

**Summary Plan Description
of the
Anadarko Health Reimbursement Arrangement
under the
Anadarko Petroleum Corporation
Retiree Health Benefits Plan
(Amended and Restated Effective as of January 1, 2018)**

Revision Date: January 1, 2018

This Summary Plan Description of the Anadarko Health Reimbursement Arrangement is one of two components of the full Summary Plan Description of the Anadarko Petroleum Corporation Retiree Health Benefits Plan. Apart from the Health Reimbursement Arrangement, other group health benefits are provided to eligible individuals under the Plan. Such benefits are described in a separate summary plan description document that constitutes the other component of the full Summary Plan Description of the Plan.

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ARTICLE I. GENERAL INTRODUCTION

Anadarko Petroleum Corporation (which is the Plan Sponsor) has amended and restated the “Anadarko Health Reimbursement Arrangement”, effective as of January 1, 2018 (“**HRA**”). The Plan Sponsor maintains the HRA under the Retiree Health Plan in order to provide for reimbursement of:

- Premiums paid by Eligible Retirees and Eligible Dependents of Eligible Retirees and deceased Employees, who are under age 65 and not enrolled in Medicare due to Medicare Disability, for (a) individual health insurance coverage purchased on a private health insurance exchange sponsored by Willis Towers Watson’s Via Benefits Insurance Services (the Plan Sponsor’s designated Concierge Service Partner) or (b) individual or group health benefits coverage obtained from other sources;
- Premiums paid by Eligible Retirees and Eligible Dependents of Eligible Retirees and deceased Employees, who are under age 65, but enrolled in Medicare due to Medicare Disability, for (a) individual health insurance coverage purchased on a private health insurance exchange sponsored by Willis Towers Watson’s Via Benefits Insurance Services, (b) individual or group health benefits coverage obtained from other sources, (c) various forms of Medicare products, or (d) coverage under Medicare Part B; and
- Premiums paid by Eligible Retirees and Eligible Dependents of Eligible Retirees and deceased Employees, who have reached age 65 and are thus eligible for Medicare on the basis of age, for various forms of Medicare products and individual dental or vision insurance policies (provided that at least one Medicare product is initially purchased through Willis Towers Watson’s Via Benefits Insurance Services), as well as premiums paid by such persons for coverage under Medicare Part B.

Reimbursements will not be made for any other medical expenses besides Covered Premiums under the terms of the HRA, and no benefits shall be paid under the HRA for any other purpose.

The terms, conditions and limitations of the HRA are set forth in this Summary Plan Description (“**SPD**”), as well as in the applicable portions of the wrap-around plan document of the Retiree Health Plan. This SPD is incorporated into the Retiree Health Plan in its entirety by reference and thus constitutes a part of the Retiree Health Plan.

It is the intention of the Plan Sponsor that the HRA qualify as a “health reimbursement arrangement” within the meaning of IRS Notice 2002-45, and a self-insured, employer-sponsored medical reimbursement plan under Sections 105 and 106 of the Code. The HRA is a group health plan for purposes of HIPAA and ERISA. The HRA does not cover any active employees of the Plan Sponsor or any other Employer, and thus it is not subject to part A of Title XXVII of the Public Health Service Act, relating to group health plans, as amended by the Affordable Care Act. The HRA is to be interpreted, and shall be administered, in a manner consistent with the foregoing.

With respect to the separate health insurance or other health benefits coverage obtained by individuals who are covered under the HRA, the premiums for which may be reimbursable Covered Premiums hereunder, neither the Plan Sponsor nor any other Employer endorses or recommends to any person any particular health coverage or any providers of such coverage. Eligible persons are encouraged to investigate such coverage and providers themselves and make their own informed decisions regarding the coverage and providers that are appropriate for them. Except to the extent that such separate health coverage is (a) COBRA continuation coverage under the Anadarko Petroleum Corporation Health Benefits Plan or the Anadarko Petroleum Corporation Retiree Health Benefits Plan,

or (b) coverage under a Pre-65 Group Health Program of the Anadarko Petroleum Corporation Retiree Health Benefits Plan, such separate health coverage consists of individual insurance policies, individual health benefits coverage or unrelated employer-sponsored group health benefits coverage, none of which are sponsored or maintained by the Plan Sponsor or other Employer or are part of any plan or program (including any “employee welfare benefit plan” subject to ERISA) established or maintained by the Plan Sponsor or other Employer .

Except as otherwise specified herein, capitalized terms referenced in this SPD are defined in Article II.

ARTICLE II. DEFINITIONS

The following terms, where capitalized, shall have the meanings set forth below when used in the HRA, unless a different meaning is plainly required by the context:

2.1 “Active Health Plan” shall mean the Anadarko Petroleum Corporation Health Benefits Plan.

2.2 “Active Health Plan Dependent” shall mean a “Dependent” of an “Employee”, as such terms are defined in the Summary Plan Description of the Active Health Plan.

2.3 “Affiliate” shall mean (a) an employer (i) that is a member of the same controlled group of corporations (within the meaning of Code Section 414(b)) as the Plan Sponsor, (ii) that is a trade or business (whether or not incorporated) that is under common control (within the meaning of Code Section 414(c)) with the Plan Sponsor, or (iii) that is a member of an affiliated service group of employers (within the meaning of Code Section 414(m)) that includes the Plan Sponsor, and (b) any other entity required to be aggregated with the Plan Sponsor pursuant to regulations under Code Section 414(o).

2.4 “Affordable Care Act” shall mean the Patient Protection and Affordable Care Act of 2010, as amended by the Health Care and Education Reconciliation Act of 2010 and as may be further amended from time to time, and the authoritative guidance issued thereunder by the appropriate governmental entities.

2.5 “Benefits Committee” shall mean the Anadarko Petroleum Corporation Health & Welfare Benefits Administrative Committee, which is a committee of one or more Employees appointed by the Plan Sponsor to act as named fiduciary and Plan Administrator of the HRA. References herein to the Benefits Committee or Plan Administrator shall include, when appropriate, any Employee, Claims Administrator, or other person or entity who has been delegated the appropriate authority by the Benefits Committee as Plan Administrator in accordance with Section 8.1.

2.6 “Claim” shall mean a request for benefits under the HRA which is filed with the Claims Administrator in accordance with the Claims Administrator’s procedures and Article VI of this SPD. Inquiries regarding, or requests for, eligibility or coverage determinations which are not associated with a request for benefits under the HRA shall not constitute a Claim for benefits under ERISA or the HRA.

2.7 “Claims Administrator” shall mean the third party administrator or other entity, as set forth in Article XIV, designated by the Plan Administrator to process Claims and perform other administrative duties under the HRA.

2.8 “Claims Fiduciary” shall mean the person or entity that serves as the named claims fiduciary with respect to reviewing and making final decisions regarding Claims under the HRA. The

Plan Administrator will be the “Claims Fiduciary” for the HRA.

2.9 “Claims Submission Deadline” shall mean (a) for Claims incurred by a Covered Person prior to his death occurring during a Plan Year, the 180th day following such person’s date of death, or (b) for all other Claims, June 30 following the last day of the Plan Year in which the Claim was incurred.

2.10 “COBRA” shall mean the continuation of coverage provisions of Title X of the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended, and the regulations and other authority issued thereunder by the appropriate governmental authority.

2.11 “COBRA Continuation Coverage” shall mean the coverage available and provided if elected under the provisions of COBRA as described in Article VII.

2.12 “Code” shall mean the Internal Revenue Code of 1986, as amended, and regulations and other authority issued thereunder by the appropriate governmental authority. References herein to any section of the Code or such regulations shall include references to any successor section or provision of the Code or such regulations, as applicable.

2.13 “Concierge Service Partner” shall mean the person or entity, as listed in Article XIV, that has been designated by the Plan Sponsor to provide concierge services to Eligible Retirees, Eligible Dependents, and Covered Persons with respect to their selections of, and enrollment in, Separate Health Coverage.

2.14 “Coverage Level” shall mean Pre-65 HRA Coverage, Pre-65 Disability HRA Coverage or Post-65 HRA Coverage, as applicable.

2.15 “Covered Dependent” shall mean an Eligible Dependent who is enrolled in Pre-65 HRA Coverage, Pre-65 Disability HRA Coverage or Post-65 HRA Coverage under the HRA.

2.16 “Covered Person” shall mean a Covered Retiree, a Covered Dependent or an alternate recipient receiving benefits under a Qualified Medical Child Support Order, who is properly enrolled in the HRA. The term “Covered Person” also includes a COBRA Qualified Beneficiary who is enrolled in COBRA Continuation Coverage under the HRA.

2.17 “Covered Premiums” shall mean only the following:

(a) With respect to a Covered Person with Pre-65 HRA Coverage who is not in a Non-Reimbursement Status, premiums incurred by the Covered Person for Separate Health Coverage; and

(b) With respect to (i) a Covered Person with Post-65 HRA Coverage or (ii) a Covered Person with Pre-65 Disability HRA Coverage who is not in a Non-Reimbursement Status, premiums incurred by the Covered Person for Separate Health Coverage or Medicare Part B coverage.

In order to qualify as Covered Premiums, the premiums described in subsections (a) and (b), above, must constitute expenses for medical care under Section 213(d) of the Code. For purposes of clarification and not limitation, contributions payable by a Covered Person toward the cost of coverage for qualified long-term care services shall not be eligible for payment or reimbursement as Covered Premiums under the HRA.

Notwithstanding the above, the term “Covered Premiums” shall not include any of the following:

- Premiums that have already been reimbursed, or are reimbursable, through any other source;

- Premiums incurred prior to the effective date of the HRA or after the date of termination of the HRA;
- Premiums incurred by an individual during any period of time (A) prior to the date on which the individual became a Covered Person, or (B) after the date on which the individual ceased to be a Covered Person;
- Premiums incurred by a Covered Person with Pre-65 HRA Coverage or Pre-65 Disability HRA Coverage who is in a Non-Reimbursement Status;
- Premiums which are paid by an individual on a pre-tax basis, through a cafeteria plan under Section 125 of the Code or otherwise; and
- Premiums that are attributable to a deduction allowed under Section 213 of the Code and taken by the Covered Person for any prior taxable year.

2.18 “Covered Retiree” shall mean an Eligible Retiree who is enrolled in Pre-65 HRA Coverage, Pre-65 Disability HRA Coverage or Post-65 HRA Coverage under the HRA.

2.19 “Dependent” shall mean:

- (a) A Spouse;
- (b) A Domestic Partner;
- (c) A Child of an Eligible Retiree, a Spouse or a Domestic Partner, but only through the end of the year of such Child’s 26th birthday; and
- (d) A Child of an Eligible Retiree, a Spouse or a Domestic Partner, beginning with the year of such Child’s 27th birthday, but only if such Child is dependent on the Eligible Retiree, the Spouse or the Domestic Partner because of a mental or physical handicap rendering the Child medically incapacitated and unable to be self-supportive (“**Incapacitated**”). The Child must satisfy either of the following requirements: (i) prior to the end of the year of the Child’s 26th birthday, the Child is Incapacitated and covered as a Dependent under the HRA, or (ii) the Child is Incapacitated and over age 26 prior to the Child’s parent first becoming eligible for coverage under the HRA, either as an Eligible Retiree or as an Eligible Dependent Spouse or Domestic Partner, and the Child is enrolled in the HRA when first eligible (*i.e.*, such Incapacitated Child cannot later be added to coverage under the HRA). In addition, the Child must reside with the Eligible Retiree 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.

For purposes of subsections (c) and (d), above, the term “Child” means a (i) biological child of an Eligible Retiree or Domestic Partner, (ii) legally adopted child or a child placed for adoption with the Eligible Retiree, Spouse or Domestic Partner, (iii) stepchild of an Eligible Retiree, or (iv) child for whom the Eligible Retiree, Spouse or Domestic Partner has a court appointed guardianship or conservatorship, but only if such child primarily lives with the Eligible Retiree, is a member of the Eligible Retiree’s household and qualifies as the Eligible Retiree’s “dependent” for federal income tax purposes under Sections 105(b) and 106 of the Code, as amended by the Affordable Care Act.

To the extent that the Domestic Partner of an Eligible Retiree (or the surviving Domestic Partner of either a deceased Eligible Retiree or deceased Employee) or the Child of such Domestic Partner is a Covered Dependent, but is not the Eligible Retiree’s (or Employee’s) “dependent” or “child” for federal income tax purposes under Sections 105(b) and 106 of the Code, as amended by the Affordable Care Act,

the value of such Domestic Partner's or Child's coverage under the HRA shall be taxable to the Eligible Retiree (or to the Domestic Partner or his Child, as applicable, if the Eligible Retiree or Employee is deceased) for purposes of federal income tax and other applicable taxes in the year in which such coverage is provided to the Domestic Partner or Child.

Notwithstanding the foregoing provisions of this Section, to the extent required by applicable law, the HRA shall treat any person as a Dependent who is required to be treated as a Dependent under the terms of any valid Qualified Medical Child Support Order. Any Dependent who is a full-time member of the armed forces is not eligible for coverage hereunder, except as may be required by the Uniformed Services Employment and Reemployment Rights Act.

An individual may not be covered as the Dependent of more than one Eligible Retiree, or covered hereunder as a Dependent and also covered under the Active Health Plan as an Active Health Plan Dependent. An individual who is eligible for coverage under the Active Health Plan as an Employee shall not be eligible at that same time for coverage as a Dependent under the HRA. In addition, no individual may be covered twice under the HRA. A Dependent Child may be covered under the HRA as a Dependent of only one of two married Eligible Retirees.

2.20 "Domestic Partner" shall mean an individual who (a) is at least 18 years of age; (b) lives with the Eligible Retiree or Employee in a committed, monogamous relationship; (c) has lived in such relationship with the Eligible Retiree or Employee at the same place of residence for at least six (6) months; (d) is not legally married to the Eligible Retiree or Employee or legally married to, or in a domestic partnership with, any other person; and (e) is not related to the Eligible Retiree or Employee by blood or adoption; provided that both such individual and the Eligible Retiree or Employee intend for their relationship to be continuous and of an indefinite duration. The Plan Administrator may require the Eligible Retiree or Employee to provide evidence that is satisfactory to the Plan Administrator in order to verify that all the requirements set forth in this Section have been met. The Plan Administrator shall have the sole and absolute discretion to determine whether an individual is the Domestic Partner (as defined above) for all purposes of the HRA.

