(Performance Pipe Hourly Employees)

Medical Plan and Behavioral Health Plan

CONTENTS

Your Coverage Options

In most locations, Chevron Phillips Chemical Company LP (Chevron Phillips Chemical or the Company) offers a choice of three medical plan options, all administered by Aetna:

- The *Select EPO Plan*,
- The *Choice PPO Plan*, or
- The *Value CDH Plan*.

For more information on eligibility and enrollment, see pages A-1 – A-7 of the ***How to Participate*** chapter.

All three plan options cover medically necessary hospital, medical and surgical services. However, there are important differences among the options that have a direct impact on the amount you pay out of your own pocket for medical care. It's important to understand how each option works so you can choose the option that's right for you.

Expatriate Employees

Health care benefits are provided to Chevron Phillips Chemical's expatriate employees and their dependents through the Aetna International (AI) program. A separate AI packet will be sent to expatriate employees.

Retirees and their spouses who are age 65 and older (or Medicare-eligible) are not eligible for the Chevron Phillips Chemical Medical Plan, but will receive an AARP Healthcare Options Medicare Supplement Plans enrollment packet directly from AARP (see page B-22).

All three options are managed care medical plan options, which means that doctors and hospitals participating in the plan network agree to accept negotiated fees as payment in full. When you see any of these participating network providers for your care, you save money because your share of covered charges is based on these discounted fees, and the medical plan pays a higher percentage of covered charges. Each medical plan option reimburses you for a percentage of covered charges once you meet an annual deductible. Each medical plan option also includes coverage under the Prescription Drug Plan, also administered by Aetna. For more information, see ***Prescription Drug Plan*** beginning on page C-1.

All options are "open access," which means that you don't have to select a primary care physician or obtain a referral from a primary care physician before you can seek treatment.

When you enroll in any of Chevron Phillips Chemical's medical plan options, you will also be enrolled in the Behavioral Health Plan, which provides coverage for inpatient and outpatient mental health and alcoholism/substance abuse treatment. For more information, see ***Behavioral Health Plan*** on page B-15.

All employees, regardless if they are enrolled in a Chevron Phillips Chemical medical plan, are automatically enrolled in the Employee Assistance Program (EAP), which is administered by Aetna. This program provides counseling and support services. For more information, see ***Employee Assistance Program (EAP)*** beginning on page D-1.

How the Options Work

THE SELECT EPO PLAN OPTION

When you enroll in the *Select EPO Plan* option, you must receive all of your medical care from doctors and hospitals that participate in the *Select EPO Plan* network (Aetna Select™ (Open Access)) in order to receive benefits. **Medical services provided by out-of-network doctors and hospitals are not covered except in emergency situations.**

Under the *Select EPO Plan* option, designated preventive care is covered at 100%. For certain other services such as non-preventive primary care office visits, Teladoc phone or online video consultations, specialist office visits and urgent care, you pay a fixed copayment. An annual deductible applies to all other covered services. After you pay the deductible, the plan pays 90% of covered charges and you pay the remaining 10% co-insurance. Once you meet the annual out-of-pocket maximum, the plan pays 100% for the rest of the calendar year.

Select EPO Plan participating network doctors and hospitals handle all claim filing for you. For more information, see ***About Participating Providers*** below.

About Participating Providers

The doctors and hospitals that participate in Aetna's networks agree to:

- Accept Aetna's negotiated fees, along with your copayments and co-insurance, as payment in full. This means that you don't have to worry about "balance billing" — being charged for the difference between plan benefits and doctor's charges — when you use network providers.
- Handle claim filing for you and be reimbursed directly by Aetna. For more information, see ***How to File a Claim*** on page B-22.
- Comply with Aetna's precertification requirements. For more information, see ***Precertification*** on page B-6.

Your doctor's office can tell you if he or she participates in the *Select EPO Plan*, *Choice PPO Plan* or *Value CDH Plan* network. If you have questions about network doctors and hospitals, call Aetna at 1-800-269-5314 or visit www.aetna.com.

About Out-of-Network Providers

Out-of-network providers do not have signed agreements with Aetna. Because the benefit amounts Aetna pays are based on recognized charge determinations, the benefit when you see out-of-network providers may be less than the amount charged by that provider. If this happens, you are responsible for the difference between the Aetna benefit payment and the provider's actual charges. You may also be required to pay out-of-network providers directly and then submit a claim for reimbursement.

THE CHOICE PPO PLAN OPTION

When you enroll in the *Choice PPO Plan* option, you have a choice when it comes to getting medical care. You can go to a *Choice PPO Plan* in-network provider (in the Aetna Choice® POS II (Open Access) network) or to an out-of-network provider each time you need care.

Under the *Choice PPO Plan* option, designated in-network preventive care services are covered at 100%. Other in-network services are covered at 80% after you meet an annual in-network deductible. Out-of-network services are covered at 60% after you meet an annual out-of-network deductible.

There are separate deductibles for in-network and out-of-network services. After you satisfy the appropriate in-network or out-of-network deductible, the plan pays a percentage of covered charges and you pay the remaining co-insurance. The **deductibles accumulate expenses separately** — only in-network expenses apply to the in-network deductible, and only out-of-network expenses apply to the out-of-network deductible.

In-Network

When you receive medical care from an in-network provider, the plan pays a higher percentage of the covered charges. Preventive care services provided by an in-network provider are paid at 100% and non-preventive services are paid at 80% — you pay the remaining 20% co-insurance.

Out-of-Network

When you receive medical care from an out-of-network provider, the plan pays a lower percentage of the covered charges. Most services provided by out-of-network providers are paid at 60%. You pay the remaining 40% co-insurance. Additionally, you may be responsible for any costs that exceed recognized charge determinations (for more information, see ***Recognized Charges*** on page B-4 and ***About Out-of-Network Providers*** on page B-2).

Remember that whether you see an in-network or out-of-network provider, you must satisfy the appropriate deductible before the plan will pay (except for ambulance services and in-network preventive care). Once you meet the annual in-network or out-of-network out-of-pocket maximum, the plan pays 100% of in-network or out-of-network expenses (as applicable) for the rest of the calendar year.

THE VALUE CDH PLAN OPTION

The *Value CDH Plan* option is a high-deductible health plan that complies with government regulations allowing you to open an associated Health Savings Account (HSA). If you enroll in the *Value CDH Plan*, Chevron Phillips Chemical will make an annual contribution to your HSA. In 2018, the Company contribution is $500 for Employee-Only coverage or $1,000 for Employee + Spouse, Employee + Child(ren) or Employee + Family coverage.

If you enroll in the *Value CDH Plan*, you may also enroll in the Limited-Purpose Flexible Spending Account (LPFSA), which you can use for expenses such as dental and vision. You can also use the LPFSA for Health Care FSA-eligible expenses after you have reached your *Value CDH Plan* deductible.

If you have Employee-Only coverage under the *Value CDH Plan*, the Employee-Only deductible applies. If you have Employee + Spouse, Employee + Child(ren) or Employee + Family coverage, the family deductible must be satisfied before the plan will begin to pay. This feature means that even if only one family member has substantial claims, your combined family deductible is still the full amount. Your family deductible is not protected by individual sub-limits as it is under the other two medical plan options.

The out-of-pocket maximum is "family style," which means that if you enroll yourself and any eligible dependents in the plan, no one person will have to contribute more than the individual out-of-pocket maximum to the total family out-of-pocket maximum. Once you meet the annual out-of-pocket maximum, the plan pays 100% for the rest of the calendar year.

When you enroll in the *Value CDH Plan*, you have the option to seek treatment from an in-network provider (in the Aetna Choice® POS II (Open Access) network) or an out-of-network provider. There are separate deductibles and out-of-pocket maximums for in-network and out-of-network services. **The deductibles and out-of-pocket maximums accumulate expenses separately** — only in-network expenses apply to the in-network deductible and in-network out-of-pocket maximum, and only out-of-network expenses apply to the out-of-network deductible and out-of-pocket maximum. See ***Your Medical Plan Options: A Comparison Chart*** on page B-11 for the annual deductibles and out-of-pocket maximums.

In-Network

If you choose an in-network provider for your preventive care, the deductible is waived and the care is covered at 100%. Non-preventive services are subject to the in-network deductible and are paid at 70%. You pay the remaining 30% co-insurance.

Out-of-Network

If you prefer to see an out-of-network provider for your preventive care, the out-of-network deductible must be satisfied and then the plan pays 50% of covered charges and you pay the remaining 50% co-insurance. Non-preventive services are generally covered at 50% and you pay the remaining 50% co-insurance with the exception of the emergency room and ambulance services, which are covered at 70% after deductible.

