OXY Benefits

Summary Plan Description

RETIREE DENTAL PLAN

Dental PPO/PDN with PPO II Network

FOR RETIREES AND THEIR DEPENDENTS

OCCIDENTAL PETROLEUM CORPORATION

your health.
your life.
your future.

Table of Contents

Effective date of this SPD is July 1, 2014. Refer to subsequent issues of *Retiree News* for any material changes to the Plan made after the date of this document.

BENEFITS AT A GLANCE

The Occidental Petroleum Corporation Retiree Dental Plan ("Dental Plan" or "Retiree Dental Plan") is designed to promote and encourage preventive dental care, provide benefits for services that are essential to the proper care of your teeth and help you pay for a portion of your covered dental expenses.

The dental benefits described in this booklet are offered to retirees of Occidental Petroleum Corporation or an affiliated company ("Oxy"), as defined in the *Eligibility and Enrollment* section. This information serves as your Summary Plan Description. You should keep and refer to it when you have questions about your dental benefits.

This Plan is administered by Aetna Life Insurance Company (referred to as "Aetna"). The dental benefits described in this booklet are not insured with Aetna or any of its affiliates, but are paid from Occidental Petroleum Corporation's general assets.

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

The chart below summarizes the Plan's deductibles, maximums and Plan payment percentages (percentage of covered expenses paid by the Plan). See *What the Plan Covers* for more detail.

DENTAL PLAN INFORMATION	
Calendar Year Deductible • Individual	$50
• Family	$150
Calendar Year Maximum *(applies to diagnostic/preventive, basic and major services)*	$2,000 per individual
Orthodontia Lifetime Maximum *(for Dependent child(ren) under age 19 only)*	$2,500 per individual

DENTAL PLAN BENEFITS	
Covered Services	**Dental Plan Pays** (Network or Out-of Network)
Diagnostic and Preventive Services *(e.g., exams, cleanings, fluoride applications, diagnostic X-rays)*	100% not subject to deductible
Basic Restorative Services *(e.g., fillings, extractions, periodontal treatment)*	80% after deductible
Major Restorative Services *(e.g., crowns, bridges, dentures, inlays)*	50% after deductible
Orthodontia *(for Dependent child(ren) under age 19 only)*	50% not subject to deductible

FOR HELP AND INFORMATION

Contact Information		
Provider:	**Address:**	**Phone:**
Aetna	**P.O. Box 14094** **Lexington, KY 40512-4094** Website: **www.aetna.com**	**800-334-0299**
OxyLink Employee Service Center	**4500 South 129th East Avenue** **Tulsa, OK 74134-5870** Email: **oxylink@oxy.com** Website: **oxylink.oxy.com**	**800-699-6903** **918-610-1990** (International)

Visit Aetna Navigator™ at www.aetna.com

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

- Access your claim Explanations of Benefits (EOBs),
- Check remaining deductibles and balances,
- Print an ID card* for you and your Dependents
- Download a list of claims for each covered family member, and
- Contact Member Services.

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

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

Mobile Access

You can also access your benefits information on your mobile phone. To learn more, visit **www.aetna.com/mobile**.

* Dental plan ID cards are no longer required to receive dental services. Your provider can confirm coverage and plan information directly with Aetna.

ELIGIBILITY AND ENROLLMENT

Eligibility

You and your Dependents are eligible for coverage under the Retiree Dental Plan if you:

- Are eligible for coverage under the Occidental Petroleum Corporation Retiree Medical Plan;
- Retire or enroll for retiree coverage on or after January 1, 2014*; and
- Are not eligible for coverage under another Oxy-sponsored retiree dental plan.

Dependents

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

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

Adding Dependents

If after your Oxy retirement date, you acquire a new dependent(s) through marriage, birth, adoption or placement for adoption, and you wish to add this dependent(s) to your Retiree Dental Plan coverage, you must enroll your new dependent(s) within 31 days of his or her first date of eligibility (i.e., the date of marriage), or if later, within 31 days of loss of other coverage. You will be required to submit proof of the event.

Dependent Coverage After Your Death

If you die while you are covered as a retiree under this Plan, your spouse may elect to continue coverage for your Dependents as of your date of death by paying the appropriate amount of retiree contributions, as described in the section entitled *Contributions*. If you had not elected retiree coverage for yourself and/or your Dependents under this Plan, your surviving spouse may elect to enroll for coverage for your Dependents within 31 days of loss of other coverage. Proof of loss of coverage will be required.