2.21 "Eligible Dependent" shall mean a Dependent who meets the eligibility requirements of Section 3.1(b).

2.22 "Eligible Retiree" shall mean a Retiree or Former Employee who meets the eligibility requirements of Section 3.1(a).

2.23 "Employee" shall mean any individual who is (1) in an employer-employee relationship with the Employer and (2) on the United States payroll records of the Employer for purposes of federal income tax withholding. The term "Employee" will not include any person during any period that such person was classified in the Employer's records as a "non-employee" or considered by the Employer to be a limited-benefit employee, an independent contractor, agent, leased employee, contract employee, temporary employee, temporary-staffing employee or worker, 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 Section 414(n)(2) of the Code, 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 on IRS Form 1099 (or its successor) for the person's services, and (c) a "contract employee" means an individual 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, the term “Employee” will not include (i) an employee who is a non-resident alien and who receives 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)), (ii) a “foreign inpatient”, which means an individual whose home country is outside the United States, but who has been seconded from an Affiliate of the Plan Sponsor to the Plan Sponsor for an employment assignment of at least 6 months in the United States, or (iii) any sole proprietors, partners in a partnership and 2% shareholders of a S corporation.

2.24 “Employer” shall mean the Plan Sponsor and any Affiliate that has elected to participate in the HRA in accordance with Retiree Health Plan’s procedures, provided, however, with respect to an Employee who retires or otherwise terminates from employment prior to January 1, 2016, the term “Employer” shall mean a corporation or other entity that was a participating employer in the Retiree Health Plan. The participating Employers of the HRA are listed in Appendix A (attached hereto), as such Appendix may be revised from time to time by the Plan Sponsor without the need for a formal amendment to the Retiree Health Plan or the HRA.

2.25 “ERISA” shall mean the Employee Retirement Income Security Act of 1974, as amended, and regulations and other authority issued thereunder by the appropriate governmental authority. References herein to any section of ERISA or such regulations shall include references to any successor section or provision of ERISA or such regulations, as applicable.

2.26 “Exhausted COBRA Continuation Coverage” shall mean that the COBRA Continuation Coverage elected by a Qualified Beneficiary (as defined in Section 7.9) has ceased for any reason other than either (a) a failure of such individual to pay the required contributions toward his COBRA Continuation Coverage on a timely basis, or (b) for cause (including, but not limited to, making a fraudulent Claim under the HRA or an intentional misrepresentation of a material fact in connection with the HRA).

2.27 “Former Employee” shall mean an Employee who terminates employment with a corporation or other entity that (a) on the date of such employment termination which is on or after January 1, 2016, is a participating Employer in the HRA, or (b) on the date of such employment termination which is prior to January 1, 2016, was a participating employer in the Retiree Health Plan.

2.28 “HRA” shall mean the Anadarko Health Reimbursement Arrangement, amended and restated effective as of January 1, 2018, which is provided under the Retiree Health Plan, as amended from time to time.

2.29 “HRA Account” shall mean the notional, recordkeeping account established for a Covered Person in order to reimburse his Covered Premiums.

2.30 “Joint HRA Account” shall mean, in the event that more than one person among an Eligible Retiree and his Eligible Dependents (or the Eligible Dependents of a deceased Employee) are Covered Persons, the single joint HRA Account that is established for such Covered Persons.

2.31 “Legacy Retiree Group” shall mean:

(a) with respect to a Retiree who retired on or before December 31, 2006, the corporation or other entity from which the Retiree retired; or

(b) with respect to a Retiree who retired after December 31, 2006, either (i) the corporation or other entity that issued his 2006 Form W-2 and that included the Retiree on its payroll as of December 31, 2006, or (ii) if the Retiree was hired on or after January 1, 2007, Anadarko Petroleum Corporation.

2.32 “Legacy Severance Retiree” shall mean a Legacy APC Severance Retiree or a Legacy KMG Severance Retiree, each defined as follows:

(a) “Legacy APC Severance Retiree” means a Former Employee who meets the Rule of 45, is a member of the Anadarko Petroleum Corporation Legacy Retiree Group, and:

(i) whose employment with the employer is involuntarily terminated by the employer on or after January 1, 2016, and prior to January 1, 2017, in connection with a program of reductions in force as declared by the Plan Sponsor in its sole discretion (the “**2016 Reduction**”) and who, as of March 31, 2017, would either:

(A) attain at least age 50 and accrue at least 15 Years of Service (following a break in service, only Years of Service after age 45 are counted); or

(B) attain at least age 55 and accrue at least 10 Years of Service (following a break in service, only Years of Service after age 45 are counted);

where, for purposes of this subsection (a)(i), the Former Employee is deemed to incur no break in employment service between his employment termination date with respect to the 2016 Reduction and March 31, 2017; or

(ii) whose employment with the employer terminates on or after January 1, 2016, at age 50 or later, with at least 15 Years of Service (following a break in service, only Years of Service after age 45 are counted), under one of the following circumstances:

(A) the Former Employee’s employment is involuntarily terminated by the employer without “cause”, as defined below, and as determined by the Plan Sponsor in its sole discretion,

(B) the Former Employee’s employment is terminated by the employer in connection with a limited program of reductions in force as declared by the Plan Sponsor in its sole discretion, or

(C) the Former Employee’s employment is terminated by reason of a shutdown or closing of a facility or significant operation as determined by the Plan Sponsor in its sole discretion.

For purposes of subsection (a)(ii)(A), above, a Former Employee’s employment with the employer shall be deemed terminated for “cause” if such termination is by reason of any of the following: (1) conviction of any felony or of a misdemeanor involving moral turpitude, (2) willful failure to perform his duties and responsibilities, (3) engagement in conduct which is materially injurious to the Plan Sponsor (or his employer, if different), (4) engagement in business activities which are materially in conflict with the business interests of the Plan Sponsor (or his employer, if different), (5) insubordination, (6) engagement in conduct which is in violation of the safety rules or standards of the Plan Sponsor (or his employer, if different) or which otherwise causes injury to another Employee or any other person, or (7) engagement in conduct which is in violation of any policy or work rule of the Plan Sponsor (or his employer, if different) or which is otherwise inappropriate in the office or work environment.

(b) “Legacy KMG Severance Retiree” means a Former Employee who meets the Rule of 45, is a member of the Kerr-McGee Corporation Legacy Retiree Group, and:

(i) whose employment with Anadarko Petroleum Corporation is involuntarily

terminated by the employer on or after January 1, 2016, and prior to January 1, 2017, in connection with the 2016 Reduction (defined in subsection (a)(i), above), and who, as of March 31, 2017, would attain at least age 50 (or age 49, with special credits to reach age 50) and accrue at least 8 Years of Service (or with special credits to reach 8 Years of Service) as determined for purposes of vesting under the Kerr-McGee Corporation Retirement Plan, where, for purposes of this subsection(b)(i), the Former Employee is deemed to incur no break in employment service between his employment termination date with respect to the 2016 Reduction and March 31, 2017; or

(ii) whose employment with Anadarko Petroleum Corporation terminates on or after January 1, 2016, at age 50 or later (or age 49, with special credits to reach age 50), with at least 8 Years of Service (or with special credits to reach 8 Years of Service) as determined for purposes of vesting under the Kerr-McGee Corporation Retirement Plan, and pursuant to the terms of a severance plan sponsored by the employer.

2.33 “Legacy Special Enrollee” shall mean:

(a) a Retiree who:

(i) is a member of the Anadarko Petroleum Corporation Legacy Retiree Group, and either:

(A) retired on or before December 31, 2007, at age 55 or later, with at least 10 Years of Service (following a break in service, only Years of Service after age 45 are counted); or

(B) met the Rule of 45 and retired on or after January 1, 2008 and before January 1, 2016, at age 55 or later, with at least 10 Years of Service (following a break in service, only Years of Service after age 45 are counted); or

(ii) is a member of the Union Pacific Resources Group, Inc. Legacy Retiree Group, and retired on or before December 31, 2007, at age 55 or later, with at least 10 Years of Service; or

(b) a Former Employee:

(i) who is a member of the Anadarko Petroleum Corporation Legacy Retiree Group;

(ii) whose date of termination of employment with the employer was on or after February 1, 2003 and prior to January 1, 2016; and

(iii) who, as of December 31, 2015:

(A) was eligible for subsidized coverage under the Retiree Health Plan based on the severance eligibility terms of the Retiree Health Plan as in effect on the date of his termination of employment with the employer, and

(B) had not yet attained Medicare Eligibility Due to Age.

2.34 “Medicare” shall mean Subchapter XVIII of Chapter 7 of Title 42 of the United States Code.

2.35 “Medicare Disabled or Medicare Disability” shall mean that the individual’s disability

meets the requirements for eligibility for coverage under Part A and Part B of Medicare on the basis of such disability. The individual may be required to provide proof of his Medicare Disability (including continued Medicare Disability) on a timely and periodic basis and in the form requested by the Plan Administrator.

2.36 “Medicare Eligibility Due to Age” shall mean eligibility for coverage under Part A and Part B of Medicare on the basis of attainment of age sixty-five (65).

2.37 “Medicare Eligibility Month” shall have the meaning described in Section 3.2(b)(ii).

2.38 “Medicare Initial Enrollment Period” shall mean an “initial enrollment period” under Part A, Part B, Part C or Part D of Medicare, as applicable.

2.39 “Medicare Product” shall mean any of the following:

(a) a “prescription drug plan”, as such term is defined under Medicare Part D at 42 USC § 1395w-151(a)(14) (“**Medicare Prescription Drug Plan**”;

(b) a “Medicare supplemental policy”, as such term is defined under Medicare Part E at 42 USC § 1395ss(g)(1) (“**Medicare Supplement Policy**”);

(c) the health benefits coverage provided under Medicare Part C at 42 USC §§ 1395w-21 et seq. (“**Medicare Advantage Plan**”); or

(d) a Medicare Advantage Plan that provides qualified prescription drug coverage, as described under Medicare Part D at 42 USC § 1395w-101(a)(3)(C) (“**Medicare Advantage-Prescription Drug Plan**”).

2.40 “Medicare Special Enrollment Period” shall mean a “special enrollment period” under Part A, Part B, Part C or Part D of Medicare, as applicable.

2.41 “Non-Reimbursement Status” shall mean the status of a Covered Person who has not yet attained Medicare Eligibility Due to Age, but opts out of eligibility for reimbursement of Covered Premiums pursuant to Section 3.2(a)(iii). A Covered Person who is in a Non-Reimbursement Status due to an Opt Out for a given month (or months) will not be entitled to reimbursement under the HRA of any Covered Premiums, or any other premiums or expenses, incurred during such month.

2.42 “Opt In” shall have the meaning described in Section 3.2(a)(i).

2.43 “Opt In Forms” shall have the meaning described in Section 3.2(a)(i).

2.44 “Opt Out” shall have the meaning described in Section 3.2(a)(iii).

2.45 “Opt Out Notice” shall have the meaning described in Section 3.2(a)(iii).

2.46 “Plan Administrator” shall mean the person or entity which has the authority and responsibility to manage and direct the operation of the HRA in its discretion. However, the Plan Administrator may assign or delegate duties to third parties, such as the Claims Administrator, under the terms of the HRA or by means of a separate written agreement. The Plan Administrator is the “plan administrator” for purposes of Section 3(16)(A) of ERISA. The Benefits Committee will be the “Plan Administrator”.

2.47 “Plan Year” shall mean each twelve (12) consecutive month period commencing

January 1st and ending on December 31st.

2.48 “Plan Sponsor” shall mean Anadarko Petroleum Corporation, or its successor in interest.

2.49 “Post-65 HRA Coverage” shall mean coverage provided under the HRA to Eligible Retirees and Eligible Dependents who (a) attain Medicare Eligibility Due to Age, (b) enroll in Separate Health Coverage and/or Medicare Part B, and (c) enroll in the HRA as described in Section 3.2(b).

2.50 “Pre-65 Disability HRA Coverage” shall mean coverage provided under the HRA to Eligible Retirees and Eligible Dependents who (a) have not yet attained Medicare Eligibility Due to Age, (b) are enrolled in Medicare on the basis of Medicare Disability, and (c) enroll (or are enrolled) in the HRA as described in Section 3.2(a)(ii).

2.51 “Pre-65 Group Health Program” shall mean:

(a) Effective from January 1, 2014 through December 31, 2015, one of the following “Welfare Programs” under the Retiree Health Plan as defined in the Retiree Health Plan 2014/2015 SPD:

- (i) UnitedHealthcare POS Choice Plus Plan Medical Benefits Program;
- (ii) UnitedHealthcare PPO Options (Utah) Plan Medical Benefits Program;
- (iii) UnitedHealthcare Out of Area Options Plan Medical Benefits Program;
- (iv) UnitedHealthcare HDHP Choice Plus Plan Medical Benefits Program;
- (v) UnitedHealthcare HDHP Options (Utah) Plan Medical Benefits Program; and
- (vi) UnitedHealthcare Out of Area HDHP Options Plan Medical Benefits Program;

and

(b) Effective on and after January 1, 2016, one of the following “Group Health Programs” under the Retiree Health Plan as defined in the applicable Retiree Health Plan Group Benefit SPD:

- (i) UnitedHealthcare HDHP Choice Plus Plan Medical Benefits Program;
- (ii) UnitedHealthcare HDHP Options (Utah) Plan Medical Benefits Program; and
- (iii) UnitedHealthcare Out of Area HDHP Options Plan Medical Benefits Program.

2.52 “Pre-65 HRA Coverage” shall mean coverage provided under the HRA to Eligible Retirees and Eligible Dependents who (a) have not yet attained Medicare Eligibility Due to Age, (b) are not enrolled in Medicare on the basis of Medicare Disability, and (c) enroll in the HRA as described in Section 3.2(a)(i).

2.53 “Retiree” shall mean an Employee who retires from employment with a corporation or other entity that (a) on the date of the Employee’s retirement which is on or after January 1, 2016, is a participating Employer in the HRA, or (b) on the date of the Employee’s retirement which is prior to January 1, 2016, was a participating employer in the Retiree Health Plan.

