



**Group Insurance Plan of Benefits for  
Chevron Phillips Chemical Company LP(Control #499719)  
Administered by Aetna International®  
Effective Date: January 1, 2021  
Middle East Plan**

Eligibility Provision			
<b>Employee</b>	Regular full-time employees of Chevron Phillips Chemical Company LP participating in this plan working a minimum of 30 hours per week and part-time employees working at least 20 hours per week.		
<b>Dependent</b>	Wife or husband; dependent children to age 26 (biological children, stepchildren, foster children, legally adopted children and/or children legally placed for adoption.)		
PPO			
PLAN FEATURES	OUTSIDE THE U.S.	In the U.S.	
		Preferred Benefits (In-Network)	Non-Preferred Benefits (Out-of-Network)
<b>Individual Deductible</b>	None	None	\$200 per calendar year
<b>Family Deductible</b>	None	None	\$400 per calendar year
<b>Individual Payment Limit</b>	None	\$1,500 per calendar year	\$3,000 per calendar year
<i>(Does not include deductibles, copays, benefit penalties, 50% items and Outpatient Prescription Drugs. Includes Outpatient Prescription Drugs when outside the US)</i>			
<b>Family Payment Limit</b>	None	\$4,500 per calendar year	\$9,000 per calendar year
<i>(Does not include deductibles, copays, benefit penalties, 50% items and Outpatient Prescription Drugs. Includes Outpatient Prescription Drugs when outside the US)</i>			
<b>Lifetime Maximum</b>	Unlimited		
<b>Inpatient Per Confinement Deductible</b> <i>(Maximum of 3 per calendar year)</i>	None	None	\$250
Plan Payment Percentages			
Hospital Services			
<b>Inpatient</b>	100%	80%	60% after deductible and \$250 inpatient per confinement deductible
<b>Outpatient</b>	100%	80%	60% after deductible
<b>Private Room Limit</b>	The institution's semiprivate rate		
<b>Pre-certification Penalty</b>	No Penalty	No Penalty	\$400
<b>Non-Emergency Use of the Emergency Room</b>	100%	80%	60% after deductible
<b>Emergency Room</b>	100%	80%	80% - not subject to deductible
<b>Urgent Care</b>	100%	80%	60% after deductible
Physician Services			
<b>PCP Office Visit</b>	100%	80%	60% after deductible
<b>Specialist Office Visit</b>	100%	80%	60% after deductible

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		Preferred Benefits (In-Network)	Non-Preferred Benefits (Out-of-Network)
<b>Plan Payment Percentages</b>			
<b>Mental Health Services</b>			
<b>Mental Health Inpatient Coverage</b> <i>(Unlimited days per calendar year combined with Alcoholism and Drug Abuse)</i>	100%	80%	60% after deductible and \$250 inpatient per confinement deductible
<b>Mental Health Outpatient Coverage</b> <i>(Unlimited visits per calendar year combined with Alcoholism and Drug Abuse)</i>	100%	80%	60% after deductible
<b>Alcohol/Drug Abuse Services</b>			
<b>Substance Abuse Inpatient Coverage</b> <i>(Unlimited days per calendar year combined with Mental Health)</i>	100%	80%	60% after deductible and \$250 inpatient per confinement deductible
<b>Substance Abuse Outpatient Coverage</b> <i>(Unlimited visits per calendar year combined with Mental Health)</i>	100%	80%	60% after deductible
<b>Other Services</b>			
<b>Skilled Nursing Facility</b> <i>(120 days per calendar year)</i>	100%	80%	60% after deductible and \$250 inpatient per confinement deductible
<b>Hospice Care Facility Inpatient</b> <i>(Unlimited lifetime maximum)</i>	100%	80%	60% after deductible and \$250 inpatient per confinement deductible
<b>Hospice Care Facility Outpatient</b> <i>(Unlimited lifetime maximum)</i>	100%	80%	60% after deductible
<b>Home Health Care</b> <i>(120 visits per calendar year; includes Private Duty Nursing)</i>	100%	80%	60% after deductible
<b>Spinal Disorder Treatment</b> <i>(\$1,000 per calendar year)</i>	100%	80%	75% after deductible
<b>Speech Therapy</b> <i>(Includes 60 visits per calendar year)</i>	100%	80%	60% after deductible
<b>Short Term Rehabilitation</b> <i>(Includes coverage for Occupational and Physical Therapy; unlimited visits per calendar year)</i>	100%	80%	75% after deductible
<b>Diagnostic Outpatient X-ray</b>	100%	80%	60% after deductible
<b>Diagnostic Outpatient Lab</b>	100%	80%	60% after deductible
<b>Inpatient Bariatric Surgery</b>	100%	80%	60% after deductible and \$250 inpatient per confinement deductible
<b>Outpatient Bariatric Surgery</b>	100%	80%	60% after deductible
<b>Durable Medical Equipment</b>	100%	80%	60% after deductible
<b>Base Infertility Services</b> <i>(Base plan coverage includes coverage limited to the testing and treatment of underlying condition)</i>	100%	80%	60% after deductible
<b>Comprehensive Infertility Services</b> <i>(6 cycles per lifetime for Comprehensive plan coverage which includes coverage for Artificial Insemination and Ovulation Induction)</i>	100%	80%	60% after deductible
<b>ART Infertility Services</b> <i>(6 cycles per lifetime for Advanced Reproductive Technology (ART) coverage with cryopreservation, storage and unlimited embryo transfers)</i>	100%	80%	60% after deductible
<b>Autism</b>	<i>Autism covered same as any other expense. Member cost sharing is based on the type of service performed and the place of service where it is rendered.</i>		