Coverage for your Dependents may continue as described in the section entitled *When Coverage Ends.*

Enrollment

You must complete an application (or waiver) for retiree dental coverage no later than 31 days after your retirement date, or the date you are first eligible to enroll, if later. You may waive coverage, but if you do, you may not reenroll for coverage under the Retiree Dental Plan, with the following exception:

> **If you or your spouse (or a surviving spouse) currently have other coverage, including through COBRA continuation coverage, and you lose eligibility for**

* If you retired prior to January 1, 2014, you are eligible for the Retiree Dental Plan effective July 1, 2014.

that coverage, you or your spouse may enroll in the Dental Plan within 31 days of the loss of coverage. Proof of loss of coverage will be required.

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

CONTRIBUTIONS

Oxy does not subsidize the cost of Retiree Dental Plan coverage; retirees pay the full cost of the plan. The cost of coverage and the coverage level you select (retiree only, retiree plus one dependent, or family) determine the amount of your contribution.

The cost of coverage is typically announced annually in the *Retiree News*, which is posted online at **oxylink.oxy.com** under *Forms, Publications & Info > Publications > Benefits News*. Current contributions are also shown on the Retiree Dental Plan summary which is posted online at **oxylink.oxy.com**.

Contributions are billed quarterly by Aetna's Individual Billing Unit. Once your retirement is processed you will receive information about how to enroll.

Dependent Contributions After Your Death

If you die while you are covered as a retiree under the Dental Plan, your spouse may elect to continue coverage for your Dependents as of your date of death by paying the appropriate amount of retiree contributions.

USING THE PLAN

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

How much you pay for your care out of your own pocket depends on whether the expense is covered by the Plan and whether you choose a Network Provider or an Out-of Network Provider.

Using Network and Out-of-Network Providers

Under the Dental Plan, you have the freedom to choose any licensed Dental Provider when you need dental care. You can select a Dentist that belongs to the network (a Network Provider) or one that does not belong to the network (an Out-of Network Provider).

Your out-of-pocket expenses may be lower when your care is provided by a Network Provider because Network Providers have agreed to provide covered services and supplies at a Negotiated Charge. In no event will you have to pay any amounts above the Negotiated Charge for a covered service or supply. Aetna's Negotiated Fees do not apply to care that is not covered under the Plan.

If you use Network Providers, you will not have to submit dental claims for treatment received. Your Network Provider will take care of claim submission. You will receive notification of what the plan has paid toward your Covered Expenses and you will be responsible for the deductible and your payment percentage.

If you receive care from an Out-of-Network Provider, your benefits are limited to the Recognized Charge and your expenses will generally be higher. If the Out-of-Network Provider's charge is more than the Recognized Charge (as defined by Aetna), you pay the difference. This excess amount will not apply toward your deductible. You must file a claim to receive reimbursement from the plan.

Aetna Provider Network

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

To find a network Dentist in your area:

- ***Use DocFind at www.aetna.com.*** Follow the prompts to select the type of search you want, the area in which you want to search and the number of miles you are willing to travel. When you are asked to select a plan, choose "Dental PPO/PDN with PPO II Network" from the "Dental PPO/PDN/EPP/HealthFund®/DentalFund® with PPO II network" plan list. You can search the online directory for a specific Dentist or all

Dentists in a given ZIP code and/or travel distance. You can also get information about a Dentist's practice, such as address, phone number(s), and access for the disabled.

- ***Call or email Aetna Member Services.*** A representative can also help you find a network Dentist in your area. The Aetna Member Services toll-free number is shown on your ID card. You also may email Aetna Member Services from Aetna's secure member website, Aetna Navigator. Just go to **www.aetna.com** and select "Member Log In."

Sharing the Cost

When you receive dental care, you pay a calendar year deductible for certain services. There are two types of deductible: individual and family.

The *individual* calendar year deductible is the part of covered expenses you and/or your covered Dependents pay each year (January 1 to December 31) before the Plan starts to pay benefits. You start over each January 1 with a new calendar year deductible.

If the covered dental expenses of all family members reach the *family* deductible, no other deductible is required for the rest of the calendar year.

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

Diagnostic and Preventive services are not subject to the deductible.

The Plan's benefits for Diagnostic and Preventive, Basic and Major services are limited to a calendar year maximum. There is a separate lifetime maximum benefit for orthodontia expenses.

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

Advance Claim Review

If your Dentist recommends a Course of Treatment expected to cost $350 or more, an Advance Claim Review (Pre-Treatment Estimate) is recommended. Ask your Dentist to provide a full description of the treatment you need, using a Dental Benefits Request form available online at **oxylink.oxy.com**. Your Dentist should send the form to Aetna *before* treatment begins. In processing the request, Aetna may ask for supporting X-rays and other diagnostic records. Once all of the information has been gathered, Aetna will review the proposed treatment plan and provide you and your Dentist with a statement

that outlines the benefits payable by the Plan. You and your Dentist can use this information to decide how to proceed.