2.54 “Retiree Health Plan” shall mean the Anadarko Petroleum Corporation Retiree Health Benefits Plan, as amended from time to time.

2.55 “Retiree Health Plan 2014/2015 SPD” shall mean the “Summary Plan Description of the Anadarko Petroleum Corporation Retiree Health Benefits Plan (Amended and Restated Effective as of January 1, 2014), Revision Date: January 1, 2014”, including any appendices attached thereto.

2.56 “Retiree Health Plan Group Benefit SPD” shall mean, effective on and after January 1, 2016, the “Summary Plan Description of the Group Health Benefit under the Anadarko Petroleum Corporation Retiree Health Benefits Plan” in effect as of the relevant date.

2.57 “Retiree Health Plan Dependent” shall mean a “Dependent” of a “Retiree”, as such terms are defined in the Retiree Health Plan 2014/2015 SPD, or, as applicable, under the terms of the Retiree Health Plan (or predecessor coverage) in effect as of the relevant date.

2.58 “Retiree Health Plan Surviving Dependent” shall mean the surviving “Dependent” of a deceased “Retiree”, as such terms are defined in the Retiree Health Plan 2014/2015 SPD.

2.59 “Rule of 45” shall mean that a Retiree (a) was employed by his Legacy Retiree Group on December 31, 2006, and (b) on December 31, 2007, (i) he was employed by Anadarko Petroleum Corporation, and (ii) his age and Years of Service totaled at least forty-five (45).

2.60 “Separate Health Coverage” shall mean:

(a) with respect to a person who has not yet attained Medicare Eligibility Due to Age and is not enrolled in Medicare due to Medicare Disability, any medical, prescription drug, dental or vision coverage which is provided through (i) an individual health insurance policy that is purchased on a private health insurance exchange sponsored by the Concierge Service Partner, or (ii) an individual or group health plan or insurance policy that is obtained from any other source;

(b) with respect to a person who has not yet attained Medicare Eligibility Due to Age, but is enrolled in Medicare due to Medicare Disability, any:

(i) medical, prescription drug, dental or vision coverage which is provided through
(A) an individual health insurance policy that is purchased on a public health insurance exchange or a private health insurance exchange sponsored by the Concierge Service Partner, or
(B) an individual or group health plan or insurance policy that is obtained from any other source; or

(ii) Medicare Product; or

(c) with respect to a person who has attained Medicare Eligibility Due to Age, an individual (i) Medicare Product or (ii) health insurance policy which provides dental or vision coverage (provided that, upon initial enrollment in the HRA, at least one Medicare Product must be purchased on a private health insurance exchange through the Concierge Service Partner).

The term “Separate Health Coverage” does not include coverage for qualified long-term care services. For purposes of clarification and not limitation, effective as of January 1, 2016, (A) coverage provided under a Pre-65 Group Health Program of the Retiree Health Plan and (B) COBRA continuation coverage under the Active Health Plan shall constitute coverage as described in subsection (a)(ii), above.

2.61 “SPD” shall mean this Summary Plan Description document, including any appendices attached here, as may be amended from time to time, and which is incorporated into the Retiree Health Plan by reference and contains certain terms of the Plan.

2.62 “Spouse” shall mean a person to whom an Eligible Retiree or deceased Employee 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 and ERISA), and any regulations promulgated under such applicable Federal law, but will not include an individual divorced from the Eligible Retiree under a court-approved divorce decree. The term "Spouse" will also include a common law spouse if the Eligible Retiree or deceased Employee and spouse became common law married in a state which recognizes common law marriages and meet all the requirements for common law marriage in that state. The Eligible Retiree or the spouse of a deceased Employee must provide proof of a ceremonial or common law marriage if 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.

2.63 "Years of Service" shall mean years of employment service with the Plan Sponsor or other Employer (or a predecessor of either), as determined by the Plan Administrator in accordance with its procedures established for such purpose.

In the event of an acquisition by the Plan Sponsor (or an Employer) of a corporation or entity or another similar corporate transaction, the Plan Administrator may, in its discretion, and in accordance with the agreements governing such corporate transaction and the Plan Administrator's procedures, treat a Retiree's (or Employee's) years of employment service with the acquired corporation or entity as Years of Service. With respect to Retirees who retired from employment prior to January 1, 2016, the Plan Administrator will treat a Retiree's years of employment service with the acquired corporation or entity as Years of Service under the HRA to the same extent as such years of employment service are accredited for purposes of the eligibility provisions of the Retiree Health Plan in effect as of the date of such Retiree's retirement from employment with the Plan Sponsor or other Employer.

ARTICLE III. ELIGIBILITY AND PARTICIPATION

3.1 Eligibility for Coverage.

(a) Retiree Eligibility The following individuals shall be eligible to participate in the HRA as "Eligible Retirees":

(i) A Retiree who, on December 31, 2015, had not yet attained Medicare Eligibility Due to Age and was receiving coverage, subsidized by the Plan Sponsor or its Affiliate, as a Retiree under a Pre-65 Group Health Program of the Retiree Health Plan;

(ii) A Former Employee who, on December 31, 2015, had not yet attained Medicare Eligibility Due to Age and was receiving coverage, subsidized by the Plan Sponsor or its Affiliate, as a former Employee under a Pre-65 Group Health Program of the Retiree Health Plan pursuant to the terms and conditions of (A) a separate written agreement between the Former Employee and the Plan Sponsor or its Affiliate (including, but not limited to, a severance agreement), (B) the portion of the Retiree Health Plan that provides for severance eligibility of certain Anadarko Petroleum Corporation Legacy Retiree Group, Kerr-McGee Corporation Legacy Retiree Group or Western Gas Resources, Inc. Legacy Retiree Group members, as in effect on the date of such Former Employee's termination of employment with the employer, or (C) a severance program or an employee benefit plan subject to ERISA that provides severance benefits, as sponsored by the Plan Sponsor or its Affiliate;

(iii) A Former Employee whose employment with his employer terminated on or after August 31, 2015, and on or before December 31, 2015, and who, as of the date of such termination, was a member of the Western Gas Resources, Inc. Legacy Retiree Group and was

eligible to receive coverage, subsidized by the Plan Sponsor or its Affiliate, as a former Employee under a Pre-65 Group Health Program of the Retiree Health Plan, but who (A) in lieu thereof, elected COBRA continuation coverage under the Active Health Plan, and (B) as of December 31, 2015, had not yet attained Medicare Eligibility Due to Age and was covered by such COBRA continuation coverage;

(iv) A Legacy Special Enrollee who, as of December 31, 2015, had not yet attained Medicare Eligibility Due to Age;

(v) A Legacy Severance Retiree;

(vi) A Retiree whose date of retirement is on or after January 1, 2016 and who meets the Rule of 45 and the following Legacy Retiree Group requirements, as applicable:

Legacy Retiree Group	Requirements
Anadarko Petroleum Corporation Legacy Retiree Group	Retirement at age 55 or later with at least 10 Years of Service (following a break in service, only Years of Service after age 45 are counted)
Kerr-McGee Corporation Legacy Retiree Group	Retirement at age 52 or later with at least 10 Years of Service
Western Gas Resources, Inc. Legacy Retiree Group	Retirement at age 55 or later with at least 10 Years of Service with the Plan Sponsor (previous service with Western Gas Resources does not count toward this total, and, following a break in service, only Years of Service after age 45 are counted) -or- Involuntary termination of employment by the employer (1) on or after August 31, 2015, and (2) on or prior to August 23, 2016, as a result of a divestiture of corporate assets by the Plan Sponsor (including, but not limited to, the Coal-Bed Methane (CBM) Divestiture), reduction in force, or other similar organizational change, if the Retiree would attain at least age 55 and accrue at least 10 Years of Service with the Plan Sponsor as of August 23, 2016 (where, for such purpose, the Retiree is deemed to incur no break in employment service between his date of retirement and August 23, 2016);

(vii) A Former Employee whose date of employment termination is on or after January 1, 2016 and who is provided coverage under the HRA pursuant to the terms and conditions of (A) a separate written agreement between the Former Employee and the Plan Sponsor or other Employer (including, but not limited to, a severance agreement), or (B) a severance program or an employee benefit plan subject to ERISA that provides severance benefits, as sponsored by the Plan Sponsor or another Employer; or

(viii) A Retiree (A) whose date of retirement is on or after December 1, 2015, but before January 1, 2016, (B) who is not a Legacy Special Enrollee, (C) who, as of December 31, 2015, had not attained Medicare Eligibility Due to Age, and (D) who, as of January 1, 2016, meets the applicable criteria in subsection (a)(vi), above.

(b) Dependent Eligibility. The following Dependents shall be eligible to participate in the HRA as “Eligible Dependents”:

(i) A Dependent who, on December 31, 2015, had not yet attained Medicare Eligibility Due to Age and was receiving coverage, subsidized by the Plan Sponsor or its Affiliate, as a Retiree Health Plan Dependent (or Retiree Health Plan Surviving Dependent) of a Retiree (or deceased Retiree) under a Pre-65 Group Health Program of the Retiree Health Plan;

(ii) A Dependent who, on December 31, 2015, had not yet attained Medicare Eligibility Due to Age and was receiving coverage, subsidized by the Plan Sponsor or its Affiliate, as a Retiree Health Plan Dependent (or Retiree Health Plan Surviving Dependent) of a Former Employee (or deceased Former Employee) described in subsection (a)(ii), under a Pre-65 Group Health Program of the Retiree Health Plan;

(iii) A Dependent who, on December 31, 2015 (A) had not yet attained Medicare Eligibility Due to Age and (B) was receiving COBRA continuation coverage under the Active Health Plan as a qualified beneficiary with respect to the termination of employment of a Former Employee described in subsection (a)(iii);

(iv) A Dependent who (A) was a Retiree Health Plan Dependent of a Legacy Special Enrollee as of the Legacy Special Enrollee’s date of retirement, and (B) as of December 31, 2015, had not yet attained Medicare Eligibility Due to Age;

(v) A Dependent who is a Dependent of a Legacy Severance Retiree as of the Legacy Severance Retiree’s employment termination date;

(vi) Effective with respect to a Retiree as described in subsection (a)(vi) whose date of retirement with the Employer is on or after January 1, 2016:

(A) An individual who is the Retiree’s Dependent on the Retiree’s retirement date; or

(B) The surviving Dependent of a deceased Retiree, provided that such Dependent was the Retiree’s Dependent on the Retiree’s retirement date;

(vii) Effective with respect to a Former Employee as described in subsection (a)(vii) whose date of termination from employment with the Employer is on or after January 1, 2016:

(A) An individual who is the Former Employee’s Dependent on the Former Employee’s date of termination from employment; or

(B) The surviving Dependent of a deceased Former Employee, provided that such Dependent was the Former Employee’s Dependent on the Former Employee’s date of termination from employment;

(viii) A Dependent who (A) on the date of retirement of a Retiree described in subsection (a)(viii), constituted an eligible Retiree Health Plan Dependent under the Retiree Health Plan of such Retiree, and (B) on December 31, 2015, had not yet attained Medicare

Eligibility Due to Age; and

(ix) The surviving Dependent of (A) a deceased Employee whose date of death is on or after January 1, 2016, provided that such Employee meets the Rule of 45 as of his date of death, or (B) a deceased Employee whose date of death was prior to January 1, 2016, provided that, on December 31, 2015, such Dependent was (1) covered under the Active Health Plan as a surviving Active Health Plan Dependent of such Employee and (2) not yet Medicare Eligible Due to Age.

3.2 Enrollment and Participation.

Notwithstanding any other provision of this SPD or the Retiree Health Plan, no person's participation in the HRA shall begin prior to January 1, 2016.

(a) Enrollment and Participation Prior to Attainment of Medicare Eligibility Due to Age. The provisions of this subsection (a) are effective as of January 1, 2016.

(i) Pre-65 HRA Coverage. An Eligible Retiree or Eligible Dependent who has not yet attained Medicare Eligibility Due to Age and is not enrolled in Medicare on the basis of Medicare Disability may enroll in the HRA (or opt back in to eligibility for reimbursement of Covered Premiums following a prior Opt Out pursuant to Section 3.2(a)(iii)) (in either case, "**Opt In**") at the Pre-65 HRA Coverage level, and thus become a Covered Person (or a Covered Person who is not in a Non-Reimbursement Status), by completing the written or electronic enrollment form required by the Claims Administrator and submitting such form, along with any related documentation and other information (whether written, electronic or verbal) required by the Benefits Committee or Claims Administrator (collectively, "**Opt In Forms**"), to the Claims Administrator in accordance with the Claims Administrator's procedures. In that case, the effective date of such Pre-65 HRA Coverage for such Eligible Retiree or Eligible Dependent will be:

(A) with respect to any enrollment during the Plan Year in which such individual first becomes eligible to participate in the HRA incident to the Eligible Retiree's retirement or other termination from employment with the Employer, the later of (1) the first day of the month next following the date of such retirement or termination, or (2) January 1, 2016; or

(B) with respect to any other later enrollment (or Opt In following a prior Opt Out pursuant to Section 3.2(a)(iii)), the first day of the month next following the month in which the Eligible Retiree or Eligible Dependent, as applicable, submits his Opt In Forms to, and such forms are approved by, the Claims Administrator.

(ii) Pre-65 Disability HRA Coverage.

(A) An Eligible Retiree or Eligible Dependent who has not yet attained Medicare Eligibility Due to Age, but is enrolled in Medicare on the basis of Medicare Disability, may Opt In to Pre-65 Disability HRA Coverage, and thus become a Covered Person (or a Covered Person who is not in a Non-Reimbursement Status), by completing the Opt In Forms and submitting them to the Claims Administrator in accordance with the Claims Administrator's procedures. In that case, the effective date of such Pre-65 Disability HRA Coverage for such Eligible Retiree or Eligible Dependent will be:

(1) with respect to any enrollment during the Plan Year in which such individual first becomes eligible to participate in the HRA incident to the

Eligible Retiree's retirement or other termination from employment with the Employer, the later of (a) the first day of the month next following the date of such retirement or termination, or (b) January 1, 2016; or

(2) with respect to any other later enrollment (or Opt In following a prior Opt Out pursuant to Section 3.2(a)(iii)), the first day of the month next following the month in which the Eligible Retiree or Eligible Dependent, as applicable, submits his Opt In Forms to, and such forms are approved by, the Claims Administrator.

