



SUMMARY PLAN DESCRIPTION

# **PRESCRIPTION DRUG**

## **Prescription Drug Program Benefit Program Summary Plan Description Effective as of January 1, 2021**

This Benefit Program Summary Plan Description (“Benefit Program SPD”) is for the Express Scripts Prescription Drug Program (“Prescription Program” or the “Program”). The Prescription Program is part of the Occidental Petroleum Corporation Welfare Plan (the “Plan”).

### About the Summary Plan Description:

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

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

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

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

|                                                                                           |          |
|-------------------------------------------------------------------------------------------|----------|
| <b>Eligibility .....</b>                                                                  | <b>1</b> |
| <b>Contact Information .....</b>                                                          | <b>2</b> |
| <b>How Deductibles and Out-of-Pocket Maximums Work for the Prescription Program .....</b> | <b>2</b> |
| <b>Schedule of Coverage .....</b>                                                         | <b>2</b> |
| <b>Covered Prescription Drug Medications .....</b>                                        | <b>5</b> |
| <b>How to Obtain Prescription Drug Medications .....</b>                                  | <b>5</b> |
| <b>In-Network Pharmacy and Maintenance Prescription Drugs .....</b>                       | <b>5</b> |
| <b>Out-of-Network Pharmacy .....</b>                                                      | <b>6</b> |
| <b>Express Scripts Mail Delivery .....</b>                                                | <b>6</b> |
| <b>Generic Drugs .....</b>                                                                | <b>6</b> |
| <b>Specialty Medications .....</b>                                                        | <b>7</b> |
| <b>Prior Authorization .....</b>                                                          | <b>7</b> |
| <b>Step Therapy .....</b>                                                                 | <b>8</b> |
| <b>Coordination of Pharmacy Benefits .....</b>                                            | <b>8</b> |
| <b>Claims Administrator and Fiduciary .....</b>                                           | <b>8</b> |
| <b>Claims .....</b>                                                                       | <b>8</b> |
| <b>Glossary .....</b>                                                                     | <b>9</b> |

## **Eligibility**

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

- an Employee who is included in a unit of Employees that is covered by an agreement which the Secretary of the federal Department of Labor finds to be a collective bargaining agreement between Employee representatives and the Employer, if the Plan or the Prescription Program in particular was the subject of good faith bargaining, unless such agreement provides for coverage of such Employees in the Plan or the Prescription Program in particular; or
- an Employee who is employed by a division or operating unit of the Employer for which the Plan or the Prescription Program in particular has not been adopted; or
- an individual who is not the Employee of an Employer.

Please see the Wrap-SPD and its Appendix G for more information on eligibility.

## Contact Information

Please find below contact information for Express Scripts, PayFlex, and the OxyLink Employee Service Center (“OxyLink”). *Wherever it is suggested that you contact one of these in this document, please reference the contact information below.*

If you have questions about your Prescription Program Copays and Coinsurance payments and how they relate to your Health Care Flexible Spending Account, Limited Purpose Flexible Spending Account, or your Health Savings Account, please contact PayFlex. PayFlex’s contact information is below.

If you have questions about eligibility to participate in the Prescription Program or other matters relating to the Benefit Program in the Plan, please contact the OxyLink Employee Service Center (“OxyLink”) at the information set forward below.

