to health benefits provided under a Benefit Program, except to the extent that such health benefits are not subject to the

Affordable Care Act.

13.16 Other Laws.

The Plan shall be construed to comply with ERISA and will comply with all other laws applicable to a Benefit Program to the extent not preempted by ERISA or other controlling federal law. Such laws will include, but not be limited to the Americans with Disabilities Act ("***ADA***"), the Pregnancy Discrimination Act ("***PDA***") and the Small Business Job Protection Act ("***SBJPA***").

13.17 Governing Law; Jurisdiction.

Except as otherwise required for a Fully-Insured Program, all matters or issues relating to the interpretation, construction, validity, and enforcement of the Plan shall be governed by the laws of the State of Texas, without giving effect to any choice-of-law principle that would cause the application of the laws of any jurisdiction other than Texas, except to the extent such laws are preempted by ERISA or other controlling federal law. As the Plan is administered in Harris County, Texas, mandatory venue for any claim, legal suit, action or other proceeding arising out of, or relating to, the Plan, other than an interpleader action under the Plan that is initiated by the Plan Sponsor, the Plan Administrator or a designee thereof, shall be the Federal District Court for the Southern District of Texas—Houston Division or any judicial district court that is situated in Harris County, Texas, subject to removal of any such action under ERISA (under 28 U.S.C. §§ 1441 et seq. or any successor provision). Venue for an interpleader action under the Plan that is initiated by the Plan Sponsor, the Plan Administrator or a designee thereof shall be, as decided by the Plan Administrator in its discretion, in (a) the state where the deceased Participant resided at his death (if the benefits which are the subject of the interpleader action are those of a deceased Participant), (b) the state in which at least one defendant in the interpleader action resides, or (c) the Federal District Court for the Southern District of Texas—Houston Division or any judicial district court that is situated in Harris County, Texas.

Each Participant, as the result of, and in consideration for, participation in the Plan, and his designated representative, with respect to any claim or dispute relating in any way to, or arising out of, the Plan, consents and agrees to such jurisdiction and venue as described in this Section 13.17 and waives any objection to such jurisdiction or venue including, without limitation, that it is inconvenient. Such parties shall not commence any legal action other than before the above-named courts. Notwithstanding the previous sentence, a party may commence any legal action in a court other than the above-named courts solely for the purpose of enforcing an order or judgment issued by one of the above-named courts.

ARTICLE XIV
IMPORTANT ERISA INFORMATION

Name of Plan: Occidental Petroleum Corporation Welfare Plan.

Plan Sponsor's Name, Address and Telephone Number: Occidental Petroleum Corporation, Attn: Vice President Compensation & Benefits, 5 Greenway Plaza, Houston, TX 77046-0506, telephone: (713) 215-7000.

Plan Administrator's Name, Address and Telephone Number: Occidental Petroleum Corporation Employee Benefits Committee, Attn: Director, Benefits & Wellbeing, 5 Greenway Plaza, Houston, TX

77046-0506, telephone: (713) 215-7000.

Plan Sponsor's Employer Identification Number: 95-4035997.

Plan Number: 591.

Type of Plan: The Plan is an "employee welfare benefit plan" subject to ERISA which provides (1) self-funded medical benefits, (2) self-funded prescription drug benefits, (3) self-funded dental benefits, (4) fully-insured vision care benefits, (5) self-funded, on-site health center benefits, (6) fully-insured global medical, dental, vision and prescription drug benefits, (7) fully-insured basic, optional and dependent life insurance benefits, (8) fully-insured basic and voluntary AD&D benefits, (9) fully-insured long-term disability benefits, and (10) self-funded employee assistance program benefits. No trust is maintained in connection with the Plan.

Type of Administration: The Plan is administered by the Plan Administrator, with benefits being provided in accordance with the terms, limits and conditions of the Plan. The Plan Administrator has engaged the Claims Administrator(s), as set forth in Appendix C, to determine eligibility for benefits, process claims and perform other administrative duties under the Plan.

Agent for Service of Legal Process: Service of legal process may be made upon the Plan Administrator at the address above.

Disclosure Administrator: OxyLink Employee Service Center, 4500 S 129th E. Ave, Tulsa, OK 74134-5801.

Plan Year: The Plan and its records are kept on a Plan Year basis. The Plan Year is the 12-month period beginning each January 1st and ending on December 31st.

Sources of Contributions: The adopting Employers and Participants pay the costs for coverage. The Plan Sponsor determines the portion of costs to be paid by the adopting Employers and the Participants.

Collective Bargaining: The Plan provides coverage to (i) eligible Employees and eligible Retirees who are not affiliated with a collective bargaining unit, and (ii) eligible Employees who are affiliated with a collective bargaining unit and whose coverage is provided pursuant to a collective bargaining agreement between the Employer and the following unions (the "***CBAs***"): United Steelworkers AFL-CIO-CLC on behalf of Local 12773 (Ludington). Copies of the current CBAs are available for examination at the Employers' offices and may be purchased upon written request to the Plan Administrator at the address above by paying the reasonable copying costs. Copies of the CBAs are also available for inspection at the union offices.

ARTICLE XV
STATEMENT OF 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). ERISA provides that all Plan Participants are entitled to:

Receive Information About Your Plan and Benefits

- Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites, all Plan documents including insurance contracts and a copy of the latest annual report (Form 5500 Series) filed with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

- Obtain copies of all Plan documents including insurance contracts and copies of the latest annual report (Form 5500 Series) and an updated Summary Plan Description, upon written request to the Disclosure Administrator (as designated in Article XIV). The Disclosure 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.

Continue Group Health Plan Coverage

- Continue healthcare coverage for yourself , Spouse or Dependents if there is a loss of coverage under the Plan as a result of a Qualifying Event. You or your Dependents may have to pay for such coverage. Review the Summary Plan Description and the documents governing the Plan on the rules governing your COBRA Continuation Coverage rights.

Prudent Actions 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 the Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of Plan Participants and Beneficiaries.

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

Enforce Your Rights

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report 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 you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.

If you have a claim for benefits which is denied or ignored, in whole or in part, and you disagree with that denial, you must file an appeal of that denial in accordance with the Claims Procedures described in the Summary Plan Description. If your appeal is denied in accordance with

the Claims Procedures herein, and you have exhausted the administrative remedies provided to you under the Plan, 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 qualified status of a domestic relations order or a Medical Child Support Order, you may file suit in Federal court. If it should happen that 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 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 who was sued to pay these costs and fees. If you are not successful, the court may order you to pay these costs and fees (for example, if it finds your claim is frivolous).

Assistance with Your Questions

If you have any questions about the Plan, you should contact the OxyLink Employee Service Center by telephone at 1-800-699-6903 or +1-918-610-1990 (outside the U.S.), or by email at OXYLINK@oxy.com.

If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in the telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

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

APPENDIX A – Participating Employers

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

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

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

APPENDIX B – Benefit Programs

As of January 1, 2021 (except as otherwise provided below), the following Benefit Programs are incorporated, in their entirety, by reference into this Wrap-SPD:

US Dollar Medical (Including Prescription Drug) Benefit Programs:

1. BCBSTX HDHP Medical Program;
2. BCBSTX PPO Medical Program;
3. BCBSWNY Medical Program *(New York Employees Only)*†;
4. Independent Health (HMO) Medical Program *(New York Employees Only)*‡; and
5. Express Scripts Prescription Drug Program;

Other US Dollar Health Benefit Programs:

6. Dental Benefit Program;
7. Vision Insurance Program; and
8. Midland Health Center Program;

Global Health Benefit Program:

9. Global Medical, Dental and Vision Insurance Program;

Active Life Insurance Programs:

10. Basic Life Insurance Program;
11. Optional Group Universal Life Insurance Program; and
12. Dependent Life Insurance Program;

Accidental Death and Dismemberment ("***AD&D***") Insurance Programs:

13. Basic AD&D Insurance Program;
14. Voluntary AD&D Insurance Program; and
15. Occupational AD&D Insurance Program;

Disability Program:

16. Long-Term Disability Insurance Program;

† The BCBSWNY Medical Program *(New York Employees Only)* shall be terminated in its entirety as of January 1, 2022.

‡ The Independent Health (HMO) Medical Program *(New York Employees Only)* shall be terminated in its entirety as of January 1, 2023.

Employee Assistance Program:

17. Employee Assistance Program;

Health Flexible Spending Arrangements *(incorporated into the Plan solely for purposes of Form 5500 reporting pursuant to ERISA under the Plan)*:

18. General Purpose Health Flexible Spending Arrangement; and
19. Limited Purpose Health Flexible Spending Arrangement;

Retiree Life Insurance Program:

20. Basic Life Insurance Program for Retirees of Occidental Petroleum Corporation and Adopting Affiliates[§];

Legacy APC Retiree and Disabled Employee Life Insurance Programs *(provided under the Plan effective as of July 1, 2020)*:

21. Legacy APC Basic, Supplemental and Dependent Life Insurance Program for APC, KM and UPR Retirees;
22. Legacy APC Basic Life Insurance Program for Oryx Retirees;
23. Legacy APC Basic Life Insurance Program for Certain Disabled Employees;
24. Legacy APC Basic Life Insurance–Guaranteed Life Insurance Funding Account (GLIFA) Program; and
25. Legacy APC LTD Employee Supplemental Life Program.

[§] The Basic Life Insurance Program for Retirees of Occidental Petroleum Corporation and Adopting Affiliates became closed to new enrollment therein effective as of a date prior to the Effective Date of this amendment and restatement of the Plan.

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

APPENDIX C – Claims Administrators and Fiduciaries

As of January 1, 2021, the following third party entities serve as Claims Administrators and Claims Fiduciaries under the Plan (except as may otherwise be noted) with respect to the following Benefit Programs:

Benefit Program	Claims Administrator and Claims Fiduciary (except as otherwise noted)
• BCBSTX HDHP Medical Program; and • BCBSTX PPO Medical Program.	**Blue Cross and Blue Shield of Texas** Medical Claims: P.O. Box 660044 Dallas, Texas 75266-0044 Telephone: 877-276-4711 Claim Appeals: BCBS of Texas Claim Review Section P.O. Box 660044 Dallas, Texas 75266-0044 International Medical Claims: BCBS Global Core Program – Service Center P.O. Box 2048 Southeastern, PA 19399 Telephone: 800-810-2583 claims@bcbsglobalcore.com

Benefit Program	Claims Administrator and Claims Fiduciary (except as otherwise noted)
• BCBSWNY Medical Program *(New York Employees Only)*	**BlueCross BlueShield of Western New York** P.O. Box 80 Buffalo, NY 14240-0080 Telephone: 800-359-5456
• Independent Health (HMO) Medical Program *(New York Employees Only)*	**Independent Health** Claims Dept P.O. Box 9066 Buffalo, NY 14231 Telephone: 800-501-3439 Pharmacy Claims: Independent Health Attn: Pharmacy Claims P.O. Box 9066 Buffalo, NY 14231
• Express Scripts Prescription Drug Program	**Express Scripts** Attn: Commercial Claims P.O. Box 14711 Lexington, KY 40512-4711 Telephone: 800-551-7680

Benefit Program	Claims Administrator and Claims Fiduciary (except as otherwise noted)
• Dental Benefit Program	**Aetna Dental** P.O. Box 14094 Lexington, KY 40512-4094 Fax #: 859-455-8650 Telephone: 800-334-0299 Claim Appeals: Aetna Attn: National Account CRT P.O. Box 14463 Lexington, KY 40512
• Vision Insurance Program	**Vision Service Plan** VSP Vision Care P.O. Box 385018 Birmingham, AL 35238-0518 Telephone: 800-877-7195 Claim Appeals: VSP Vision Care 3333 Quality Drive Rancho Cordova, CA 95670-7985
• Midland Health Center Program	**Occidental Petroleum Corporation Employee Benefits Committee** Attn: Director, Benefits & Wellbeing 5 Greenway Plaza, Houston, TX 77046-0506 Telephone: (713) 215-7000
• Global Medical, Dental and Vision Insurance Program	**UnitedHealthcare** Medical Claims: P.O. Box 740111 Atlanta, GA 30374-0111 International Fax #: +1-813-877-8167 Dental & Vision Claims: P.O. Box 30978 Salt Lake City, UT 84130 Claim Appeals: Contact UHC to request: By Telephone: +1-763-274-7362; or In writing at: P.O. Box 740111, Atlanta, GA 30374-0111

Benefit Program	Claims Administrator and Claims Fiduciary (except as otherwise noted)
• Basic Life Insurance Program; • Optional Group Universal Life Insurance Program; • Dependent Life Insurance Program; • Basic Life Insurance Program for Retirees of Occidental Petroleum Corporation and Adopting Affiliates; • Legacy APC Basic, Supplemental and Dependent Life Insurance Program for APC, KM and UPR Retirees; • Legacy APC Basic Life Insurance Program for Oryx Retirees; • Legacy APC Basic Life Insurance Program for Certain Disabled Employees; • Legacy APC Basic Life Insurance–Guaranteed Life Insurance Funding Account (GLIFA) Program; and • Legacy APC LTD Employee Supplemental Life Program.	**Metropolitan Life Insurance Company** New York, NY 10166 For a Death Claim Form: Report a death under Group Universal Life: Telephone: 800-756-0124 Report a death for Basic Life and Term Life: Phone: 866-492-6983 For help contact: Claims Concierge Team: Telephone: 832-707-7427 Online: https://www.benefits-concierge.com/ Claimant's packet will be mailed to the beneficiary(ies) Claim Appeals: Metropolitan Life Insurance Company 700 Quaker Lane, 2nd Floor Warwick, RI 02886 Telephone: 800-438-6388
• Basic AD&D Insurance Program; and • Voluntary AD&D Insurance Program • Occupational AD&D Insurance Program	**Gerber Life Insurance Company** 1311 Mamaroneck Avenue White Plains, NY 10605 Telephone: 800-253-3074 A.C. Newman & Company Insurance (Broker) Fig Garden Financial Center 5200 N. Palm Avenue, Suite 107 Fresno, CA 93704
• Long-Term Disability Insurance Program	**Prudential Insurance Company of America** Disability Management Services P.O. Box 13480 Philadelphia, PA 19176 Telephone: 800-842-1718 Fax #: 877-889-4885 www.prudential.com/mybenefits