(B) In addition, the Coverage Level of a Covered Person who enrolled in Pre-65 HRA Coverage pursuant to subsection (a)(i), above, and subsequently becomes enrolled in Medicare on the basis of Medicare Disability will automatically be changed to Pre-65 Disability HRA Coverage effective as of the first day of the first month in which such Medicare enrollment is effective. A Covered Person with Pre-65 HRA Coverage must notify the Plan Administrator of his Medicare enrollment based on Medicare Disability no later than thirty (30) days following the date that his Medicare enrollment becomes effective.

(iii) Opt Out of Pre-65 HRA Coverage or Pre-65 Disability HRA Coverage. Once enrolled in Pre-65 HRA Coverage or Pre-65 Disability HRA Coverage, a Covered Person may thereafter elect to opt out of eligibility to receive reimbursements of Covered Premiums for a given full month or months ("**Opt Out**") by providing written or electronic notice of such election ("**Opt Out Notice**") to the Claims Administrator in accordance with the Claims Administrator's procedures for such purpose. In that case, a Covered Person's Pre-65 HRA Coverage or Pre-65 Disability HRA Coverage, as applicable, will remain in effect, but he will be placed in a Non-Reimbursement Status effective as of the first day of the month following the month in which his Opt Out Notice is submitted to and approved by the Claims Administrator, unless a later Opt Out date is requested by the Covered Person in his Opt Out Notice and agreed to by the Claims Administrator. A Covered Person who is in a Non-Reimbursement Status due to an Opt Out for a given month (or months) will not be entitled to reimbursement under the HRA of any Covered Premiums or any other premiums or expenses incurred during such month, but will remain eligible for the prorated portion of the Plan Sponsor's contribution to his HRA Account, as described in Section 4.2(b), for such month, subject to the other terms and conditions of the HRA.

A Covered Person who is enrolled in Pre-65 HRA Coverage or Pre-65 Disability HRA Coverage must Opt Out, and thus be placed in a Non-Reimbursement Status, upon his enrollment as an employee in (A) coverage under the Active Health Plan or (B) coverage under another employer-sponsored group health plan for which premiums are paid on a pre-tax basis (through a cafeteria plan under Section 125 of the Code, or otherwise), in order for such Covered Person to remain eligible to participate in the HRA (subject to the other terms and conditions of the HRA) upon the termination of such other coverage.

A Covered Person who is in a Non-Reimbursement Status and who has not yet attained Medicare Eligibility Due to Age may opt back in to eligibility for reimbursement of Covered Premiums in accordance with the provisions of subsection (i) or (ii), above, in which case his Non-Reimbursement Status shall end on the date immediately prior to the date that his eligibility for reimbursement of Covered Premiums is reinstated pursuant to subsection (i)(B) or (ii)(A)(2), above, as applicable.

(iv) Automatic Termination upon Attainment of Medicare Eligibility Due to Age. A Covered Person's Pre-65 HRA Coverage or Pre-65 Disability HRA Coverage, as applicable

(including such coverage of an individual who is in a Non-Reimbursement Status), will automatically terminate on the last day of the month immediately preceding the month in which he attains Medicare Eligibility Due to Age.

(b) Enrollment and Participation Upon, or Following, Attainment of Medicare Eligibility Due to Age. The provisions of this subsection (b) are effective as of January 1, 2016.

(i) Enrollment at Retirement or Other Termination of Employment from an Anadarko Employer.

(A) An individual who (1) first becomes eligible to participate in Post-65 HRA Coverage as an Eligible Retiree or Eligible Dependent as a result of the Eligible Retiree's retirement or other termination of employment with an Employer (including a termination of employment due to death), (2) has attained Medicare Eligibility Due to Age as of the date of such retirement (or termination), and (3) has coverage under the Active Health Plan based on the "current employment status" of such individual or his spouse, as defined for purposes of Medicare Parts A and B, on the date immediately prior to the date of such retirement (or termination), may Opt In to Post-65 HRA Coverage, and thus become a Covered Person, by both (a) completing the Opt In Forms and submitting them to the Claims Administrator in accordance with the Claims Administrator's procedures and (b) enrolling in a Medicare Product purchased through the Concierge Service Partner no later than the last day of the 8-month period that begins with the month next following the Eligible Retiree's retirement (or termination) date.

(B) Such Eligible Retiree or Eligible Dependent who completes the enrollment procedures of subsection (i)(A), above, shall be enrolled in Post-65 HRA Coverage beginning effective as of the date that his coverage under the Medicare Product purchased through the Concierge Service Partner becomes effective.

(ii) Enrollment Upon Initial Attainment of Medicare Eligibility Due to Age.

(A) An Eligible Retiree or Eligible Dependent may, upon initial attainment of Medicare Eligibility Due to Age, Opt In to Post-65 HRA Coverage, and thus become (or remain) a Covered Person by both (1) completing the Opt In Forms and submitting them to the Claims Administrator in accordance with the Claims Administrator's procedures and (2) enrolling in a Medicare Product purchased through the Concierge Service Partner within the 7-month period which begins three months prior to the first day of the month in which the Eligible Retiree or Eligible Dependent, as applicable, attains Medicare Eligibility Due to Age ("**Medicare Eligibility Month**") and ends on the last day of the third month next following such individual's Medicare Eligibility Month, or within any other period that qualifies as an applicable Medicare Initial Enrollment Period for such individual.

An Eligible Retiree or Eligible Dependent who, upon his attainment of Medicare Eligibility Due to Age, is covered by Pre-65 Disability HRA Coverage and already enrolled in a Medicare Product purchased through the Concierge Service Partner shall be deemed to have completed the enrollment procedures of this subsection (ii)(A).

(B) Such Eligible Retiree or Eligible Dependent who completes the enrollment procedures of subsection (ii)(A), above, shall be enrolled in Post-65 HRA Coverage beginning effective as of the date that his coverage under the Medicare Product purchased through the Concierge Service Partner becomes effective.

(iii) Enrollment Following Termination of Other Post-Retirement Health Coverage.

(A) Other Group Health Plan Coverage.

(1) An Eligible Retiree or Eligible Dependent who (a) did not enroll in the HRA when first eligible, but (b) enrolled in and maintained other group health plan coverage (including, without limitation, coverage based on the “current employment status” of such individual or his spouse, as defined for purposes of Medicare Parts A and B, and “creditable prescription drug coverage”, as defined for purposes of Medicare Part D) and then (c) loses such coverage, thus becoming entitled to a Medicare Special Enrollment Period, and (d) has attained Medicare Eligibility Due to Age, may Opt In to Post-65 HRA Coverage, and thus become a Covered Person, by both (i) completing the Opt In Forms and submitting them to the Claims Administrator in accordance with the Claims Administrator’s procedures and (ii) enrolling in a Medicare Product purchased through the Concierge Service Partner no later than the last day of the 8-month period that begins with the month next following the date of the Eligible Retiree’s or Eligible Dependent’s loss of such other group health plan coverage, or within any other period that qualifies as an applicable Medicare Special Enrollment Period for such individual.

(2) Such Eligible Retiree or Eligible Dependent who completes the enrollment procedures of subsection (iii)(A)(1), above, shall be enrolled in Post-65 HRA Coverage beginning effective as of the date that his coverage under the Medicare Product purchased through the Concierge Service Partner becomes effective.

(B) Prior Coverage under a Medicare Product.

(1) An Eligible Retiree or Eligible Dependent who (a) did not enroll in the HRA when first eligible, but (b) enrolled in and maintained coverage under a Medicare Product that was not purchased through the Concierge Service Partner, and (c) has attained Medicare Eligibility Due to Age, may Opt In to Post-65 HRA Coverage, and thus become a Covered Person, upon termination of such other Medicare Product coverage by both (i) completing the Opt In Forms and submitting them to the Claims Administrator in accordance with the Claims Administrator’s procedures and (ii) enrolling in a Medicare Product purchased through the Concierge Service Partner.

(2) Such Eligible Retiree or Eligible Dependent who completes the enrollment procedures of subsection (iii)(B)(1), above, shall be enrolled in Post-65 HRA Coverage beginning effective as of the date that his coverage under the Medicare Product purchased through the Concierge Service Partner becomes effective.

(C) Other Delayed Enrollment.

(1) An Eligible Retiree or Eligible Dependent who (a) did not enroll in the HRA when first eligible, (b) does not meet the criteria set forth in subsections (i), (ii), (iii)(A) or (iii)(B), above, and (c) has attained Medicare Eligibility Due to Age, may Opt In to Post-65 HRA Coverage, and thus become a Covered Person, by both (i) completing the Opt In Forms and submitting them to the Claims Administrator in accordance with the Claims Administrator’s

procedures and (ii) enrolling in a Medicare Product purchased through the Concierge Service Partner.

(2) Such Eligible Retiree or Eligible Dependent who completes the enrollment procedures of subsection (iii)(C)(1), above, shall be enrolled in Post-65 HRA Coverage beginning effective as of the date that his coverage under the Medicare Product purchased through the Concierge Service Partner becomes effective.

(iv) Enrollment by a Surviving Dependent. An individual who becomes an Eligible Dependent as the surviving Dependent of a deceased Employee, as described in Section 3.1(b)(ix), and has attained Medicare Eligibility Due to Age may Opt In to Post-65 HRA Coverage, and thus become a Covered Person, in accordance with the applicable provisions of this subsection (b).

(v) Opt Out of Post-65 HRA Coverage. Once enrolled in Post-65 HRA Coverage, a Covered Person may Opt Out of his Post-65 HRA Coverage by submitting an Opt Out Notice to the Claims Administrator in accordance with the Claims Administrator's procedures for such purpose. In that case, such Covered Person's Post-65 HRA Coverage will terminate as of the last day of the month in which he submits his Opt Out Notice to the Claims Administrator, unless a later termination date is requested by the Covered Person in his Opt Out Notice and agreed to by the Claims Administrator. Notwithstanding any other provision of this SPD, a Covered Person who Opts Out of Post-65 HRA Coverage will not be permitted to again Opt In to any HRA coverage, and he shall forfeit any future eligibility to participate in the HRA.

(c) Acceptance of Plan and HRA Terms, Determinations and Decisions. To the full extent permitted by law or regulation, an Eligible Retiree or Eligible Dependent, upon his Opt In to participate in the HRA, shall be deemed to have accepted, and shall be bound by, all the applicable terms, provisions, conditions, and limitations of the Retiree Health Plan (including the HRA), as well as any and all amendments thereto, and any decisions and determinations made by the Benefits Committee with respect to such individual's rights or entitlement to benefits under the Retiree Health Plan and the HRA.

3.3 Termination of Coverage. A Covered Person's coverage under the HRA shall automatically terminate immediately upon the earliest of the following dates:

(a) The date on which the HRA terminates or is amended to eliminate coverage for the Covered Person, for whatever reason;

(b) The date of the Covered Person's death;

(c) With respect to a Covered Person with Post-65 HRA Coverage, the effective date of the Covered Person's Opt Out election pursuant to Section 3.2(b)(v);

(d) With respect to a Covered Person with Post-65 HRA Coverage, the first date upon which the Covered Person has both (i) enrolled as an employee in (A) coverage under the Active Health Plan or (B) coverage under another employer-sponsored group health plan for which premiums are paid on a pre-tax basis (through a cafeteria plan under Section 125 of the Code, or otherwise) and (ii) ceased to maintain coverage under any Medicare Product purchased through the Concierge Service Partner;

(e) The last day of the month in which the Covered Dependent ceases to be an Eligible Dependent under the HRA;

(f) The date on which the Covered Person fails to provide all information requested by the

Claims Administrator, the Benefits Committee or its or their representatives, as deemed by such entities or persons to be necessary or advisable for the administration and operation of the HRA or the Covered Person's coverage;

(g) The date on which the Covered Person falsifies information provided to the HRA, fraudulently or deceptively uses HRA services, or knowingly permits such fraud or deception by another person; or

(h) The date on which the Covered Person who is a Qualified Beneficiary under COBRA has Exhausted COBRA Continuation Coverage.

ARTICLE IV. BENEFIT AMOUNTS

4.1 Funding of Benefits. The benefits provided under the HRA shall be provided by the Employer out of its general assets, and no assets shall be segregated or earmarked for the purpose of providing benefits hereunder.

Each HRA Account established under the HRA shall be a notional, recordkeeping account only and does not represent assets of any Employer which are set aside for the exclusive purpose of providing benefits to a Covered Person. To the extent not inconsistent with applicable law or regulation, nothing herein shall be construed to require any Employer to maintain any trust, fund, or otherwise segregate any amount for the benefit of any Covered Person or other person, and no person with a claim for benefits hereunder shall have any claim against, right to, security or other interest in, any fund, account, or assets of any Employer.

4.2 Health Reimbursement Benefits. Notwithstanding any other provision of this SPD or the Retiree Health Plan, no HRA Account shall be funded prior to January 1, 2016.

(a) **Annual Employer Contributions Based on Coverage Level.** The Plan Sponsor shall make a per-Plan-Year annual contribution to the HRA Account (including, as applicable, a Joint HRA Account) of each Covered Person in the following amounts (subject to subsections (b) and (c), below):

(i) For the Plan Year beginning on January 1, 2016:

Coverage Level	Covered Persons	Annual Plan Sponsor Contribution to HRA Account
Pre-65 HRA Coverage (not Medicare Disabled)	Eligible Retirees, Spouses and Domestic Partners	\$6,000
Pre-65 Disability HRA Coverage	Eligible Retirees, Spouses and Domestic Partners	\$6,000
Post-65 HRA Coverage	Eligible Retirees, Spouses and Domestic Partners	\$2,000
All Coverage Levels	Dependent Children	\$2,000

(ii) For Plan Years beginning on and after January 1, 2017, the annual contribution amounts listed in subsection (i), above, will be adjusted each Plan Year by the lesser of (A) the Consumer Price Index-Urban ("CPI-U") or (B) 5% (provided, however, that the Plan Sponsor

may determine another adjustment amount for a given Plan Year and communicate it to Eligible Retirees and Eligible Dependents prior to the start of the Plan Year). In no event will the adjusted annual contribution amounts for a Plan Year be less than the amounts listed in subsection (i), above.