|                                                                                                                                             |                                                                                                                                                                                                                                                                                                              |                                                                                                                                            |
|---------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Express Scripts, Inc. (ESI)</b><br>Prescription Drug Program                                                                             | <ul style="list-style-type: none"><li>• US: 1-800-551-7680</li><li>• Outside U.S. 1-800-759-1089</li><li>• <a href="http://www.express-scripts.com">www.express-scripts.com</a></li><li>• Express Scripts App – available at the Apple and Google App stores</li><li>• See Express Scripts ID Card</li></ul> | <ul style="list-style-type: none"><li>• 24 hours a day</li><li>• 7 days a week</li></ul> (Except Thanksgiving & Christmas)                 |
|                                                                                                                                             |                                                                                                                                                                                                                                                                                                              |                                                                                                                                            |
| <b>PayFlex</b><br>FSA, LPFSA and HSA Administration                                                                                         | <ul style="list-style-type: none"><li>• 844-PAYFLEX (844-729-3539)</li><li>• Outside U.S.: 402-345-0666</li><li>• <a href="http://www.PayFlex.com">www.PayFlex.com</a></li></ul>                                                                                                                             | <ul style="list-style-type: none"><li>• Monday through Friday</li><li>• 7 a.m. – 7 p.m. CT</li><li>• Saturday, 9 a.m.– 2 p.m. CT</li></ul> |
|                                                                                                                                             |                                                                                                                                                                                                                                                                                                              |                                                                                                                                            |
| <b>OxyLink Employee Service Center</b><br>Eligibility, Life Events, Contributions,<br>Plan Documents including Summary<br>Plan Descriptions | <ul style="list-style-type: none"><li>• 1-800-699-6903</li><li>• Outside U.S. - +1-918-610-1990</li><li>• Email: <a href="mailto:www.oxylink@oxy.com">www.oxylink@oxy.com</a></li></ul>                                                                                                                      | <ul style="list-style-type: none"><li>• Monday – Friday</li><li>• 8:00 a.m. – 4:30 p.m. CT</li></ul> (Except Holidays)                     |

## How Deductibles and Out-of-Pocket Maximums Work for the Prescription Program

The Prescription Program and the applicable BCBSTX Medical Program (PPO or HDHP) in which you are enrolled have combined Deductibles and Out-of-Pocket Maximums. This means that the payments (as administered and credited through the applicable program’s claims process and the provisions of the program) that you make to pharmacies under the Prescription Program and medical providers under the applicable BCBSTX Medical Program are added together to determine whether the applicable Deductibles and Out-of-Pocket Maximums have been met. If you are enrolled in the BCBSTX PPO Medical Program, there is no annual deductible for the Prescription Plan, as shown in the following Schedule of Coverage section.

## Schedule of Coverage

In order to participate in the Prescription Program, you must also be enrolled in either the Oxy BCBSTX PPO Medical Program or the BCBSTX HDHP Medical Program. Please refer to the applicable BCBSTX PPO Program table or the BCBSTX HDHP Program table below, as applicable.



Please note that other provisions of this Benefit Program SPD affect the coverage and benefits set forward in the following tables. The entire Benefit Program SPD must be read in conjunction with the tables.