Important Features

Here are some additional features of the three Chevron Phillips Chemical medical plan options:

PREVENTIVE CARE

Designated preventive care is covered at 100% across all three medical plan options when an in-network provider is used.

For more information, see ***Specific Covered Expenses*** beginning on page B-24.

Finding Medical Plan Providers

Access the DocFind feature at www.aetna.com/docfind.

Enter a name, provider type, condition or procedure and your location.

Under "Plan":

- For the *Select EPO Plan*, choose "**Aetna Select℠ (Open Access)**" from the list under Aetna Open Access® Plans
- For the *Choice PPO Plan* and *Value CDH Plan*, choose "**Aetna Choice® POS II (Open Access)**" from the list under Aetna Open Access® Plans

EMERGENCY CARE

No matter where you are, if you have a medical emergency — that is, a **life-threatening or severe medical condition** — it's recommended that you go to the nearest emergency room to get the care you need. Here are some examples of medical emergencies:

- Suspected heart attack or stroke,
- Complex fractures,
- Poisoning,
- Seizure or loss of consciousness,
- Severe burns,
- Severe shortness of breath,
- Stroke,
- Sudden paralysis or slurred speech,
- Suspected medication overdose, or
- Uncontrollable bleeding.

Emergency care **must** be certified within 48 hours, or as soon as reasonably possible, or your benefits may be reduced. For more information, see ***Specific Covered Expenses*** beginning on page B-24 and ***Precertification*** on page B-6.

RECOGNIZED CHARGES

When you use an out-of-network provider, Aetna bases its benefit payment on the recognized charge. The recognized charge is the amount of an out-of-network provider's charge that is eligible for coverage. You are responsible for all amounts above the recognized charge. The recognized charge may be less than the provider's full charge.

The plan's recognized charge applies to all out-of-network eligible health services except out-of-network emergency services. It applies even to charges from an out-of-network provider in a hospital that is a network provider. It also applies when your PCP or other network provider refers you to an out-of-network provider. In all cases, the recognized charge is determined based on the Geographic area where you receive the service or supply.

Except as otherwise specified below, the recognized charge for each service or supply is the lesser of what the provider bills and:

- For professional services and for other services or supplies not mentioned below: 105% of the Medicare allowable rate.
- For services of hospitals and other facilities: 140% of the Medicare allowable rate.
- For prescription drugs: 110% of the Average wholesale price (AWP).

For emergency services, the recognized charge is the negotiated charge for providers with whom Aetna has a direct contract but are not network providers.

Aetna has the right to apply Aetna's reimbursement policies. Those policies may further reduce the recognized charge. These policies take into account factors such as:

- The duration and complexity of a service,
- When multiple procedures are billed at the same time, whether additional overhead is required,
- Whether an assistant surgeon is necessary for the service,
- If follow-up care is included,
- Whether other characteristics modify or make a particular service unique,
- When a charge includes more than one claim line, whether any services described by a claim line are part of or incidental to the primary service provided, and
- The educational level, licensure or length of training of the provider.

Aetna's reimbursement policies are based on Aetna's review of:

- The Centers for Medicare and Medicaid Services' (CMS) National Correct Coding Initiative (NCCI) and other external materials that say what billing and coding practices are and are not appropriate,
- Generally accepted standards of medical and dental practice, and
- The views of physicians and dentists practicing in the relevant clinical areas.

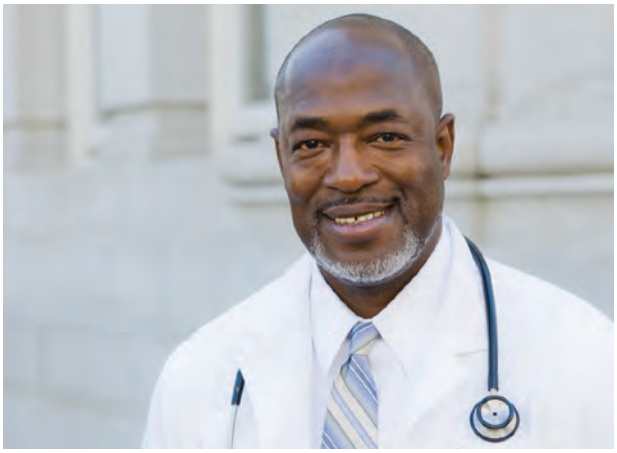
Aetna uses commercial software to administer some of these policies. Some policies are different for professional services than for facility services.

Average wholesale price (AWP), Geographic area and Medicare allowable rates are defined as follows:

- **Average wholesale price (AWP):** The current average wholesale price of a prescription drug listed in the Medi-span weekly price updates (or any other similar publication chosen by Aetna).
- **Geographic area:** The Geographic area made up of the first three digits of the U.S. Postal Service ZIP codes. If Aetna determines that Aetna needs more data for a particular service or supply, Aetna may base rates on a wider Geographic area such as an entire state.
- **Medicare allowable rates:** Except as specified below, these are the rates CMS establishes for services and supplies provided to Medicare enrollees. Aetna updates its systems with these revised rates within 180 days of receiving them from CMS. If Medicare does not have a rate, Aetna will determine the rate as follows:
  - Use the same method CMS uses to set Medicare rates.
  - Look at what other providers charge.
  - Look at how much work it takes to perform a service.
  - Look at other things as needed to decide what rate is reasonable for a particular service or supply.

If the recognized charge is less than your doctor's charge, **you are responsible for paying the difference** — in addition to the required deductibles, copayments and co-insurance.

If network providers are used, recognized charge limits do not apply because network providers accept Aetna's negotiated fees for each covered service as payment in full.



PRECERTIFICATION

Certain medical services, procedures and treatments must be approved in advance by Aetna. For a list of them, see ***Services Requiring Precertification*** on this page.

How to Obtain Precertification

Precertification can be arranged by calling the phone number on your medical ID card during normal business hours.

You do not need to precertify services provided by an in-network provider. **If you're enrolled in one of the three medical plan options** and use an in-network doctor, he or she handles precertification for you.

If you're enrolled in the *Choice PPO Plan* option or *Value CDH Plan* option and use an out-of-network provider, you, a family member, your doctor or the facility must precertify benefits. If you fail to obtain a required precertification prior to incurring certain medical expenses, Aetna may reduce the amount paid towards your coverage, or your expenses may not be covered. You will be responsible for the unpaid balance of the bills.

- **In emergency situations,** certification must be requested within 48 hours, or as soon as reasonably possible.
- **In a non-emergency situation,** precertification must be requested at least 14 days in advance.

For any inpatient procedures not certified or precertified, the amount paid toward your covered services will be reduced by $250.

Aetna will provide a written notification to you and your physician of the precertification decision. If precertification determines that the stay or services and supplies are not covered expenses, the notification will explain why and how Aetna's decision can be appealed.

It is important to remember that any additional out-of-pocket expenses incurred because your precertification requirement was not met will not count toward your deductible or payment percentage or out-of-pocket maximum.

Services Requiring Precertification

Hospital Admissions

Before you're admitted for an inpatient hospital stay, Aetna must review and approve the admission. Admission certifications specify the number of approved inpatient days. If additional days are required, the hospital or your doctor must request them no later than the last day of the originally approved hospital stay. Aetna will send written notice regarding the number of approved hospital days to you, as well as to the hospital and your physician.

Other Admissions and Outpatient Care

Precertification is required for the following types of medical expenses:

- Stays in Convalescent facilities,
- Stays in Rehabilitation facilities,
- Stays in Hospice facilities,
- Outpatient hospice care,
- Stays in residential treatment facilities for the treatment of mental disorders, alcoholism or substance abuse,
- Home health care,
- Private duty nursing care, and
- High-tech radiology services.

MEDSOLUTIONS

MedSolutions is a radiology management company that works with Aetna to help achieve appropriate and effective diagnostic imaging procedures for patients. MedSolutions uses a specialized team of physicians and nurses with high-tech radiology expertise to help your physician make diagnostic imaging decisions to meet your needs. As a participant, there is no action on your part.

High-tech radiology services, such as MRI, CT and PET scans require precertification. When your doctor requests precertification for a particular high-tech radiology procedure or imaging study, the request will be sent to MedSolutions for review and approval. They then use their clinical expertise in conjunction with national radiology standards to review all details of the request.

What the Options Pay

Although each medical plan option pays the majority of covered charges, you share in the cost of covered services through deductibles, copayments and any applicable co-insurance. These cost-sharing features vary from option to option, and they can have a big impact on your out-of-pocket expenses.

For the *Select EPO Plan* and *Choice PPO Plan*, prescription drug expenses do **not** count toward the medical deductible.