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

In determining the amount of benefits payable, Aetna will take into account alternate procedures, services or courses of treatment needed to accomplish the appropriate result.

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

Alternate Treatment

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

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

You should review the differences in the cost of alternate treatment with your Dental Provider. Of course, you and your Dental Provider can still choose the more costly treatment method. You are responsible for any charges in excess of what the plan will cover.

WHAT THE PLAN COVERS

The Plan covers medically Necessary dental care expenses incurred while your coverage is in effect. An expense is incurred on the day you receive a dental service or supply. Also, the Plan covers only expenses related to a Non-Occupational Injury or a Non-Occupational Illness. Coverage for services and supplies applies only if they are provided to a person at the time he or she is covered under the Plan.

This section lists the services covered under each of the four types of dental care. If any limits apply, they are described below.

Diagnostic and Preventive Services

To encourage regular dental checkups, the Plan pays 100 percent of the Negotiated or Recognized Charges, with no deductible, for preventive and diagnostic services. For purposes of this Plan, diagnostic and preventive services include the following:

- Routine oral exams twice per calendar year
- Cleaning and scaling of teeth (prophylaxis) (limit of 3 treatments per calendar year)
- Problem-focused exams
- One topical application of fluoride per calendar year for Dependents under age 16
- Diagnostic X-rays, and other X-rays not to exceed one full mouth or panoramic series every three years
- Two sets of bitewing X-rays in a calendar year for Dependents under age 14
- One set of bitewing X-rays in a calendar year for individuals age 14 and older
- Sealants only for permanent molars once every three rolling years, for Dependents under age 16
- Emergency treatment to relieve pain
- Space maintainers for premature loss of primary teeth only

Basic Restorative Services

The Plan will pay 80 percent of the Negotiated or Recognized Charges for basic restorative services after the annual deductible is satisfied. The following services are considered basic restorative services under the Plan:

- Simple extractions
- Oral surgery for non-impacted wisdom teeth extractions
- Oral surgery (including extraction of impacted teeth) if the procedure is not covered under your medical plan
- Fillings, except gold
- General anesthetics, if medically necessary
- Treatment of diseased periodontal structures
- Endodontic treatment, such as pulp capping and root canals
- Repair or recementing of crowns, inlays, bridgework or dentures
- Relining/rebasing of dentures

Major Restorative Services

The Plan will pay 50 percent of the Negotiated or Recognized Charges for major restorative services after the annual deductible is satisfied. For purposes of the Dental Plan, the following are considered major restorative services:

- Inlays, gold fillings or crowns. This includes precision attachments for dentures.
- First installation of removable dentures and partial dentures to replace one or more natural teeth. This includes adjustments for the six-month period after they were installed.
- First installation of fixed bridgework to replace one or more natural teeth. This includes inlays and crowns as abutments.
- Occlusal adjustment for temporomandibular joint disease (TMJ). Covered services include night guards for grinding the teeth or equilibration, capping the teeth and fixed or partial bridgework.
- Dental implants and related services.
- Replacement of an existing removable denture or fixed bridgework by a new denture or fixed bridgework, or addition of teeth to existing partial removable denture or fixed bridgework. The Replacement Rule below must be met.

Replacement Rule

Inlays, onlays and veneers, complete dentures, removable partial dentures, fixed partial dentures (bridges) and other prosthetic services are subject to the plan's replacement rule. That means certain replacements of, or additions to, existing inlays, onlays, veneers, dentures or bridges are covered only when you give proof to Aetna that:

- You had a tooth (or teeth) extracted after the existing denture or bridge was installed. As a result, you need to replace or add teeth to your denture or bridge.
- The present inlay and onlay, veneer, complete denture, removable partial denture, fixed partial denture (bridge), or other prosthetic service was installed at least 5 years before its replacement and cannot be made serviceable.
- Your present denture is an immediate temporary one that replaces an extracted tooth (or teeth). A permanent denture is needed, and the temporary denture cannot be used as a permanent denture. Replacement must occur within 12 months from the date that the temporary denture was installed.

Dental Work Completed After Termination of Coverage

Your dental coverage may end while you or your covered dependent is in the middle of treatment. The Plan does not cover dental services that are given after your coverage terminates. There is an exception. The Plan will cover the following services if they are ordered while you were covered by the Plan, and installed within 60 days after your coverage ends.

- Inlays;
- Onlays;
- Crowns;
- Removable bridges;
- Cast or processed restorations;
- Dentures;
- Fixed partial dentures (bridges); and
- Root canals.