| BCBSTX High Deductible Health Plan (HDHP) Medical Program                 |                                                                                                                                                                                                                                                                                                                                                                                               | HDHP |
|---------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------|
| Annual Deductible<br>(Combined Medical and Prescription)                  | In-Network <ul style="list-style-type: none"><li>Individual: \$1,500</li><li>Family: \$3,000</li></ul>                                                                                                                                                                                                                                                                                        |      |
|                                                                           | Out-of-Network <ul style="list-style-type: none"><li>Individual: \$3,000</li><li>Family: \$6,000</li></ul>                                                                                                                                                                                                                                                                                    |      |
| Annual Out of Pocket (OOP) Maximum<br>(Combined Medical and Prescription) | In-Network <ul style="list-style-type: none"><li>Individual: \$3,000</li><li>Family: \$6,000</li></ul>                                                                                                                                                                                                                                                                                        |      |
|                                                                           | Out-of-Network <ul style="list-style-type: none"><li>Individual: \$6,000</li><li>Family: \$12,000</li></ul>                                                                                                                                                                                                                                                                                   |      |
| Preventive Care Medications                                               | <ul style="list-style-type: none"><li>Covered at 100%; No deductible</li><li>ACA drugs - No Copay or Coinsurance</li><li>Non-ACA drugs – No deductible; Subject to Copay or Coinsurance</li></ul>                                                                                                                                                                                             |      |
| In-Network Pharmacy*<br>(Non-Maintenance Drugs)                           | <ul style="list-style-type: none"><li>Must meet applicable deductible first</li><li>Generic Drugs – \$5 Copay (no Coinsurance)</li><li>Brand Name Drugs – Coinsurance<ul style="list-style-type: none"><li>Preferred: 25%, Min \$10 / Max \$50</li><li>Non-Preferred: 25%, Min \$25 / Max \$100</li></ul></li></ul>                                                                           |      |
| In-Network Pharmacy<br>(Maintenance Drugs)                                | <ul style="list-style-type: none"><li>Must meet applicable deductible first</li><li>Same benefits as Non-Maintenance Drug for an initial 30-day prescription plus two 30-day refills</li><li>For subsequent refills not filled through Express Scripts, Coinsurance is 100% (i.e., you pay 100% of cost)</li><li>Not applicable for participants residing outside the United States</li></ul> |      |
| Express Scripts Mail Delivery<br>(Maintenance Drugs)                      | <ul style="list-style-type: none"><li>Must meet applicable deductible first</li><li>90-day prescriptions only</li><li>Generic Drugs – \$10 Copay (no Coinsurance)</li><li>Brand Name Drugs – Coinsurance<ul style="list-style-type: none"><li>Preferred 25%, Min \$20 / Max \$100</li><li>Non-Preferred 25%, Min \$50 / Max \$200</li></ul></li></ul>                                         |      |
| Lifetime Maximums                                                         | <ul style="list-style-type: none"><li>None except infertility Prescription Drug Medications are subject to a \$10,000 lifetime maximum benefit.</li></ul>                                                                                                                                                                                                                                     |      |

\* Use of Express Scripts Mail for delivery of Non-Maintenance Drugs is processed as if you filled the prescription at an In-Network Pharmacy.

| <b>BCBSTX Preferred Provider Organization (“PPO”) Medical Program</b>            |                                                                                                                                                                                                                                                                                                                                                                                                                                 | <b>PPO</b> |
|----------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------|
| <b>Annual Deductible</b><br>(Combined Medical and Prescription Program)          | In-Network – None for Prescription Program                                                                                                                                                                                                                                                                                                                                                                                      |            |
|                                                                                  | Out-of-Network – None for Prescription Program                                                                                                                                                                                                                                                                                                                                                                                  |            |
| <b>Annual Out of Pocket (OOP) Maximum</b><br>(Combined Medical and Prescription) | In-Network <ul style="list-style-type: none"> <li>Individual: \$2,000</li> <li>Family: \$4,000</li> </ul>                                                                                                                                                                                                                                                                                                                       |            |
|                                                                                  | Out-of-Network <ul style="list-style-type: none"> <li>Individual: \$4,000</li> <li>Family: \$8,000</li> </ul>                                                                                                                                                                                                                                                                                                                   |            |
| <b>Preventive Care Medications</b>                                               | <ul style="list-style-type: none"> <li>Covered at 100%</li> <li>No Copayment or Coinsurance</li> </ul>                                                                                                                                                                                                                                                                                                                          |            |
| <b>In-Network Pharmacy*</b><br>(Non-Maintenance Drugs)                           | <ul style="list-style-type: none"> <li>Generic Drugs – \$5 Copay (no Coinsurance)</li> <li>Brand Name Drugs – Coinsurance <ul style="list-style-type: none"> <li>Preferred: 25%, Min \$10 / Max \$50</li> <li>Non-Preferred: 25%, Min \$25 / Max \$100</li> </ul> </li> </ul>                                                                                                                                                   |            |
| <b>In-Network Pharmacy</b><br>(Maintenance Drugs)                                | <ul style="list-style-type: none"> <li>Same benefits as Non-Maintenance Drug for an initial 30-day prescription plus two 30-day refills</li> <li>For subsequent refills not filled through Express Scripts: <ul style="list-style-type: none"> <li>Generic Drugs – Copay is \$10</li> <li>Brand Name Drugs – 50% Coinsurance</li> </ul> </li> <li>Not applicable for participants residing outside the United States</li> </ul> |            |
| <b>Express Scripts Mail Delivery</b><br>(Maintenance Drugs)                      | <ul style="list-style-type: none"> <li>90-day prescriptions only</li> <li>Generic Drugs – \$10 Copay (no Coinsurance)</li> <li>Brand Name Drugs – Coinsurance <ul style="list-style-type: none"> <li>Preferred 25%, Min \$20 / Max \$100</li> <li>Non-Preferred 25%, Min \$50 / Max \$200</li> </ul> </li> </ul>                                                                                                                |            |
| <b>Lifetime Maximums</b>                                                         | <ul style="list-style-type: none"> <li>None except infertility Prescription Drug Medications are subject to a \$10,000 lifetime maximum benefit.</li> </ul>                                                                                                                                                                                                                                                                     |            |