THE DEDUCTIBLE

The deductible is the amount you pay each calendar year for covered medical services before the medical plan begins to pay benefits. Calendar year deductibles apply to the out-of-pocket maximums under all three medical plan options. Any service that is covered at 100% (such as designated preventive care) is not subject to the deductible.

Depending on the medical plan option you select, your deductible is based on the number of people you cover and whether you use in- or out-of-network providers. For the *Select EPO Plan* and the *Choice PPO Plan*, no one individual is required to contribute more than the Employee-Only deductible amount to the family deductible. For the *Value CDH Plan*, your family deductible must be met by one family member or a combination of family members before co-insurance applies if you have Employee + Spouse, Employee + Child(ren) or Employee + Family coverage.

Deductibles

For the *Select EPO Plan* and *Choice PPO Plan* deductibles, if you sign up for Employee + Spouse, Employee + Child(ren) or Employee + Family coverage, no one individual is required to contribute more than the individual deductible amount to the total deductible. This feature may reduce the family's overall deductible if you sign up for Employee + Spouse or Employee + Child(ren) coverage and only one family member has substantial claims, or if you sign up for Employee + Family coverage and only one or two family members have substantial claims.

For the *Value CDH Plan*, the deductible is $3,000/year (in-network) or $4,500/year (out-of-network) whether you sign up for Employee + Spouse, Employee + Child(ren) or Employee + Family coverage. There are no individual sub-limits on the deductible for each covered person. Therefore, even if only one person makes claims during the year, you will pay 100% of that person's non-preventive medical costs until the deductible is met.

Your Calendar-Year Deductible

	Select EPO Plan	Choice PPO Plan		Value CDH Plan	
	In-Network Only	In-Network[1]	Out-of-Network[1]	In-Network[1]	Out-of-Network[1]
Employee-Only	$ 400	$ 600	$ 900	$1,500	$2,250
Employee + Spouse	$ 800	$1,200	$1,800	$3,000	$4,500
Employee + Child(ren), 1 child	$ 800	$1,200	$1,800	$3,000	$4,500
Employee + Child(ren), 2+ children	$1,200	$1,800	$2,700	$3,000	$4,500
Employee + Family	$1,200	$1,800	$2,700	$3,000	$4,500

[1] *For the **Choice PPO Plan** and the **Value CDH Plan**, only in-network expenses apply to the in-network deductible, and only out-of-network expenses apply to the out-of-network deductible.*

CO-INSURANCE/COPAYMENTS

When you incur a covered medical expense, you and the plan share the cost, called co-insurance. After you meet the applicable deductible, the plan pays a percentage of eligible medical charges and you are required to pay the remaining percentage. To see how co-insurance is applied to various covered services, see ***Your Medical Plan Options: A Comparison Chart*** on page B-11.

Some covered services require you to pay a fixed charge, called a copayment, either instead of, or in addition to, co-insurance. As shown in the following table, your co-insurance/copayment amount depends on the medical plan option you select and whether you use in-network providers.

Use of Out-of-Network Providers

Some out-of-network providers may not require you to pay a deductible or co-insurance/copayment. Because you are required under the plan terms to first meet your deductible or payment obligations ***before*** the plan is required to pay a designated portion of the medical charges, please be aware that if a provider agrees to waive your payment obligations, **the plan is no longer required to pay a designated portion of the medical charges under the plan's terms and administrative practices**.

Your Co-insurance/Copayment

	Select EPO Plan	Choice PPO Plan		Value CDH Plan	
	In-Network Only[1]	In-Network[1]	Out-of-Network[2]	In-Network[1]	Out-of-Network[2]
Primary care office visits (surgical & non-surgical)	Preventive: 0% — deductible waived Non-preventive: $35 copayment	Preventive: 0% — deductible waived Non-preventive: 20% after annual deductible	Preventive: 40% after annual deductible Non-preventive: 40% after annual deductible	Preventive: 0% — deductible waived Non-preventive: 30% after annual deductible	Preventive: 50% after annual deductible Non-preventive: 50% after annual deductible
Specialist office visits (surgical & non-surgical)	$50 copayment	20% after annual deductible	40% after annual deductible	30% after annual deductible	50% after annual deductible
Teladoc phone or online video consultation	$20 copayment	20% after annual deductible	N/A	30% after annual deductible	N/A
Other physician services	10% after annual deductible	20% after annual deductible	40% after annual deductible	30% after annual deductible	50% after annual deductible
Inpatient hospital services (includes maternity care)	10% after annual deductible and $250 copayment per admission[3]	20% after annual deductible and $250 copayment per admission[3]	40% after annual deductible and $250 copayment per admission[3]	30% after annual deductible	50% after annual deductible
Hospital emergency room	$150 copayment (waived if admitted), then 10%[4]	20% after annual deductible	20% after annual deductible	30% after annual deductible	30% after annual deductible

[1] ***For all three medical plan options,*** *benefit payments to in-network providers are based on the Aetna-negotiated fee for each covered service.*

[2] ***If you're enrolled in the*** **Choice PPO Plan** ***option or*** **Value CDH Plan** ***option and use out-of-network providers,*** *benefit payments are based on recognized charges. You are responsible for the amount that exceeds the recognized charges in addition to your deductible and any applicable co-insurance. For more information, see* ***Recognized Charges*** *on page B-4.*

[3] *For the* ***Select EPO Plan*** *and* ***Choice PPO Plan****, the deductible is waived for healthy newborns discharged with their mother. Also, the admission copayment/deductible is waived for newborns that enter a hospice or a skilled nursing facility, or for healthy newborns that leave with their mother.*

[4] *In a medical emergency, out-of-network hospital emergency room services will be covered at the in-network level.*

OUT-OF-POCKET MAXIMUMS

Out-of-pocket maximums protect you from catastrophic medical costs by limiting the amount you must pay out of your pocket each calendar year. When this limit is reached, your plan will pay 100% of the family's covered expenses for the rest of the calendar year. These maximums are reset at the beginning of every calendar year. Depending on the medical plan option you select, your out-of-pocket maximum is based on the number of people you cover and whether you use in- or out-of-network providers. Under all three medical plan options, no one individual is required to contribute more than the Employee-Only out-of-pocket maximum amount to the family out-of-pocket maximum.

Out-of-Pocket Maximums

Under all three medical plan options, if you sign up for Employee + Spouse, Employee + Child(ren) or Employee + Family coverage, no one individual is required to contribute more than the individual out-of-pocket maximum to the total family out-of-pocket maximum. This feature may reduce the family's overall out-of-pocket expenses if you sign up for Employee + Spouse or Employee + Child(ren) coverage and only one family member has substantial claims, or if you sign up for Employee + Family coverage and only one or two family members have substantial claims.

Your Annual Out-of-Pocket Maximums

	Select EPO Plan	Choice PPO Plan		Value CDH Plan	
	In-Network Only	In-Network[1]	Out-of-Network[1]	In-Network[1]	Out-of-Network[1]
Employee-Only	$2,000	$ 3,000	$ 4,000	$ 4,500	$ 6,750
Employee + Spouse	$4,000	$ 6,000	$ 8,000	$ 9,000	$13,500
Employee + Child(ren), 1 child	$4,000	$ 6,000	$ 8,000	$ 9,000	$13,500
Employee + Child(ren), 2+ children	$6,000	$ 9,000	$12,000	$ 9,000	$13,500
Employee + Family	$6,000	$ 9,000	$12,000	$ 9,000	$13,500

[1] *For the **Choice PPO Plan** and the **Value CDH Plan**, only in-network expenses apply to the in-network out-of-pocket maximum, and only out-of-network expenses apply to the out-of-network out-of-pocket maximum.*

For all plans, all out-of-pocket expenses for covered medical and prescription drug services, including deductibles, co-insurance and copays, count toward your out-of-pocket maximum.

The following expenses do **not** apply toward the satisfaction of your out-of-pocket maximum, regardless of the medical plan option you choose:

- Charges that exceed the recognized charges as determined by Aetna,
- Non-covered services,
- Expenses for non-emergency use of an emergency room,
- Expenses incurred for non-urgent use of an urgent care provider,
- Expenses paid because of failure to precertify a service,
- Expenses above the discounted cost of prescriptions when filled at a non-network pharmacy,
- Expenses for the difference in cost between a non-preferred brand-name drug and a generic drug when you choose to fill a prescription with the brand-name drug,
- Surcharges for use of a retail pharmacy for 30-day supplies of maintenance drugs after a second 30-day fill, and
- Charges that exceed plan limits for short-term rehabilitation therapy, spinal manipulation, autism treatment (speech and physical therapy), convalescent facility care, home health care and private duty nursing.