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		Preferred Benefits (In-Network)	Non-Preferred Benefits (Out-of-Network)
<b>Payment for Non-Preferred Providers*</b>	Not Applicable	Not Applicable	Professional: 105% of Medicare Facility: 140% of Medicare
<b>Routine Hearing Exam</b> <i>Includes one routine exam per calendar year</i>	100%	100%	60% after deductible
<b>Hearing Aids</b> <i>1 hearing aid per ear to \$3,000 maximum per ear every 3 years</i>	100%	80%	60% after deductible
<b>Wellness Benefits</b>			
<b>Routine Children Physical Exams</b> <i>Children age 0-18: 7 exams first year of life; 3 exams second year of life; 3 exams third year of life and 1 exam per year thereafter (includes immunizations)</i>	100%	100%	60% after deductible
<b>Routine Adult Physical Exams</b> <i>Adults age 18+ &amp; -65: 1 exam/12 months Adults age 65+: 1 exam/12 months (includes immunizations)</i>	100% up to \$1,000 Calendar year maximum (Includes immunizations, x-rays and labs)	100%	60% after deductible
<b>Routine Gynecological Exams</b> <i>Includes 1 exam and pap smear per calendar year</i>	100%	100%	60% after deductible
<b>Mammograms</b> <i>Unlimited exams per calendar year</i>	100%	100%	60% after deductible
<b>Prostate Specific Antigen (PSA)</b> <i>Unlimited tests per calendar year</i>	100%	100%	60% after deductible
<b>Digital Rectal Exam (DRE)</b> <i>Unlimited exams per calendar year</i>	100%	100%	60% after deductible
<b>Cancer Screening</b> <i>Includes 1 flex sigmoid and double barium contrast every 5 years; and at age 45+ 1 colonoscopy every 5 years</i>	100%	100%	60% after deductible
<b>Office Visits at Diabetes America Locations</b>	Not Covered	100% after \$10 copay	Not Covered
<b>Prescription Drug Coverage</b>			
<b>Generic Drugs</b> <i>(365 day maximum supply)</i>	100%	75% (includes Mail Order Drugs; member cost not to exceed \$50 per 30 day supply)	60% after deductible
<b>Brand Name Drugs</b> <i>(365 day maximum supply)</i>	100%	75% (includes Mail Order Drugs; member cost not to exceed \$100 per 30 day supply)	60% after deductible
<b>Non Brand Formulary</b> <i>(365 day maximum supply)</i>	100%	75% (includes Mail Order Drugs; member cost not to exceed \$125 per 30 day supply)	60% after deductible
<b>Vision Expenses</b>			
<b>Routine Eye Exam</b> <i>(Covered under medical) Includes one routine exam per calendar year</i>	100%	100%	60% after deductible
<b>Vision Care Supplies</b> <i>(Schedule maximums apply every 12 months; Includes one pair of frames/lenses or contacts per 12 months)</i>	100% after \$35 deductible	80% after \$35 deductible	60% after \$35 deductible