Benefit Program	Claims Administrator and Claims Fiduciary (except as otherwise noted)
• Employee Assistance Program	***Claims Administrator*** **Aetna Resources for Living** Complaint or Grievance 10260 Meanly Drive San Diego, CA 92131 Request form: 1-888-238-6232 or www.resourcesforliving.com U.S. Employees: Telephone: 888-238-6232 Online: https://www.resourcesforliving.com/login Non-U.S. Employees: [Telephone numbers for in-country toll-free access by country are set out in the Benefit Summary Plan Description Document for the Employee Assistance Program.] Online: Login at https://www.resourcesforliving.com/login, then to find country-specific information, select Services> International employee benefits> WPO Home Page (at bottom of page) ***Claims Fiduciary*** **Occidental Petroleum Corporation Employee Benefits Committee** Attn: Director, Benefits & Wellbeing 5 Greenway Plaza, Houston, TX 77046-0506 Telephone: (713) 215-7000

As of January 1, 2021, the following party serves as COBRA Administrator under the Plan:

COBRA Administrator:
OxyLink Employee Service Center
4500 S. 129th East Avenue
Tulsa, OK 74134-5801

Appeals of questions regarding COBRA Coverage and Entitlement (not for benefit claims):
Occidental Petroleum Corporation Employee Benefits Committee
Attn: Director, Benefits & Wellbeing
5 Greenway Plaza
Houston, TX 77046-0506
Telephone: (713) 215-7000

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

APPENDIX D – HIPAA

The following job classifications of employees (or classes of employees) are hereby designated as being entitled to receive Protected Health Information (*a.k.a.*, PHI) subject to HIPAA from the Health Care Component of the Plan:

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

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

APPENDIX E – Medicare Notice of Creditable Coverage

NOTICE OF CREDITABLE COVERAGE

Important Notice from Occidental Petroleum Corporation About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Occidental Petroleum Corporation (Oxy) 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:

1. 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.

2. Oxy has determined that the prescription drug coverage offered by the Occidental Petroleum Corporation Welfare Plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is 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 15th to December 7th.

However, if you lose your current creditable prescription drug coverage through no fault of your own, you will also be eligible for a two (2) 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 join a Medicare drug plan, please be advised that you cannot cancel only your prescription drug coverage without canceling all of your Oxy medical plan coverage. If you

cancel Oxy's medical plan coverage, be aware that you may not be able to get this coverage back later.

To re-enroll in the Oxy medical plan, you must have obtained other health coverage and provide proof of loss of that other health (including prescription drug) coverage within 31 days of the loss of coverage.

Your current Oxy coverage pays for other health expenses, in addition to prescription drugs, and you will still be eligible to receive all of your current health and prescription drug benefits if you choose to enroll in a Medicare prescription drug plan.

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 coverage with Oxy 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 get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Oxy 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 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. Information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Date: October 1, 2020
Name of Entity/Sender: Occidental Petroleum Corporation
Contact--Position/Office: OxyLink Corporate Benefits Department
Address: 4500 South 129th East Avenue, Tulsa OK, 74134-5801
Phone Number: 800-699-6903

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

APPENDIX F – Benefit Program Summary Plan Descriptions

The following Benefit Program Summary Plan Description documents which are operative as of January 1, 2021 are incorporated, in their entirety, into this Wrap-SPD by reference:*

- BCBSTX HDHP Medical Program:
    - Benefit Program Summary Plan Description, effective as of January 1, 2021, of the BCBSTX HDHP Medical Program;
- BCBSTX PPO Medical Program:
    - Benefit Program Summary Plan Description, effective as of January 1, 2021, of the BCBSTX PPO Medical Program;
- BCBSWNY Medical Program *(New York Employees Only)*:
    - Benefit Program Summary Plan Description, effective as of January 1, 2021, of the BCBSWNY Medical Program *(New York Employees Only)*;
- Independent Health (HMO) Medical Program *(New York Employees Only)*:
    - Benefit Program Summary Plan Description, effective as of January 1, 2021, of the Independent Health (HMO) Medical Program *(New York Employees Only)*;
- Express Scripts Prescription Drug Program:
    - Benefit Program Summary Plan Description, effective as of January 1, 2021, of the Express Scripts Prescription Drug Program;
- Dental Benefit Program:
    - Benefit Program Summary Plan Description, effective as of January 1, 2021, of the Dental Benefit Program;
- Vision Insurance Program:
    - Benefit Program Summary Plan Description, effective as of January 1, 2021, of the Vision Insurance Program;
- Midland Health Center Program:
    - Benefit Program Summary Plan Description, effective as of January 1, 2021, of the Midland Health Center Program;

* The Benefit Program Summary Plan Description documents listed in this Appendix shall also include any other amendments, riders or attachments thereto, or any other documents under which a Benefit Program is established and operated, as of January 1, 2021.

- Global Medical, Dental and Vision Insurance Program:
    - Benefit Program Summary Plan Description, effective as of January 1, 2021, of the Global Medical, Dental and Vision Insurance Program;†

- Basic Life Insurance Program:
    - Benefit Program Summary Plan Description, effective as of January 1, 2021, of the Basic Life Insurance Program;

- Optional Group Universal Life Insurance Program:
    - Benefit Program Summary Plan Description, effective as of January 1, 2021, of the Optional Group Universal Life Insurance Program;

- Dependent Life Insurance Program:
    - Benefit Program Summary Plan Description, effective as of January 1, 2021, of the Dependent Life Insurance Program;

- Basic AD&D Insurance Program:
    - Benefit Program Summary Plan Description, effective as of January 1, 2021, of the Basic AD&D Insurance Program;

- Voluntary AD&D Insurance Program:
    - Benefit Program Summary Plan Description, effective as of January 1, 2021, of the Voluntary AD&D Insurance Program;

- Occupational AD&D Insurance Program:
    - Benefit Program Summary Plan Description, effective as of January 1, 2021, of the Occupational AD&D Insurance Program;

- Long-Term Disability Insurance Program:
    - Benefit Program Summary Plan Description, effective as of January 1, 2021, of the Long-Term Disability Insurance Program;

- Employee Assistance Program:
    - Benefit Program Summary Plan Description, effective as of January 1, 2021, of the Employee Assistance Program;

- General Purpose Health Flexible Spending Arrangement and Limited Purpose Health Flexible Spending Arrangement (collectively, the "***FSAs***")*(incorporated into the Plan solely*

† This Benefit Program Summary Plan Description for the Global Medical, Dental and Vision Insurance Program may contain terms and provisions that apply with respect to both (a) Employees or former Employees (and their Dependents) and (b) individuals (and their dependents) who are employees of the Plan Sponsor or its affiliate but are not "Employees", as defined under the Plan ("***Non-Employees***"). For purposes of the Plan, references herein to this Benefit Program Summary Plan Description or the Global Medical, Dental and Vision Insurance Program shall not include any terms and provisions thereunder that apply only with respect to Non-Employees.

for purposes of IRS Form 5500 reporting under the Plan):

- Portions of the plan document of the Occidental Petroleum Corporation Cafeteria Benefit Plan, amended and restated effective as of January 1, 2021, that are applicable to the FSAs; and
- Portions of the Occidental Petroleum Corporation Cafeteria Plan Summary, effective as of January 1, 2021, that are applicable to the FSA (which, for purposes of this Plan, constitute the Benefit Program Summary Plan Description, effective as of January 1, 2021, of the FSAs);

- Basic Life Insurance Program for Retirees of Occidental Petroleum Corporation and Adopting Affiliates:
  - Benefit Program Summary Plan Description, effective as of January 1, 2021, of the Basic Life Insurance Program for Retirees of Occidental Petroleum Corporation and Adopting Affiliates;

- Legacy APC Basic, Supplemental and Dependent Life Insurance Program for APC, KM and UPR Retirees:
  - Benefit Program Summary Plan Description, effective as of January 1, 2021, of the Legacy APC Basic, Supplemental and Dependent Life Insurance Program for APC, KM and UPR Retirees;

- Legacy APC Basic Life Insurance Program for Oryx Retirees:
  - Benefit Program Summary Plan Description, effective as of January 1, 2021, of the Legacy APC Basic Life Insurance Program for Oryx Retirees;

- Legacy APC Basic Life Insurance Program for Certain Disabled Employees:
  - Benefit Program Summary Plan Description, effective as of January 1, 2021, of the Legacy APC Basic Life Insurance Program for Certain Disabled Employees;

- Legacy APC Basic Life Insurance–Guaranteed Life Insurance Funding Account (GLIFA) Program:
  - Benefit Program Summary Plan Description, effective as of January 1, 2021, of the Legacy APC Basic Life Insurance–Guaranteed Life Insurance Funding Account (GLIFA) Program; and

- Legacy APC LTD Employee Supplemental Life Program:
  - Benefit Program Summary Plan Description, effective as of January 1, 2021, of the Legacy APC LTD Employee Supplemental Life Program.

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

APPENDIX G – Eligibility

1. **Application and Interpretation.**

(a) This Appendix sets forth certain terms and conditions of eligibility to participate in the Benefit Programs hereunder, subject to subsection (b), below; provided, however, the controlling terms and conditions of eligibility to participate in the Employee Assistance Program are set forth in the Benefit Program Summary Plan Description of the Employee Assistance Program.

Additional terms and conditions of eligibility specified in the Benefit Program Summary Plan Description documents that are not contrary to, or inconsistent with, the terms and conditions in this Appendix G shall also apply. References herein to "Section" or "subsection" shall mean a reference to this Appendix G unless otherwise specified.

(b) If a term or condition of this Appendix G conflicts with a term or condition set forth in the Benefit Program Summary Plan Description document for a Fully-Insured Program, the term or condition in such Benefit Program Summary Plan Description document shall govern and control with respect to that Fully-Insured Program; otherwise, the terms and conditions of this Appendix G shall supersede any conflicting term or condition set forth in a Benefit Program Summary Plan Description document, and shall govern and control unless specifically stated otherwise herein. Notwithstanding the foregoing, if any such conflict involves a term or condition required by ERISA, the Code or other controlling law, on the one hand, and a term or condition not so required on the other, the term or condition required by controlling law shall control. Further, the following terms and conditions shall be subject to all other provisions of this document (without regard to any Benefit Program Summary Plan Description document incorporated herein) that govern eligibility for participation in the Plan.

(c) For purposes of this Appendix:

(i) the US Dollar Medical (Including Prescription Drug) Benefit Programs, the Other US Dollar Health Benefit Programs, the Global Health Benefit Program, the Active Life Insurance Programs, the Accidental Death and Dismemberment ("*AD&D*") Insurance Programs, the Disability Program, and the Retiree Life Insurance Program, as each is described in Appendix B, shall be referred to collectively herein as the "***US Dollar H&W Programs***"; and

(ii) the (A) Legacy APC Basic, Supplemental and Dependent Life Insurance Program for APC, KM and UPR Retirees, (B) Legacy APC Basic Life Insurance Program for Oryx Retirees, (C) Legacy APC Basic Life Insurance Program for Certain Disabled Employees, (D) Legacy APC Basic Life Insurance–Guaranteed Life Insurance Funding Account (GLIFA) Program, and (E) Legacy APC LTD Employee Supplemental Life Program, as each is described in Appendix B, shall be referred to collectively herein as the "***Legacy APC Welfare Benefit Programs***".

2. **Eligibility.**

(a) ***US Dollar H&W Programs.***

The following individuals shall be eligible to participate in the US Dollar H&W Programs (subject to any other applicable terms and conditions of eligibility in the relevant Benefit Program Summary Plan Description):

(i) A regular, hourly-paid or salaried Employee who is regularly scheduled to work at least 20 hours per week;

(ii) An Employee who is (A) regularly scheduled to work fewer than 20 hours per week, (B) classified by his Employer as "part-time", and (C) designated and approved by his Employer for participation in its "***Phased Retirement Program***" (subject to any other applicable terms and conditions of eligibility under the Phased Retirement Program); and

(iii) The Dependent(s) of an eligible Employee under subsection (a)(i) or (a)(ii), above;

provided that (A) only eligible Employees who work in the State of New York ("***New York Employees***") and their eligible Dependents shall be eligible to participate in either the BCBSWNY Medical Program or the Independent Health (HMO) Medical Program, and (B) New York Employees and their Dependents shall be ineligible to participate in the BCBSTX HDHP Medical Program and the BCBSTX PPO Medical Program.