"Ordered" means:

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

Orthodontic Treatment

Orthodontic coverage is only for covered dependent children who are under age 19 on the date active orthodontic treatment begins.

The Plan does not cover the following orthodontic services and supplies:

- Replacement of broken appliances;
- Re-treatment of orthodontic cases;
- Changes in treatment necessitated by an accident;
- Maxillofacial surgery;
- Myofunctional therapy;
- Treatment of cleft palate;
- Treatment of micrognathia;
- Treatment of macroglossia;
- Treatment of primary dentition;
- Treatment of transitional dentition;
- Lingually placed direct bonded appliances and arch wires (i.e. "invisible braces")*; or
- Removable acrylic aligners (i.e. "invisible aligners")*.

* These services may be subject to the Alternate Treatment provision.

WHAT THE PLAN DOES NOT COVER

Not every dental care service or supply is covered by the Plan, even if prescribed, recommended, or approved by your Physician or Dentist. The Plan covers only those services and supplies that are Medically Necessary and included in the *What the Plan Covers* section. Charges made for the following are not covered except to the extent listed under the *What the Plan Covers* section. In addition, some services are specifically limited or excluded. This section describes expenses that are not covered or are subject to special limitations.

The Plan does not cover expenses for:

- Any instruction for diet, plaque control and oral hygiene.

- Cosmetic services and supplies including plastic surgery, reconstructive surgery, cosmetic surgery, personalization or characterization of dentures or other services and supplies which improve alter or enhance appearance, augmentation and vestibuloplasty, and other substances to protect, clean, whiten bleach or alter the appearance of teeth; whether or not for psychological or emotional reasons; except to the extent coverage is specifically provided in the *What the Plan Covers* section.

- Crown, inlays and onlays, and veneers unless:

  - It is treatment for decay or traumatic Injury and teeth cannot be restored with a filling material; or
  - The tooth is an abutment to a covered partial denture or fixed bridge.

- Dental services and supplies that are covered in whole or in part:

  - Under any other part of this plan; or
  - Under any other plan of group benefits provided by the contractholder.

- Dentures, crowns, inlays, onlays, bridges, or other appliances or services used for the purpose of splinting, to alter vertical dimension, to restore occlusion, or correcting attrition, abrasion, or erosion.

- Except as covered in the What the Plan Covers section, treatment of any Jaw Joint Disorder and treatments to alter bite or the alignment or operation of the jaw, including temporomandibular joint disorder (TMJ) treatment, orthognathic surgery, and treatment of malocclusion or devices to alter bite or alignment.

- First installation of a denture or fixed bridge, and any inlay and crown that serves as an abutment to replace congenitally missing teeth or to replace teeth all of which were lost while the person was not covered.

- General anesthesia and intravenous sedation, unless specifically covered and only when done in connection with another necessary covered service or supply.

- Orthodontic treatment except as covered in the *What the Plan Covers* section.

- Prescribed drugs; pre-medication; or analgesia.

- Replacement of a device or appliance that is lost, missing or stolen, and for the replacement of appliances that have been damaged due to abuse, misuse or neglect and for an extra set of dentures.

- Services and supplies done where there is no evidence of pathology, dysfunction, or disease other than covered preventive services.

- Services and supplies provided for your personal comfort or convenience, or the convenience of any other person, including a provider.

- Services and supplies provided in connection with treatment or care that is not covered under the plan.

- Space maintainers except when needed to preserve space resulting from the premature loss of deciduous teeth.

- Surgical removal of impacted wisdom teeth only for orthodontic reasons.

- Treatment by other than a dentist. However, the plan will cover some services provided by a licensed dental hygienist under the supervision and guidance of a dentist. These are:
  - Scaling of teeth;
  - Cleaning of teeth; and
  - Topical application of fluoride.

Additional Items Not Covered By A Health Plan

Not every health service or supply is covered by the Plan, even if prescribed, recommended, or approved by your Physician or Dentist. The Plan covers only those services and supplies that are Medically Necessary and included in the *What the Plan Covers* section. Charges made for the following are not covered except to the extent listed under the *What the Plan Covers* section.

- Acupuncture, acupressure and acupuncture therapy, except as provided in the *What the Plan Covers* section.

- Any charges in excess of the benefit, dollar, day, visit or supply limits stated in this booklet.

- Charges submitted for services by an unlicensed hospital, Physician or other provider or not within the scope of the provider's license.

- Charges submitted for services that are not rendered, or not rendered to a person not eligible for coverage under the Plan.

- Court ordered services, including those required as a condition of parole or release.

