Group Insurance Plan of Benefits for Chevron Phillips Chemical Company LP (Control #499719) Administered by Aetna International® Effective Date: January 1, 2020

Eligibility Provision			
Employee	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.		
Dependent	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)**
Individual Deductible	None	None	$200 per calendar year
Family Deductible	None	None	$400 per calendar year
Individual Payment Limit	$1,500 per calendar year	$1,500 per calendar year	$3,000 per calendar year
(Does not include deductibles, copays, benefit penalties, 50% items and Outpatient Prescription Drugs. Includes Outpatient Prescription Drugs when outside the US)			
Family Payment Limit	$4,500 per calendar year	$4,500 per calendar year	$9,000 per calendar year
(Does not include deductibles, copays, benefit penalties, 50% items and Outpatient Prescription Drugs. Includes Outpatient Prescription Drugs when outside the US)			
Lifetime Maximum	Unlimited		
Inpatient Per Confinement Deductible *(Maximum of 3 per calendar year)*	None	None	$250
Plan Payment Percentages			
Hospital Services			
Inpatient	90%	80%	60% after deductible and $250 inpatient per confinement deductible
Outpatient	90%	80%	60% after deductible
Private Room Limit	The institution's semiprivate rate		
Pre-certification Penalty	No Penalty	No Penalty	$400
Non-Emergency Use of the Emergency Room	90%	80%	60% after deductible
Emergency Room	90%	80%	80% - not subject to deductible
Urgent Care	90%	80%	60% after deductible
Physician Services			
PCP Office Visit	90%	80%	60% after deductible
Specialist Office Visit	90%	80%	60% after deductible

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PLAN FEATURES	OUTSIDE THE U.S.	In the U.S.	
		Preferred Benefits (In-Network)	Non-Preferred Benefits (Out-of-Network)
Plan Payment Percentages			
Mental Health Services			
Mental Health Inpatient Coverage *(Unlimited days per calendar year combined with Alcoholism and Drug Abuse)*	90%	80%	60% after deductible and $250 inpatient per confinement deductible
Mental Health Outpatient Coverage *(Unlimited visits per calendar year combined with Alcoholism and Drug Abuse)*	90%	80%	60% after deductible
Alcohol/Drug Abuse Services			
Substance Abuse Inpatient Coverage *(Unlimited days per calendar year combined with Mental Health)*	90%	80%	60% after deductible and $250 inpatient per confinement deductible
Substance Abuse Outpatient Coverage *(Unlimited visits per calendar year combined with Mental Health)*	90%	80%	60% after deductible
Other Services			
Skilled Nursing Facility *(120 days per calendar year)*	90%	80%	60% after deductible and $250 inpatient per confinement deductible
Hospice Care Facility Inpatient *(Unlimited lifetime maximum)*	90%	80%	60% after deductible and $250 inpatient per confinement deductible
Hospice Care Facility Outpatient *(Unlimited lifetime maximum)*	90%	80%	60% after deductible
Home Health Care *(120 visits per calendar year; includes Private Duty Nursing)*	90%	80%	60% after deductible
Spinal Disorder Treatment *($1,000 per calendar year)*	90%	80%	75% after deductible
Speech Therapy *(Includes 60 visits per calendar year)*	90%	80%	60% after deductible
Short Term Rehabilitation *(Includes coverage for Occupational and Physical Therapy; unlimited visits per calendar year)*	90%	80%	75% after deductible
Diagnostic Outpatient X-ray	90%	80%	60% after deductible
Diagnostic Outpatient Lab	90%	80%	60% after deductible
Inpatient Bariatric Surgery	90%	80%	60% after deductible and $250 inpatient per confinement deductible
Outpatient Bariatric Surgery	90%	80%	60% after deductible
Durable Medical Equipment	90%	80%	60% after deductible
Base Infertility Services *(Base plan coverage includes coverage limited to the testing and treatment of underlying condition)*	90%	80%	60% after deductible
Comprehensive Infertility Services *(6 cycles per lifetime for Comprehensive plan coverage which includes coverage for Artificial Insemination and Ovulation Induction)*	90%	80%	60% after deductible
ART Infertility Services *(6 cycles per lifetime for Advanced Reproductive Technology (ART) coverage with cryopreservation, storage and unlimited embryo transfers)*	90%	80%	60% after deductible
Autism	*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.*		