Most people do not incur enough medical expenses to reach the out-of-pocket maximum in any given year — it's your financial protection in a worst-case situation. If you're enrolled in the *Choice PPO Plan* option or *Value CDH Plan* option, you can protect yourself even further by using in-network doctors and hospitals.

If you are enrolled in the *Select EPO Plan* option or *Choice PPO Plan* option, you may want to consider contributing to the Health Care Flexible Spending Account (HCFSA) so you can cover your out-of-pocket medical costs with pre-tax dollars. See ***Using the Health Care FSA (HCFSA) or Limited-Purpose FSA (LPFSA)*** on pages H-3 – H-7.

If you are enrolled in the *Value CDH Plan* option, you cannot participate in the HCFSA. However, you can contribute to a Health Savings Account (HSA) to help pay for out-of-pocket medical costs with pre-tax dollars. Additionally, you may participate in the Limited-Purpose FSA (LPFSA) to cover vision and dental expenses before you have met your *Value CDH Plan* deductible, and Health Care FSA-eligible expenses after you have met your deductible. See ***The Value CDH Plan Option*** on page B-3, the ***Health Savings Account (HSA)*** chapter on pages I-1 – I-8 and ***Using the Health Care FSA (HCFSA) or Limited-Purpose FSA (LPFSA)*** on pages H-3 – H-7.

BENEFIT MAXIMUMS

Benefits for specific services or treatments are limited as follows:

Spinal manipulation	20 visits per calendar year
Home health care	Up to 100 visits per calendar year
Convalescent facility treatment	100 days per calendar year
Outpatient short-term rehabilitation	60 visits per calendar year for treatment of acute conditions only (maintenance care is not covered)
Autism treatment — speech and physical therapy	60 visits per calendar year for speech therapy and 60 visits per calendar year for physical therapy
Private duty nursing	70 shifts per calendar year

LIFETIME MAXIMUM BENEFIT

All three medical plan options have unlimited lifetime benefit maximums for covered services.

Your Medical Plan Options: A Comparison Chart

This chart compares treatments and services under the medical plan options:

	Select EPO Plan	Choice PPO Plan[1]		Value CDH Plan[1]	
	In-Network Only[2]	In-Network[2]	Out-of-Network[2]	In-Network[2]	Out-of-Network[2]
Aetna network	Aetna Select™ (Open Access) network	Aetna Choice® POS II (Open Access) network		Aetna Choice® POS II (Open Access) network	
Deductible					
• EE Only	$ 400	$ 600	$ 900	$ 1,500	$ 2,250
• EE + Spouse	$ 800	$ 1,200	$ 1,800	$ 3,000[3]	$ 4,500[3]
• EE + 1 Child	$ 800	$ 1,200	$ 1,800	$ 3,000[3]	$ 4,500[3]
• EE + 2+ Children	$ 1,200	$ 1,800	$ 2,700	$ 3,000[3]	$ 4,500[3]
• EE + Family	$ 1,200	$ 1,800	$ 2,700	$ 3,000[3]	$ 4,500[3]
Out-of-pocket maximum					
• EE Only	$ 2,000	$ 3,000	$ 4,000	$ 4,500	$ 6,750
• EE + Spouse	$ 4,000	$ 6,000	$ 8,000	$ 9,000	$13,500
• EE + 1 Child	$ 4,000	$ 6,000	$ 8,000	$ 9,000	$13,500
• EE + 2+ Children	$ 6,000	$ 9,000	$12,000	$ 9,000	$13,500
• EE + Family	$ 6,000	$ 9,000	$12,000	$ 9,000	$13,500
Lifetime maximum benefit	Unlimited	Unlimited		Unlimited	
For the following treatments and services, the medical plan options pay:					
Preventive Care[4]					
Routine physicals (includes labs)	100% — deductible waived	100% — deductible waived	60%	100% — deductible waived	50%
Annual well-woman exam (includes labs)	100% — deductible waived	100% — deductible waived	60%	100% — deductible waived	50%
Mammograms (routine for women ages 39 and over)	100% — deductible waived	100% — deductible waived	60%	100% — deductible waived	50%
Well-child care (includes labs)	100% — deductible waived	100% — deductible waived	60%	100% — deductible waived	50%
Physician Office Visits					
Primary care office visits (surgical & non-surgical)	Preventive: 100% — deductible waived Non-preventive: 100% after $35 copay[5]	Preventive: 100% — deductible waived Non-preventive: 80%	Preventive: 60% Non-preventive: 60%	Preventive: 100% — deductible waived Non-preventive: 70%	Preventive: 50% Non-preventive: 50%
Specialist office visits (surgical & non-surgical)	100% after $50 copay[5]	80%	60%	70%	50%
Teladoc phone or online video consultation	100% after $20 copay — deductible waived	80%	N/A	70%	N/A
Lab & X-ray	Preventive: 100% — deductible waived Non-preventive: 90%[5]	Preventive: 100% — deductible waived Non-preventive: 80%	Preventive: 60% Non-preventive: 60%	Preventive: 100% — deductible waived Non-preventive: 70%	Preventive: 50% Non-preventive: 50%
Maternity care	Prenatal office visits: 100% — deductible waived[6]. All other visits/services covered at 90%[5]	Prenatal office visits: 100% — deductible waived[6]. All other visits/services covered at 80%	60%	Prenatal office visits: 100% — deductible waived[6]. All other visits/services covered at 70%	50%

Please see the footnotes on page B-14.

(continued)

	Select EPO Plan	Choice PPO Plan[1]		Value CDH Plan[1]	
	In-Network Only[2]	In-Network[2]	Out-of-Network[2]	In-Network[2]	Out-of-Network[2]
Emergency Services					
Hospital emergency room	90% after $150 copay (waived if admitted)[7]	80%	80%	70%	70%
Urgent care	100% after $75 copay — deductible waived	80%	60%	70%	50%
Non-emergency use of the emergency room	Not covered	Not covered	Not covered	Not covered	Not covered
Ambulance	100% — deductible waived[7]	80% — deductible waived	80% — deductible waived	70%	70%
Outpatient Services					
Outpatient surgery	90%	80%	60%	70%	50%
Physician/surgeon and related professional fees (non-office visits)	90%	80%	60%	70%	50%
Hospital Services					
Per confinement copay	$250	$250	$250	Not applicable	Not applicable
Inpatient (includes maternity care)	90%	80%	60%	70%	50%
Outpatient	90%	80%	60%	70%	50%
Other Covered Services					
Spinal manipulation (limits apply)[8]	100% after $50 copay	80%	60%	70%	50%
Sterilization (tubal ligation/vasectomy)	Physician services covered at 100% after $100 copay; other services, such as hospital and lab, covered at 90%	Tubal ligation, including ancillary services: 100% — deductible waived; vasectomy covered at 80%	60%	Tubal ligation, including ancillary services: 100% — deductible waived; vasectomy covered at 70%	50%
Short-term rehabilitation (limits apply)[9]	100% after $50 copay if received in doctor's office or special rehabilitation facility; otherwise, covered at 90%	80%	60%	70%	50%
Autism treatment (inpatient/outpatient services, medication management and diagnostic services; speech therapy up to 60 visits/year)	100% after $50 copay	80%	60%	70%	50%
Hearing aids (maximum benefit of $3,000 every 36 months)	90%	80%	60%	70%	50%
Routine eye exam[4]	100% — deductible waived	100% — deductible waived	60%	100% — deductible waived	50%

Please see the footnotes on page B-14.

(continued)

	Select EPO Plan	Choice PPO Plan[1]		Value CDH Plan[1]	
	In-Network Only[2]	In-Network[2]	Out-of-Network[2]	In-Network[2]	Out-of-Network[2]
Routine hearing exam[4]	100% — deductible waived	100% — deductible waived	60%	100% — deductible waived	50%
Fitness Program	Included	Included	Not covered	Included	Not covered
Vision Discounts Program	Included	Included	Not covered	Included	Not covered
Beginning Right Maternity Management Program	Included	Included	Included	Included	Included
Prescription Drug Coverage					
For covered prescription drugs, you pay:					
Deductible	N/A			N/A — Prescription costs other than the generic $10/$20 preventive drug copays are subject to the *Value CDH Plan* medical deductible	
Retail (30-day supply)	*Generic Preventive Drugs:* $10 copay from a designated list of drugs and conditions *Other Drugs:* – Generic: 15%, $10 min. and $50 max. – Preferred Brand: 20%, $25 min. and $100 max. – Non-Preferred Brand: 30%, $50 min. and $200 max.			*Generic Preventive Drugs:* $10 copay from a designated list of drugs and conditions (deductible waived) *Other Preventive Drugs:* – Preferred Brand: 20%, $25 min. and $100 max. – Non-Preferred Brand: 30%, $50 min. and $200 max. *Other Non-Preventive Drugs (deductible applies):* 30%	
Specialty Drugs (30-day supply)	– Generic: 15%, $10 min. and $50 max. – Preferred Brand: 20%, $25 min. and $100 max. – Non-Preferred Brand: 30%, $50 min. and $200 max.			30% (deductible applies)	
Mail-Order and CVS Retail (90-day supply)	*Generic Preventive Drugs:* $20 copay from a designated list of drugs and conditions *Other Drugs:* – Generic: $ 25 – Preferred Brand: $ 68 – Non-Preferred Brand: $125			*Generic Preventive Drugs:* $20 copay from a designated list of drugs and conditions (deductible waived) *Other Preventive Drugs:* – Preferred Brand: $68 – Non-Preferred Brand: $125 *Other Non-Preventive Drugs (deductible applies):* 30%	

Please see the footnotes on page B-14.