(iii) The Plan Sponsor contribution shall be allocated to each Covered Person's HRA Account on an annual basis as of January 1 of the applicable Plan Year.

(b) Allocation for a Partial Plan Year. If an Eligible Retiree or Eligible Dependent initially enrolls in the HRA during a Plan Year, with coverage effective as of any date other than January 1 (and thus he is a Covered Person for only part of the Plan Year), the Plan Sponsor's annual contribution to the Covered Person's HRA Account shall be prorated based on the number of full months of the Plan Year in which the Covered Person was covered under the HRA. In that case, the Plan Sponsor's contribution shall be allocated to the Covered Person's HRA Account as of the effective date of the Covered Person's enrollment in the HRA.

(c) Adjusted Allocation for Mid-Year Coverage Level Change. In the event that a Covered Person's Coverage Level changes during the Plan Year, the Plan Sponsor's annual contribution to the Covered Person's HRA will be adjusted on a pro-rata basis to reflect the number of months of the Plan Year in which the Covered Person was enrolled in each Coverage Level.

(d) Forfeiture of Unused Amounts Upon End of Plan Year. If a Covered Person does not use all of the funds allocated to his HRA Account for a Plan Year, such funds shall be forfeited as of the Claims Submission Deadline for that Plan Year. The Plan Sponsor shall retain forfeitures and/or apply forfeitures to defray the administrative costs of the HRA. The Covered Person shall have no further claim to such forfeited amount for any reason.

(e) Forfeiture of Unused Amounts Upon Termination of Coverage. Subject to subsection (f), below, upon termination of a Covered Person's participation in the HRA, any amount remaining in the Covered Person's HRA Account as of the Claims Submission Deadline for the Plan Year in which such termination of coverage occurred shall be forfeited unless the Covered Person is a Qualified Beneficiary who elects COBRA Continuation Coverage in accordance with Article VII, in which case any such amount shall be forfeited as of the Claims Submission Deadline for the Plan Year in which he Exhausted COBRA Coverage. The Plan Sponsor shall retain forfeitures and/or apply forfeitures to defray the administrative costs of the HRA. The Covered Person shall have no further claim to such forfeited amount for any reason.

(f) Death of a Covered Person. In the event that a Covered Person dies with an unused allocation remaining in his HRA Account, the deceased Covered Person's estate or representatives may submit Claims for Covered Premiums that were incurred by the Covered Person during the Plan Year prior to the date of his death, provided that such Claims are submitted by the applicable Claims Submission Deadline. Furthermore, to the extent that the deceased Covered Person's HRA Account is a Joint HRA Account, any unused allocation remaining in his HRA Account at the time of his death may be applied toward the reimbursement of Claims for Covered Premiums incurred by any other Covered Person who is an accountholder of such Joint HRA Account (other than a Domestic Partner who is not the deceased Covered Person's "dependent" for federal income tax purposes under Sections 105(b) and 106 of the Code, as amended by the Affordable Care Act) during the Plan Year in which the Covered Person's death occurred, provided that such Claims are submitted by the Claims Submission Deadline for such Plan Year.

Any amounts remaining in the Covered Person's HRA Account as of the Claims Submission Deadline for the Plan Year in which his death occurred shall be forfeited.

ARTICLE V. COVERED EXPENSES

5.1 Covered Premiums. The funds allocated to a Covered Person's HRA Account may only be used to reimburse Covered Premiums. Any funds allocated, pursuant to Section 4.1, to the HRA Accounts of Covered Persons who are holders of a single Joint HRA Account shall be aggregated under the Joint HRA Account, and such aggregated funds may be applied toward the reimbursement of Claims for Covered Premiums incurred by any Covered Person who a holder of the Joint HRA Account.

The HRA shall reimburse Covered Premiums up to a maximum of the remaining balance in the Covered Person's HRA Account (or Joint HRA Account) for the Plan Year in which such Covered Premiums were incurred, provided that such Covered Premiums were incurred by the Covered Person when the Covered Person was (a) participating in and covered by the HRA and (b) with respect to a Covered Person with Pre-65 HRA Coverage or Pre-65 Disability HRA Coverage, not in a Non-Reimbursement Status.

All Claims for Covered Premiums must be submitted in accordance with the claim and appeal procedures of the HRA, as set out in Article VI.

5.2 Benefits From Another Source. Reimbursement of Covered Premiums under the HRA shall be made only in the event, and to the extent, that such Covered Premiums have not been previously reimbursed, or are not reimbursable, under the terms of (a) any insurance policy or plan of the Plan Sponsor or other Employer, (b) any insurance policy or plan of another employer, (c) any program of federal or state law, or (d) any other source besides the HRA. To the extent that reimbursement of an otherwise Covered Premium is available from another source, then that other source shall pay or reimburse prior to payment or reimbursement from the HRA and, to the extent of the coverage under such source, the HRA shall be relieved of any and all liability for such Covered Premium hereunder. Without limiting the foregoing, if a Covered Person's otherwise Covered Premium is reimbursable under both the HRA and a health flexible spending arrangement, the HRA shall not be available for reimbursement of such Covered Premium until after amounts available for reimbursement under the health flexible spending account have been exhausted.

ARTICLE VI. CLAIM AND APPEAL PROCEDURES

6.1 Claims Procedure.

Claims for benefits under the HRA must be submitted no later than the Claims Submission Deadline. Furthermore, a submitted Claim is not treated as filed until all information necessary to process the Claim is submitted. If the Claim, as originally submitted, is not complete, the Claimant will be notified and will then be responsible for providing the missing information. For purposes of this Article VI, the term "Claimant" means a Covered Person or his authorized representative under ERISA who is designated by the Covered Person to act on his behalf; the term "Disability Claim" means a Claim for benefits that is conditioned upon a showing of "disability" (including Medicare Disability) by the Claimant; and the term "Health Claim" means a Claim for benefits that is other than a Disability Claim.

The claims provisions of this Article VI describe the procedures that apply to the Claims Administrator's review and determination regarding Claims for benefits under the HRA, including the timeframes for making such determinations. The timeframes do not refer to the period in which payments for Claims that are determined to be payable will be made by the Claims Administrator. Instead, the Claims Administrator will issue payments on Claim finally determined to be payable as soon as reasonably practicable following such determination.

6.2 Claim Submission Process.

(a) General. No benefit shall be paid hereunder unless a Claim for benefits has been filed with the Claims Administrator. A Claim for reimbursement of Covered Premiums under the HRA must be made by proper completion and submission of the Claim form specified by the Claims Administrator, and attachment of itemized documentation as described in the Claim form, including documentation which states:

- (i) the Covered Person on whose behalf the Covered Premiums have been incurred;
- (ii) the nature and date of the Covered Premiums so incurred;
- (iii) the amount of the requested reimbursement; and
- (iv) a statement that such Covered Premiums have not otherwise been reimbursed and are not reimbursable through any other source and any coverage of the Covered Person under a health flexible spending arrangement for such Covered Premiums has been exhausted.

The Claim shall be accompanied by bills, invoices, receipts, canceled checks or other supporting documentation evidencing the amount for which the Claimant seeks reimbursement. "Self-substantiation" or "self-certification" of a premium payment by the Covered Person does not constitute the required substantiation under this Section.

(b) Auto-Reimbursement. Notwithstanding Section 6.2(a), upon enrollment in Post-65 HRA Coverage, a Covered Person may elect to submit Claims for "auto-reimbursement", whereby the Covered Person's Claim for coverage of Covered Premiums shall be deemed to be substantiated, provided that the applicable insurer or other provider of the Separate Health Coverage to which such Covered Premiums apply (i) offers auto-reimbursement, and (ii) submits the information described in Section 6.2(a) to the Claims Administrator in accordance with its procedures for such purpose. In such a case, the Covered Person's Claim shall be deemed fully substantiated without the need for submission of any receipt by the Covered Person or further review by the Claims Administrator.

(c) Recurring Claim Process. The provisions of this subsection (c) are effective as of January 1, 2016.

If the monthly amount of a Covered Person's Covered Premiums is fixed for each month of the Plan Year or other specified period of time within a Plan Year, the Covered Person may submit a "recurring Claim" for such Covered Premiums in accordance with the Claims Administrator's procedures for such purpose. Under the recurring Claim process, the Covered Person will submit a single Claim to the Claims Administrator that includes the information described in Section 6.2(a) and designates the time period (in full months of the Plan Year) with respect to which the Claim should be reapplied. In that case, the Covered Person shall be deemed to have substantiated any recurring Claims that are applied during the designated time period. Notwithstanding, the recurring Claim process is not available with respect to Claims for (i) Covered Premiums that are subject to auto-reimbursement, as described in subsection (b), above, (ii) Covered Premiums for Medicare Part B coverage which are not deducted from the Covered Person's monthly Social Security benefit payments, and (iii) Covered Premiums paid by a Covered Person who has not attained Medicare Eligibility Due to Age for COBRA continuation coverage under the Active Health Plan or for coverage under a Pre-65 Group Health Program of the Retiree Health Plan.

(d) Deadline to Submit Claims. Claims for benefits under the HRA must be submitted no later than the Claims Submission Deadline.

6.3 Applicable Time Limitations For Initial Claim Decision.

(a) Health Claims. With respect to a Claim that is a Health Claim, the Claimant will be notified of the benefit determination by the Claims Administrator, regardless of whether the determination is adverse or not, within a reasonable period of time, but not later than thirty (30) days after the Claim is filed. If the Claims Administrator requires additional time to make a benefit determination for matters beyond the control of the HRA, the time period for making the initial benefit determination may be extended for up to fifteen (15) additional days. If such extension is required, the Claims Administrator will notify the Claimant within the initial thirty (30) day period of the circumstances requiring the extension and the date by which a HRA expects to render a benefit decision.

If additional time is required to render a benefit decision because of the Claimant's failure to submit the information necessary to decide the Claim (for example, the Claimant fails to submit copies of all bills related to the Claim), the notice informing the Claimant of the extended period of time required to render a benefit determination shall also include a specific description of the information necessary to decide the Claim. The Claimant will have at least forty-five (45) days from the date the notice is received to provide the specified information.

(b) Disability Claims. With respect to a Claim that is a Disability Claim, 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 Claim (the "**Initial Period**"). The Initial Period may be extended by the HRA for up to thirty (30) days (the "**First Extension**"), provided that the Claims Administrator both (i) determines that such an extension is necessary due to matters beyond the control of the HRA, and (ii) notifies the Claimant, prior to the expiration of the Initial Period, of the circumstances requiring the First Extension and the date by which the HRA expects to render a decision.

If, prior to the end of the First Extension, the Claims Administrator determines that, due to matters beyond the control of the HRA, 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 HRA expects to render a decision.

In the case of any extension under this subsection (b), the notice of extension will specifically explain (i) the standards on which entitlement to a benefit is based, (ii) the unresolved issues that prevent a decision on the claim, and (iii) 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.

6.4 Notice of Adverse Benefit Determination. The Claims Administrator will provide written or electronic notification of any adverse benefit determination with respect to a Claim. The notice will set forth, in a manner that is calculated to be understood by the Claimant, the following:

- The specific reason(s) for the adverse determination;
- Reference to the specific HRA provision(s) on which the determination was based;
- A description of any additional material or information necessary for the Claimant to perfect the Claim and an explanation of why such material or information is necessary;
- A description of the HRA's appeal procedures and the time limits applicable to such

procedures, as well as 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 with respect to the second-level appeal of the adverse benefit determination, and any other statement required by law; and

- 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 Claim.

For the purposes of the foregoing notice, a document, record, or other information will be considered "relevant" to a Claimant's Claim if such document, record, or other information:

- was relied upon in making the adverse benefit determination;
- was submitted, considered, or generated in the course of making the adverse benefit determination, without regard to whether such document, record, or other information was relied upon in making the adverse benefit determination;
- demonstrates compliance with any administrative processes and safeguards in making the adverse benefit determination; or
- constitutes a statement of policy or guidance with respect to the HRA 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 adverse benefit determination.

In addition, if the adverse benefit determination was based on an internal rule, guideline, protocol, or other similar criterion, the specific rule, guideline, protocol, or criterion will be provided free of charge. If this is not practical, a statement will be included that such rule, guideline, protocol, or criterion was relied upon in making the adverse benefit determination and a copy will be provided free of charge to the Claimant upon request.

If the adverse benefit determination is based on the fact that the treatment was not medically necessary or the experimental/investigational exclusion or similar exclusion or limit was applied, an explanation of the scientific or clinical judgment for the determination, applying the terms of the HRA to the Claimant's medical circumstances, will be provided. If this is not practical, a statement will be included that such explanation will be provided free of charge, upon request.

6.5 Appeal of Adverse Benefit Determination. The HRA provides for two levels of internal appeal of an adverse benefit determination. If the Claimant receives an adverse benefit determination with respect to his Claim, he will have (a) 180 days following his receipt of the notification of the initial benefit determination in which to submit a first-level appeal of the decision to the Claims Administrator, or (b) 60 days following his receipt of the notification of an adverse benefit determination with respect to his first-level appeal of the decision in which to submit a second-level appeal of such decision to the Claims Fiduciary.

The Claimant may submit written comments, documents, records, and other information relating to the Claim. Upon request, the Claimant will be provided, free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claim.

The appeal will take into account all comments, documents, records, and other information that the Claimant submitted relating to the Claim, without regard to whether such information was submitted or considered in the initial benefit determination.

The appeal will not afford deference to the initial adverse benefit determination and will be conducted by a fiduciary of the HRA who is neither the individual who made the initial adverse determination or any subordinate of that person.

If the adverse determination was based on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate, the Claims Administrator (or Claims Fiduciary, with respect to a second-level appeal), will consult with a health care professional who was not involved in the initial benefit determination and is not the subordinate of any health care professional that was involved in the initial benefit determination. This health care professional will have appropriate training and experience in the field of medicine involved in the medical judgment. Additional medical or vocational experts whose advice was obtained on behalf of the HRA in connection with the initial determination will be identified upon request.

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. A Claimant will not be subject to mandatory arbitration of an adverse benefit determination, except to the extent that (a) the arbitration is counted as one of the two appeals described herein and is conducted in accordance with the requirements applicable to such appeals; and (b) the Claimant is not precluded from challenging the decision resulting from such arbitration under section 502(a) of ERISA or other applicable law.