- Examinations:
  - Any dental examinations:
    - required by a third party, including examinations and treatments required to obtain or maintain employment, or which an employer is required to provide under a labor agreement;
    - required by any law of a government, securing insurance or school admissions, or professional or other licenses;
    - required to travel, attend a school, camp, or sporting event or participate in a sport or other recreational activity; and
    - any special medical reports not directly related to treatment except when provided as part of a covered service.

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

- Medicare: Payment for that portion of the charge for which Medicare or another party is the primary payer.

- Miscellaneous charges for services or supplies including:

  - Cancelled or missed appointment charges or charges to complete claim forms;

- Charges the recipient has no legal obligation to pay; or the charges would not be made if the recipient did not have coverage (to the extent exclusion is permitted by law) including:
  - Care in charitable institutions;
  - Care for conditions related to current or previous military service; or
  - Care while in the custody of a governmental authority.

- Non-Medically Necessary services, including but not limited to, those treatments, services, prescription drugs and supplies which are not Medically Necessary, as determined by Aetna, for the diagnosis and treatment of Illness, Injury, restoration of physiological functions, or covered preventive services. This applies even if they are prescribed, recommended or approved by your Physician or Dentist.

- Routine dental exams and other preventive services and supplies, except as specifically provided in the *What the Plan Covers* section.

- Services rendered before the effective date or after the termination of coverage, unless coverage is continued under the Continuation of Coverage section of this booklet.

- Work related: Any Illness or Injury related to employment or self-employment including any injuries that arise out of (or in the course of) any work for pay or profit, unless no other source of coverage or reimbursement is available to you for the services or supplies. Sources of coverage or reimbursement may include your employer, workers' compensation, or an occupational Illness or similar program under local, state or federal law. A source of coverage or reimbursement will be considered available to you even if you waived your right to payment from that source. If you are also covered under a workers' compensation law or similar law, and submit proof that you are not covered for a particular Illness or Injury under such law, that Illness or Injury will be considered "non-occupational" regardless of cause.

COORDINATION WITH OTHER PLANS

When Coordination of Benefits Applies

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

Getting Started - Important Terms

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

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

1. If a covered person is confined in a private Hospital room, the difference between the cost of a semi-private room in the Hospital and the private room is not an allowable expense. This does not apply if one of the Plans provides coverage for a private room.
2. If a person is covered by 2 or more Plans that compute their benefit payments on the basis of reasonable or Recognized Charges, any amount in excess of the highest of the reasonable or Recognized Charges for a specific benefit is not an allowable expense.
3. If a person is covered by 2 or more Plans that provide benefits or services on the basis of negotiated charges, an amount in excess of the highest of the negotiated charges is not an allowable expense.

4. The amount a benefit is reduced or not reimbursed by the primary Plan because a covered person does not comply with the Plan provisions is not an allowable expense. Examples of these provisions are second surgical opinions, precertification of admissions, and preferred provider arrangements.
5. If all Plans covering a person are high deductible Plans and the person intends to contribute to a health savings account established in accordance with section 223 of the Internal Revenue Code of 1986, the primary high deductible Plan's deductible is not an allowable expense, except as to any health expense that may not be subject to the deductible as described in section 223(c)(2)(C) of the Internal Revenue Code of 1986.

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

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

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

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

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

- Group or nongroup, blanket, or franchise health insurance policies issued by insurers, including health care service contractors;
- Other prepaid coverage under service Plan contracts, or under group or individual practice;
- Uninsured arrangements of group or group-type coverage;
- Labor-management trustee Plans, labor organization plans, employer organization Plans, or employee benefit organization Plans;
- Medical benefits coverage in a group, group-type, and individual automobile "no-fault" and traditional automobile "fault" type contracts;

- Medicare or other governmental benefits;
- Other group-type contracts. Group type contracts are those which are not available to the general public and can be obtained and maintained only because membership in or connection with a particular organization or group.

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

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

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

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

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

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

Which Plan Pays First

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

- The primary plan pays or provides its benefits as if the secondary plan or plans did not exist.
- A plan that does not contain a coordination of benefits provision that is consistent with this provision is always primary. There is one exception: coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits may provide that the supplementary coverage shall be excess to any other parts of the plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan Hospital and surgical benefits, and insurance type coverages that are written in connection with a closed panel plan to provide out-of-network benefits.
- A plan may consider the benefits paid or provided by another plan in determining its benefits only when it is secondary to that other plan.