\* Use of Express Scripts Mail for delivery of Non-Maintenance Drugs is processed as if you filled the prescription at an In-Network Pharmacy.

### **Covered Prescription Drug Medications**

The Prescription Program will pay for all or a portion of a Prescription Drug Medication that is medically necessary to treat an illness or injury, is prescribed for you by your Health Care Provider, and all requirements of the Prescription Program have been met. The amount the Prescription Program will pay depends upon the factors set forward in this Benefit Program SPD.

In addition, coverage and benefits may be subject to the following which are discussed subsequently:

- Prior authorization requirements, if applicable
- Limitations for Specialty Medications
- Step Therapy requirements
- Coordination of Benefits (if the Prescription Program provides secondary coverage to another plan)

### **How to Obtain Prescription Drug Medications**

The methods by which you may obtain Prescription Drug Medications through the Prescription Program are listed below. Please note that coverage and the amount of the benefit available depends upon factors set forward in this Benefit Program SPD.

1. In-Network Pharmacy – This is designed to meet your short-term prescription drug needs for up to 30 days.
2. Out-of-Network Pharmacy – This can provide certain benefits if you purchase a prescription outside of the Express Scripts network of pharmacies.
3. Express Scripts Mail Delivery – This is designed for non-urgent Maintenance Prescription Drugs required for more than 30 days. Express Scripts will mail Prescription Drug Medications to your residence.

### **In-Network Pharmacy and Maintenance Prescription Drugs**

The In-Network Pharmacy feature is intended for filling your short-term prescriptions (up to a 30-day supply). When you show your Express Scripts ID card to the In-Network Pharmacy, you will pay the applicable amount required by the Prescription Program plus any cost difference if a non-Generic Drug is filled (see later discussion).

You must either show your Express Script ID card at the time you obtain your Prescription Drug Medication at an In-Network Pharmacy or you must provide the In-Network Pharmacy with identifying information that can be verified under its current process and procedures. If you do not show your ID card or provide verifiable information to an In-Network Pharmacy, you may be required to pay in full or the Prescription Drug Medication at the pharmacy and then you can submit a reimbursement claim to Express Scripts to receive payment for the amount covered by the Prescription Program.

For Maintenance Prescription Drugs, you may obtain your initial prescription plus two 30-day refills at an In-Network Pharmacy. After your initial prescription plus two refills have been dispensed, you should then use the Express Scripts Mail Delivery. If you continue to use an In-Network Pharmacy and not Express Scripts Mail Delivery, the Prescription Plan benefits for the In-Network Pharmacy are reduced, which means you will have pay more (“Additional Cost Contributions”). Please see the Schedule of Coverage for more information. Please note that Additional Cost Contributions that you make due to not using the Express Scripts Mail Delivery after your second refill are not counted towards the Out-of-Pocket Maximum. In addition, reaching the Out-of-Pocket Maximum will not negate the need to make the

Additional Cost Contributions if you do not use the Express Scripts Mail Delivery after filling your third prescription.