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Passive PPO Dental			
PLAN FEATURES	OUTSIDE THE U.S.	In the U.S.	
		Preferred Benefits (In-Network)	Non-Preferred Benefits (Out-of-Network)
<b>Individual Deductible</b>	\$50 per calendar year	\$50 per calendar year	\$50 per calendar year
<b>Family Deductible</b>	\$150 per calendar year	\$150 per calendar year	\$150 per calendar year
<b>Type A Expense</b> <i>(Diagnostic &amp; Preventative)</i>	100% - not subject to deductible	100% - not subject to deductible	100% - not subject to deductible
<b>Type B Expense</b> <i>(Basic Restorative)</i>	80% after deductible	80% after deductible	80% after deductible
<b>Type C Expense</b> <i>(Major Restorative)</i>	50% after deductible	50% after deductible	50% after deductible
<b>TMJ Expense</b>	50% after deductible	50% after deductible	50% after deductible
<b>Calendar Year Maximum</b>	\$2,000	\$2,000	\$2,000
<b>Orthodontic Treatment Coverage</b> For Employees & Dependents	50% - not subject to deductible	50% - not subject to deductible	50% - not subject to deductible
<b>Orthodontic Lifetime Maximum</b>	\$2,000	\$2,000	\$2,000
<b>Services and Programs</b>			
<b>Emergency Assistance Services</b> <i>Global emergency evacuation services</i> \$500,000 calendar year maximum	Included	Included	Included
<b>Global Crisis Management Program, powered by WorldAware</b> <i>Includes security, political &amp; natural disaster coverage (Program is underwritten by Aetna Life &amp; Casualty (Bermuda) Ltd.</i>	Included	Included	Included
<b>Employee Assistance Program (EAP)</b> <i>Includes up to 5 counseling sessions per issue per year per enrolled member. Access benefits by calling the member service number on ID card: 800-231-7729 or collect 813-775-0190. Services include: Cultural adjustment assistance, Marital/Family Stress, Child care and behavioral concerns, Social adaptation needs, Alcohol/Substance Abuse, Work/Life Balance and Depression.</i>	Included	Included	Included
<b>24-Hour nurse line</b>	Included	Included	Included
<b>In Touch Care</b>	Included	Included	Included
<b>International Maternity Management Program</b>	Included	Included	Included
<b>Teladoc</b>	Not Included	Included	Included
<b>Health Assessment</b>	Included	Included	Included

*\*This plan includes coverage under the extent required in accordance with the Federal Mental Health Parity and Addiction Equity Act (MHPAEA) beginning with plan years starting on or after January 1, 2018.*

*This plan includes coverage for women's preventive health benefits to the extent required under U.S. federal law effective beginning with plan years starting on or after August 1, 2012.*

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**\* Payment for Non-Preferred Providers**

*We cover the cost of care differently based on whether health care providers, such as doctors and hospitals, are "in network" or "out of network." We want to help you understand how much Aetna pays for your out-of-network care. At the same time, we want to make it clear how much more you will need to pay for this out-of-network care.*

*As an example, you may choose a doctor in our network. You may choose to visit an out-of-network doctor. If you choose a doctor who is out of network, your Aetna health plan may pay some of that doctor's bill. Most of the time, you will pay a lot more money out of your own pocket if you choose to use an out-of-network doctor or hospital.*

*When you choose out-of-network care, Aetna limits the amount it will pay. This limit is called the "recognized" or "allowed" amount. When you choose out-of-network care, Aetna "recognizes" an amount based on what Medicare pays for these services. The government sets the Medicare rate. Exactly how much Aetna "recognizes" depends on the plan you or your employer picks.*

*Your out-of-network doctor sets the rate to charge you. It may be higher -- sometimes much higher -- than what your Aetna plan "recognizes" or "allows." Your doctor may bill you for the dollar amount that Aetna doesn't recognize. You must also pay any copayments, coinsurance and deductibles under your plan. No dollar amount above the recognized charge counts toward your deductible or maximum out-of-pocket. To learn more about how we pay out-of-network benefits visit [Aetna.com](http://Aetna.com). Type "how Aetna pays" in the search box.*