- The first of the following rules that describes which plan pays its benefits before another plan is the rule to use:

    1. Non-Dependent or Dependent. The plan that covers the person other than as a dependent, for example as an employee, member, subscriber or retiree is primary and the plan that covers the person as a dependent is secondary. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the plan covering the person as a dependent; and primary to the plan covering the person as other than a dependent (e.g. a retired employee); then the order of benefits between the two plans is reversed so that the plan covering the person as an employee, member, subscriber or retiree is secondary and the other plan is primary.

    2. Child Covered Under More than One Plan. The order of benefits when a child is covered by more than one plan is:

        A. The primary plan is the plan of the parent whose birthday is earlier in the year if:

            i. The parents are married or living together whether or not married;
            ii. A court decree awards joint custody without specifying that one party has the responsibility to provide health care coverage or if the decree states that both parents are responsible for health coverage. If both parents have the same birthday, the plan that covered either of the parents longer is primary.

        B. If the specific terms of a court decree state that one of the parents is responsible for the child's health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is primary. If the parent with responsibility has no health coverage for the dependent child's health care expenses, but that parent's spouse does, the plan of the parent's spouse is the primary plan.

        C. If the parents are separated or divorced or are not living together whether or not they have ever been married and there is no court decree allocating responsibility for health coverage, the order of benefits is:
            - The plan of the custodial parent;
            - The plan of the spouse of the custodial parent;
            - The plan of the noncustodial parent; and then
            - The plan of the spouse of the noncustodial parent.

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

3. Active Employee or Retired or Laid off Employee. The plan that covers a person as an employee who is neither laid off nor retired or as a dependent of an active employee, is the primary plan. The plan covering that same person as a retired or laid off employee or as a dependent of a retired or laid off employee is the secondary plan. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored. This rule will not apply if the Non-Dependent or Dependent rules above determine the order of benefits.

4. Continuation Coverage. If a person whose coverage is provided under a right of continuation provided by federal or state law also is covered under another plan**,** the plan covering the person as an employee, member, subscriber or retiree (or as that person's dependent) is primary, and the continuation coverage is secondary. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored. This rule will not apply if the Non-Dependent or Dependent rules above determine the order of benefits.

5. Longer or Shorter Length of Coverage. The plan that covered the person as an employee, member, subscriber longer is primary.

6. If the preceding rules do not determine the primary plan, the allowable expenses shall be shared equally between the plans meeting the definition of plan under this provision. In addition, this plan will not pay more than it would have paid had it been primary.

How Coordination of Benefits Works

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

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

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

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

Right To Receive And Release Needed Information

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

Facility of Payment

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

Right of Recovery

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

CLAIMS AND BENEFIT PAYMENT

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

Keeping Records of Expenses

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

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

Filing Claims

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

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

Claims should be submitted to:	Aetna P.O. Box 14094 Lexington, KY 40512-4094

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

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

Time Frames for Claim Processing

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

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

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

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

Type of Claim	Response Time
Urgent care claim: a claim for dental care or treatment where delay could: • Seriously jeopardize your life or health, or your ability to regain maximum function; or • Subject you to severe pain that cannot be adequately managed without the requested care or treatment.	As soon as possible, but not later than 72 hours
Pre-service claim: a request for a benefit determination in advance of obtaining dental care (Advance Claim Review).	15 calendar days
Concurrent care claim extension: a request to extend a previously approved Course of Treatment.	• Emergency or urgent care claims - as soon as possible, but not later than 24 hours, provided the request was received at least 24 hours prior to the expiration of the approved treatment • Other claims – 15 calendar days
Concurrent care claim reduction or termination: a decision to reduce or terminate a Course of Treatment that was previously approved.	With enough advance notice to allow you to appeal
Post-service claim: a claim for dental care or treatment that has been rendered.	30 calendar days

Extensions of Time Frames

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

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

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

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

Payment of Benefits

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

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

Recovery of Overpayment

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

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

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

Legal Action

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

Complaints

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

WHEN YOU DISAGREE WITH A CLAIM DECISION

The Appeal Process

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

Your appeal should include:

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

Written requests for appeals may be sent to:	Aetna Attn: National Account CRT P.O. Box 14463 Lexington, KY 40512

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

Type of Claim	**Level One Appeal Response Time**	**Level Two Appeal Response Time**
Urgent care claim: a claim for dental care or treatment where delay could: • Seriously jeopardize your life or health, or your ability to regain maximum function; or • Subject you to severe pain that cannot be adequately managed without the requested care or treatment.	36 hours Review provided by Aetna personnel not involved in making the adverse benefit determination.	36 hours Review provided by Aetna personnel not involved in making the adverse benefit determination.