To find an In-Network Pharmacy near you:

- Log on to [express-scripts.com](https://www.express-scripts.com) and, under Manage Prescriptions, select Locate a Pharmacy. Or you may contact Express Scripts.
- Ask your retail pharmacy whether it participates in the Express Scripts network.

### **Out-of-Network Pharmacy**

If you use an Out-of-Network Pharmacy, you must pay the entire non-discounted cost (i.e., “retail price”) of the Covered Prescription Drug Medication and then submit a reimbursement claim form to Express Scripts. You will be reimbursed for the amount the Covered Prescription Drug Medication would have cost at an In-Network Pharmacy less any applicable Deductible, Copay, or Coinsurance. For more information on filing a claim for reimbursement, please see the Claims section.

### **Express Scripts Mail Delivery**

The Express Scripts Mail Delivery service provides significant cost savings on medications that are dispensed by Express Scripts. If you take Maintenance Prescription Drugs, you may order up to a 90-day supply through the Express Scripts Mail Delivery service. This service can also be used to fill non-urgent, short-term prescriptions. The In-Network Pharmacy Copays or Coinsurance will apply to mail delivery prescriptions of 30 days or fewer.

Refills can be ordered by mail, online at [express-scripts.com](https://www.express-scripts.com), the Express Scripts app, or by phone any time day or night. Refills are usually delivered within three to five days after the order is received.

To use the Express Scripts Mail Delivery service, send your original prescription, completed order form and payment of the applicable Copay or Coinsurance amount to Express Scripts. If you choose not to provide debit or credit card information, you can pay by check. To pay by check, you must contact Express Scripts and receive a cost estimate of your Copay or Coinsurance amount. If the estimate is low, you will be required to send in a supplemental payment. Order forms are available on [My HR](#) on [oxynet.oxy.com](https://oxynet.oxy.com), [express-scripts.com](https://www.express-scripts.com), or by contacting Express Scripts. Mail your order forms to:

Express Scripts  
P.O. Box 66564  
St. Louis, MO 63166-6564

You may also have your Health Care Provider send in your prescriptions via fax or electronically. Ask your Health Care Provider to call 800-551-7680 or 817-417-2000, ext. 4154016 if outside the U.S for instructions.

### **Generic Drugs**

Your share for the cost of a covered prescription is affected by whether it is a Generic Drug, Preferred Brand-Name Drug, or a Non-Preferred Brand-Name Drug. For an Express Scripts Mail Delivery and retail prescriptions at both In-Network and Out-of-Network Pharmacies, if a Generic Drug is available and your prescription is filled with a Preferred or a Non-Preferred Brand-Name Drug, the Prescription Program will pay up to what it would have paid for the Generic Drug. You will be responsible for paying the balance.



The Deductibles, Coinsurance, and Out-of-pocket maximums do not apply to this balance paid by you. Please refer to the Schedule of Coverage for more information.

### Specialty Medications

The Prescription Program covers Specialty Drugs under certain circumstances. Please see the Glossary for the definition of a Specialty Medication.

| EXAMPLES OF SPECIALTY MEDICATION CATEGORIES | SPECIALTY MEDICATION EXAMPLES |
|---------------------------------------------|-------------------------------|
| Self-administered drugs                     | Growth hormones               |
| Anemia                                      | Procrit, Aranesp              |
| Rare disease                                | Immune Globulin               |
| Administered injectable                     | Synagis                       |
| Administered infused                        | Remicade, Orencia             |

If other coverage requirements are met, Specialty Medications may be obtained only through Accredo, which is the Express Scripts Specialty Pharmacy. Accredo provides enhanced clinical benefits as well as cost savings to you and the Plan. Specialty Medications are not covered if obtained from any other provider than Accredo.

A staff of specially trained Accredo pharmacists and nurses are available 24 hours a day, seven days a week, to help ensure the Specialty Medications and dosing you receive are clinically appropriate. Additional benefits include safety procedures to help prevent drug interactions, as well as ancillary supplies and equipment such as syringes and sharps containers.