6.6 Applicable Time Limitation For Decision on Appeal of Adverse Benefit Determination.

(a) **Health Claims.** With respect to a Claim that is a Health Claim, the Claims Administrator (or the Claims Fiduciary, with respect to a second-level appeal) will notify the Claimant of its benefit determination on appeal within a reasonable period of time, but no later than thirty (30) days after the Claims Administrator (or Claims Fiduciary, with respect to a second-level appeal) receives the Claimant's request for review.

(b) **Disability Claims.** With respect to a Claim that is a Disability Claim, the Claims Administrator (or the Claims Fiduciary, with respect to a second-level appeal) will notify the Claimant of its benefit determination on appeal within a reasonable period of time, but not later than forty-five (45) days after the Claims Administrator (or Claims Fiduciary, with respect to a second-level appeal) receives the Claimant's request for review, unless the Claims Administrator (or Claims Fiduciary, with respect to a second-level appeal) determines that special circumstances require an extension of time for processing the claim. If the Claims Administrator (or Claims Fiduciary, with respect to a second-level appeal) 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 HRA expects to render the benefit determination on review.

6.7 Notice of Adverse Benefit Determination on Appeal. The Claims Administrator (or Claims Fiduciary, with respect to a second-level appeal) will provide written or electronic notification of an adverse benefit determination on appeal. The notification will set forth the following:

- The specific reason(s) for the adverse determination;
- A reference to the specific HRA or Retiree Health Plan provision(s) upon which the determination was based;
- 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;

- A statement of 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;
- 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"; and
- Any other information required by law.

For the purposes of the foregoing notice, a document, record, or other information will be considered "relevant" to a Claimant's Claim if such document, record, or other information:

- was relied upon in making the adverse benefit determination;
- was submitted, considered, or generated in the course of making the adverse benefit determination, without regard to whether such document, record, or other information was relied upon in making the adverse benefit determination;
- demonstrates compliance with any administrative processes and safeguards in making the adverse benefit determination; or
- constitutes a statement of policy or guidance with respect to the HRA 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 adverse benefit determination.

In addition, if the determination was based upon an internal rule, guideline, protocol, or other similar criterion, the specific rule, guideline, protocol, or other similar criterion will be provided free of charge. If this is not practical, a statement will be included in the notice of adverse determination that such rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and a copy will be provided free of charge, upon request.

If the adverse determination was based on a medical necessity, or experimental treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination, applying the terms of the HRA to the Claimant's medical circumstances, or a statement that such explanation will be provided free of charge, upon request, will be included in the notice of adverse determination.

6.8 Exhaustion of Administrative Remedies. No action at law or in equity may be brought to recover under the Retiree Health Plan with respect to the HRA until all administrative remedies have been exhausted (including two appeals of an adverse benefit determination). If a Claimant fails to file a timely Claim, or if the Claimant fails to request a review in accordance with the HRA'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.

6.9 Covered Person's Responsibilities. Each Covered Person will be responsible for providing the Claims Administrator, the Claims Fiduciary, the Plan Administrator and/or the Employer with the his current U.S. mailing address and electronic address. Accordingly, any notices required or

permitted to be given by the Claims Administrator, Claims Fiduciary, Plan Administrator or Employer hereunder will be deemed given if directed to such address furnished by the Covered Person 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-1(c) of ERISA. The Claims Administrator, Claims Fiduciary, Plan Administrator and the Employer will not have any obligation or duty to locate a Covered Person. In the event that a Covered Person becomes entitled to a payment under the HRA and such payment is delayed or cannot be made:

- (a) because the current address according to the Claims Administrator's or Claims Fiduciary's records is incorrect;
- (b) because the Covered Person fails to respond to the notice sent to the current address according to the Claims Administrator's or 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 HRA without payment of any interest or earnings.

To the extent that the entitlement of a Covered Person or other individual to a benefit under the HRA 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 HRA, which action shall satisfy its fiduciary and other duties under the HRA.

6.10 Unclaimed Benefits. If, within twelve months after any amount becomes payable hereunder to a Covered Person, and the same will not have been claimed or any check issued under the HRA 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 Retiree Health Plan with respect to the HRA.

ARTICLE VII. CONTINUATION COVERAGE UNDER COBRA

7.1 Continuation of Benefits under COBRA. Qualified Beneficiaries will have all continuation rights required by COBRA under the HRA. The Plan Administrator will adopt such policies and provide such forms, as it deems advisable to implement the rights contemplated by this Section.

7.2 Election of COBRA Coverage.

Retirees and Former Employees are not eligible to elect COBRA Continuation Coverage upon termination of their coverage under the HRA.

(a) COBRA Continuation Coverage for Qualifying Dependent.

Subject to Section 7.5, a Qualified Beneficiary who is a Qualifying Dependent of a Covered Retiree may elect COBRA Continuation Coverage, at his own expense, if his participation under the HRA would terminate as a result of a Qualifying Event.

(b) 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 VII. 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 Retiree's Spouse will be deemed to be an election for that Covered Retiree's Qualifying Dependents who would otherwise lose coverage under the HRA, 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).

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 HRA's "COBRA Administrator", at the address listed in Section 7.10.

7.3 Period of COBRA Coverage. A Qualified Beneficiary who is a Qualifying Dependent may continue COBRA Continuation Coverage for up to thirty-six (36) months from the date of the Qualifying Event.

Coverage under this Section 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 7.4;
- (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 preexisting 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 7.6, 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 HRA can terminate for cause the coverage of a Qualified Beneficiary on the same basis that

the HRA terminates for cause the coverage of Similarly Situated Beneficiaries, for example, for the submission of a fraudulent Claim.

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

7.4 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 7.6, 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 HRA 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 HRA's requirement for the amount that must be paid for Continuation Coverage Contribution, unless the HRA 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, an amount not significantly less than the amount the HRA requires to be paid will be defined as the lesser of fifty dollars (\$50) or ten percent (10%) of the required payment amount.

7.5 Limitation on Qualified Beneficiary's Rights to COBRA Coverage. If a Qualified Beneficiary loses, or will lose, health coverage under the HRA as a result of a Qualifying Event that is a divorce, legal separation or ceasing to be a Dependent, such Qualified Beneficiary (or representative) must notify the Plan Administrator, as described in Section 7.10, 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 this SPD or a COBRA notice provided upon enrollment, of his responsibility to provide a Qualifying Event notice as described in this Section and the HRA'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 VII.

For all other Qualifying Events, 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.

7.6 Extension of COBRA Coverage Period. A Qualified Beneficiary (or representative) must notify the Plan Administrator, as described in Section 7.10, 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 this SPD or a COBRA general notice, of his responsibility to provide a notice of a second Qualifying Event and the HRA's procedures for providing such notice.

If a second Qualifying Event occurs during an eighteen (18) month period of COBRA Continuation Coverage explained in Section 7.3 (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 HRA in the absence of the first Qualifying Event. Any such extension of COBRA Continuation Coverage applies only to Qualifying Dependents.

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 representative) provides notice to the Plan Administrator, as described in Section 7.10, 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 this SPD or a COBRA general notice, of the obligation to provide the disability notice and the HRA'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 representative) must notify the Plan Administrator, as described in Section 7.10, 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 this SPD or a COBRA general notice, of the obligation to provide the end-of-disability notice and the HRA'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.

7.7 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 HRA to confirm coverage of a Qualified Beneficiary during the election period, the HRA 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 HRA 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 HRA 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.

7.8 Coordination of Benefits - Medicare and COBRA. For purposes of this Article VII, "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.

7.9 Definitions. For purposes of this Article VII 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 HRA 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 Covered Persons, if any, 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 Retiree means a Retiree or Former Employee who is provided coverage under the HRA due to his performance of services for the Employer.

(f) Qualified Beneficiary means a Covered Retiree or Qualifying Dependent.

(g) Qualifying Dependent means:

(i) a Dependent covered under the HRA on the day prior to the Qualifying Event (except that such term shall not include the covered Domestic Partner of a Covered Retiree, 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 child who is covered under the HRA on the day prior to the Qualifying Event

pursuant to the terms of a qualified medical child support order.

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

- (i) a Covered Retiree's divorce or legal separation;
- (ii) a Qualified Dependent ceasing to qualify as a Dependent under the provisions of the HRA;
- (iii) a Covered Retiree's entitlement to benefits under Medicare;
- (iv) the death of a Covered Retiree; or
- (v) a proceeding in bankruptcy under Title 11 of the U.S. Code with respect to an Employer from whose employment a Covered Retiree retired at any time.

Note: A loss of health coverage under the HRA includes any increase in the premium or contribution that must be paid by the Covered Employee (or Spouse or Dependent) for coverage under the HRA that results from the occurrence of one of the events listed in subsections (h)(i) – (h)(v), above. 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.

(i) Similarly Situated Beneficiaries means Retirees, Former Employees, or their Dependents, as applicable, who are Covered Persons under the HRA.

7.10 Qualified Beneficiary Notice Procedures. The Plan Administrator has contracted with a third-party administrator, Willis Towers Watson, to perform services as the HRA's "**COBRA Administrator.**" Any notice that a Qualified Beneficiary is required to provide under this Article VII ("**Notice**") must be made in accordance with the COBRA Administrator's procedures. A Qualified Beneficiary must provide his Notice to the Anadarko Benefits Center, on behalf of the COBRA Administrator, by either:

- (a) Contacting the Anadarko Benefits Center by telephone at 1-866-472-4711 and then providing any required information and supporting documentation, as specified by the Anadarko Benefits Center; or
- (b) Accessing www.AnadarkoAdvantage.ehr.com, and providing the required information and supporting documentation specified in the website.

Any Notice must be provided by the Qualified Beneficiary no later than the last day of the applicable required notice period.

7.11 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 HRA ends. A Covered Employee who qualifies or may qualify for this special election period should contact the Eligibility Administrator at the address and telephone number listed in Appendix C for additional information.

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

Neither the covered Domestic Partner of a Covered Retiree 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 the HRA terminates due to the occurrence an event specified in Section 7.9(h), 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 HRA.

7.13 Questions and Other Information Regarding COBRA Coverage. The Covered Retiree will be responsible for keeping the Plan Administrator informed of any changes in his address and the addresses of his Spouse, Domestic Partner, and other Dependents. Questions concerning an individual's COBRA coverage rights under the HRA should be directed to the COBRA Administrator at the address and/or telephone number listed in Section 7.10.

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

ARTICLE VIII. PLAN ADMINISTRATION

8.1 Plan Administrator. The administration of the HRA shall be under the supervision of the Plan Administrator. The Benefits Committee shall be the Plan Administrator. The Benefits Committee will control and manage the operation and administration of the HRA, except to the extent such duties have been delegated to other persons or entities as provided in this SPD. The Benefits Committee shall consist of one or more members, as appointed from time to time by the Plan Sponsor by action of the Executive Vice President responsible for Human Resources of the Plan Sponsor (the "**EVP-HR**"). The members of the Benefits Committee shall serve at the discretion of the EVP-HR without additional compensation, but may be reimbursed for proper expenditures incurred during the course of performance of duties hereunder in accordance with applicable law. The Benefits Committee shall be subject to such duties and procedures as may be designated by the Plan Sponsor pursuant to a separate instrument.

Any decisions made by the Plan Administrator, including in its capacity as Claims Fiduciary, or any other person or entity delegated authority by the Plan Administrator to determine benefits in accordance with the HRA, will be final and conclusive on all Covered Persons, and all other persons and entities, subject only to the Claims appeal provisions of the HRA. The Plan Administrator will have full power to administer the HRA in all of its details, subject to the applicable requirements of law. The Plan Administrator will 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 HRA, (ii) make decisions relating to all questions of eligibility to participate, and (iii) make a determination of benefits including, without limitation, reconciling any inconsistency, correcting any defect, supplying any omission, and making all findings of fact;

(b) to prescribe procedures to be followed by Covered Persons 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 HRA and benefits thereunder;

(d) to receive from the Employer and from Covered Persons such information as necessary for the proper administration of the HRA;

(e) to furnish the Employer and the Covered Persons such annual reports with respect to the administration of the HRA 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 HRA relating to the records of Covered Persons, including an examination at the Employer's expense of the records of the HRA 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 HRA.

If, due to errors in drafting, any HRA 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 in a fashion consistent with its intent, as determined by the Plan Administrator. The HRA may be amended retroactively to cure any such ambiguity, notwithstanding anything in the HRA to the contrary.

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

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

8.2 Delegation by the Plan Administrator. The Plan Administrator may delegate to other persons or entities any of the administrative functions relating to the HRA, 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 Plan Administrator may employ such counsel, accountants, Claims Administrators, 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 HRA 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.

8.3 Rules and Decisions. The Plan Administrator may adopt such rules and procedures, as it deems necessary or appropriate for the proper administration of the HRA. 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.

8.4 Examination of Records. The Plan Administrator shall make available to each Covered Person such of its records under the HRA as pertain to him or her for examination at reasonable times during normal business hours.

8.5 Named Fiduciary. The Plan Administrator shall be the “named fiduciary” for purposes of ERISA Section 402(a)(1). The “named fiduciary” has the authority to control and manage the operation and administration of the HRA and to review and make final decisions regarding Claim determinations and appeals under the HRA and will be responsible for complying with all of the reporting and disclosure requirements of Part 1 of Subtitle B of Title I of ERISA.

8.6 Nondiscriminatory Exercise of Authority. In the administration of the HRA, whenever any discretionary action by the Plan Administrator is required, the Plan Administrator shall exercise its authority in a nondiscriminatory manner in order that all persons similarly situated will receive substantially the same treatment.

8.7 Facility of Payment for Incapacitated Covered Person. Whenever, in the Plan Administrator’s opinion, a Covered Person 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 Plan Administrator 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 Plan Administrator), dependent, or relative of such person for such person’s benefit, or the Plan Administrator may direct payment for the benefit of such person in such manner as the Plan Administrator considers advisable in its discretion. Any payment of a benefit, to the full extent thereof, in accordance with the provisions of this Section will be a complete discharge of any liability for the making of such payment under the Retiree Health Plan with respect to the HRA.