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

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

Exhaustion of Process

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

Claim Fiduciary

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

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

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

WHEN COVERAGE ENDS

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

When Your Coverage Ends

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

- The Plan is discontinued;
- You voluntarily stop your coverage;
- The coverage described in this booklet is terminated under the group contract;
- You are no longer eligible as defined in the *Eligibility and Enrollment* section of this booklet; or
- You fail to make any required contribution.

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

Death

If you die and were eligible for retiree dental coverage as described in the *Eligibility and Enrollment* section, your spouse may elect retiree coverage under the Plan for your covered Dependents. If coverage is elected, your spouse must pay the applicable retiree contribution. Coverage would continue for your Dependents until the earliest occurrence of one of the following events:

- Dependent coverage is terminated under this Plan;
- A Dependent is or becomes covered as an employee;
- A Dependent is or becomes eligible for coverage under another group plan;*
- A dependent no longer meets the Plan's definition of a Dependent;
- Failure to pay any required contributions; or
- Your spouse's remarriage or death.

Your surviving Dependents may have a right to continue their coverage. See "Under COBRA" further in this section, or contact an OxyLink representative for more information.

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

When Dependent Coverage Ends

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

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

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

Your Dependents may have a right to continue their coverage. See "Under COBRA" further in this section, or contact an OxyLink representative for more information.

See the *Continuation of Coverage* section or contact OxyLink for details regarding how coverage may be continued.

CONTINUATION OF COVERAGE

Under COBRA

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

Qualifying Events and Continuation Periods

The chart below outlines:

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

Qualifying Event Causing Loss of Coverage	Covered Persons Eligible for Continued Coverage	Maximum Continuation Period
Divorce or legal separation	Your spouse Your Dependent children	36 months
Children no longer qualify as eligible for Dependent coverage	Your Dependent children	36 months
Death of your surviving spouse	Your Dependent children	36 months

The required premium for the 36-month continuation period will be 102% of the total Plan cost.

Electing COBRA Continuation Coverage

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

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

Acquiring New Dependents During Continuation

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

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

When COBRA Continuation Ends

Continued coverage ends on the first of the following events:

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

Other Continuation Provisions

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

Keep the Plan Informed of Changes

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

GENERAL INFORMATION

Other Plan Provisions

Multiple Employers and Misstatement of Fact

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

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

Outcome of Covered Services and Supplies

Neither Aetna nor Oxy is responsible for, nor do they make any guarantees concerning, the outcome of the covered services and supplies you receive.

Reporting and Disclosures

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

Privacy Notice for Health Plans

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

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

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

The Plan maintains a privacy notice, which provides a complete description of your rights under HIPAA's privacy rules. For a copy of the notice, you may either call the OxyLink

Employee Service Center at 800-699-6903 or go directly to the OxyLink home page at **oxylink.oxy.com** and select *Health, Life and Disability*, then print the *HIPAA Privacy Notice.* If you have questions about the privacy of your health information or if you wish to file a complaint under HIPAA, contact the OxyLink Employee Service Center.

Your Rights as a Plan Participant

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

Receive Information About Your Plan and Benefits

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

Continue Dental Plan Coverage

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

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

Prudent Action by Plan Fiduciaries

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

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

Enforce Your Rights

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

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

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

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

Help With Your Questions

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

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

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

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

Plan Documents

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

Discretionary Authority of Plan Administrator and Claims Administrator

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

No Guarantee of Employment

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

Future of the Plan and Plan Amendment

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

Plan Administration

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

Plan Name	**Occidental Petroleum Corporation** **Retiree Dental Plan**
Employer Identification Number	**95-4035997**
Plan Number	**652**
Plan Administrative Services Provided by	**Occidental Petroleum Corporation** **10889 Wilshire Boulevard** **Los Angeles, California 90024** **310-208-8800**
Type of Administration	*Administrative Services Contract with:* **Aetna Life Insurance Company** **151 Farmington Avenue** **Hartford, CT 06156**
Plan Administrator	**Occidental Petroleum Corporation** **Employee Benefits Committee**
Plan Sponsor and Address for Legal Process	**Occidental Petroleum Corporation** **10889 Wilshire Boulevard** **Los Angeles, CA 90024** **310-208-8800**
Named Fiduciary	**Aetna Life Insurance Company**
Claims Administrator	**Aetna Life Insurance Company** **151 Farmington Avenue** **Hartford, CT 06156**
End of Plan Year	**December 31**
Type of Plan	**ERISA Welfare Plan**
Source of Contributions	**Participant Contributions**

GLOSSARY

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

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

Dental Provider
This is:

- Any dentist;
- Group;
- Organization;
- Dental facility; or
- Other institution or person;

legally qualified to furnish dental services or supplies.