*You can avoid these extra costs by getting your care from Aetna's broad network of health care providers. Go to [www.aetna.com](http://www.aetna.com) and click on "Find a Doctor" on the left side of the page. If you are already a member, sign on to your Aetna Navigator member site.*

*This way of paying out-of-network doctors and hospitals applies when you choose to get care out of network. When you have no choice (for example: emergency room visit after a car accident), we will pay the bill as if you got care in network. You pay your plan's copayments, coinsurance and deductibles for your in-network level of benefits. Contact Aetna if your provider asks you to pay more. You are not responsible for any outstanding balance billed by your providers for emergency services beyond your copayments, coinsurance and deductibles.*

## For Plan Compliant with United States Federal Affordable Care Act (ACA) legislation

Aetna complies with applicable Federal civil rights laws and does not discriminate, exclude or treat people differently based on their race, color, national origin, sex, age, or disability.

Aetna provides free aids/services to people with disabilities and to people who need language assistance.

If you need a qualified interpreter, written information in other formats, translation or other services, call the number on your ID card.

If you believe we have failed to provide these services or otherwise discriminated based on a protected class noted above, you can also file a grievance with the Civil Rights Coordinator by contacting:

Civil Rights Coordinator,

P.O. Box 14462, Lexington, KY 40512 (CA HMO customers: PO Box 24030 Fresno, CA 93779),

1-800-648-7817, TTY: 711,

Fax: 859-425-3379 (CA HMO customers: 860-262-7705), [CRCoordinator@aetna.com](mailto:CRCoordinator@aetna.com).

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, or at 1-800-368-1019, 800-537-7697 (TDD).

*Aetna is the brand name used for products and services provided by one or more of the Aetna group of subsidiary companies, including Aetna Life Insurance Company, Coventry Health Care plans and their affiliates (Aetna).*

TTY: 711

For language assistance in your language call the number listed on your ID card at no cost. (English)

Para obtener asistencia lingüística en español, llame sin cargo al número que figura en su tarjeta de identificación. (Spanish)

欲取得繁體中文語言協助，請撥打您ID卡上所列的號碼，無需付費。(Chinese)

Pour une assistance linguistique en français appeler le numéro indiqué sur votre carte d'identité sans frais. (French)

Para sa tulong sa wika na nasa Tagalog, tawagan ang nakalistang numero sa iyong ID card nang walang bayad. (Tagalog)

Benötigen Sie Hilfe oder Informationen auf Deutsch? Rufen Sie kostenlos die auf Ihrer Versicherungskarte aufgeführte Nummer an. (German)

تغيير عتلا كاتقابطي ف روكذملا ي ناجملا مقرلا لى لعل لاصتلا ءاجرلا ،)تغيير عتلا تغللا (ي ف ءدعاسملا. (Arabic)

Pou jwenn asistans nan lang Kreyòl Ayisyen, rele nimewo a yo endike nan kat idantifikasyon ou gratis. (French Creole)

Per ricevere assistenza linguistica in italiano, può chiamare gratuitamente il numero riportato sulla Sua scheda identificativa. (Italian)

日本語で援助をご希望の方は、IDカードに記載されている番号まで無料でお電話ください。(Japanese)

한국어로 언어 지원을 받고 싶으시면 보험 ID 카드에 수록된 무료 통화번호로 전화해 주십시오. (Korean)

دیر یگ سامتسا هدمآ امش ی یاسانش تراکی ور ربهکی ا هرامشادی انیزه چیه نودب، ی سراف نابز عب ی یامنهار ی ارد (Persian)

Aby uzyskać pomoc w języku polskim, zadzwoń bezpłatnie pod numer podany na karcie ID. (Polish)

Para obter assistência linguística em português ligue para o número grátis listado no seu cartão de identificação. (Portuguese)

Чтобы получить помощь русскоязычного переводчика, позвоните по бесплатному номеру, указанному в вашей ID-карте удостоверения личности. (Russian)

Để được hỗ trợ ngôn ngữ bằng (ngôn ngữ), hãy gọi miễn phí đến số được ghi trên thẻ ID của quý vị. (Vietnamese)