ARTICLE IX. AMENDMENT OR TERMINATION OF PLAN

9.1 Amendment of HRA. The Board of Directors (or a committee of the Board of Directors), or an officer of the Plan Sponsor who is duly authorized by the Board of Directors (or such committee) for this purpose, will each have the right, authority and power to make, at any time, any amendment to the HRA. Notwithstanding the previous sentence, (a) the CFO and the CEO acting jointly, or (b) the CFO and the General Counsel of the Plan Sponsor acting jointly, will each have the power to approve, adopt, and execute any amendment to the HRA that (i) is required to comply with changes in applicable law or (ii) does not increase the cost of the HRA by more than five percent (5%) per year 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 HRA that was incurred but not paid prior to the effective date of the amendment, unless the person or entity responsible for the amendment, as applicable, determines such amendment is necessary or desirable to comply with applicable law. Moreover, if the HRA is amended, a Covered Person's right to receive coverage for expenses incurred for supplies or services that were actually received or actually rendered on his behalf before the effective date of such amendment will not be reduced or eliminated. However, an amendment may reduce or eliminate a Covered Person'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 effective 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 effective date.

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

The CFO and the CEO, acting jointly, or the CFO and the General Counsel of the Plan Sponsor, acting jointly, may, in their discretion, terminate the participation of any Employer, with respect to its Retirees and Former Employees only, in the HRA, effective as of any date such officers deem advisable. The Plan Sponsor may revise Appendix A of this SPD, as needed, to reflect the termination of an Employer from participation in the HRA, without regard to the formal amendment provisions of the HRA.

ARTICLE X. QUALIFIED MEDICAL CHILD SUPPORT ORDERS

10.1 Qualified Medical Child Support Orders. Rules relating to Qualified Medical Child Support Orders ("QMCSO") – The HRA will provide benefits in accordance with the applicable requirements of any QMCSO.

(a) Definitions. For purposes of Sections 10.1, 10.2, 10.3 and 10.4, the following definitions apply:

(i) The term "Qualified Medical Child Support Order" will be defined for purposes of Sections 10.1, 10.2, 10.3 and 10.4 as 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 Covered Person is eligible under the HRA; and

(B) with respect to which the requirements of this Section 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 10.1, 10.2, and 10.3 as 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 Covered Person under the HRA 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 HRA; 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 the HRA.

(iii) For purposes of Sections 10.1, 10.2, 10.3 and 10.4, the term "Alternate Recipient" will be defined as follows: Any child of a Covered Person who is recognized under a Medical Child Support Order as having the right to enrollment under a health plan provided within the HRA with respect to such Covered Person.

(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 Covered Person 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 HRA 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.

10.2 Procedural Requirements

(a) Timely Notifications and Determinations. In the case of any Medical Child Support Order received by the Plan Administrator for the HRA -

(i) the Plan Administrator will promptly notify the Covered Person and each Alternate Recipient of the receipt of such order and the HRA'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 Covered Person 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 HRA (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 Covered Person may obtain a copy of the QMCSO procedures, without charge, upon request to the Benefits Department of the Plan Administrator at the address and/or telephone number listed in Article XIV.

10.3 Actions Taken by Fiduciaries.

(a) General Requirement. If the Plan Administrator acts in accordance with Sections 10.1, 10.2, and 10.3 in treating a Medical Child Support Order as being (or not being) a Qualified Medical Child Support Order, then the HRA's obligation to the Covered Person 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 HRA 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 Covered Person 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 HRA's Obligation to Make Payment to Alternate Recipient. Payment of benefits by the HRA 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.

10.4 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 HRA to provide any type of form of benefit, or any option, not otherwise provided under the HRA, 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 Covered Person 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 10.4(a) (above), is issued for a child of a Covered Person under the HRA 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 HRA and, if so, whether such child is covered under the HRA 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 10.4(a)(i) (above) 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.

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

ARTICLE XI. HIPAA PRIVACY AND SECURITY

11.1 HIPAA Privacy and Security in General. This Article XI 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 XI, “Protected Health Information” (“**PHI**”) means information, including genetic information, that is created or received by the HRA 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 that is created or received by the HRA and transmitted by or maintained in electronic media.

11.2 Designation of Health Care Components and Safeguards. To the extent the HRA is a hybrid entity (as defined by 45 CFR § 164.103 of the Privacy Standards), the provisions of this Article XI will only apply to the health care components of the HRA (collectively referred to as the “**Health Care Components**”). All references to Protected Health Information (PHI) or Electronic Protected Health Information (ePHI) in this Article XI 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 HRA will not disclose PHI to another component of the HRA 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 HRA and for another component of the HRA, 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, the portions of the HRA which provide medical benefits, prescription drug benefits, dental benefits, and vision care benefits constitute the Health Care Components.

11.3 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 HRA, 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 Covered Person's or Dependent's PHI in connection with payment, treatment, and health care operations, or as otherwise permitted or required by law. The HRA will not use or disclose PHI that is genetic information for underwriting purposes.

Payment includes activities undertaken by the Health Care Component of the HRA to obtain premiums or determine or fulfill its responsibility for coverage and provision of HRA 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, HRA 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 a Covered Person's or Dependent's 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 HRA.

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 HRA 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 HRA, including formulary development and administration, development or improvement of payment methods or coverage policies; and

(g) Business management and general administrative activities of the HRA, 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.

11.4 Certification of Amendment of HRA Documents by Plan Sponsor. The HRA will disclose PHI to the Plan Sponsor only upon receipt of a certification from the Plan Sponsor that the HRA

documents have been amended to incorporate the provisions set forth in this Article XI.

11.5 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 HRA document or as required by law;
- (b) Ensure that any agents, including a subcontractor, to whom the Plan Sponsor provides PHI received from the HRA 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 HRA 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 HRA available to the HHS Secretary for the purposes of determining the HRA's compliance with HIPAA;
- (j) If feasible, return or destroy all PHI received from the HRA 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 HRA 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 HRA, to:

- (i) 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 HRA;
- (ii) Ensure that adequate separation required by 45 C.F.R. §164.504(f)(2)(iii) under the Privacy Standards is supported by reasonable and appropriate security measures;
- (iii) Ensure that any agent, including a subcontractor, to whom it provides this information or who receives this information on behalf of the HRA agrees to implement reasonable and appropriate security measures to protect the information; and

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

11.6 Adequate Separation Between the HRA and the Plan Sponsor. In accordance with the Privacy Standards, only the following employees or classes of employees may be given access to PHI:

<u>Employee/Position</u>	<u>Categories of PHI under the Plan to which Access is Needed and Conditions on Access</u>
Human Resources Manager, Global Benefits	PHI as needed to perform duties as Privacy Official and Complaint Official
All active employees of the Anadarko Benefits Department of Human Resources (“ Benefits Department ”)	PHI as needed to perform administration of the Plan and assist Plan participants with questions
Systems Department employees who are responsible for maintenance of systems that may contain electronic PHI	PHI as needed to maintain and administer systems that may contain electronic PHI
Legal Department Counsel assigned to support the Benefits Department	PHI as needed to advise and counsel on any claims or other Plan administrative issues that might arise relating to PHI
Paralegals and administrative staff supporting Legal Department Counsel (above)	
Executive Vice President responsible for Human Resources	PHI as needed to perform executive functions associated with oversight of the Benefits Department and sponsorship of the Plan
Vice President, Human Resources	
Director, Global Total Rewards	
Director, Strategy, Talent Acquisition and Corporate Services	PHI as need to assist Benefits Department with claims and administrative matters under the Plan

11.7 Limitations of PHI Access and Disclosure. The persons described in Section 11.6 may only have access to and use and disclose PHI for HRA administration functions that the Plan Sponsor performs for the HRA.

11.8 Noncompliance Issues. If the persons described in Section 11.6 do not comply with the HRA document, the Plan Sponsor will provide a mechanism for resolving issues of noncompliance, including disciplinary sanctions.

11.9 Members of Organized Health Care Arrangement. To the extent that any Health Care Component is fully-insured, the HRA 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 Covered Persons or Dependents in such Health Care Component.

11.10 Additional Requirements Imposed by HITECH. The provisions of this Section will apply to the HRA to the extent the HRA 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 HRA 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.

11.11 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).

11.12 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 HRA, 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 HRA, 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 HRA, 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 HRA 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 HRA, or its designee, will also notify prominent media outlets that service the state or jurisdiction of the Breach. Additionally, the HRA will notify the Secretary of the Department of Health and Human Services of the Breach as required by 45 CFR 164.408.

11.13 Other Medical Privacy Laws. The HRA 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 XII.
MISCELLANEOUS LAW PROVISIONS

12.1 Rights of States for Group Health Plans where Covered Persons are Eligible for Medical Benefits.

(a) Compliance by HRAs with Assignment of Rights. To the extent required by law, the HRA shall comply with any assignment of rights made by or on behalf of a Covered Person as required by a state plan for medical assistance approved under Title XIX of the Social Security Act pursuant to Section 1912(a)(1)(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 Covered Person, 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 HRA 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 HRA will be made in accordance with any state law which provides that the state has acquired the rights with respect to a Covered Person to such payment for such items or services; provided, however that in no event shall 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 Covered Person under the HRA, 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 HRA.

12.2 Continued Coverage of Pediatric Vaccine under Group Health Plans. To the extent required by law, the HRA 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.

12.3 Newborns' and Mothers' Health Protection Act. The HRA shall comply with the applicable requirements of the Newborns' and Mothers' Health Protection Act ("NMHPA"). To the extent required by the NMHPA: (a) the HRA 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, (b) the HRA may pay for a shorter stay if the attending provider, after consultation with the mother, discharges the mother or newborn earlier, (c) the HRA 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, and (d) the HRA 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.

12.4 Genetic Information Nondiscrimination Act. The HRA will comply with the applicable requirements of 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.

12.5 Medicare Secondary Payer Rules. The HRA will comply with the applicable requirements of the Medicare Secondary Payer Rules.

12.6 Affordable Care Act. The HRA will comply with the applicable requirements of the

Affordable Care Act, and the regulations and other authority promulgated thereunder by the appropriate governmental authority.

12.7 Other Laws. The HRA shall be construed to comply with ERISA and comply with all other applicable laws to the extent not preempted by ERISA or other controlling federal law. Such laws shall 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”).

ARTICLE XIII. GENERAL PROVISIONS

13.1 Interpretation. The terms, conditions and limitations of the HRA are set forth in this SPD, as well as in the applicable portions of the wrap-around plan document of the Retiree Health Plan. This SPD is incorporated into the Retiree Health Plan in its entirety by reference and thus constitutes a part of the Retiree Health Plan. If a term or provision of this SPD conflicts with any term or provision of the wrap-around plan document of the Retiree Health Plan, the term or provision of this SPD will control.

Notwithstanding the foregoing, if there is a conflict between a term or provision of such wrap-around plan document and a term or provision of this SPD, 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 this SPD will not enlarge the rights of a Covered Person or any other person to any benefit available under the Retiree Health Plan.

13.2 Waiver or Estoppel. No term, condition or provision of the HRA shall be waived, and there shall be no estoppel against the enforcement of any provision of the HRA, except by written direction of the Plan Administrator. No such waiver shall be deemed a continuing waiver unless specifically stated. Each waiver shall operate only as to the specific term or condition waived and shall not constitute a waiver of such term or condition for the future or as to any act other than that specifically waived.

13.3 Legal Proceedings. Any action at law or in equity with respect to a Claim must be brought for recovery within one year following the earlier of (a) the date of a final adverse benefit determination on review with respect to such Claim, if applicable, or (b) the accrual of such Claim, to the extent that it does not result in a final adverse benefit determination on review. Any action with respect to any other claim under the HRA must be brought within one year following the date that the alleged action or omission that is the subject of the claim occurred.

13.4 Time Limitation. If any time limitation of the HRA with respect to giving notice of claim or furnishing proof of loss, or the bringing of an action at law or in equity, is less than that permitted by the law of the state in which the HRA is existence, such limitation is hereby extended to agree with the minimum period permitted by such law.

13.5 Conformity with Law. If any provision of the HRA is contrary to any law to which it is subject, such provision is hereby amended to conform thereto.

13.6 Statements. In the event of fraud, all statements made by a Covered Person will be deemed representations. Such representations will void the HRA benefits or be used by the HRA in defense of any unpaid Claim.

13.7 References. Article and Section titles are for conveniences of reference only, and are

not to be considered in interpreting the HRA.

13.8 Right to Receive and Release Necessary Information. For the purpose of determining the applicability of and implementing the terms of this provision of the HRA or any provision of similar purpose or any other HRA, the Plan Administrator may, without the consent of or notice to any person, release to or obtain from, any insurance company or other organization or person any information, with respect to any person, that the Plan Administrator deems to be necessary for such purposes, subject to the provisions of Article XI. Any person claiming benefits under the HRA shall furnish to the Plan Administrator such information as may be necessary to implement this provision.

13.9 Information to be Furnished. All Covered Persons shall provide the Employer, the Claims Administrator, and the Plan Administrator with such information and evidence as may reasonably be requested from time to time for the purpose of administering the HRA.

13.10 Limitation of Rights. Neither the establishment of the HRA, nor any amendment thereof, nor the payment of any benefits will be construed as giving to any Covered Person or other person any legal or equitable right against the Employer or Plan Administrator or their respective officers and directors, as an Employee or otherwise, except as expressly provided herein, and in no event will the terms of employment or service of any Covered Person or Employee be modified or in any way affected hereby.

13.11 Nonassignability of Rights or Benefits. No benefit, right or interest of any Covered Person under the HRA shall be subject to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance or charge, seizure, attachment or legal, equitable or other process, or be liable for, or subject to, the debts, liabilities or other obligations of such person, except as otherwise required by law or as permitted under the terms of the HRA. Neither the Plan Sponsor nor any other Employer shall be in any manner liable for or subject to the debts, contracts, liabilities, engagements or torts of any Covered Person entitled to benefits hereunder.

Disclosures of information about the Covered Person can only be made to the Covered Person or his authorized representative and in accordance with applicable law and the terms of the HRA.