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PLAN FEATURES	OUTSIDE THE U.S.	In the U.S.	
		Preferred Benefits (In-Network)	Non-Preferred Benefits (Out-of-Network)
Payment for Non-Preferred Providers*	Not Applicable	Not Applicable	Professional: 105% of Medicare Facility: 140% of Medicare
Routine Hearing Exam *Includes one routine exam per calendar year.*	90%	100%	60% after deductible
Hearing Aids *1 hearing aid per ear to $3,000 maximum per ear every 3 years*	90%	80%	60% after deductible
Global Emergency Assistance Program *($500,000 calendar year maximum)*	100%	100%	100% - not subject to deductible
Wellness Benefits			
Routine Children Physical Exams *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)*	90%	100%	60% after deductible
Routine Adult Physical Exams *Adults age 18+ & -65: 1 exam/12 months Adults age 65+: 1 exam/12 months (includes immunizations)*	90% up to $1,000 Calendar year maximum (Includes immunizations, x-rays and labs)	100%	60% after deductible
Routine Gynecological Exams *Includes 1 exam and pap smear per calendar year*	90%	100%	60% after deductible
Mammograms *Unlimited exams per calendar year*	90%	100%	60% after deductible
Prostate Specific Antigen (PSA) *Unlimited tests per calendar year*	90%	100%	60% after deductible
Digital Rectal Exam (DRE) *Unlimited exams per calendar year*	90%	100%	60% after deductible
Cancer Screening *Includes 1 flex sigmoid and double barium contrast every 5 years; and at age 45+ 1 colonoscopy every 5 years*	90%	100%	60% after deductible
Office Visits at Diabetes America Locations	Not Covered	100% after $10 copay	Not Covered
Prescription Drug Coverage			
Generic Drugs *(365 day maximum supply)*	75%	75%(includes Mail Order Drugs; member cost not to exceed $50 per 30 day supply)	60% after deductible
Brand Name Drugs *(365 day maximum supply)*	75%	75% (includes Mail Order Drugs; member cost not to exceed $100 per 30 day supply)	60% after deductible
Non Brand Formulary *(365 day maximum supply)*	75%	75% (includes Mail Order Drugs; member cost not to exceed $125 per 30 day supply)	60% after deductible

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PPO			
PLAN FEATURES	OUTSIDE THE U.S.	In the U.S.	
		Preferred Benefits (In-Network)	Non-Preferred Benefits (Out-of-Network)
Vision Expenses			
Routine Eye Exam	90%	100%	60% after deductible
(Covered under medical) Includes one routine exam per calendar year			
Vision Care Supplies	90% after $35 deductible	80% after $35 deductible	60% after $35 deductible
(Schedule maximums apply every 12 months; Includes one pair of frames/lenses or contacts per 12 months)			

Passive PPO Dental			
PLAN FEATURES	OUTSIDE THE U.S.	In the U.S.	
		Preferred Benefits (In-Network)	Non-Preferred Benefits (Out-of-Network)
Individual Deductible	$50 per calendar year	$50 per calendar year	$50 per calendar year
Family Deductible	$150 per calendar year	$150 per calendar year	$150 per calendar year
Type A Expense *(Diagnostic & Preventative)*	100% - not subject to deductible	100% - not subject to deductible	100% - not subject to deductible
Type B Expense *(Basic Restorative)*	80% after deductible	80% after deductible	80% after deductible
Type C Expense *(Major Restorative)*	50% after deductible	50% after deductible	50% after deductible
TMJ Expense	50% after deductible	50% after deductible	50% after deductible
Calendar Year Maximum	$1,750	$1,750	$1,750
Orthodontic Treatment Coverage For Employees & Dependents	50% - not subject to deductible	50% - not subject to deductible	50% - not subject to deductible
Orthodontic Lifetime Maximum	$1,750	$1,750	$1,750
Services and Programs			
International Employee Assistance Program **International Disease Management** **International Maternity Management Program** **Simple Steps To A Healthier Life®** **red24 - Includes security, political & natural disaster coverage** *(Program is underwritten by Aetna Life & Casualty (Bermuda) Ltd.)*			

**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. 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 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.

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)

للمساعدة في (اللغة العربية)، الرجاء الاتصال على الرقم المجاني المذكور في بطاقتك التعريفية. (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)

(Persian)برای راهنمایی به زبان فارسی، بدون هیچ هزینه ای با شماره ای که بر روی کارت شناسایی شما آمده است تماس بگیرید. انگلیسی

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)