[1] *For the **Choice PPO Plan** and the **Value CDH Plan**, in-network expenses don't apply to the out-of-network deductible or out-of-pocket maximum, and out-of-network expenses don't apply to the in-network deductible or out-of-pocket maximum.*

[2] *Unless otherwise noted, benefits paid at 90%, 80%, 70%, 60% or 50% co-insurance are paid only after the deductible has been met.*

[3] *For the **Value CDH Plan** only, the deductible is the same whether you and your family sign up for Employee + Spouse, Employee + Child(ren), or Employee + Family coverage, and there are no individual sub-limits for each covered person. The full deductible can be met by one family member or a combination of family members.*

[4] *For limits, see the Preventive Care Guide on www.mycpchembenefits.com.*

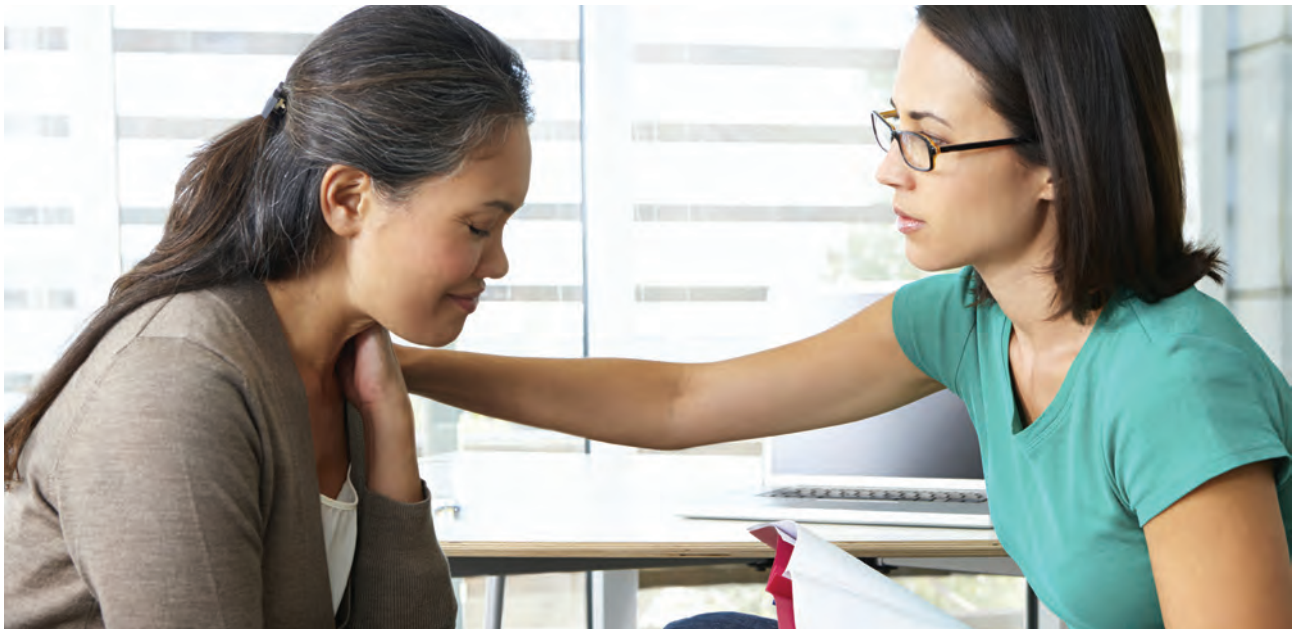
[5] *For the **Select EPO Plan** only, lab and X-ray charges for services performed at a doctor's office and billed as part of the visit are covered by the office visit copay. When these services are not performed at the time of the office visit, are performed at another facility or are performed by an entity other than the doctor's office, you and/or your family must first meet your deductible, and then the expense will be covered at 90%. The deductible is waived for preventive services regardless of where services are performed.*

[6] *100% coverage for prenatal office visits does not include inpatient admissions, high risk specialist visits, ultrasounds, amniocentesis, fetal stress tests, certain diagnostic lab tests or delivery including anesthesia.*

[7] *In a medical emergency, out-of-network hospital emergency room and ambulance will be covered at the in-network level.*

[8] *Spinal manipulation includes non-surgical spinal manipulation provided by chiropractor, physical therapist or other applicable licensed provider — up to 20 visits/year. The limit applies to the total of both in-network and out-of-network visits.*

[9] *The combined maximum for physical, occupational and speech therapy is 60 visits/year. The limit applies to the total of both in-network and out-of-network visits.*



Behavioral Health Plan

The Behavioral Health Plan is administered by Aetna. It includes coverage for treatment obtained from behavioral health providers for mental disorders, alcoholism and substance abuse.

TREATMENT OF MENTAL DISORDERS

In addition to meeting all other conditions for coverage, the treatment of mental disorders must meet the following criteria:

- There is a written treatment plan prescribed and supervised by a behavioral health provider,
- The plan includes follow-up treatment, and
- The plan is for a condition that can favorably be changed.

Benefits are payable for charges incurred in a hospital, psychiatric hospital, residential treatment facility or behavioral health provider's office for the treatment of mental disorders.

Inpatient Treatment for Mental Disorders

Covered expenses include charges for room and board at the semi-private room rate, and other services and supplies provided during your stay in a hospital, psychiatric hospital or residential treatment facility. Inpatient benefits are payable only if your condition requires services that are only available in an inpatient setting.

Partial Confinement Treatment for Mental Disorders

Covered expenses include charges for partial confinement in a facility or program for the intermediate short-term or medically-directed intensive treatment of a mental disorder. Benefits are payable if your condition requires services that are only available in a partial confinement treatment setting.

Outpatient Treatment for Mental Disorders

Covered expenses include charges for treatment received while not confined as a full-time inpatient in a hospital, psychiatric hospital, residential treatment facility or behavioral health provider's office.

The plan covers partial hospitalization services (more than four hours, but less than 24 hours per day) provided in a facility or program for the intermediate short-term or medically-directed intensive treatment of a mental disorder. The partial hospitalization will only be covered if you would need inpatient care if you were not admitted to this type of facility.

Important Reminder:

Inpatient care must be precertified by Aetna. For more information, see ***Precertification*** on page B-6.

ALCOHOLISM AND SUBSTANCE ABUSE

In addition to meeting all other conditions for coverage, the treatment of alcoholism and substance abuse must meet the following criteria:

- There is a program of therapy prescribed and supervised by a behavioral health provider, and
- The program of therapy includes either:
  - a follow-up program directed by a behavioral health provider on at least a monthly basis, or
  - meetings at least twice a month with an organization devoted to the treatment of alcoholism or substance abuse.

The ***Aetna Behavioral Health Plan Covered Services Chart*** on page B-17 shows the benefits payable for the treatment of alcoholism and substance abuse.

Inpatient Treatment for Alcoholism and Substance Abuse

The plan covers room and board at the semi-private room rate and other services and supplies provided during your stay in a psychiatric hospital or residential treatment facility appropriately licensed by the State Department of Health or its equivalent. Coverage includes:

- Treatment in a hospital for medical complications of alcoholism or substance abuse. "Medical complications" include:
  - detoxification,
  - electrolyte imbalances,
  - malnutrition,
  - cirrhosis of the liver,
  - delirium tremens, and
  - hepatitis, and
- Treatment in a hospital if the hospital does not have a separate treatment facility.

Partial Confinement Treatment for Alcoholism and Substance Abuse

Covered expenses include charges for partial confinement in a facility or program for the intermediate short-term or medically-directed intensive treatment of alcoholism or substance abuse. Benefits are payable only if you would need a hospital stay if you were not admitted to this type of facility.

Outpatient Treatment for Alcoholism and Substance Abuse

Covered expenses include charges for outpatient treatment received for alcoholism and substance abuse.