13.12 Overpayments. If, for any reason, any benefit under the HRA is erroneously paid to a Covered Person or other person or entity for the benefit of a Covered Person (collectively, a "Payee"), such person or entity shall be responsible for refunding the overpayment to the Plan. If such overpayment is not refunded within a reasonable time period as determined by the Plan Administrator, the overpayment shall be (a) charged directly to the Covered Person or Payee as a reduction of the amount of future benefits otherwise payable to or on behalf of the Covered Person, or (b) recouped by any other method which the Plan Administrator or Claims Administrator deems appropriate in its discretion.

13.13 No Guarantee of Tax Consequences. Neither the Employer, nor the Plan Administrator makes any commitment or guarantee that any amounts paid to or for the benefit of a Covered Person under the HRA will be excludable from the Covered Person's gross income for federal or state income and employment tax purposes, or that any other federal or state tax treatment will apply to or be available to any Covered Person. It shall be the obligation of each Covered Person to determine whether each payment under the HRA is excludable from the Covered Person's gross income for federal and state income and employment tax purposes, and to notify the Employer if the Covered Person has reason to believe that any such payment is not so excludable.

13.14 Indemnification of Employer by Covered Persons. If any Covered Person receives one or more payments or reimbursements under the HRA that are not for Covered Premiums, such Covered Person shall indemnify and reimburse the Employer for any liability it may incur for failure to

withhold federal or state income tax or Social Security tax from such payments or reimbursements. However, such indemnification and reimbursement shall not exceed the amount of additional federal and state income tax that the Covered Person would have owed if the payments or reimbursements had been made to the Covered Person as regular cash compensation, plus the Covered Person's share of any Social Security tax that would have been paid on such compensation, plus any applicable fines or penalties assessed against the Employer, less any such additional income and Social Security tax actually paid by the Covered Person.

13.15 Severability. If any provision of the HRA is held invalid, unenforceable, or inconsistent with any law, regulation, or requirement for a reimbursement, its invalidity, unenforceability or inconsistency shall not affect any other provision of the HRA, and the HRA shall be construed and enforced as if such provision were not a part of the HRA.

13.16 Construction of Terms. Words of gender shall include persons and entities of any gender, the plural shall include the singular, and the singular shall include the plural. Section headings exist for reference purposes only and shall not be construed as part of the HRA.

13.17 Governing Law. All matters or issues relating to the interpretation, construction, validity, and enforcement of the HRA 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 HRA is administered in Montgomery County, Texas, mandatory venue for any claim, legal suit, action or other proceeding arising out of, or relating to, the HRA, other than an interpleader action under the HRA 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 either Montgomery County, Texas, or 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 HRA that is initiated by the Plan Sponsor, the Plan Administrator or a designee thereof shall be, as decided by the Benefits Committee in its discretion, in (a) the state where the deceased Covered Person resided at his death (if the benefits which are the subject of the interpleader action are those of a deceased Covered Person), (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 Montgomery County, Texas.

Each Covered Person, as the result of, and in consideration for, participation in the HRA, and his designated representative, with respect to any claim or dispute relating in any way to, or arising out of, the HRA, consents and agrees to such jurisdiction and venue as described in this Section 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 PLAN INFORMATION**

Plan Name: Anadarko Petroleum Corporation Retiree Health Benefits Plan.

Plan Number: 504

Plan Sponsor's Name, Address and Telephone Number: Anadarko Petroleum Corporation, c/o Benefits Department – Human Resources, Attn: Director, Global Benefits, 1201 Lake Robbins Drive, The Woodlands, Texas 77380; (832) 636-1000.

Plan Administrator's Name, Address and Telephone Number: Anadarko Petroleum Corporation Health and Welfare Benefits Administrative Committee, Attn: Director, Global Benefits, 1201 Lake Robbins Drive, The Woodlands, Texas 77380; (832) 636-1000.

Plan Sponsor's EIN: 76-0146568

Plan Type (with respect to the HRA): Employee welfare benefit plan providing self-funded health reimbursement benefits.

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.

Type of Administration: The HRA coverage under the Plan is administered by the Plan Administrator, with benefits being provided in accordance with the applicable terms, limits and conditions of the Plan, including this SPD. The Plan Administrator has engaged the Claims Administrator to process Claims and perform other administrative duties under the HRA.

HRA Claims Administrator and Concierge Service Partner:

Pre-65 HRA Coverage	Post-65 HRA Coverage and Pre-65 Disability HRA Coverage
Via Benefits Insurance Services Telephone: 1-844-824-7653 Marketplace.ViaBenefits.com/Anadarko	Via Benefits Insurance Services Telephone: 1-855-323-8829 My.ViaBenefits.com/Anadarko

Agent for Service of Legal Process: Anadarko Petroleum Corporation Health & Welfare Benefits Administrative Committee, Anadarko Petroleum Corporation Retiree Health Benefits Plan, Anadarko Petroleum Corporation, c/o CT Corporation System, 350 N. St. Paul Street, Dallas, TX 75201.

Source of Contributions: The Plan Sponsor and the other adopting Employers (if any) pay the costs for HRA coverage under the Plan.

Funding: The HRA coverage under the Plan is self-funded through the general assets of the Plan Sponsor.

ARTICLE XV. STATEMENT OF ERISA RIGHTS

As a Covered Person under the HRA, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Covered Persons are entitled to:

Receive Information About Your HRA and Benefits

Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites, all HRA 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 HRA 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 Plan Administrator. The Plan Administrator may make a reasonable charge for the copies.

Receive a summary of the HRA's annual financial report. The Plan Administrator is required by law to furnish each Covered Person 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 HRA as a result of a Qualifying Event. You or your Dependents may have to pay for such coverage. Review this Summary Plan Description and the documents governing the HRA on the rules governing your COBRA Continuation Coverage rights.

Prudent Actions by HRA Fiduciaries

In addition to creating rights for Covered Persons, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate the HRA, called "fiduciaries" of the HRA, have a duty to do so prudently and in the interest of Covered Persons 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 HRA documents or the latest annual report from the HRA 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 this SPD. If your appeal is denied in accordance with the Claims Procedures herein, and you have exhausted the administrative remedies provided to you under the HRA, you may file suit in a state or Federal court.

In addition, if you disagree with the HRA'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 HRA fiduciaries misuse the HRA'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 HRA, you should contact the Plan Administrator at (832) 636-1000 and ask for the HR-Benefits Department. 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
ANADARKO HEALTH REIMBURSEMENT ARRANGEMENT**

(Revision Date: January 1, 2018)

APPENDIX A

As of January 1, 2018, the only Employer which has adopted and is participating in the HRA is the Plan Sponsor.

**FIRST SUMMARY OF MATERIAL MODIFICATIONS
TO THE SUMMARY PLAN DESCRIPTION OF THE ANADARKO HEALTH
REIMBURSEMENT ARRANGEMENT (Revision Date: January 1, 2018)
UNDER THE ANADARKO PETROLEUM CORPORATION
RETIREE HEALTH BENEFITS PLAN
(Amended and Restated Effective as of January 1, 2018)**

General

This Summary of Material Modifications (“**SMM**”) amends certain portions of the Summary Plan Description of the Anadarko Health Reimbursement Arrangement under the Anadarko Petroleum Corporation Retiree Health Benefits Plan (Amended and Restated Effective as of January 1, 2018), Revision Date: January 1, 2018 (“**HRA SPD**”), and is effective as provided below. You should keep this SMM with your copy of the HRA SPD which more fully describes the Plan.

Capitalized terms not defined herein shall have the meanings ascribed to them under the terms of the HRA SPD. Any provisions of the HRA SPD that are not specifically modified by this SMM have not been changed and thus remain in effect.

For purposes of clarification, the amendment set forth in this SMM is further subject to Article IX of the HRA SPD and Article V of the Wrap-Plan.

Change of Control Amendment

- The HRA SPD is amended, effective as of the Effective Time, to provide that, upon the occurrence of a change of control, an Employee who is a party to a change of control agreement with the Plan Sponsor (or another Employer) (“**COC Agreement**”) will be accredited with additional years of employment service for purposes of determining his eligibility as a “retiree” to participate in the HRA, to the extent required by, and in accordance with, the applicable terms of the Employee’s COC Agreement.

Except as modified herein, you should refer to your copy of the HRA SPD for any questions relating to the Anadarko Health Reimbursement Arrangement under the Anadarko Petroleum Corporation Retiree Health Benefits Plan.

**SECOND SUMMARY OF MATERIAL MODIFICATIONS
TO THE SUMMARY PLAN DESCRIPTION OF THE ANADARKO HEALTH
REIMBURSEMENT ARRANGEMENT
UNDER THE ANADARKO PETROLEUM CORPORATION
RETIREE HEALTH BENEFITS PLAN
(Amended and Restated Effective as of January 1, 2018)**

This Summary of Material Modifications (“**SMM**”) amends certain portions of the Summary Plan Description of the Anadarko Health Reimbursement Arrangement under the Anadarko Petroleum Corporation Retiree Health Benefits Plan (Amended and Restated Effective as of January 1, 2018), (“**HRA SPD**”), and is effective as of January 1, 2021. You should keep this SMM with your copy of the HRA SPD which more fully describes the Plan.

Capitalized terms not defined herein shall have the meanings ascribed to them under the terms of the HRA SPD. Any provisions of the HRA SPD that are not specifically modified by this SMM have not been changed and thus remain in effect.

For purposes of clarification, the amendment set forth in this SMM is further subject to Article IX of the HRA SPD and Article V of the Wrap-Plan.

1. All references to the Anadarko Benefits Center or www.AnadarkoAdvantage.ehr.com in the HRA SPD shall mean the OxyLink Employee Service Center, 4500 South 129th East Avenue, Tulsa, OK 74134-5801, 1-800-699-6903 (US), 1-918-610-1990 (Outside US), oxygenlink@oxy.com.
2. Section 2.5 of the HRA SPD was replaced entirely with the following:

“2.5 “Benefits Committee” shall mean the Anadarko Petroleum Corporation Health & Welfare Benefits Administrative Committee, which is a committee of one or more Employees appointed by the Plan Sponsor to act as named fiduciary and Plan Administrator of the HRA. References herein to the Benefits Committee or Plan Administrator shall include, when appropriate, any Employee, Claims Administrator, or other person or entity who has been delegated the appropriate authority by the Benefits Committee as Plan Administrator in accordance with Section 8.1.”
3. The table in Section 11.6 was replaced entirely with the table in Attachment A.
4. Article XIV of the HRA SPD was replaced entirely with the document at Attachment B.

Except as modified herein, you should refer to your copy of the HRA SPD for any questions relating to the Anadarko Health Reimbursement Arrangement under the Anadarko Petroleum Corporation Retiree Health Benefits Plan.

**SECOND SUMMARY OF MATERIAL MODIFICATIONS
TO THE SUMMARY PLAN DESCRIPTION OF THE
HEALTH REIMBURSEMENT ARRANGEMENT
UNDER THE ANADARKO PETROLEUM CORPORATION
RETIREE HEALTH BENEFITS PLAN
(Amended and Restated Effective as of January 1, 2021)**

Attachment A

**SUMMARY PLAN DESCRIPTION OF THE
HEALTH REIMBURSEMENT ARRANGEMENT UNDER THE
ANADARKO PETROLEUM CORPORATION RETIREE HEALTH BENEFITS PLAN
(Amended and Restated Effective as of January 1, 2018)**

Employee/Position	Categories of PHI under the Plan to which Access is Needed and Conditions on Access
Vice President, Compensation & Benefits	PHI as needed to perform duties as Privacy Official and Complaint Official
All active employees of the HR Benefits Planning Department and the HR Systems & Data Admin of Human Resources (“ HR Departments ”)	PHI as needed to perform administration of the Plan and assist Plan participants with questions
Systems Department employees who are responsible for maintenance of systems that may contain electronic PHI	PHI as needed to maintain and administer systems that may contain electronic PHI
Legal Counsel assigned to support the HR Departments Paralegals and administrative staff supporting Legal Counsel (above)	PHI as needed to advise and counsel on any claims or other Plan administrative issues that might arise relating to PHI
Vice President Human Resources	PHI as needed to perform executive functions associated with oversight of the Benefits Department and sponsorship of the Plan

EFFECTIVE Jan 1 2021

**SECOND SUMMARY OF MATERIAL MODIFICATIONS
TO THE SUMMARY PLAN DESCRIPTION OF THE
HEALTH REIMBURSEMENT ARRANGEMENT
UNDER THE ANADARKO PETROLEUM CORPORATION
RETIREE HEALTH BENEFITS PLAN
(Amended and Restated Effective as of January 1, 2021)**

Attachment B

ARTICLE XIV
IMPORTANT PLAN INFORMATION

Name of Plan: Anadarko Petroleum Corporation Retiree Health Benefits Plan

Plan Number: 504

Plan Sponsor's Name, Address and Telephone Number: Anadarko Petroleum Corporation, c/o Human Resources Department, Occidental Petroleum Corporation, 5 Greenway Plaza, Suite 110 Houston, Texas, 77046-0521, (713) 215-7000.

Plan Administrator's Name, Address and Telephone Number: Occidental Petroleum Corporation Employee Benefits Committee, c/o Human Resources Department, Occidental Petroleum Corporation, 5 Greenway Plaza, Suite 110 Houston, Texas, 77046-0521, (713) 215-7000.

Employer Identification Number: 76-0146568.

Plan Type (with respect to the HRA): Employee welfare benefit plan providing self-funded health reimbursement benefits.

Type of Administration: The HRA coverage under the Plan is administered by the Plan Administrator, with benefits being provided in accordance with the applicable terms, limits and conditions of the Plan, including this SPD. The Plan Administrator has engaged the Claims Administrator to process Claims and perform other administrative duties under the HRA.

HRA Claims Administrator and Concierge Service Partner:

Pre-65 HRA Coverage	Post-65 HRA Coverage and Pre-65 Disability HRA Coverage
Via Benefits Insurance Services Telephone: 1-844-824-7653 Marketplace.ViaBenefits.com/Anadarko	Via Benefits Insurance Services Telephone: 1-844-824-7653 Marketplace.ViaBenefits.com/Anadarko

Agent for Service of Legal Process: Service for legal process related to the Plan may be made upon the Plan Administrator or claims administrators at the addresses listed above

Sources of Contributions: The adopting Employers pay the costs for HRA coverage under the Plan.

Funding: The HRA coverage under the Plan is self-funded through the general assets of the Plan Sponsor.

EFFECTIVE Jan 1, 2021