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

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

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

Your children may include your:

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

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

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

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

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

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

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

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

Hospital
An institution that:

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

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

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

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

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

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

Jaw Joint Disorder
This is:

- A Temporomandibular Joint (TMJ) dysfunction or any similar disorder of the jaw joint; or
- A Myofacial Pain Dysfunction (MPD); or
- Any similar disorder in the relationship between the jaw joint and the related muscles and nerves.

Medically Necessary or Medical Necessity
These are health care or dental services, and supplies or prescription drugs that a physician, other health care provider or dental provider, exercising prudent clinical judgment, would give to a patient for the purpose of:

- preventing;
- evaluating;
- diagnosing; or
- treating:
  - an illness;
  - an injury;
  - a disease; or
  - its symptoms.

The provision of the service, supply or prescription drug must be:

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

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

Network Provider
This is a Dentist who belongs to Aetna's network and has contracted to furnish services or supplies at a Negotiated Charge.

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

Non-Occupational Illness
A non-occupational illness is an illness that does not:

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

An Illness will be deemed to be non-occupational regardless of cause if proof is furnished that the person:

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

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

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

Orthodontic Treatment
This is any:

- Medical service or supply; or
- Dental service or supply;

furnished to prevent or to diagnose or to correct a misalignment:

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

whether or not for the purpose of relieving pain.

The following are not considered orthodontic treatment:

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

Out-of-Network Provider
This is a Dentist who does not belong to Aetna's network and has not contracted with Aetna to furnish services or supplies at a Negotiated Charge**.**

Physician
A duly licensed member of a medical profession who:

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

This also includes a health professional who:

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

Plan
"Plan" means the Occidental Petroleum Corporation Retiree Dental Plan, and as used in this Summary Plan Description, unless the context otherwise plainly requires, "Plan" further means the dental benefits described here. Also, in this Summary Plan Description, "Plan" is used interchangeably with "Dental Plan" or "Retiree Dental Plan."

Recognized Charge
The covered expense is only that part of a charge which is the recognized charge.

As to dental expenses, the recognized charge for each service or supply is the lesser of:

- What the provider bills or submits for that service or supply; and
- The 80th percentile of the Prevailing Charge Rate (below);
- For the Geographic Area where the service is furnished.

If Aetna has an agreement with a provider (directly, or indirectly through a third party) which sets the rate that Aetna will pay for a service or supply, then the recognized charge is the rate established in such agreement.

Aetna may also reduce the recognized charge by applying Aetna Reimbursement Policies. Aetna Reimbursement Policies address the appropriate billing of services, taking into account factors that are relevant to the cost of the service such as:

- The duration and complexity of a service;
- Whether multiple procedures are billed at the same time, but no additional overhead is required;
- Whether an assistant surgeon is involved and necessary for the service;
- If follow up care is included;
- Whether there are any other characteristics that may modify or make a particular service unique; and
- When a charge includes more than one claim line, whether any services described by a claim line are part of or incidental to the primary service provided.

Aetna Reimbursement Policies are based on Aetna's review of: the policies developed for Medicare; the generally accepted standards of medical and dental practice, which are based on credible scientific evidence published in peer-reviewed literature generally recognized by the relevant medical or dental community or which is otherwise consistent with physician or dental specialty society recommendations; and the views of physicians and dentists practicing in the relevant clinical areas. Aetna uses a commercial software package to administer some of these policies.

As used above, Geographic Area and Prevailing Charge Rates are defined as follows:

- Geographic Area: This means an expense area grouping defined by the first three digits of the U.S. Postal Service zip codes. If the volume of charges in a single three digit zip code is sufficient to produce a statistically valid sample, an expense area is made up of a single three digit zip code. If the volume of charges is not sufficient to produce a statistically valid sample, two or more three digit zip codes are grouped to produce a statistically valid sample. When it is necessary to group three digit zip codes, the grouping never crosses state lines.
- Prevailing Charge Rates: These are the rates reported by FAIR Health, a nonprofit company, in their database. FAIR Health reviews and, if necessary, changes these rates periodically. Aetna updates its systems with these changes within 180 days after receiving them from FAIR Health.

Important Note
Aetna periodically updates its systems with changes made to the Prevailing Charge Rates. What this means to you is that the recognized charge is based on the version of the rates that is in use by Aetna on the date that the service or supply was provided.

Additional Information

Aetna's website, **www.aetna.com**, may contain additional information which may help you determine the cost of a service or supply. Log on to Aetna Navigator to access the "Estimate the Cost of Care" feature. Within this feature, view our "Cost of Care" and "Member Payment Estimator" tools, or contact our Customer Service Department for assistance.