### Prior Authorization

The Prescription Program requires prior authorization for certain Prescription Drug Medications and has certain coverage limits. For example, prescription drugs used for cosmetic purposes (e.g., Botox, Retin-A) may not be covered for a specific use, or a medication might be limited to a certain amount (e.g., such as the number of pills or total dosage) within a specific time period (e.g., Imitrex). Another example is growth hormones. You may check for prior authorization requirements or other coverage limits by contacting Express Scripts or visiting [www.express-scripts.com](http://www.express-scripts.com).

For Non-Participating Pharmacies, it is your responsibility to ensure that all prior authorizations and coverage limitations have been addressed prior to having the prescription filled. If you have a prescription filled by a Non-Participating Retail Pharmacy without obtaining a prior authorization or reviewing applicable coverage limitations, your claim for reimbursement may be denied in part or completely.

For Participating Pharmacies, the pharmacy staff should verify and advise you if a prescription requires prior authorization or has coverage limits and should also tell you if approval is needed before the prescription can be filled. If necessary, the pharmacy should provide you with an Express Scripts number that you or your Health Care Provider may call for additional information. If this number is not provided, please see the contact information for Express Scripts or call the customer service number on the back of your ID card.

If you use the Express Scripts Mail Delivery pharmacy, your prescribing Health Care Provider will be contacted directly regarding prior authorization or coverage limits.

If a prior authorization or a coverage limit is required, Express Scripts may request information to determine whether your use of the medication meets the Prescription Program's coverage protocols. You and your Health Care Provider should provide all information requested by Express Scripts necessary to substantiate your request for benefits.

After Express Scripts receives all necessary information for prior authorization, Express Scripts will notify you and your Health Care Provider in writing of its decision. If coverage is approved, the letter will indicate the amount of time for which coverage is valid. If coverage is denied, an explanation will be provided, along with instructions on how to submit an appeal. Please see the Claim Procedures in the Wrap-SPD for more information.

### **Step Therapy**

Express Scripts' Step Therapy Program is also a form of Prior Authorization under which certain Prescription Drug Medications are covered by the Prescription Program only after one or more other prerequisite medications (i.e., clinically appropriate and/or cost-effective alternatives) are tried first. Your Health Care Provider may also contact Express Scripts to request coverage of a prerequisite drug without a trial.

If the Prescription Drug Medication you are prescribed requires step therapy, you should arrange for your Health Care Provider to contact Express Scripts to begin the certification process. Benefits may not be payable unless the required procedures are followed and certification is approved.

### **Coordination of Pharmacy Benefits**

Express Scripts does not coordinate benefits. If you or your dependent has coverage from another prescription plan and the Prescription Program is secondary, your benefits under the Prescription Program will be subject to coordination of benefits. Please see the Wrap-SPD for information on coordination of benefits.

### **Claims Administrator and Fiduciary**

The Claims Administrator and Claims Fiduciary for the Prescription Program is Express Scripts, Inc. ("Express Scripts"). All claims for benefits under the Prescription Program must be filed with Express Scripts. Please see the following Claims section for how to make a claim and where to send your claim.

### **Claims**

In most situations, your claim for benefits will be submitted by the pharmacy that fills the prescription. In some cases you may need to submit an initial claim, such as filling a prescription at an Out-of-Network Pharmacy or if you visit an In-Network Pharmacy, but you do not have your Express Scripts ID Card. In any event, if a claim is not filed by a pharmacy, it is your responsibility to file the claim and comply with all substantiation requirements.

If you need to file an initial claim, reimbursement forms are available on [My HR](#) on [oxy.net](http://oxy.net), [oxy.com](http://oxy.com), [express-scripts.com](http://express-scripts.com), or by contacting Express Scripts. Return the completed form and receipts to:

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

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

If your claim is denied, you may appeal the denial. For additional information on the Claims Procedures regarding both initial claims and appeals, please see the Wrap-SPD.