Notwithstanding the foregoing:

- The BCBSWNY Medical Program *(New York Employees Only)* shall be terminated in its entirety effective as of January 1, 2022, and thus, effective as of January 1, 2022, (A) no Employees, Dependents or any other individuals shall be eligible to participate in the BCBSWNY Medical Program *(New York Employees Only)*, and (B) the coverage of all Participants (if any) in the BCBSWNY Medical Program *(New York Employees Only)* shall be terminated;

- Salaried New York Employees who have been given advance notice by the Employer of the termination of their employment on February 28, 2022 (the "***February Terminated Employees***") and their Dependents shall, effective as of January 1, 2022, be (A) ineligible to participate in the Independent Health (HMO) Medical Program *(New York Employees Only)* and (B) eligible to participate in either the BCBSTX HDHP Medical Program or the BCBSTX PPO Medical Program;

- Upon their termination of employment, the February Terminated Employees and their Dependents, who are entitled to and elect continuation of their medical coverage under COBRA with respect to such termination of employment, shall be provided such COBRA coverage under the applicable BCBSTX HDHP Medical Program or the BCBSTX PPO Medical Program;

- The Independent Health (HMO) Medical Program *(New York Employees Only)* shall be terminated in its entirety as of January 1, 2023, and thus, effective as of January 1, 2023,

(A) no Employees, Dependents or any other individuals shall be eligible to participate in the Independent Health (HMO) Medical Program *(New York Employees Only)*, and (B) the coverage of all Participants in the Independent Health (HMO) Medical Program *(New York Employees Only)* shall be terminated;

- Salaried New York Employees (other than the February Terminated Employees) whose employment terminates on a date that is after December 31, 2021, and their Dependents, who are entitled to and elect continuation of their medical coverage under COBRA with respect to such termination of employment, shall be provided such COBRA coverage under the Independent Health (HMO) Medical Program *(New York Employees Only)* until December 31, 2022;

- Effective as of January 1, 2023, actively employed Salaried New York Employees shall be eligible to participate in either the BCBSTX HDHP Medical Program or the BCBSTX PPO Medical Program; and

- The Basic Life Insurance Program for Retirees of Occidental Petroleum Corporation and Adopting Affiliates became closed to new enrollment therein as of an effective date prior to the Effective Date of this amendment and restatement of the Plan, and thus no Employees, Dependents or any other individuals are, or shall be, eligible to enroll in the Basic Life Insurance Program for Retirees of Occidental Petroleum Corporation and Adopting Affiliates as new Participants subsequent to such date.

A covered Employee who qualifies for long-term disability benefits under the Disability Program (an "***LTD Employee***") shall be eligible to continue coverage for himself and his covered Dependents under (A) the applicable US Dollar Medical (Including Prescription Drug) Benefit Program(s), (B) the Dental Benefit Program, and (C) the Basic Life Insurance Program (whether or not his employment with the Employer terminates following the date of his qualification for long-term disability benefits), through the last day of the period for which he qualifies for such long-term disability benefits, subject to the other applicable terms and conditions of eligibility and coverage under the Plan and the relevant Benefit Program.

An Employee or former Employee who (1) incurred an injury or illness prior to April 1, 2020 with respect to which such Employee qualified for long-term disability benefits under the APC Ancillary Plan, and (2) since the date of such initial qualification, has continuously maintained his qualification for such benefits under the same terms as applied by the applicable claims administrator or claims fiduciary to the initial qualification determination (a "***Legacy APC LTD Employee***") shall be eligible for coverage under the following Benefit Programs for himself and his eligible Dependents :

- the US Dollar Medical (Including Prescription Drug) Benefit Program(s);
- the Dental Benefit Program;
- the Vision Insurance Program; and
- the Basic Life Insurance Program;

through the last day of the period for which the Legacy APC LTD Employee qualifies for such long-term disability benefits, subject to the other applicable terms and conditions of eligibility and coverage under the Plan and the relevant Benefit Program. In addition, to the extent that a Legacy APC LTD Employee was enrolled in supplemental life insurance benefits coverage under the APC Ancillary

Plan on the date of his qualification for long-term disability benefits under the APC Ancillary Plan, he shall be eligible to continue supplemental life insurance benefits coverage under the Legacy APC LTD Employee Supplemental Life Program for a period of up to sixty (60) months following such qualification date, subject to the other applicable terms and conditions of eligibility and coverage under the Plan and the relevant Benefit Program.

Otherwise-eligible Employees and their eligible Dependents shall not be eligible to participate in the US Dollar H&W Program to the extent they are already covered with respect to the same benefits under the Global Health Benefit Program.

(b) ***Global Health Benefit Program.***

The following individuals shall be eligible to participate in the Global Health Benefit Program (subject to any other applicable terms and conditions of eligibility in the Benefit Program Summary Plan Description for the Global Health Benefit Program):

(i) An Employee who is:

(A) either:

(1) hourly-paid or salaried, regularly scheduled to work at least 20 hours per week, and classified by his Employer as "full-time"; or

(2) regularly scheduled to work fewer than 20 hours per week, classified by his Employer as "part-time", and designated and approved by his Employer for participation in its "***Phased Retirement Program***" (subject to any other applicable terms and conditions of eligibility under the Phased Retirement Program); and

(B) on the United States payroll of the Plan Sponsor or other Employer; and

(C) placed on a work assignment as an expatriate in a country outside the United States where (1) the Employee is expected to reside for a continuous period of time in excess of three months, and (2) the Plan Sponsor has determined, in its discretion, that the coverage provided under the US Dollar H&W Program is inadequate or inappropriate for such Employee and/or his Dependents.

(ii) The Dependent(s) of an eligible Employee under subsection (b)(i), above.

Employees who are placed as expatriates on rotational work assignments where they return to their home countries on a regular basis (and their Dependents) are not eligible to participate in the Global Health Benefit Program. Employees and their Dependents are ineligible to participate in the Global Health Benefit Program to the extent that they are already covered with respect to the same benefit under a US Dollar H&W Program.

(c) ***Legacy APC Welfare Benefit Programs***.

Effective as of July 1, 2020:

(i) Subject to subsections (c)(ii) and (c)(iii), below, an Employee (or former Employee) or Retiree shall be eligible to participate in a Legacy APC Welfare Benefit Program under the Plan if and to the extent such person is eligible under the terms of the applicable Benefit Program Summary Plan Description for such Legacy APC Welfare Benefit Program. The terms of such Benefit Program Summary Plan Description shall also (A) determine the Dependents or Beneficiaries of an Employee (or former Employee) or Retiree who are eligible to receive benefits under the Legacy APC Welfare Benefit Program, and (B) provide for the criteria for coverage thereunder.

(ii) With respect to a Legacy APC Welfare Benefit Program that provides for Retiree coverage thereunder:

(A) the status of an individual as a "Retiree" who is eligible to participate in such Retiree coverage; and

(B) to the extent that eligibility for such Retiree coverage is based on (1) the Retiree's "***Legacy Retiree Group***" (as such term is defined in the Anadarko Health Reimbursement Arrangement under the APC Retiree Health Plan (the "***APC Retiree HRA***"), including the relevant point in time at which such identification is made), if the Retiree's termination from employment with his employer occurred on or after January 1, 2007, or (2) the employer with respect to which the Retiree terminated from employment ("***Termination Employer***"), if the Retiree's termination from employment with such employer occurred prior to January 1, 2007, the identification of such Legacy Retiree Group or Termination Employer, as applicable;

shall be determined based on the same terms that are applied for such purpose under the APC Retiree HRA; provided, however, such Retiree coverage shall be further subject to (a) the applicable eligibility requirements of the Benefit Program Summary Plan Description for such Legacy APC Welfare Benefit Program which are not inconsistent with the foregoing and (b) the other eligibility requirements of the Plan.

(iii) Certain Legacy APC LTD Employees who previously participated in supplemental life insurance benefits coverage under the APC Ancillary Plan shall be eligible to continue supplemental life insurance benefits coverage under the Legacy APC LTD Employee Supplemental Life Program, as described in Section 2(a), above.

Notwithstanding the foregoing:

- The Legacy APC Basic Life Insurance Program for Certain Disabled Employees became closed to any new enrollment therein effective as of July 1, 2020;

- The Legacy APC Basic, Supplemental and Dependent Life Insurance Program for APC, KM and UPR Retirees became closed to any new enrollment therein effective as of July 1, 2021, except with respect to Employees who are entitled to enroll in APC COC Life Coverage thereunder pursuant to the Anadarko Petroleum

Corporation Change of Control Severance Plan, as described in Section 2(e), below;

- The Legacy APC Basic Life Insurance Program for Oryx Retirees and the Legacy APC Basic Life Insurance–Guaranteed Life Insurance Funding Account (GLIFA) Program each became closed to any new enrollment therein as of a date prior to the Effective Date of this amendment and restatement of the Plan; and

- The Legacy APC LTD Employee Supplemental Life Program became closed to any new enrollment therein effective as of July 1, 2020.

Consequently, no Employees, Dependents or any other individuals shall be eligible to enroll in the above-referenced Benefit Programs as new Participants therein effective as of the applicable closure date (except as otherwise provided above).

(d) ***Eligibility Pursuant to a Separate Written Agreement***.

(i) *Officer Status at Time of Employment Termination*. The Plan Sponsor may, in its discretion, offer extended medical, prescription drug, dental and/or vision benefits coverage under the Plan to an Employee whose medical, prescription drug, dental and/or vision benefits coverage would otherwise terminate under the terms of the Plan due to the termination of his employment with his Employer ("***Termination Event***") and who, at the time of the Termination Event, is an officer of the Plan Sponsor (or other Employer) ("***Extended Officer Coverage***"). The Extended Officer Coverage shall be provided pursuant to a separate written agreement entered into by and between the Employee and the Plan Sponsor ("***Extended Officer Coverage Agreement***"). The Extended Officer Coverage may, but need not, include continued coverage for the Employee's Dependents (or any of them). The Plan Sponsor may, but need not, obtain separate group or individual policies of insurance under the Plan through which the Extended Officer Coverage will be provided.

The terms of the Extended Officer Coverage, including the particular benefits under the Plan to which the Extended Officer Coverage applies, the extent to which Dependent coverage will be included, the period for which the Extended Officer Coverage will be provided, and any required contributions by the Employee toward the cost of coverage and the related payment terms, will be set out in and administered in accordance with the Extended Officer Coverage Agreement. The relationship of the Extended Officer Coverage to any COBRA continuation coverage to which the Employee and any Dependent may be eligible as a result of the Termination Event may also be specified in the Extended Officer Coverage Agreement; provided, however, if the Extended Officer Coverage Agreement does not so specify, then upon exhaustion or other termination of the Extended Officer Coverage, each covered Employee and his covered Dependents shall be permitted to elect COBRA Continuation Coverage in accordance with Article XI of the Plan if otherwise eligible and to the extent permitted by applicable law, in which case the period of Extended Employee Coverage shall not be applied to offset any portion of the maximum period of COBRA Continuation Coverage to which such Employee or Dependents are otherwise entitled.

(ii) *Other Employees*. The Plan Sponsor may, in its discretion, offer extended coverage under the Plan to an Employee whose coverage under the Plan would otherwise terminate under the terms of the Plan due a Termination Event ("***Extended Employee Coverage***"). The Extended Employee Coverage shall be provided pursuant to a separate

written agreement entered into by and between the Employee and the Plan Sponsor ("***Extended Employee Coverage Agreement***"). The Extended Employee Coverage may, but need not, include continued coverage for the Employee's Dependents (or any of them). The Plan Sponsor may, but need not, obtain separate group or individual policies of insurance under the Plan through which the Extended Employee Coverage will be provided.

The terms of the Extended Employee Coverage, including the particular benefits under the Plan to which the Extended Employee Coverage applies, the extent to which Dependent coverage will be included, the period for which the Extended Employee Coverage will be provided, any required contributions by the Employee toward the cost of coverage and the related payment terms, will be set out in and administered in accordance with the Extended Employee Coverage Agreement. The relationship of the Extended Employee Coverage to any COBRA continuation coverage to which the Employee and any Dependent may be eligible as a result of the Termination Event will also be specified in the Extended Employee Coverage Agreement; provided, however, if the Extended Employee Coverage Agreement does not so specify, then upon exhaustion or other termination of the Extended Employee Coverage, each covered Employee and his covered Dependents shall be permitted to elect COBRA Continuation Coverage in accordance with Article XI of the Plan if otherwise eligible, in which case the period of Extended Employee Coverage shall not be applied to offset any portion of the maximum period of COBRA Continuation Coverage to which such Employee or Dependents are otherwise entitled.

(e) ***Eligibility Pursuant to Severance Plan***.

(i) Anadarko Petroleum Corporation Change of Control Severance Plan ("***APC COC Plan***"). Effective as of January 1, 2021, and in accordance with the terms of the APC COC Plan, a covered Employee under the Plan who has satisfied the applicable conditions of the APC COC Plan for continued life, medical and dental benefits coverage in connection with his termination of employment under the APC COC Plan shall be entitled to receive (A) continued, Employer-paid basic life insurance coverage ("***APC COC Life Coverage***") under the Basic Life Insurance Program, and (B) continued coverage for himself and for his covered Dependents, if any, under (1) the applicable US Dollar Medical (Including Prescription Drug) Benefit Program(s) and (2) the Dental Benefit Program, at the Participant Contribution rates paid by similarly-situated active Employees ("***APC COC Health Coverage***"), each for a period of up to six (6) months (or other prescribed period) following the date of the Employee's termination from employment or other applicable date under the terms of the APC COC Plan.

If, as of the Employee's employment termination date or other applicable date under the terms of the APC COC Plan, such Employee meets the terms of eligibility to participate in retiree medical coverage under the APC Retiree Health Plan, then subsequent to the expiration of the 6-month (or other prescribed) period of APC COC Life Coverage described above in this subsection (i), he shall be eligible to receive APC COC Life Coverage under the Legacy APC Basic, Supplemental and Dependent Life Insurance Program for APC, KM and UPR Retirees.

The APC COC Life Coverage and APC COC Health Coverage may be terminated prior to such 6-month (or other prescribed) period as provided in Section 5, below, or in the applicable Benefit Program Summary Plan Description, and as may be provided under the APC COC Plan. Upon exhaustion or other termination of the APC COC Health Coverage,

each covered Employee and his covered Dependents shall be permitted to elect COBRA Continuation Coverage in accordance with Article XI of the Plan if otherwise eligible. In that case, the period of APC COC Health Coverage shall not be applied to offset any portion of the maximum period of COBRA Continuation Coverage to which such Employee or Dependents are otherwise entitled.