The plan covers partial hospitalization services (more than four hours, but less than 24 hours per day) provided in a facility or program for the intermediate short-term or medically-directed intensive treatment of alcoholism and/or substance abuse. The partial hospitalization will only be covered if you would need inpatient care if you were not admitted to this type of facility.

AETNA BEHAVIORAL HEALTH PLAN COVERED SERVICES CHART

Covered Expense	Select EPO Plan	Choice PPO Plan		Value CDH Plan	
	In-Network Only *(Deductibles and Co-insurance Limits combined with Medical)*	**In-Network** *(Deductibles and Co-insurance Limits combined with Medical)*	**Out-of-Network** *(Deductibles and Co-insurance Limits combined with Medical)*	**In-Network** *(Deductibles and Co-insurance Limits combined with Medical)*	**Out-of-Network** *(Deductibles and Co-insurance Limits combined with Medical)*
Mental Health Services					
Inpatient Mental Disorders Co-insurance	90% after deductible	80% after deductible	60% after deductible	70% after deductible	50% after deductible
Inpatient Mental Disorders Per Confinement Copay	$250	$250	$250	Not applicable	Not applicable
Maximum Inpatient Days Per Year	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited
Outpatient Mental Disorders Co-insurance	90% after deductible	80% after deductible	60% after deductible	70% after deductible	50% after deductible
Outpatient Mental Disorders Copay (per visit)	100% after $35 Specialist copay	80% after deductible	60% after deductible	70% after deductible	50% after deductible
Maximum Outpatient Visits Per Year	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited
Partial Hospitalization	Paid same as outpatient	Paid same as outpatient	Paid same as outpatient	Paid same as outpatient	Paid same as outpatient
Residential Treatment Facility — aligns with Inpatient Hospitalization benefit	90% after deductible	80% after deductible	60% after deductible	70% after deductible	50% after deductible
Mental Disorders Lifetime Maximum	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited
Alcoholism/Substance Abuse					
Inpatient Rehabilitation & Detoxification	90% after deductible	80% after deductible	60% after deductible	70% after deductible	50% after deductible
Inpatient Alcoholism/ Substance Abuse Per Confinement Copay	$250	$250	$250	Not applicable	Not applicable
Maximum Inpatient Days Per Year	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited
Outpatient Alcoholism/ Substance Abuse Co-insurance	90% after deductible	80% after deductible	60% after deductible	70% after deductible	50% after deductible
Outpatient Alcoholism/ Substance Abuse Copay/Deductible	100% after $35 Specialist copay	80% after deductible	60% after deductible	70% after deductible	50% after deductible
Maximum Outpatient Visits Per Year	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited
Residential Treatment Facility — aligns with Inpatient Hospitalization benefit	90% after deductible	80% after deductible	60% after deductible	70% after deductible	50% after deductible
Alcoholism/Substance Abuse Lifetime Maximum	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited

Important Reminder:

Inpatient care must be precertified by Aetna. For more information, see ***Precertification*** on page B-6.

Additional Programs

TELADOC TELEMEDICINE

When you enroll in any of the medical plan options, you can take advantage of a low-cost telemedicine feature available through Teladoc. Teladoc gives you 24/7 access to a doctor via phone or online video consultations. Teladoc does not replace your primary care physician, but it is a great alternative when you need immediate care for a non-emergency issue (for example, cold and flu symptoms, allergies, bronchitis, respiratory infection, urinary tract infection, etc.) or when you are away from home. A Teladoc doctor can even write you a prescription for minor ailments.

You will pay a lower copayment or co-insurance than a non-preventive physician office visit. For example, the typical cost for a Teladoc consultation is $40 before insurance, compared to a primary care physician office visit of approximately $100.

You can reach Teladoc at 1-855-TELADOC (1-855-835-2362) or online at www.teladoc.com/Aetna.

AETNA VISION℠ DISCOUNT PROGRAM

As a plan participant, you are eligible to receive discounts on eyeglasses, contact lenses and nonprescription items such as sunglasses and contact lens solutions through the Aetna Vision℠ Discount program at thousands of locations nationwide. Just log on to Aetna Navigator™ at www.aetna.com and click on "Coverage & Benefits," then "Discounts," then "Vision Discounts" or call 1-800-793-8616 to find more information and the location nearest you. Once you select a provider, simply tell the provider you're enrolled in Aetna when making an appointment and show your medical ID card when you receive services.

You are also eligible to receive a 15% discount off the provider's usual retail charge (5% off special advertised prices) for Lasik surgery (the laser vision corrective procedure) offered by Aetna Vision℠ Discount through the U.S. Laser Network. Patient education, an initial screening, the Lasik procedure and follow-up care are included. To find the closest surgeons, call 1-800-422-6600 and speak to a Lasik customer service representative, or visit the Aetna website at www.aetna.com.

Note: You can get additional coverage for corrective eye exams, lenses, frames and contacts through the Vision PLUS Vision Plan. See the ***Vision PLUS Plan*** chapter beginning on page G-1.

INFORMED HEALTH® LINE

Employees and their family members enrolled in any of the medical plan options have around-the-clock access to reliable health information through Aetna's Informed Health® Line. This program, which is available at no cost to you, includes:

- **The Informed Health® Line** — You can call 1-800-556-1555 toll-free anytime, day or night, to talk to a registered nurse, who can provide information about a variety of health and wellness topics. For more information, visit www.aetna.com and click on "24-Hour Nurse Line" under the Health Programs tab.
- **The Healthwise® Knowledgebase** — You can log on to Aetna Navigator™ at Aetna's website, www.aetna.com, and click on "Health Topics A-Z" under the Care Treatment tab to browse an advanced health information database.

BEGINNING RIGHT MATERNITY PROGRAM

The Beginning Right Maternity Program provides you with maternity health care information, and guides you through pregnancy. This program provides:

- Assistance in accessing prenatal care,
- Case management by registered nurses, who will assist in arranging covered services, coordinate covered specialty care, review the program's features and answer general pregnancy-related questions,
- A personalized stop-smoking program designed specifically for pregnant women,
- Focused, educational information, "For Dad or Partner," and
- A comprehensive pregnancy handbook.

Under the program, all care during your pregnancy is coordinated by your participating obstetrical care provider and Beginning Right Maternity Program case managers, so there is no need to return to your PCP for referrals. However, your obstetrician will need to request a referral (precertification) from Aetna for any tests performed outside of the office. To ensure that you are covered, please make sure your obstetrician has obtained this referral before the tests are performed.

Another important feature, Pregnancy Risk Assessment, identifies women who may need more specialized prenatal and/or postnatal care due to medical history or present health status. If risk is identified, the program assists you and your physician in coordinating any specialty care that may be medically necessary.

ALTERNATIVE CARE PROGRAMS

Natural Alternatives

This program offers you special rates on alternative therapies, including visits to acupuncturists, chiropractors, massage therapists and nutritional counselors. Natural Alternatives is not available in all states.

Vitamin Advantage™

This program offers you savings on certain vitamins and nutritional supplements purchased by mail, telephone, fax or Internet.

Natural Products

This program offers you savings on many health-related products, including aromatherapy, foot care and natural body care products purchased by mail, telephone, fax or Internet.

To take advantage of any of the Alternative Care programs, call the Member Services number on your ID card, or visit the Aetna website at www.aetna.com and select "Health Programs" under the Benefits tab for a list of participating providers, vendors and the latest additions to the product list.

MYTOTALCARE PROGRAM

Employees and their dependents with certain chronic conditions can participate in the MyTotalCare Program, a multi-condition disease management program, which is a supplement to the medical plan and is coordinated through ActiveHealth. Eligible conditions include:

- Coronary artery disease,
- Congestive heart failure,
- Hypertension (high blood pressure),
- Hyperlipidemia (high cholesterol),
- Diabetes,
- Asthma,
- Chronic pulmonary disease (COPD),
- Neck/back pain,
- Acid reflux (GERD), and
- Osteoarthritis.

If you have one of these conditions, disease management can help you understand your condition and work with your doctor(s) to better manage your care. Participation in this program is voluntary and all information provided to ActiveHealth will be kept strictly confidential. You may opt out of the program at any time.

How Disease Management Works

Participants in the disease management program have access to one-on-one support, advice and assistance from an experienced registered nurse who is the single point of contact. While your doctor focuses on your treatment, your disease management nurse coordinates interventions, supports the doctor with a plan of care and emphasizes prevention of complications. The program interactively engages all parties — the physician, the program nurse and the patient — in the care process.

The disease management program includes an incentive feature for prescription drugs that treat chronic conditions and offers certain medications at reduced costs to those who participate in the program.