### **Glossary**

The definitions below are in addition to those definitions in the Wrap-SPD and definitions that appear in the text of this document.

Additional Cost Contributions – Higher Copays and/or Coinsurance payments that are due if the Express Scripts Mail Delivery is not used after your second refill of a maintenance Prescription Drug Medication.

Brand-Name Drug – A Prescription Drug Product that is either: (a) manufactured and marketed under a trademark or name by a specific drug manufacturer; or (b) identified by Express Scripts as a Brand-name Drug based on available data resources. A “Brand-Name” designation by a manufacturer, pharmacy, or your Health Care Provider is not controlling on the Prescription Program.

Coinsurance – Coinsurance is the percentage of the cost of a Covered Prescription Drug Medication you are responsible for paying. Coinsurance is a fixed percentage that is applicable after you meet the Annual Deductible, if applicable. Please see the “Schedule of Coverage” Section for applicable Coinsurance.

Copayment (or Copay) – The amount you pay each time you have a prescription filled under the Prescription Program. The Copay is a flat dollar amount and is paid at the time of service or when billed by the pharmacy. Copays do not count toward the Annual Deductible but do count toward the Out-of-Pocket-Maximum. Please see the “Schedule of Coverage” Section for applicable Copays.

Covered Prescription Drug Medication – A Prescription Drug Medication that meets the provisions in the section of this document entitled “Covered Prescription Drug Medication”

Deductible (or Annual Deductible) – The amount that you must pay each calendar year for Covered Prescription Drug Medications and services under the BCBSTX HDHP Medical Program before the Prescription Program will commence paying for all or a portion of a Covered Prescription Drug Medications. There are separate Participating In-Network Pharmacy and Out-of-Network Pharmacy Annual Deductibles for the Prescription Program. The amounts you pay toward your Annual Deductible accumulate over the course of the calendar year. Please see the “Schedule of Coverage” section for applicable Deductibles.

Express Scripts Mail Delivery – A program maintained by Express Scripts where you may receive up to a 90-day supply of a maintenance Prescription Drug Medication, which is delivered to your home by mail.

Generic Drug – A Prescription Drug Medication that is either: (a) chemically equivalent to a Brand-name drug; or (b) identified by Express Scripts as generic based on available data resources. A “generic” designation by a manufacturer, pharmacy, or your Health Care Provider is not controlling on the Prescription Program.

Health Care Provider – A physician or other health care service provider who is licensed, accredited, or certified to perform the specified health services consistent with state law.

Maintenance Prescription Drugs – A Prescription Drug Medication prescribed for long-term treatment (i.e., more than 30 days).

Out-of-Network Pharmacy (Out-of-Network) – A retail or mail order pharmacy that is not a participating Express Scripts In-Network Pharmacy.

Non-Preferred Brand-Name Drug – Any Brand-Name Drug that is not a Preferred Brand-Name Drug. For information on Preferred and Non-Preferred Preferred Brand-Name Drugs, please contact Express Scripts.

Out-of-Pocket Maximum – The maximum amount you are required to pay each calendar year for covered Prescription Drug Medications and covered services under the BCBSTX Medical Program in which you are enrolled. There are separate Out-of-Pocket Maximums for Participating and Non-Participating Pharmacies. If your eligible out-of-pocket expenses in a calendar year exceed the annual Out-of-Pocket Maximum, you are no longer required to make Copay or Coinsurance payments for the costs of Covered Prescription Drug Medications acquired from Express Scripts or an In-Network Pharmacy for the remainder of the calendar year. However, reaching the Out-of-Pocket Maximum will not eliminate the need to pay Additional Cost Contributions when not using the Express Scripts Mail Delivery for Maintenance Prescription Drugs. In addition, the following do not count towards the Out-of-Pocket Maximums: (i) costs that you pay for drugs or services that are not covered by the Prescription Program; (ii) any balance that you must pay for a prescription filled by an Out-of-Network Pharmacy; and (iii) any Additional Cost Contributions that result from you not using the Express Scripts Mail Delivery for Maintenance Prescription Drugs.