(ii) Anadarko Petroleum Corporation 2019 Voluntary Separation Plan ("***2019 APC VSP***"). Effective as of January 1, 2021, and in accordance with the terms of the 2019 APC VSP, a covered Employee under the Plan who has satisfied the applicable conditions of the 2019 APC VSP for continued life, medical and dental benefits coverage in connection with his termination of employment thereunder shall be entitled to receive (A) continued, employer-paid coverage under the Basic Life Insurance Program ("***2019 APC VSP Life Coverage***"), and (B) continued coverage for himself and for his covered Dependents, if any, under (1) the applicable US Dollar Medical (Including Prescription Drug) Benefit Program(s) and (2) the Dental Benefit Program, at the Participant Contribution rates paid by similarly-situated active Employees ("***2019 APC VSP Health Coverage***"), each for a period of up to six (6) months (or other prescribed period) following the date of the Employee's termination from employment or other applicable date under the terms of the 2019 APC VSP.

The 2019 APC VSP Life Coverage and 2019 APC VSP Health Coverage may be terminated prior to such 6-month (or other prescribed) period as provided in Section 5, below, or in the applicable Benefit Program Summary Plan Description, and as may be provided under the 2019 APC VSP. Upon exhaustion or other termination of the 2019 APC VSP Health Coverage, each covered Employee and his covered Dependents shall be permitted to elect COBRA Continuation Coverage in accordance with Article XI of the Plan if otherwise eligible. In that case, the period of 2019 APC VSP Health Coverage shall not be applied to offset any portion of the maximum period of COBRA Continuation Coverage to which such Employee or Dependents are otherwise entitled.

(iii) Occidental Petroleum Corporation 2019 Voluntary Separation Plan ("***2019 Oxy VSP Component***") *(which is a component of the Separate Coverage under the Plan)*. Effective as of July 1, 2019, and in accordance with the terms of the 2019 Oxy VSP Component, a covered Employee under the Plan who has satisfied the applicable conditions of the 2019 Oxy VSP Component for continued medical, dental, and vision benefits coverage (other than coverage under the retiree medical and dental benefit plans sponsored by Occidental Petroleum Corporation or its affiliate) in connection with his termination of employment thereunder shall be entitled to receive continued coverage for himself and for his covered Dependents, if any, under (A) the applicable US Dollar Medical (Including Prescription Drug) Benefit Program(s) and (B) the Dental Benefit Program, at the Participant Contribution rates paid by similarly-situated active Employees ("***2019 Oxy VSP Health Coverage***"), each for a period of up to twelve (12) months (or other prescribed period) following the date of the Employee's termination from employment or other applicable date under the terms of the 2019 Oxy VSP Component.

The 2019 Oxy VSP Health Coverage may be terminated prior to such 12-month (or other prescribed) period as provided in Section 5, below, or in the applicable Benefit Program Summary Plan Description, and as may be provided under the 2019 Oxy VSP Component. Upon exhaustion or other termination of the 2019 Oxy VSP Health Coverage, each covered Employee and his covered Dependents shall be permitted to elect COBRA Continuation

Coverage in accordance with Article XI of the Plan if otherwise eligible. In that case, the period of 2019 Oxy VSP Health Coverage shall not be applied to offset any portion of the maximum period of COBRA Continuation Coverage to which such Employee or Dependents are otherwise entitled.

(iv) Occidental Petroleum Corporation Notice and Severance Pay Plan ("***Oxy NSPP Component***") *(which is a component of the Separate Coverage under the Plan)*. Effective as of May 1, 2020, and in accordance with the terms of the Oxy NSPP Component, a covered Employee under the Plan who has satisfied the applicable conditions of Option A of the Oxy NSPP Component for continued medical and dental benefits coverage (other than coverage under the retiree medical and dental benefit plans sponsored by Occidental Petroleum Corporation or its affiliate) in connection with his termination of employment thereunder shall be entitled to receive continued coverage for himself and for his covered Dependents, if any, under (A) the applicable US Dollar Medical (Including Prescription Drug) Benefit Program(s) and (B) the Dental Benefit Program, at the Participant Contribution rates paid by similarly-situated active Employees ("***Oxy NSPP Health Coverage***"), each for the period of such Employee's "severance" (as determined under the Oxy NSPP Component) which immediately follows the last day of the Employee's "notice" period (as determined under the Oxy NSPP Component) or other applicable date under the terms of the Oxy NSPP Component.

The Oxy NSPP Health Coverage may be terminated prior to the last day of such severance period, as provided in Section 5, below, or in the applicable Benefit Program Summary Plan Description, and as may be provided under the Oxy NSPP Component. Upon exhaustion or other termination of the Oxy NSPP Health Coverage, each covered Employee and his covered Dependents shall be permitted to elect COBRA Continuation Coverage in accordance with Article XI of the Plan if otherwise eligible. In that case, the period of Oxy NSPP Health Coverage shall not be applied to offset any portion of the maximum period of COBRA Continuation Coverage to which such Employee or Dependents are otherwise entitled.

(v) Occidental Petroleum Corporation Change in Control Severance Plan ("***Oxy CIC Component***") *(which is a component of the Separate Coverage under the Plan)*. Effective as of February 13, 2020, and in accordance with the terms of the Oxy CIC Component, a covered Employee under the Plan who has satisfied the applicable conditions of the Oxy CIC Component for continued life, medical and dental benefits coverage in connection with his termination of employment under the Oxy CIC Component shall be entitled to receive (A) continued, employer-paid coverage under the Basic Life Insurance Program ("***Oxy CIC Life Coverage***"), and (B) continued coverage for himself and for his covered Dependents, if any, under (1) the applicable US Dollar Medical (Including Prescription Drug) Benefit Program(s) and (2) the Dental Benefit Program, at the Participant Contribution rates paid by similarly-situated active Employees ("***Oxy CIC Health Coverage***"), each for a period of up to six (6) months (or other prescribed period) following the date of the Employee's termination from employment or other applicable date under the terms of the Oxy CIC Component. The Oxy CIC Life Coverage and Oxy CIC Health Coverage may be terminated prior to such 6-month (or other prescribed) period as provided in Section 5, below, or in the applicable Benefit Program Summary Plan Description, and as may be provided under the Oxy CIC Component. Upon exhaustion or other termination of the Oxy CIC Health Coverage, each covered Employee and his covered Dependents shall be permitted to elect COBRA Continuation Coverage in accordance with Article XI of the Plan if otherwise eligible. In that case, the period

of Oxy CIC Health Coverage shall not be applied to offset any portion of the maximum period of COBRA Continuation Coverage to which such Employee or Dependents are otherwise entitled.

In the event that a covered Employee under the Plan is a participant in the Oxy CIC Component, but is barred from participating in the Oxy CIC Health Coverage due to applicable law or terms of this Plan, and such Employee instead elects to continue his participation and that of his eligible dependents in the US Dollar Medical (Including Prescription Drug) Benefit Program(s) and/or the Dental Benefit Program under COBRA, then, until the conclusion of the 6-month (or other prescribed) period following the date of the Employee's termination from employment (or other applicable date under the terms of the Oxy CIC Component) or, if earlier, until the date such Employee begins new employment or otherwise ceases to be eligible for coverage with respect to the US Dollar Medical (Including Prescription Drug) Benefit Program(s) and/or the Dental Benefit Program under COBRA, the Plan Sponsor shall contribute to the premium cost of such Employee's COBRA coverage and that of his eligible Dependents under such Plan programs at the rate it contributed to such Employee's premium cost of coverage on the date of the Employee's termination from employment (or other applicable date under the terms of the Oxy CIC Component), which contributions shall be subject to withholding taxes to the extent treated as taxable income to the Employee.

(f) ***General Exclusions from Eligibility***.

Notwithstanding the foregoing provisions of this Section 2, no individual who meets any one of the following may be an eligible Employee with respect to the Plan (or the particular Benefit Program, as applicable):

- 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 a particular Benefit Program, as applicable) was the subject of good faith bargaining, unless such agreement provides for coverage of such Employees in the Plan (or the particular Benefit Program, as applicable); or

- an Employee who is employed by a division or operating unit of the Employer for which the Plan (or the particular Benefit Program, as applicable) has not been adopted; or

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

An individual may not be eligible for coverage under the Plan as the Dependent of more than one Employee. In addition, an individual who has coverage under another group health or welfare benefit plan maintained by the Plan Sponsor or other Employer ("***Other Employer Coverage***") shall not be eligible to participate as the Dependent of an Employee in a Benefit Program that provides the same type of benefits coverage (for example, medical or dental benefits coverage) as the Other Employer Coverage.

Only one of two married Employees, or one of two Employee members of a Domestic Partnership, may cover Children as eligible Dependents.

(g) ***Nondiscrimination in Eligibility***.

The eligibility requirements of the Plan shall not discriminate in any manner that is prohibited under the applicable nondiscrimination requirements of the Code.

3. **Accreditation of Employment Service and Accrued Benefits in Certain Circumstances**.

In the event of an acquisition or merger transaction involving the Plan Sponsor (or other Employer or an Affiliate) and a non-affiliated corporate entity or entities (collectively, the "***Target***"), incident to which employees of Target become employed as Employees of the Plan Sponsor or other Employer, the Plan Administrator may, in its discretion, apply years of employment service or benefits that were accrued by such employees and their dependents (or certain non-discriminatory classes of such individuals) under Target's welfare benefits plans toward such employees' and dependents' eligibility for participation and coverage under the corresponding Benefit Programs of the Plan.

The Plan Administrator may also, in its discretion, recognize and credit any additional years of service that are accredited to an Employee for purposes of eligibility or other term of coverage under the Plan pursuant to the terms of a separate written agreement between such Employee and the Plan Sponsor or other Employer.

The provisions of this Section 3 will not apply to a Fully-Insured Program to the extent not permitted by the terms of such Fully-Insured Program.

Any decision by the Plan Administrator to so recognize and credit the employment service and/or accrued benefits of any Employee shall be made on a nondiscriminatory basis pursuant to rules consistently applied to similarly-situated Employees and shall not discriminate in operation in favor of highly-compensated Employees or key Employees under applicable requirements of the Code.

4. **Benefits Paid to or on Behalf of Ineligible Dependent**.

If an individual receives a benefit or reimbursement under the Plan as the Dependent of an Employee at a time when such individual did not satisfy the applicable criteria for Dependent eligibility, such Employee will be subject to remedial action by the Employer, including, but not limited to, (i) repayment of such benefit or reimbursement to the Plan, (ii) reporting such benefit or reimbursement as taxable income to the Employee to the Internal Revenue Service, as applicable, and (iii) disciplinary action up to and including termination of employment. The Plan may require an Employee to make such repayment according to the provisions of Section 10.10 of the Wrap-SPD.

5. Termination of Coverage.

(a) ***Employee Coverage***.

Subject to subsection (c), below, and the provisions of Section 2 of this Appendix, above, that provide for the post-termination extension of an Employee's coverage, an Employee's coverage will terminate on the earliest to occur of the following:

(i) With respect to (A) the US Dollar Medical (Including Prescription Drug)

Benefit Programs, (B) the Other US Dollar Health Benefit Programs (except for the Midland Health Center Program), and (C) the Global Health Benefit Program, the last day of the month in which the Employee terminates employment; with respect to all other Benefit Programs, the date of the Employee's termination of employment;

(ii) The date on which the Plan terminates, or is amended to eliminate coverage for the Employee, for whatever reason;

(iii) With respect to (A) the US Dollar Medical (Including Prescription Drug) Benefit Programs, (B) the Other US Dollar Health Benefit Programs (except for the Midland Health Center Program), and (C) the Global Health Benefit Program, the last day of the month in which the Employee ceases to be eligible to participate in the Plan; with respect to all other Benefit Programs, the date on which the Employee ceases to be eligible to participate in the Plan;

(iv) The date of the Employee's death;

(v) The last day of the period for which any required Participant Contribution for the Employee's coverage has been made if the Participant Contribution for the next period of coverage is not paid when due (unless the Plan Administrator grants an extension of such due date based on the Employee's incapacity or other similar circumstances, as determined by the Plan Administrator in its discretion);

(vi) The date on which the Employee falsifies information provided to the Plan, fraudulently or deceptively uses Plan services, or knowingly permits such fraud or deception by another person, including enrolling a person as a Spouse, Domestic Partner or other Dependent who does not qualify as a Dependent under the terms of the Plan;

(vii) The last day of the month in which the Employee completes six months of unpaid leave of absence; or

(viii) With respect to an LTD Employee (as defined in Section 2(a), the last day of the period for which the LTD Employee qualifies for such long-term disability benefits.

(b) ***Dependent Coverage***.

Subject to subsections (c), below, the provisions of Section 2, above, that provide for the post-termination extension of coverage for an Employee and his Dependents, and Section 6 of this Appendix, coverage for a Dependent will terminate on the earliest to occur of the following:

(i) The date on which the Plan terminates, or is amended to eliminate coverage for the Dependent, for whatever reason;

(ii) The last day of the period for which any required Participant Contribution for the Dependent's coverage has been made if the Participant Contribution for the next period of coverage is not paid when due (unless the Plan Administrator grants an extension of such due date based on the Employee's or Surviving Dependent's incapacity or other similar circumstance, as determined by the Plan Administrator in its discretion);

(iii) The date the Dependent becomes covered under the Plan as an Employee;

(iv) With respect to (A) the US Dollar Medical (Including Prescription Drug) Benefit Programs, (B) the Other US Dollar Health Benefit Programs (except for the Midland Health Center Program), and (C) the Global Health Benefit Program, the last day of the month in which the Dependent ceases to be eligible to participate in the Plan; with respect to all other Benefit Programs, the date on which the Dependent ceases to be eligible to participate in the Plan;

(v) The date on which the Dependent falsifies information provided to the Plan, fraudulently or deceptively uses Plan services, or knowingly permits such fraud or deception by another person;

(vi) For other than a Surviving Dependent, the date the Dependent's coverage ceases to be available to the Employee;

(vii) For other than a Surviving Dependent, the date on which an Employee elects to terminate coverage for his Dependent;

(viii) With respect to a Surviving Dependent, the last day of the second month following the month in which the Employee's date of death occurred; and

(ix) With respect to the Dependent of an LTD Employee (as defined in Section 2(a) of this Appendix), the last day of the period for which the LTD Employee qualifies for such long-term disability benefits.