The program also offers self-paced online digital health and wellness tools through ActiveHealth's interactive website. These online tools are available to all plan participants even if they don't have a chronic condition.

If you have any of the conditions that are eligible for disease management, a registered nurse from ActiveHealth may contact you by phone. To learn more about disease management or to self-identify for the program, visit www.MyActiveHealth.com/cpchem or call ActiveHealth at 1-877-489-9398.

HEALTH INFORMATION WEBSITE

ActiveHealth's secure, online website gathers all the health information that's important to you in one convenient place at www.MyActiveHealth.com/cpchem. This site is your personal gateway to a variety of health programs and services. You can log on 24 hours a day, 7 days a week. There's even a homepage that you can design around your preferences.

At MyActiveHealth.com, you can:

- Create e-mail reminders of doctor's appointments and record them on a calendar,
- Use any computer to access your secure Personal Health Record and share health information,

- See the most important things you can do for your health — and take action on them,
- Listen to a podcast, watch a video or print out information on health topics of interest to you,
- Get the latest news on health issues,
- Find out about additional resources and programs available under your health plan, and
- Check for potential drug interactions among the prescriptions you are taking.

PERSONAL HEALTH RECORD

Your Personal Health Record is available through MyActiveHealth.com when you need it, at any time and any location. This tool is available for you and your eligible dependents.

This record combines your important health information into a safe, secure home. Each time you have a claim against your insurance (doctor's visit, prescription fill, etc.), it will automatically show up in your Personal Health Record. You can even add other important information such as over-the-counter medications you are taking and allergic drug reactions.

The Personal Health Record helps you share information about your health with your health care providers during scheduled appointments or in an emergency. You can print out a Health Summary to give your doctor a clear picture of your health history, or an emergency card to carry that lists your doctors, emergency phone numbers and other important health information such as drug allergies.

The information in your Personal Health Record is secure — ActiveHealth and Aetna are committed to protecting the privacy of personal health information. Each record is kept confidential, private and secure, in compliance with federal and state laws. Access to the Personal Health Record requires a secure username and password, so you control who sees the information. Chevron Phillips Chemical **does not** have access to the information in your record, and it cannot be used in any way to limit the ability to get or use medical insurance.

CARE CONSIDERATIONS

CareEngine® is a program that uses the data resources of ActiveHealth and Aetna to give physicians information they can use to improve clinical quality and safety for you and your family. The program looks at your medical claims, pharmacy claims, lab results and patient demographics and analyzes that data to give your physician a broader view of your clinical profile. The data is compared against thousands of evidence-based care guidelines that have been adopted within the medical community as the standard of care.

The comparison identifies potential gaps — either omissions in care (for example, certain accepted treatments that are absent) or hazards from care (for example, drug-to-drug or drug-to-disease interactions). These gaps, called Care Considerations, are identified for your physician to improve your care. A Care Consideration, communicated by phone, fax or letter, depending on urgency, typically recommends a procedure that hasn't been conducted, the stopping of a treatment or the addition of a treatment. This is a valuable free program that can help you avoid potentially serious and costly medical problems, providing you with better overall care.

FITNESS PROGRAM

Aetna offers discounts to plan participants for fitness services provided by GlobalFit™. Depending on your location, you may be eligible for one of two GlobalFit programs:

- Under GlobalFit A Plan, you can join the GlobalFit network and receive discounts on your health club membership rate, or
- Under GlobalFit B Plan, you can join participating clubs directly, receiving the club's lowest corporate rate for the type of membership selected.

Both programs offer:

- Low or discounted membership rates at independent health clubs contracted with GlobalFit,
- Free guest passes to allow you to sample facilities before selecting a club* to join,
- Guest privileges at other participating GlobalFit health clubs*, and
- Discounts on certain home exercise equipment.

** Not available at all clubs.*

If you are a current club member, participation under this program may not be available.

To determine which program is offered in your area and to view a list of included clubs, log on to Aetna Navigator™ at www.aetna.com and click on "Coverage & Benefits," then "Discounts," then "Fitness Discounts." If you would like to speak with a GlobalFit representative, you can call the GlobalFit Health Club Help Line at 1-800-298-7800.

What's Covered

MEDICALLY NECESSARY EXPENSES

The plan pays benefits for services and supplies that are "medically necessary" (as determined by Aetna) for the diagnosis, care or treatment of an illness or injury. Aetna could find certain services or treatments to be unnecessary, even if they are recommended, prescribed or approved by your physician.

To be considered medically necessary, services and supplies must be provided for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms. A medically necessary service is:

- In accordance with generally accepted standards of medical or dental practice,*
- Clinically appropriate in terms of type, frequency, extent, site and duration; and is considered effective for the patient's illness, injury or disease,
- Not primarily for the convenience of the patient, physician or other health care provider, and
- One that does not cost more than an alternative service which would produce the same results.

** For this purpose, "generally accepted standards of medical or dental practice" means standards that are based on credible scientific evidence published in peer-reviewed literature generally recognized by the relevant medical or dental community, or otherwise consistent with physician or dental specialty society recommendations and the view of physicians and dentists practicing in relevant clinical areas and any other relevant factors.*

EXPERIMENTAL OR INVESTIGATIONAL SERVICES

Experimental, investigative or research-oriented services are covered if a disease is expected to cause death within one year and a panel of independent medical professionals selected by Aetna agrees that the care or treatment is effective, or shows promise of being effective, for that disease as demonstrated by scientific data.

A drug, device, procedure or treatment is considered a covered experimental or investigational expense if all of the following conditions are met:

- You have been diagnosed with cancer or a condition likely to cause death within one year or less,
- Standard therapies have not been effective or are inappropriate,
- Aetna determines, based on at least two documents of medical and scientific evidence, that you would likely benefit from the treatment, and
- There is an ongoing clinical trial. You are enrolled in a clinical trial that meets these criteria:
  - the drug, device, treatment or procedure to be investigated has been granted investigational new drug (IND) or Group c/treatment IND status,
  - the clinical trial has passed independent scientific scrutiny and has been approved by an Institutional Review Board that will oversee the investigation,
  - the clinical trial is sponsored by the National Cancer Institute (NCI) or similar national organization (such as the Food & Drug Administration or the Department of Defense) and conforms to the NCI standards,
  - the clinical trial is not a single institution or investigator study unless the clinical trial is performed at an NCI-designated cancer center, and
  - you are treated in accordance with protocol.

SPECIFIC COVERED EXPENSES

For a list of specific covered expenses, see ***Appendix A*** beginning on page B-24.

What's Not Covered

The plan does not cover all medical expenses. There are some exclusions and limitations. For a list of specific non-covered expenses, see ***Appendix B*** beginning on page B-36.

How to File a Claim

IF YOU'RE ENROLLED IN THE SELECT EPO PLAN OPTION

Select EPO Plan network providers handle claim filing for you. All you need to do is show your medical ID card each time you obtain a medical service. The provider's office collects your copayment (if one is required), any applicable deductible or co-insurance, and submits the claim for you. It's a good idea to check with your doctor from time to time to ensure that he or she continues to participate in the *Select EPO Plan* network.

If you need immediate medical attention as the result of an emergency, or if you are traveling outside the network area, you may be required to pay for services and then file a claim to obtain reimbursement. If this happens, you should call Aetna at 1-800-269-5314.

All claims should be reported promptly. The deadline for filing a claim is 90 days after the date of the service.

If, through no fault of your own, you are not able to meet the deadline for filing a claim, your claim will still be accepted if you file as soon as possible. Unless you are legally incapacitated, late claims for health care benefits will not be covered if they are filed more than two years after the deadline.

IF YOU'RE ENROLLED IN THE CHOICE PPO PLAN OPTION OR VALUE CDH PLAN OPTION

Choice PPO Plan and *Value CDH Plan* in-network providers handle claim filing for you. All you need to do is show your medical ID card each time you obtain a medical service. The provider's office collects your deductible or co-insurance amount and submits the claim for you. It's a good idea to check with your doctor from time to time to ensure that he or she continues to participate in the *Choice PPO Plan* or *Value CDH Plan* network.

The plan prohibits assignment of benefit claims or any other types of claims or ERISA rights to an out-of-network provider including, but not limited to, any claims for benefits under the plan, any claim under ERISA or any other applicable law, regardless of the nature of such claims.

In order to obtain reimbursement for out-of-network services, you may need to submit a claim. However, in most cases, your doctor's office or other provider's office will handle claim submission for you. Aetna may choose to pay the provider directly. However, such payment shall in no way be interpreted as a waiver of the plan's prohibition on assignment of benefits. If Aetna does not pay the out-of-network service provider directly, payment will be made to you.