In-Network Pharmacy (In-Network) - A retail or mail order pharmacy that has: (a) entered into an agreement with Express Scripts to dispense Prescription Drug Medications to Covered Persons; (b) agreed to accept specified reimbursement rates for Prescription Drug Medications; and (c) been designated by the Claims Administrator as an In-Network Pharmacy.

Preferred Brand-Name Drug – A Brand-Name Drug that Express Scripts has designated preferred and therefore may have lower Copay/Coinsurance requirements than a Non-Preferred Brand-Name Drug.

Prescription Drug Medication – A medication or product that has been approved by the U.S. Food and Drug Administration (FDA) and that can, under federal or state law, be dispensed only pursuant to a prescription order or refill. Prescription Drug Medication includes a medication that, due to its characteristics, is appropriate for self-administration or administration by a non-skilled caregiver. A Prescription Drug Medication includes:

- Federal legend drugs, which are drugs that require a label stating: “Caution: Federal law prohibits dispensing without a prescription” (Age restrictions apply to coverage for certain prescription drugs.)
- Compound medications if they are medically necessary, not experimental or investigative, do not contain any excluded ingredients, and determined by Express Scripts to be reasonably priced. You may obtain a list of approved compound medications by contacting Express Scripts.
- Any other drug which, under applicable state law, may be dispensed only upon a physician’s written prescription
- Infertility prescription drugs up to a \$10,000 lifetime maximum benefit
- Insulin

- Standard insulin needles and syringes
- These over-the-counter diabetic supplies when approved by your Health Care Provider: blood-testing strips (glucose), urine-testing strips (glucose), ketone-testing strips and tables; lancets and lancet devices, and glucose meters approved by Express Scripts. Continuous glucose monitors are not included; this equipment must be obtained through the applicable BCBSTX Medical Program in which you are enrolled.
- Oral, transdermal, intravaginal, and injectable contraceptives
- Legend contraceptive devices
- Legend prenatal vitamins (expectant mothers only)
- Legend pediatric fluoride vitamin drops up to a 50-day supply
- Legend smoking deterrents

Prescription Drug Medication does not include the following:

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

Preventive Care Medications – The ACA medications that are obtained at an In-Network Pharmacy are payable at 100% (without application of any Copay, Coinsurance, Annual Deductible) and non-ACA preventative medications that are not subject to your Annual Deductible (but are subject to any Copay or Insurance requirement) as required by applicable law, providing that at least one of the following is applicable: (a) evidence-based items or services that have in effect a rating of “A” or “B” in the current recommendations of the United States Preventive Services Task Force; (b) with respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; or (c) with respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the Health Resources and Services Administration. Note: The Plan considers all Prescription Drug



Medications used for contraceptive purposes to be Preventive Care Medications. This includes oral contraceptives, injectable drugs and contraceptive devices. You may determine whether a drug is a Preventive Care Medication through the internet at [express-scripts.com](http://express-scripts.com) or by contacting Express Scripts.

Specialty Medication – A Prescription Drug Medication that is generally high cost and is used to treat patients with certain types of illnesses such as hemophilia and rheumatoid arthritis. It includes drugs administered by a Health Care Provider or his/her staff, a self-injectable, an oral medication, or an inhaled biotechnology drug. Specialty Medications include certain drugs for infertility. For more information on Specialty Medications under the Prescription Program, visit [express-scripts.com](http://express-scripts.com) or contact Express Scripts.

Wrap-SPD – The Prescription Program is part of the Occidental Petroleum Corporation Welfare Plan. The Plan's Summary Plan Description consists of the wrap-around summary plan description document (or "Wrap-SPD") and the Benefit Program SPDs for each benefit program in the Plan.



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