(c) ***Retroactive Termination***.

Coverage under a Benefit Program that is subject to the Affordable Care Act may be retroactively terminated only (i) if an Employee or Dependent performs an act, practice or omission that constitutes fraud, (ii) if an Employee or Dependent makes an intentional misrepresentation of material fact, as determined by the Plan Administrator in its discretion, (iii) as permitted under the Affordable Care Act and the authoritative guidance issued thereunder, or (iv) for failure to pay Participant Contributions when due.

6. Surviving Dependent Coverage.

If an Employee dies while covered under the Plan, and he did not meet the eligibility criteria for coverage as a "retiree" under the Plan Sponsor's retiree group health plan as of his date of death, then any coverage under the US Dollar Medical (Including Prescription Drug) Benefit Programs, the Dental Benefit Program and the Vision Insurance Program as then in effect for the deceased Employee's surviving Spouse or Domestic Partner and other Dependents who are covered under the Plan on the date of the Employee's death (the "***Surviving Dependents***") may, at the election of such Surviving Dependents, be continued through the last day of the second month following the month in which the Employee's date of death occurred, or until terminated pursuant to Section 5, above, if earlier ("***Surviving Dependent Coverage***").

Surviving Dependents who decline Surviving Dependent Coverage will be entitled to elect COBRA Continuation Coverage in accordance with the terms of the Plan; however, once Surviving Dependent Coverage is declined, Surviving Dependents will not again be eligible to elect Surviving Dependent Coverage.

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

APPENDIX H – Provisions Related to COVID-19

A. Defined Terms.

Capitalized terms used in this Appendix shall have the definitions set forth in Section J of this Appendix, or otherwise as set forth in Article I of this Wrap-SPD. Such definitions shall supersede any other definitions for the same terms as set forth in the Benefit Program Summary Plan Description documents for the Benefit Programs, unless a different definition is plainly required by the context.

B. Application and Interpretation.

The provisions of this Appendix are effective as specified herein. Such provisions are intended to comply with the COVID-19 Laws and shall be interpreted, construed and applied accordingly. They shall supersede any contrary or inconsistent provisions elsewhere in this Wrap-SPD, as well as any provisions in a Benefit Program Summary Plan Description regarding the same subject that are contrary to (or inconsistent with) and more restrictive than the provisions herein, except to the extent otherwise required by applicable law.

C. Coverage of COVID-19 Diagnostic Services.

The Plan shall provide coverage, and shall not impose any cost-sharing (including deductibles, copayments, and coinsurance) requirements or prior authorization or other medical management requirements, for the following items and services which are furnished during the period beginning on March 18, 2020 and ending on the last day of the COVID-19 Public Health Emergency Period:

(1) An in vitro diagnostic test defined in section 809.3 of title 21, Code of Federal Regulations (or successor regulations) for the detection of SARS-CoV-2 or the diagnosis of the virus that causes COVID-19, and the administration of such a test—

  (a) that is approved, cleared, or authorized under section 510(k), 513, 515, or 564 of the Federal Food, Drug, and Cosmetic Act ("***FDC Act***");

  (b) for which the developer has requested, or intends to request, emergency use authorization under section 564 of the FDC Act, unless and until the emergency use authorization request under such section 564 has been denied or the developer of such test does not submit a request under such section within a reasonable timeframe;

  (c) that is developed in and authorized by a State that has notified the Secretary of HHS of its intention to review tests intended to diagnose COVID-19; or

  (d) that is another test that the Secretary of HHS determines appropriate in guidance;

the foregoing referred to collectively herein as "***COVID-19 Diagnostic Testing***"; and

(2) Items and services furnished to an individual during health care provider office visits (which includes in-person visits and telehealth visits, as well as any other traditional and non-traditional care settings in which COVID-19 Diagnostic Testing is ordered or administered, including COVID-19 drive-through screening and testing sites where licensed healthcare providers are administering COVID-19 Diagnostic Testing), urgent care center visits, and emergency room visits that result in an order for or administration of COVID-19 Diagnostic Testing, but only to the extent such items and services relate to the furnishing or administration of such COVID-19 Diagnostic Testing or to the evaluation of such individual for purposes of determining the need of such individual for such COVID-19 Diagnostic Testing (the foregoing referred to collectively herein as "***COVID-19 Diagnostic Visit Services***").

The coverage of the COVID-19 Diagnostic Testing and COVID-19 Diagnostic Visit Services (collectively, the "***COVID-19 Diagnostic Services***") described hereunder shall be provided when medically appropriate for the individual, as determined by his attending healthcare provider in accordance with accepted standards of current medical practice.

COVID-19 testing that is conducted to screen for general workplace health and safety (such as employee "return to work" programs), for public health surveillance for SARS-CoV-2, or for any other purpose not primarily intended for individualized diagnosis or treatment of COVID-19 or another health condition does not constitute a COVID-19 Diagnostic Service that is subject to the requirements hereunder.

D. Reimbursements for COVID-19 Diagnostic Services.

For the period beginning on March 18, 2020, and ending on the last day of the COVID-19 Public Health Emergency Period, reimbursements to the provider of any COVID-19 Diagnostic Service for such service shall be provided under the Plan as follows, to the extent required by the COVID-19 Laws:

(1) If the Plan Administrator of the Plan or the Claims Administrator of the applicable Benefit Program has a negotiated rate with such provider in effect before the COVID-19 Public Health Emergency Period, such negotiated rate shall apply throughout the COVID-19 Public Health Emergency Period; or

(2) If the Plan Administrator of the Plan or the Claims Administrator of the applicable Benefit Program does not have a negotiated rate with such provider, reimbursements to the provider shall be provided under the Plan (or Benefit Program) in an amount that equals the cash price for the COVID-19 Diagnostic Service as listed by the provider on a public internet website, or the Plan Administrator of the Plan or Claims Administrator of the applicable Benefit Program may negotiate a rate with such provider for less than such cash price.

E. Pre-Deductible Services and High Deductible Health Plan Status.

(1) *COVID-19 Diagnostic Services*. With respect to reimbursements of expenses incurred on or after January 1, 2020, a Benefit Program that otherwise satisfies the requirements to be an HDHP under Code Section 223(c)(2)(A) will not fail to be an HDHP solely because the Benefit Program provides medical care services and items purchased related to testing for and treatment of COVID-19 prior to the satisfaction of the

applicable minimum deductible. For this purpose, (a) a panel of diagnostic testing for influenza A & B, norovirus and other coronaviruses, and respiratory syncytial virus (RSV) and (b) any COVID-19 Diagnostic Services are part of testing for and treatment of COVID-19.

(2) *Telehealth and Remote Health Care Services*. With respect to services provided on or after January 1, 2020, during Plan Years beginning on or before December 31, 2021, a Benefit Program that otherwise satisfies the requirements to be an HDHP under Code Section 223(c)(2)(A) will not fail to be an HDHP solely by reason of (a) failing to have a deductible for any telehealth and other remote care services provided thereunder or (b) having a deductible for such services that is below the minimum annual deductible otherwise required by Code Section 223(c)(2)(A).

F. Coronavirus Preventive Services.

Effective from March 27, 2020, through the last day of the COVID-19 Public Health Emergency Period, the Plan shall cover (without cost-sharing) any Qualifying COVID-19 Preventive Service pursuant to the preventive services requirements of the Affordable Care Act, regardless of whether such service is delivered by an in-network or out-of-network provider. Such coverage shall become effective no later than the date that is 15 business days after the date on which an Agency Recommendation is made regarding the particular Qualifying COVID-19 Preventive Service. If the Qualifying COVID-19 Preventive Service is delivered by an out-of-network provider, the Plan shall reimburse the provider for such service in an amount that is reasonable, as determined in comparison to prevailing market rates for such services, as determined by the Plan Administrator or its designee.

G. Extension of Certain Timeframes.

Effective as of March 1, 2020, the following Compliance Timeframes under the Plan shall be tolled during the COVID Disregarded Period:

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

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

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

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

(5) In the event that an Employee is entitled to special enrollment under the Plan for himself and/or his Dependents (including his Spouse) pursuant to HIPAA, the 30-day (or 60-day, if applicable) timeframe within which such enrollment must be requested;

(6) The timeframe within which individuals are permitted to file a benefit claim under the Plan's claim and appeal procedures;

(7) The timeframe within which claimants are permitted to file an appeal of an adverse benefit determination under the Plan's claim and appeal procedures;

(8) The timeframe within which claimants are permitted to file a request for an external review, if applicable, after receipt of an adverse benefit determination or final internal adverse benefit determination under the Plan's claim and appeal procedures; and

(9) The timeframe within which a claimant is permitted to file information to perfect a request for external review, if applicable, upon a finding that the request was not complete under the Plan's claim and appeal procedures.

The application of the COVID-19 Disregarded Period under the Plan is intended to comply with ERISA Section 518, Code Section 7508A(b), the Relief Notice, and any subsequent related law or authoritative guidance that is issued or adopted by the appropriate government agency, and shall be interpreted and construed accordingly.

H. Good Faith Relief Regarding Disclosures.

As provided in Disaster Relief Notice 2020-01, "Guidance and Relief for Employee Benefit Plans Due to the COVID-19 (Novel Coronavirus) Outbreak", issued by the Employee Benefit Security Administration of the DOL, effective during the period beginning on March 1, 2020 and ending on the Relief End Date, the Plan and the responsible Plan fiduciary will not be in violation of ERISA for a failure to timely furnish a notice, disclosure, or document which is required by the provisions of Title I of ERISA over which the DOL has interpretive and regulatory authority (except for those notices and disclosures addressed in the Relief Notice and which must be furnished between March 1, 2020, and the Relief End Date), if the Plan and responsible fiduciary act in good faith and furnish the notice, disclosure, or document as soon as administratively practicable under the circumstances. Good faith acts shall include, without limitation, use of electronic alternative means of communicating with Participants who the Plan fiduciary reasonably believes have effective access to electronic means of communication, including email, text messages, and continuous access websites.

I. COBRA Subsidy under American Rescue Plan Act of 2021.

Notwithstanding anything in this Wrap-SPD, the Wrap-Plan or a Benefit Program Summary Plan Description to the contrary, the Plan will be administered in accordance with the applicable requirements of Section 9501 of the American Rescue Plan Act of 2021 and the authoritative legal guidance issued thereunder (collectively, the "***ARPA COBRA Provisions***"). The ARPA COBRA Provisions provide for subsidized COBRA continuation coverage with respect to "assistance eligible individuals", as such term is defined thereunder. A Covered Employee who qualifies or may qualify for subsidized COBRA continuation coverage under the ARPA COBRA Provisions should contact the Plan Administrator at the address and telephone number listed in Article XIV for additional information.

J. Definitions.

(1) "***Agency Recommendation***" means a recommendation referenced in subsection (13)(a) or subsection (13)(b), below.

(2) "***Compliance Timeframe***" shall mean each elapsed timeframe under the Plan that is

subject to relief under the Relief Notice.

(3) "***COVID-19 Diagnostic Testing***" shall have the meaning for such term as set forth in Section C of this Appendix.

(4) "***COVID-19 Diagnostic Visit Services***" shall have the meaning for such term as set forth in Section C of this Appendix.

(5) "***COVID-19 Disregarded Period***" shall mean, as applicable to each Participant individually, and with respect to each Compliance Timeframe under the Plan, the period described as follows:

(a) If the first day of the Compliance Timeframe ("***Timeframe Start Date***") occurs on or prior to March 1, 2020, the period which (i) begins on March 1, 2020 and (ii) ends on the Relief End Date, or February 28, 2021, if earlier; or

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

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

(6) "***COVID-19 Laws***" means, collectively, (a) the Families First Coronavirus Response Act, (b) the Coronavirus Aid, Relief, and Economic Security Act, (c) IRS Notice 2020-15, (d) IRS Notice 2020-29, (e) the "Notice of Relief; Extension of Timeframes", at 85 FR 26351 (May 4, 2020), and (f) any applicable authoritative guidance related to the foregoing as issued by the appropriate federal agencies.

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

(8) "***COVID-19 Public Health Emergency Period***" means the period during which there exists the public health emergency (i) as initially declared by the Secretary of HHS on January 31, 2020, which begins as of January 27, 2020, entitled "Determination that a Public Health Emergency Exists Nationwide as the Result of the 2019 Novel Coronavirus"; and (ii) any renewal by the Secretary of HHS of such declaration.

(9) "***DOL***" means the U.S. Department of Labor.

(10) "***FDC Act***" shall have the meaning for such term as set forth in Section C of this Appendix.

(11) "***HDHP***" means a "high deductible health plan" as defined by Code Section 223(c)(2)(A).

(12) "***HHS***" means the U.S. Department of Health and Human Services.

(13) "***Qualifying COVID-19 Preventive Service***" means an item, service, or immunization that is intended to prevent or mitigate COVID-19 and that is, with respect to the individual involved —

(a) An evidence-based item or service that has in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force; or

(b) An immunization that has in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (regardless of whether the immunization is recommended for routine use).

(14) "***Relief End Date***" means the 60th day following the announced end of the COVID National Emergency or such other date announced by the DOL and the Treasury Department in authoritative guidance issued subsequent to the Relief Notice.

(15) "***Relief Notice***" means the "Extension of Certain Timeframes for Employee Benefit Plans, Participants, and Beneficiaries Affected by the COVID-19 Outbreak", issued by the DOL and the Treasury Department at 86 FR 26351 (May 4, 2020).

(16) "***Treasury Department***" means the U.S. Department of the Treasury.

FIRST SUMMARY OF MATERIAL MODIFICATIONS
Occidental Petroleum Corporation Welfare Plan

The Occidental Petroleum Corporation Welfare Plan ("Plan") provides certain benefit programs to eligible Employees and their Dependents. This Summary of Material Modifications ("SMM") reflects changes to the Occidental Petroleum Corporation Welfare Plan ("Plan") and its Summary Plan Description ("SPD").

Unless defined in this SMM document, defined terms in the Plan's SPD shall have the same meaning in this SMM. Any provisions of the SPDs that are not specifically modified by this SMM have not been changed and remain in effect. You should keep this SMM with your copies of the relevant SPDs.

1. Effective January 1, 2022, the Wellthy Employee Assistance Program as reflected in the Benefit Program Summary Plan Description at Attachment 1 is added as a Benefit Program.

   a. Number 17 of Appendix B to the Wrap-SPD is removed in its entirety and replaced with the following:

      17(a) Employee Assistance Program – Aetna Resources for Living; and

      17(b) Employee Assistance Program – Wellthy, Inc.

   b. The following is added under the "Employee Assistance Program" heading on Appendix F to the Wrap-SPD.

      - Benefit Program Summary Plan Description – Wellthy, Inc., effective as of January 1, 2022, of the Employee Assistance Program.

2. Effective January 1, 2022, the 2nd.MD Program as reflected in the Benefit Program Summary Plan Description at Attachment 2 is added as a Benefit Program.

   a. The following is added to the end of Appendix B to the Wrap-SPD:

      2nd.MD Program (*provided under the Plan effective as January 1, 2022*)

      26. 2nd.MD Program

   b. The following is added to the end of Appendix F to the Wrap-SPD:

      2nd.MD Program

      - Benefit Program Summary Plan Description – 2nd.MD, effective as of January 1, 2022.

3. Effective January 1, 2022, Page 93 of the Appendix F to the Wrap- SPD is removed and replaced with the two documents at Attachment 3.

Attachment 1

Wellthy Employee Assistance Program
Benefit Program Summary Plan Description
Effective as of January 1, 2022

The Wellthy Inc. Employee Assistance Program ("***Wellthy EAP***") can help you deal with personal challenges that might impact your health, well-being, or work performance. In addition, Wellthy can guide you in helping a loved one so that you can be productive.

Wellthy, Inc. ("***Wellthy***") is the employee assistance program provider and the Claims Administrator and Claims Fiduciary for the Wellthy EAP. Wellthy has discretionary authority to make final determinations regarding claims for benefits under the Wellthy EAP.

The Wellthy EAP is a Benefit Program offered under, and incorporated into, the Occidental Petroleum Corporation Welfare Plan (the "***Plan***"). Capitalized terms used, but not otherwise defined, in this Benefit Program Summary Plan Description ("***Benefit Program SPD***") will have the same meanings as provided for those terms in the wrap-around summary plan description document ("***Wrap-SPD***"), as applicable. For additional information on the Wrap-SPD, please see the section at the end.

Eligibility

All regular full-time and part-time Employees and their Spouses ("Dependent Spouse(s)") are eligible to participate in the Wellthy EAP 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 eligible to be in the Wellthy EAP:

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

Participation

Eligible Employees and their Dependent Spouses are automatically enrolled as "Participants" in the Wellthy EAP upon meeting the requirements for eligibility to participate.

Wellthy EAP Services

The Wellthy EAP provides confidential, personalized support to help you and your family navigate the logistical and administrative tasks of caring for loved ones, including yourself. Support may be available for obtaining the following assistance from one or more third-party providers:

- Aging
  - Finding the right provider or in-patient/out-patient program
  - Navigating in-network and out-of-network options
  - Exploring alternative therapy options
  - Ongoing check-ins and support
- Health Conditions
  - Finding providers, scheduling appointments, contesting insurance bills
  - Navigating alternative treatment, clinical trials, and top research centers

    - Handling the transfer of medical records and tracking down referrals
    - Sourcing support groups and therapists
- Mental Health
    - Finding the right provider or in-patient/out-patient program
    - Navigating in-network and out-of-network options
    - Exploring alternative therapy options
    - Ongoing check-ins and support
- Special Needs
    - Managing and sourcing aides and therapists
    - Navigating state and employer-sponsored benefits and coverage
    - Assisting with school decisions and transitions of care
    - Tracking down insurance approvals
- Financial Support
    - Sourcing providers who work on a sliding scale (for those uninsured or underinsured)
    - Securing third party prescription or copay coverage
    - Advocating on appeals, bills, and financial aid applications
    - Vetting affordable housing options
    - Exploring community-based resources and programs
- Veterans Support
    - Helping veterans and caregivers gain access to benefits and providers
    - Navigating benefits and coverage offered through the VA and privately
    - Helping with a veteran's financial benefit application
    - Finding the right emotional support programs
    - Smoothing the transition from the military to private citizenship
- Childcare
    - Finding the right in-home nanny or daycare
    - Evaluating local camps, clinics, day programs, and other activities
    - Sourcing supplemental academic support
    - Referring third-party back-up options
- Teen Support
    - Finding a mental health service for a teen
    - Evaluating post-high school education options
    - Finding academic and tutoring support for teens
    - Finding LGBTQ+ support services for a teen
    - Finding substance use support services for a Teen

No Cost to Participants

There is no cost for participating in the Wellthy EAP or using its services. You may incur costs in retaining the services of a third-party provider recommended to you by Wellthy.

Access to Services

You may access services through visiting Wellthy's website at http://www.wellthy.com/oxy.

In order to receive services, you must comply with Wellthy's processes and procedures. These may include providing certain required information and accepting Wellthy's terms and conditions. These requirements will be presented to you when you seek services.

Exclusions and Limitations

The Wellthy EAP will provide assistance in securing services for you or a loved one. However, the Wellthy EAP does not actually provide the services. As a non-exhaustive list of examples, the Wellthy EAP will not be the provider of the following services:

- Counseling services;
- Physician services, including services from a psychiatrist;
- Hospital services (inpatient and outpatient services);
- Diagnostic laboratory and diagnostic and therapeutic radiological services;
- Home health services;
- Emergency health care services;
- Drugs and medications;
- Investment advice or loan financing;
- Legal advice and/or legal representation;
- Review of real estate or trust documents;
- Services that constitute significant benefits in the nature of medical care or treatment; or
- Services related to any legal matter with respect to which the Plan Sponsor (or another Employer or affiliate), the Plan, the Wellthy EAP, the Plan Administrator, another Employee or the Dependent of an Employee is a named party.

Wellthy, the Wellthy EAP, the Plan Sponsor, the Plan Administrator, the Employer, and any employee or representative of any of the foregoing will not provide legal or tax advice to, or legal representation of, any person or entity under, or related to, the Plan or the Wellthy EAP. If there are any communications relating to legal or tax topics, such communications should be considered as only general information on the topic. If advice is required regarding a legal or tax matter, participants should seek advice from a qualified professional.

Additional Information

1. Definitions

Capitalized terms used, but not otherwise defined, in this Benefit Program SPD will have the same meanings as provided for those terms in the wrap-around Plan document ("***Wrap-Plan***") or the wrap-around summary plan description document of the General Health & Welfare Component of the Plan ("***Wrap-SPD***") as applicable.

2. Health Component

As used in this document, "Health Component" means the portion of the Wellthy EAP that constitutes a group health plan for purposes of ERISA, the Code, HIPAA and the Affordable Care Act.

3. Status of the Wellthy EAP

The Plan Sponsor intends that the Wellthy EAP not provide any services that constitute significant benefits in the nature of medical care or treatment. The Health Component of the Wellthy EAP is intended to meet the requirements of (i) IRS Notice 2004-50, Q/A-10 (with respect to whether Wellthy EAP coverage

would disqualify an individual from participating in a health savings account under Section 223 of the Code) and (ii) the final regulations issued by the U.S. Departments of Labor, Treasury, and Health and Human Services at 79 FR 59130 (Oct. 1, 2014) (with respect to whether the Health Component of the Wellthy EAP constitutes an "excepted benefit" for purposes of Title XXVII of the Public Health Services Act, Part 7 of ERISA, and Chapter 100 of the Code), and any subsequent authoritative guidance. The Wellthy EAP will be administered and construed accordingly.

The Wellthy EAP is provided under the "General Health & Welfare Component" of the Plan. Other benefits unrelated to the General Health & Welfare Component 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 herein or appropriate in context.

4. Benefit Claims and Appeals

A Participant's request for Wellthy EAP services, submitted by the Participant, or by the Participant's authorized representative on his behalf, in accordance with Wellthy's applicable procedures, will constitute a claim for benefits under the Wellthy EAP and ERISA. Casual or general inquiries regarding eligibility or coverage under the Wellthy EAP do not constitute benefit claims under the Wellthy EAP or ERISA. Benefits claims under the Wellthy EAP will be administered in accordance with **ARTICLE VI CLAIMS PROCEDURES** of the Wrap-SPD.

In the event that Wellthy, as Claims Administrator, denies a Participant's claim for benefits, the Participant is entitled to appeal the claim denial to the Claims Fiduciary in writing as provided in **ARTICLE VI CLAIMS PROCEDURES** of the Wrap-SPD. Any such appeal must be submitted to the Claims Fiduciary using the contact information set out in Appendix C of the Wrap-SPD.

5. Cost

Benefits are provided under the Wellthy EAP based on fees paid to Wellthy by the Employer from its general assets. No benefits under the Wellthy EAP are provided pursuant to a contract of insurance or a trust account. No Participant premiums or contributions toward the cost of Wellthy EAP coverage are required. Benefits under the Health Component of the Wellthy EAP are provided to Participants on a first-dollar basis, *i.e.*, without any requirement for Participant copayments or other cost-sharing.

6. No Coordination with Other Group Health Benefits

Participation in the Health Component of the Wellthy EAP is not contingent upon a Participant's enrollment in a medical or other group health option under the Plan. To the extent that a Participant is also enrolled in another group health option under the Plan: (a) the Participant is not required to exhaust his benefits under the Health Component of the Wellthy EAP before being eligible for benefits under the other group health option, and (b) benefits between the Health Component of the Wellthy EAP and the other group health option are not coordinated.

7. Termination of Coverage

A Participant will cease to be a Participant on the earliest of (a) the effective date on which the Wellthy EAP is terminated, (b) the effective date on which the Participant's eligibility status terminates, for whatever reason, or (c) with respect to a Participant who is a Spouse or Domestic Partner or a Dependent

Child, the effective date on which the Employee's Wellthy EAP coverage terminates. However, continuation of coverage under COBRA may be available pursuant to **ARTICLE XI COBRA CONTINUATION COVERAGE** of the Wrap-SPD.

The Wellthy EAP may be amended (including to eliminate or reduce any services or benefits provided by the Wellthy EAP) or terminated at any time, as provided in **ARTICLE IX AMENDMENT OR TERMINATION** of the Wrap-SPD.

8. Additional Information about this Wellthy EAP Benefit Program SPD

This Wellthy EAP Benefit Program SPD is incorporated into the **Wrap-SPD** and constitutes a part of the "Summary Plan Description" of the General H&W Component of the Plan under ERISA ("***H&W Summary Plan Description***"). The full H&W Summary Plan Description consists of the Wrap-SPD, this Wellthy EAP Benefit Program SPD, and the Benefit Program SPDs for each other Benefit Program of the General H&W Component under the Plan.

This Wellthy EAP Benefit Program SPD must be read in conjunction with the Wrap-SPD because both documents contain terms and provisions that are applicable to the Wellthy EAP. For additional information regarding the interaction of this Wellthy EAP Benefit Program SPD with the Wrap-SPD, please consult ARTICLE II INTERPRETATION of the Wrap-SPD.

Copies of the Wrap-SPD and the Benefit Program SPDs are available **here** or at My HR at https://oxynet.oxy.com and on OxyLink Online at **https://oxylink.oxy.com**. Alternatively, you may contact the OxyLink Employee Service Center, and either hardcopy or electronic copies will be provided to you. OxyLink's telephone numbers are 1-800-699-6903 (inside US) and 1-918-610-1990 (outside US). OxyLink's email is oxylink@oxy.com.

Attachment 2

2nd.MD Program
Benefit Program Summary Plan Description
Effective as of January 1, 2022

The 2nd.MD Program provides convenient virtual access to experts from top national institutions who are leading the research, clinical trials, and next generation of health care. Whether it's a new diagnosis, upcoming surgery, or questions about a chronic condition or pain, the 2nd.MD Program can help you on your healthcare journey.

2nd.MD has access to more than 900 expert physician specialists representing all specialties and subspecialties, ensuring you are connected to the appropriate specialist. 2nd.MD selects the specialists based on their years of practice in their niche subspecialty, research, and academic publications.

Accolade 2ndMD LLC (or "2nd.MD") is the benefits provider and the Claims Administrator and Claims Fiduciary for the 2nd.MD Program. 2nd.MD has discretionary authority to make final determinations regarding claims for benefits under the 2nd.MD Program.

The 2nd.MD Program is a Benefit Program offered under, and incorporated into, the Occidental Petroleum Corporation Welfare Plan (the "***Plan***"). Capitalized terms used, but not otherwise defined, in this Benefit Program Summary Plan Description ("***Benefit Program SPD***") will have the same meanings as provided for those terms in the wrap-around summary plan description document ("***Wrap-SPD***"), as applicable. For additional information on the Wrap-SPD, please see the section at the end.

Eligibility

All regular full-time and part-time Employees and their Spouses or Domestic Partners and Dependent Children are eligible to participate in the 2nd.MD 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 2nd.MD Program:

- an Employee who is employed by a division or operating unit of the Employer for which the Plan or the 2nd.MD Program in particular has not been adopted; or
- an individual who is not the Employee of an Employer.

Participation

Eligible Employees and their Spouses or Domestic Partners and Dependent Children are automatically enrolled as "Participants" in the 2nd.MD Program upon meeting the requirements for eligibility to participate.

2nd.MD Program Services

The 2nd.MD Program services include:

- ***Expert Medical Consultation***: With the assistance of 2nd.MD, you can select a medical specialist located in the United States from 2nd.MD's list of approved specialists. You will then share your relevant medical background information with 2nd.MD. At your request, 2nd.MD will schedule a

consultation with the selected specialist. You may speak with the specialist by secure video or phone. Following the consultation, written notes and recommendations from the specialist will be available to you via the 2nd.MD secure portal or sent to you via postal mail.

- ***Specialty Care Navigation***: You may receive guidance via various 2nd.MD communication channels on your healthcare journey by 2nd.MD condition-specific nurses. This clinical guidance may include condition-specific education, coaching, scheduling expert medical consultations, and other services that can help you to navigate the complexities of managing your health and achieving better health outcomes.

- ***Personalized Support***: 2nd.MD can provide you with support and education, which may include recommendations of a local, in-network physician, if requested by you. 2nd.MD will use your location and specific case needs to locate a physician for you.

- ***Medical Records Assistance***: To the extent necessary and only if authorized by you, 2nd.MD can obtain, and securely store in the 2nd.MD portal, medical records from providers that you have seen.

No Cost to Participants

There is no cost for using or receiving any services or resources of the 2nd.MD Program.

Access to Services

In order to receive Covered Services, you must comply with 2nd.MD's procedures and processes. These may include providing certain required information and accepting 2nd.MD's terms and conditions. These requirements will be presented to you when you contact 2nd.MD.

You may access 2nd.MD Program services as follows:

- 2nd.MD's website dedicated to Oxy employees at https://www.2nd.MD/oxy. Create an account using your personal or work email address.
- Call 2nd.MD at 1.866.841.2575

2nd.MD does not provide services outside of the United States.

Except to the extent required or permitted by HIPAA or other applicable law, a Participant's use of 2nd.MD services is confidential and is not shared with Occidental Petroleum Corporation or any of its affiliates (defined as the "Plan Sponsor" or any "Employer" in the Wrap-SPD).

OxyLink Assistance

If you have questions about the 2nd.MD Program, please contact OxyLink. OxyLink's telephone numbers are 1-800-699-6903 (inside US) and 1-918-610-1990 (outside US). OxyLink's email is oxylink@oxy.com.

Exclusions and Limitations

The 2nd.MD Program's benefits are limited to a consultation with a medical specialist, receipt of information relating to your medical condition, and assistance with navigating through medical options. No benefits will be provided under the 2nd.MD Program for the following:

- Medical care or treatment;
- Hospital services (inpatient and outpatient services);
- Diagnostic laboratory and diagnostic and therapeutic radiological services;
- Home health services;
- Emergency health care services; or
- Services that constitute significant benefits in the nature of medical care or treatment.

In addition, the 2nd.MD Program may provide not provide services if 2nd.MD determines that an individual's particular circumstances are not suited for assistance by 2nd.MD.

Additional Information

1. Definitions

Capitalized terms used, but not otherwise defined, in this Benefit Program SPD will have the same meanings as provided for those terms in the wrap-around Plan document ("***Wrap-Plan***") or the wrap-around summary plan description document of the General Health & Welfare Component of the Plan ("***Wrap-SPD***") as applicable.

2. Health Component

"Health Component" means the portion of the 2nd.MD Program that constitutes a group health plan for purposes of ERISA, the Code, HIPAA and the Affordable Care Act.

2. Status of the 2nd.MD Program

The Plan Sponsor intends that the 2nd.MD Program not provide any services that constitute significant benefits in the nature of medical care or treatment. The Health Component of the 2nd.MD Program is intended to meet the requirements of (i) IRS Notice 2004-50, Q/A-10 (with respect to whether 2nd.MD services would disqualify an individual from participating in a health savings account under Section 223 of the Code) and (ii) the final regulations issued by the U.S. Departments of Labor, Treasury, and Health and Human Services at 79 FR 59130 (Oct. 1, 2014) (with respect to whether the Health Component of the 2nd.MD Program constitutes an "excepted benefit" for purposes of Title XXVII of the Public Health Services Act, Part 7 of ERISA, and Chapter 100 of the Code), and any subsequent authoritative guidance. The 2nd.MD Program will be administered and construed accordingly.

The 2nd.MD Program is provided under the "General Health & Welfare Component" of the Plan. Other benefits unrelated to the General Health & Welfare Component 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 herein or appropriate in context.

4. Benefit Claims and Appeals

A Participant's request for 2nd.MD services, submitted by the Participant, or by the Participant's authorized representative on his behalf, in accordance with 2nd.MD's applicable procedures, will constitute a claim for benefits under the 2nd.MD Program and ERISA. Casual or general inquiries regarding eligibility or coverage under the 2nd.MD Program do not constitute benefit claims under the 2nd.MD Program or ERISA. Benefits claims under the 2nd.MD Program will be administered in accordance with **ARTICLE VI CLAIMS PROCEDURES** of the Wrap-SPD.

In the event that 2nd.MD, as Claims Administrator, denies a Participant's claim for benefits, the Participant is entitled to appeal the claim denial to the Claims Fiduciary in writing as provided in **ARTICLE VI CLAIMS PROCEDURES** of the Wrap-SPD. Any such appeal must be submitted to the Claims Fiduciary using the contact information set out in Appendix C of the Wrap-SPD.

5. Cost

Benefits are provided under the 2nd.MD Program based on fees paid to 2nd.MD by the Employer from its general assets. No benefits under the 2nd.MD Program are provided pursuant to a contract of insurance or a trust account. No Participant premiums or contributions toward the cost of 2nd.MD coverage are required. Benefits under the Health Component of the 2nd.MD Program are provided to Participants on a first-dollar basis, *i.e.*, without any requirement for Participant copayments or other cost-sharing.

6. No Coordination with Other Group Health Benefits

Participation in the Health Component of the 2nd.MD Program is not contingent upon a Participant's enrollment in a medical or other group health option under the Plan. To the extent that a Participant is also enrolled in another group health option under the Plan: (a) the Participant is not required to exhaust his benefits under the Health Component of the 2nd.MD Program before being eligible for benefits under the other group health option, and (b) benefits between the Health Component of the 2nd.MD Program and the other group health option are not coordinated.

7. Termination of Coverage

A Participant will cease to be a Participant on the earliest of (a) the effective date on which the 2nd.MD Program is terminated, (b) the effective date on which the Participant's status as an eligible Employee, Spouse, Domestic Partner or Dependent Child terminates, for whatever reason, or (c) with respect to a Participant who is a Spouse or Domestic Partner or a Dependent Child, the effective date on which the Employee's 2nd.MD Program terminates. However, continuation of coverage under COBRA may be available pursuant to **ARTICLE XI COBRA CONTINUATION COVERAGE** of the Wrap-SPD.

The 2nd.MD Program may be amended (including to eliminate or reduce any services or benefits provided by the 2nd.MD Program) or terminated at any time, as provided in **ARTICLE IX AMENDMENT OR TERMINATION** of the Wrap-SPD.

8. Additional Information about this 2nd.MD Benefit Program SPD

This 2nd.MD Benefit Program SPD is incorporated into the **Wrap-SPD** and constitutes a part of the "Summary Plan Description" of the General H&W Component of the Plan under ERISA ("***H&W Summary***

Plan Description"). The full H&W Summary Plan Description consists of the Wrap-SPD, this 2nd.MD Benefit Program SPD, and the Benefit Program SPDs for each other Benefit Program of the General H&W Component under the Plan.

This 2nd.MD Benefit Program SPD must be read in conjunction with the Wrap-SPD because both documents contain terms and provisions that are applicable to the 2nd.MD Program. For additional information regarding the interaction of this 2nd.MD Benefit Program SPD with the Wrap-SPD, please consult ARTICLE II INTERPRETATION of the Wrap-SPD.

Copies of the Wrap-SPD and the Benefit Program SPDs are available **here** or at My HR at https://oxynet.oxy.com and on OxyLink Online at **https://oxylink.oxy.com**. Alternatively, you may contact the OxyLink Employee Service Center, and either hardcopy or electronic copies will be provided to you. OxyLink's telephone numbers are 1-800-699-6903 (inside US) and 1-918-610-1990 (outside US). OxyLink's email is oxylink@oxy.com.

Attachment 3

Benefit Program	Claims Administrator and Claims Fiduciary (except as otherwise noted)
• Employee Assistance Program – Aetna	***Claims Administrator*** **Aetna Resources for Living** Complaint or Grievance 10260 Meanly Drive San Diego, CA 92131 Request form: 1-888-238-6232 or www.resourcesforliving.com U.S. Employees: Telephone: 888-238-6232 Online: https://www.resourcesforliving.com/login Non-U.S. Employees: [Telephone numbers for in-country toll-free access by country are set out in the Benefit Summary Plan Description Document for the Employee Assistance Program.] Online: Login at https://www.resourcesforliving.com/login, then to find country-specific information, select Services> International employee benefits> WPO Home Page (at bottom of page) ***Claims Fiduciary*** **Occidental Petroleum Corporation Employee Benefits Committee** Attn: Director, Benefits & Wellbeing 5 Greenway Plaza, Houston, TX 77046-0506 Telephone: (713) 215-7000
• Employee Assistance Program – Wellthy	***Claims Administrator*** Wellthy, Inc 300 W 57th St 33rd Floor New York, NY 10019 www.wealthy.com You may contact Wellthy by visiting its website at http://www.wellthy.com/oxy or by calling (877) 588-3917. ***Claims Fiduciary*** **Occidental Petroleum Corporation Employee Benefits Committee** Attn: Director, Benefits & Wellbeing 5 Greenway Plaza, Houston, TX 77046-0506 Telephone: (713) 215-7000

Benefit Program	Claims Administrator and Claims Fiduciary (except as otherwise noted)
• 2nd.MD Program	***Claims Administrator*** Accolade 2ndMD LLC 9655 Katy Freeway Suite 300 Houston, TX 77024 Telephone: 1.866.841.2575 Online: 2nd.MD's Oxy dedicated website: https://www.2nd.MD/oxy ***Claims Fiduciary*** **Occidental Petroleum Corporation Employee Benefits Committee** Attn: Director, Benefits & Wellbeing 5 Greenway Plaza, Houston, TX 77046-0506 Telephone: (713) 215-7000

SECOND SUMMARY OF MATERIAL MODIFICATIONS
Occidental Petroleum Corporation Welfare Plan

The Occidental Petroleum Corporation Welfare Plan ("Plan") provides certain benefit programs to eligible Employees and their Dependents. This Second Summary of Material Modifications ("SMM") reflects changes to the Occidental Petroleum Corporation Welfare Plan ("Plan") and its Summary Plan Description ("SPD").

Unless defined in this SMM document, defined terms in the Plan's SPD shall have the same meaning in this SMM. Any provisions of the SPDs that are not specifically modified by this SMM have not been changed and remain in effect. You should keep this SMM with your copies of the relevant SPDs.

1. Effective January 1, 2023, the Employee Assistance Program ("EAP") provided by Aetna Resources for Living ("Aetna") is no longer offered by the Plan, and the Benefit Program Summary Plan Description for the Aetna provider is removed. In its place, the Lyra Employee Assistance Program as reflected in the Benefit Program Summary Plan Description at Attachment 1 is added as a Benefit Program.

   a. Page 93a to Appendix C of the Wrap- SPD is removed and replaced with the document at Attachment 2.

   b. Number 17 of Appendix B to the Wrap-SPD is amended as follows:

      Employee Assistance Programs

      17(a) Employee Assistance Program – Lyra Health, Inc.; and

      17(b) Employee Assistance Program – Wellthy, Inc.

   c. The statements under the "Employee Assistance Program" heading on Appendix F to the Wrap-SPD is removed and replaced with the following.

      - Benefit Program Summary Plan Description – Lyra, effective as of January 1, 2022, of the Employee Assistance Program.

      - Benefit Program Summary Plan Description – Wellthy, Inc., effective as of January 1, 2022, of the Employee Assistance Program.

2. Effective July 1, 2023, TerraLithium LLC is added to Appendix A to the Wrap-SPD as Participating Employer.

3. The following is added to the end of Appendix G to the Wrap-SPD.

   Notwithstanding any other provision of the Wrap-SPD or a Benefit Program Summary Plan Description, an Employee who has been approved for Phased Retirement by the Occidental Petroleum Corporation Vice President, Human Resources is eligible to participate in the following programs provided that (i)

such Employee is scheduled to work 10 or more hours per week; and (ii) all other criteria for participation in the program are satisfied.

- BCBSTX HDHP Medical Program;
- BCBSTX PPO Medical Program.
- Dental Benefit Program;
- Vision Insurance Program;
- Midland Health Center Program;
- Basic Life Insurance Program;
- Optional Group Universal Life Insurance Program;
- Basic AD&D Insurance Program;
- Voluntary AD&D Insurance Program; and
- Occupational AD&D Insurance Program;
- Employee Assistance Programs;
- General Purpose Health Flexible Spending Arrangement;
- Limited Purpose Health Flexible Spending Arrangement; and
- 2nd.MD Program.

An Employee scheduled to work 20 hours or more per week may continue to participate in the Long-Term Disability Insurance Program, but benefits will be based upon Employee's base salary after commencing Phased Retirement. An Employee scheduled to work less than 20 hours per week may not participate in the Long-Term Disability Insurance Program as of the date that the Employee's schedule of less than 20 hours per week becomes effective.

Attachment 1

Lyra Employee Assistance Program
Benefit Program Summary Plan Description
Effective as of January 1, 2023

The Lyra Employee Assistance Program ("***Lyra EAP***") can help you and your immediate family deal with personal challenges that might impact your health, well-being, or work performance. Lyra Health, Inc. ("***Lyra***") is the employee assistance provider and the Claims Administrator and Claims Fiduciary for the EAP. Lyra has discretionary authority to make final determinations regarding claims for benefits under the EAP.

The Lyra EAP is a Benefit Program offered under, and incorporated into, the Occidental Petroleum Corporation Welfare Plan (the "***Plan***"). Capitalized terms used, but not otherwise defined, in this Benefit Program Summary Plan Description ("***Benefit Program SPD***") will have the same meanings as provided for those terms in the wrap-around summary plan description document ("***Wrap-SPD***"), as applicable. For additional information on the Wrap-SPD, please see the section at the end.

Eligibility

All regular full-time and part-time Employees and their Spouses or Domestic Partners and Dependent Children are eligible to participate in the Lyra EAP 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 Lyra EAP:

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

Participation

Eligible Employees and their Spouses or Domestic Partners and Dependent Children are automatically enrolled as "Participants" in the Lyra EAP upon meeting the requirements for eligibility to participate.

Lyra EAP Counseling Services

The Lyra EAP provides assessment, treatment, referral, and crisis intervention services by Participating Providers with respect to the following types of matters, subject to the Exclusions and Limitations Section:

- Anxiety
- Chronic self-criticism
- Crisis (e.g., death of a loved one)
- Decreased motivation
- Difficulty concentrating
- Feeling hopeless
- Frequent worry
- Relationship conflict
- Stress management
- Sleep problems
- Persistent irritability
- Parenting challenges

- Excessive alcohol & substance use
- Depression
- PTSD

Each Participant (i.e., the Eligible Employee and each eligible Dependent) may receive up to 12 sessions with a Participating Provider per Plan Year (*i.e.*, a calendar year).

To receive Lyra EAP counseling services, a Participant may select a Participating Provider from Lyra's website or may contact a Lyra representative for assistance with locating a Participating Provider. A Participant is responsible for setting session times and dates with a Participating Provider. A participant should follow all Lyra instructions and guidance including ensuring that the Participating Provider understands that the services are being provided through Lyra.

Lyra EAP Online Resources

Lyra provides online resources to Participants to help improve wellbeing. These can include an online library of tools and resources, on-demand learning, and small group discussions. Check Lyra's website for current offerings at: https://oxy.lyrahealth.com/.

For Lyra Essentials and the Lyra Hub, use company code: **Oxy**. For on-demand learning and small-group discussions, register using your Oxy email and company code: **aoxy883**.

For assistance using Lyra's online resources, please contact Lyra at the contact information in the "Access to Services" section.

Work-Life Services

You can receive the following at no cost to you:

- Legal Assistance: 30-minute consultation with an attorney or mediator, access to 24-hour emergency support.
- Financial Assistance: 30-minute consultation with a financial counselor and 30-minute consultation with a CPA.
- Dependent Care Assistance: Referrals for child, elder and pet care; 24-hour online and phone support.

No Cost to Participants

There is no cost for using or receiving any services or resources of the Lyra EAP. However, if an appointment with a Participating Provider for a counseling session is missed by a Participant, a non-appearance fee may be charged as communicated in advance by Lyra. Prior to receipt of counseling services, Lyra may require the submission of credit-card information to facilitate payment of a non-appearance fee if one becomes due.

Access to Services

In order to receive Covered Services, you must comply with Lyra's procedures and processes. These may include providing certain required information and accepting Lyra's terms and conditions. These requirements will be presented to you when you seek Covered Services.

You may access Covered Services 24 hours per day, 7 days per week as follows:

- Lyra's Oxy webpage at https://oxy.lyrahealth.com/. Create an account using your personal or work email address.
- Lyra's App for use on a phone or tablet. This can be accessed at the Apple App Store or Google Play.
- Call the Lyra Care Navigator Team at one of the following telephone numbers:

  In the United States: 877-913-0557

  Outside of the United States: Please see following table for contact information:

Country	Toll-free In-country Phone Number	Out-of-Country Phone Number
Algeria	-44 20 300 66217	+44 20 300 66217
Belgium	0800 88 084	+32 2 89 75005
Brazil	0800 887 0591	+55 11 2071 4865
Bolivia	800 100 569	+54 11 3988 2061
Chile	12300 201 815 (9am - 6pm) 8001 23540 (24/7 - answered by regional center in Argentina)	+54 11 3988 2061
Colombia	01800 518 0835	+54 11 3988 2061
Côte d'Ivoire	+44 33 00 241 021	-44 33 00 241 021
Hong Kong	27 21 3939	+852 27 21 3939
Japan	0120 247 553	+81 3 3541 8650
Mexico	800 800 9010	-52 55 110 70199
Oman	800 77179	.+44 20 300 66217

Qatar	00800 100 250	+44 20 300 66217
Singapore	800 852 8526	+65 6011 6345
UAE	8000 44 0626	+44 20 300 66217
United Kingdom	0800 088 5484	+44 203 727 0697

In-person counseling may be available at Participating Providers' offices. Tele-video and web-based chat counseling may be also available.

Except to the extent required or permitted by HIPAA or other applicable law, a Participant's use of Lyra EAP services is confidential and is not shared with Occidental Petroleum Corporation or any of its affiliates (defined as the "Plan Sponsor" or any "Employer" in the Wrap-SPD).

OxyLink Assistance

If you have questions about Lyra EAP, please contact OxyLink. OxyLink's telephone numbers are 1-800-699-6903 (inside US) and 1-918-610-1990 (outside US). OxyLink's email is oxylink@oxy.com.

Exclusions and Limitations

No benefits will be provided under the Lyra EAP for the following:

- Hospital services (inpatient and outpatient services);
- Diagnostic laboratory and diagnostic and therapeutic radiological services;
- Home health services;
- Emergency health care services;
- Investment advice or loan financing;
- Legal advice and/or legal representation;
- Review of real estate or trust documents;
- Services that constitute significant benefits in the nature of medical care or treatment; or
- Services that are not provided by a Participating Provider.

In addition, the Lyra EAP shall provide no Covered Services in the following situations:

- The individual's condition is high-risk or requires urgent care, including, but not limited to, presenting a risk of harm to himself or others or involving advanced-stage alcohol or drug usage (in which case, such individuals will be directed to call 9-1-1 or to otherwise seek care outside the Lyra EAP); or
- the individual has already received a diagnosis, or the individual is already receiving care or treatment, for a condition where Lyra determines that the provision of Lyra services would not be appropriate.

Finally, Lyra, the Lyra EAP, the Plan Sponsor, the Plan Administrator, the Employer, and any employee or representative of any of the foregoing will not provide legal or tax advice to, or legal representation of,

any person or entity under, or related to, the Plan or the Lyra EAP. If there are any communications relating to legal or tax topics, such communications should be considered as only general information on the topic and not as advice upon which one should rely in taking or not taking any action. If advice is required regarding a legal or tax matter, participants should seek advice from a qualified professional.

Additional Information

1. Definitions

Capitalized terms used, but not otherwise defined, in this Benefit Program SPD will have the same meanings as provided for those terms in the wrap-around Plan document ("***Wrap-Plan***") or the wrap-around summary plan description document of the General Health & Welfare Component of the Plan ("***Wrap-SPD***") as applicable.

(a) "Covered Services" means services that are provided under the Lyra EAP, as described in the "Lyra EAP Counseling Services", "Lyra EAP Online Resources", and "Exclusions and Limitations" sections of this Benefit Program SPD.

(b) "Health Component" means the portion of the Lyra EAP that constitutes a group health plan for purposes of ERISA, the Code, HIPAA and the Affordable Care Act.

(c) "Participating Provider" means a trained counselor, licensed clinician or other professional that has contracted with Lyra (or one or more of its affiliates) to provide Covered Services to Participants under the Lyra EAP.

2. Status of the Lyra EAP

The Plan Sponsor intends that the Lyra EAP not provide any services that constitute significant benefits in the nature of medical care or treatment. The Health Component of the Lyra EAP is intended to meet the requirements of (i) IRS Notice 2004-50, Q/A-10 (with respect to whether Lyra EAP coverage would disqualify an individual from participating in a health savings account under Section 223 of the Code) and (ii) the final regulations issued by the U.S. Departments of Labor, Treasury, and Health and Human Services at 79 FR 59130 (Oct. 1, 2014) (with respect to whether the Health Component of the Lyra EAP constitutes an "excepted benefit" for purposes of Title XXVII of the Public Health Services Act, Part 7 of ERISA, and Chapter 100 of the Code), and any subsequent authoritative guidance. The Lyra EAP will be administered and construed accordingly.

The Lyra EAP is provided under the "General Health & Welfare Component" of the Plan. Other benefits unrelated to the General Health & Welfare Component 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 herein or appropriate in context.

3. Benefit Claims and Appeals

A Participant's request for Lyra EAP services, submitted by the Participant, or by the Participant's authorized representative on his behalf, in accordance with Lyra's applicable procedures, will constitute a claim for benefits under the Lyra EAP and ERISA. Casual or general inquiries regarding eligibility or coverage under the Lyra EAP do not constitute benefit claims under the Lyra EAP or ERISA. Benefits claims under the Lyra EAP will be administered in accordance with **ARTICLE VI CLAIMS PROCEDURES** of the Wrap-SPD.

In the event that Lyra, as Claims Administrator, denies a Participant's claim for benefits, the Participant is entitled to appeal the claim denial to the Claims Fiduciary in writing as provided in **ARTICLE VI CLAIMS PROCEDURES** of the Wrap-SPD. Any such appeal must be submitted to the Claims Fiduciary using the contact information set out in Appendix C of the Wrap-SPD.

4. Cost

Benefits are provided under the Lyra EAP based on fees paid to Lyra by the Employer from its general assets. No benefits under the Lyra EAP are provided pursuant to a contract of insurance or a trust account. No Participant premiums or contributions toward the cost of Lyra EAP coverage are required. Benefits under the Health Component of the Lyra EAP are provided to Participants on a first-dollar basis, *i.e.*, without any requirement for Participant copayments or other cost-sharing.

5. No Coordination with Other Group Health Benefits

Participation in the Health Component of the Lyra EAP is not contingent upon a Participant's enrollment in a medical or other group health option under the Plan. To the extent that a Participant is also enrolled in another group health option under the Plan: (a) the Participant is not required to exhaust his benefits under the Health Component of the Lyra EAP before being eligible for benefits under the other group health option, and (b) benefits between the Health Component of the Lyra EAP and the other group health option are not coordinated.

6. Termination of Coverage

A Participant will cease to be a Participant on the earliest of (a) the effective date on which the Lyra EAP is terminated, (b) the effective date on which the Participant's status as an eligible Employee, Spouse, Domestic Partner or Dependent Child terminates, for whatever reason, or (c) with respect to a Participant who is a Spouse or Domestic Partner or a Dependent Child, the effective date on which the Employee's Lyra EAP coverage terminates. However, continuation of coverage under COBRA may be available pursuant to **ARTICLE XI COBRA CONTINUATION COVERAGE** of the Wrap-SPD.

The Lyra EAP may be amended (including to eliminate or reduce any services or benefits provided by the Lyra EAP) or terminated at any time, as provided in **ARTICLE IX AMENDMENT OR TERMINATION** of the Wrap-SPD.

7. Additional Information about this Lyra EAP Benefit Program SPD

This Lyra EAP Benefit Program SPD is incorporated into the **Wrap-SPD** and constitutes a part of the "Summary Plan Description" of the General H&W Component of the Plan under ERISA ("***H&W Summary***

Plan Description"). The full H&W Summary Plan Description consists of the Wrap-SPD, this Lyra EAP Benefit Program SPD, and the Benefit Program SPDs for each other Benefit Program of the General H&W Component under the Plan.

This Lyra EAP Benefit Program SPD must be read in conjunction with the Wrap-SPD because both documents contain terms and provisions that are applicable to the Lyra EAP. For additional information regarding the interaction of this Lyra EAP Benefit Program SPD with the Wrap-SPD, please consult ARTICLE II INTERPRETATION of the Wrap-SPD.

Copies of the Wrap-SPD and the Benefit Program SPDs are available **here** or at My HR at https://oxynet.oxy.com and on OxyLink Online at **https://oxylink.oxy.com**. Alternatively, you may contact the OxyLink Employee Service Center, and either hardcopy or electronic copies will be provided to you. OxyLink's telephone numbers are 1-800-699-6903 (inside US) and 1-918-610-1990 (outside US). OxyLink's email is oxylink@oxy.com.

Attachment 2

Benefit Program	Claims Administrator and Claims Fiduciary (except as otherwise noted)
• Employee Assistance Program – Aetna	***Claims Administrator*** Lyra Health, Inc. 287 Lorton Avenue Burlingame, California 94010 Lyra's website: www.lyrahealth.com In the United States: 877-913-0557 Outside the United States: [Telephone numbers for in-country toll-free access by country are set out in the Benefit Summary Plan Description Document for the Employee Assistance Program.] Online: Visit Lyra's Oxy webpage at https://oxy.lyrahealth.com/ ***Claims Fiduciary*** **Occidental Petroleum Corporation Employee Benefits Committee** Attn: Director, Benefits & Wellbeing 5 Greenway Plaza, Houston, TX 77046-0506 Telephone: (713) 215-7000
• Employee Assistance Program – Wellthy	***Claims Administrator*** Wellthy, Inc 300 W 57th St 33rd Floor New York, NY 10019 www.wealthy.com You may contact Wellthy by visiting its website at http://www.wellthy.com/oxy or by calling (877) 588-3917. ***Claims Fiduciary*** **Occidental Petroleum Corporation Employee Benefits Committee** Attn: Director, Benefits & Wellbeing 5 Greenway Plaza, Houston, TX 77046-0506 Telephone: (713) 215-7000