Some medical providers will not handle claim filing for you. When this happens, you are required to pay for services directly and then file a claim. Claim forms are available by calling Aetna at 1-800-269-5314, and on the Internet at www.aetna.com or www.mycpchembenefits.com (under "Forms").

All claims should be reported promptly. The deadline for filing a claim is 90 days after the date of the service.

If, through no fault of your own, you are not able to meet the deadline for filing a claim, your claim will still be accepted if you file as soon as possible. Unless you are legally incapacitated, late claims for health care benefits will not be covered if they are filed more than two years after the deadline.

AARP Medicare Supplement Plans

For retirees and their spouses who are age 65 or older, or Medicare-eligible, Chevron Phillips Chemical offers the AARP Healthcare Options Medicare Supplement Plans. Eligible participants will receive information directly from AARP approximately 90 days before their 65th birthday. Highlights of the Medicare supplement options available to you are described on the next page.

ACCESS

- Retirees and/or their spouses have total freedom to choose their own Medicare-approved doctors and hospitals.
- The plan is 100% portable. Retirees who move or travel are assured of coverage wherever they live or relocate to in the U.S.
- As a Chevron Phillips Chemical retiree, no Statement of Health is required — coverage is guaranteed.

PREMIUM/RATES

- Medicare Supplement Plans' rate increases have averaged less than 5%/year nationally since 2000.
- As a Chevron Phillips Chemical retiree, you will receive the lowest rates available in your state through AARP.

CLAIMS PAYMENTS

92.5% of Part B claims for Medicare Supplement Insurance are sent electronically by the Medicare carriers — which means a quick turnaround.

For more information about the Medicare Supplement Plan options, call AARP Health Care Options Customer Service at 1-800-392-7537, Monday through Friday from 7:00 a.m. to 11:00 p.m., or Saturday from 9:00 a.m. to 5:00 p.m. Eastern Standard Time. Just be sure to identify yourself as a retiree of Chevron Phillips Chemical (Group #845).

Coordination of Benefits

Many people have medical coverage from more than one source. When this happens, benefits payable from Chevron Phillips Chemical's medical plan are coordinated with coverage you may have under another group medical plan. For more information, see ***How Health Care Coordination of Benefits Works*** on page A-20.

Situations That Affect Your Benefits or Coverage

Your medical benefits or coverage may be affected in the following situations:

- No benefits are payable for treatment you or a dependent receives before coverage begins or after coverage ends.
- If you decline coverage under Chevron Phillips Chemical's medical plan, no medical benefits are payable.
- A new dependent must be enrolled within 31 days following the date of marriage, birth, legal adoption, permanent legal guardianship or permanent sole managing conservatorship. No medical benefits are payable on behalf of a dependent who is not properly enrolled under a Chevron Phillips Chemical medical plan.
- If you delay your enrollment when you are first eligible, eligibility status will be delayed or denied.
- If you use out-of-network providers, you may need to file a claim before benefits can be paid.
- If all or part of your claim is denied, you are entitled to a complete and fair review. For more information on claims appeal procedures, see the ***Claims*** section beginning on page P-2.
- If you recover money for covered expenses from a third party (as the result of a lawsuit, automobile accident, etc.), Chevron Phillips Chemical's medical plan is entitled to recover any money it paid to cover those expenses. This is called subrogation. You are required to assist the plan in recovering this money. For more information, see ***Subrogation*** on page P-12.
- The medical plan has the right to recover amounts that are paid to you by mistake. For example, if a claim payment exceeds the amount allowed by the plan, the plan has the right to recover the excess amount from the person or facility that received it.
- As a participant in Chevron Phillips Chemical's medical plan, you have certain rights under the Employee Retirement Income Security Act of 1974 (ERISA). For information about your rights under ERISA and other important information, see ***Your ERISA Rights*** on page P-14.

Appendix A

SPECIFIC COVERED EXPENSES

The following list describes specific covered expenses. Remember, the way benefits are paid for these services is dictated by the option you select and whether you use in-network providers.

- Abortion — physician and facility charges are covered **in connection with non-elective and medically necessary procedures**.
- Acupuncture — acupuncture services are covered when treatment is provided by a licensed medical doctor or osteopathic physician and used as an anesthetic agent for a covered surgical procedure.
- Allergy Testing and Treatment — these services must be precertified if you use an out-of-network provider under the *Choice PPO Plan* or *Value CDH Plan*.
  - Covered testing services include:
    - scratch, prick and puncture testing,
    - intradermal testing,
    - skin endpoint titration testing,
    - skin patch testing,
    - oral challenge testing, or
    - bronchial challenge testing.

    These and other allergy testing and surveys are covered based on the type of suspected allergy and the patient's medical history and current symptoms.
  - Allergy immunotherapy services are covered for the treatment of the following:
    - allergic asthma,
    - hymenoptera (sensitivity to bees, wasps or ants),
    - mold-induced allergic rhinitis,
    - perennial rhinitis, or
    - seasonal allergic rhinitis or conjunctivitis.
  - Therapy services are covered when the following conditions are met:
    - the patient has symptoms of allergic rhinitis and/or asthma after natural exposure to the allergen, or has a life-threatening allergy to bee, wasp or ant stings,
    - the patient has skin test or other evidence of an antibody to an extract of the allergen, or
    - avoidance of the allergen or drug therapy cannot control allergic symptoms.
  - Rapid desensitization treatment is also covered for the following conditions:
    - hypersensitivity to bee, wasp or ant stings, and
    - moderate to severe rhinitis during the season of the affecting allergy.
- Ambulance — services must be provided by a licensed ambulance company. Ambulance services provided by a fire department, a rescue squad or other carrier — as long as the patient is legally obligated to pay — are covered.

  Ground Ambulance

  Covered expenses include charges for transportation:
  - to the first hospital where treatment is given in a medical emergency,
  - from one hospital to another hospital in a medical emergency when the first hospital does not have the required services or facilities to treat your condition,
  - from hospital to home or to another facility when other means of transportation would be considered unsafe due to your medical condition,
  - from home to hospital for covered inpatient or outpatient treatment when other means of transportation would be considered unsafe due to your medical condition (limited to 100 miles), or
  - when during a covered inpatient stay at a hospital, skilled nursing facility or acute rehabilitation hospital, an ambulance is required to safely and adequately transport you to or from an inpatient or outpatient treatment.

  Air or Water Ambulance

  Covered expenses include charges for transportation to a hospital by air or water ambulance when all of these conditions are met:
  - ground ambulance transportation is not available,
  - your condition is unstable and requires medical supervision and rapid transport, and
  - in a medical emergency, transportation from one hospital to another hospital when the first hospital does not have the required services or facilities to treat your condition and you need to be transported to another hospital.
- Anesthesia — when necessary in connection with a covered procedure or medical service. The administration of drugs or gases by a physician other than the operating surgeon or assistant is covered. Anesthesia administered by a certified or registered nurse anesthetist under the supervision of an anesthesiologist is also covered.

Specific Covered Expenses *(continued)*

- Autism Treatment — for autism spectrum disorders such as autism, Asperger's syndrome and Rett syndrome. Coverage includes diagnostic services, speech therapy (limited to 60 visits per calendar year), physical therapy (limited to 60 visits per calendar year), medication management and inpatient and outpatient treatment services.
- Birthing Centers — costs of childbirth in a licensed birthing center are covered in lieu of hospital benefits.
- Blood Services — blood derivatives, whole blood, blood plasma and supplies used in administering blood are covered when needed during an inpatient hospital admission or outpatient hospital visit. Self-donated blood stored in preparation for a covered procedure is covered if charges are billed by a hospital.
- Cardiac and Pulmonary Rehabilitation Benefits:
  - Cardiac rehabilitation is covered as part of an inpatient hospital stay. Outpatient cardiac rehabilitation is covered (in accordance with a treatment plan when recommended by a physician) when following angioplasty, cardiovascular surgery, congestive heart failure or myocardial infarction, to a maximum of 36 sessions in a 12-week period.
  - Pulmonary rehabilitation is covered as part of an inpatient hospital stay. Outpatient pulmonary rehabilitation is covered for the treatment of reversible pulmonary disease, to a maximum of 36 hours or a six-week period.
- Certified Nurse Midwife Services — pre- and post-natal care and delivery services are covered.
- Chemotherapy — treatment provided in a hospital, the outpatient department of a hospital or a physician's office is covered. Covered charges include the administration and cost of drugs. Inpatient hospitalization for chemotherapy is limited to the initial dose while hospitalized for the diagnosis of cancer and when a hospital stay is otherwise medically necessary based on your health status.
- Consultations — includes inpatient, outpatient and office visits when requested by the attending physician. Physician consultation charges in connection with eligible procedures are covered. Consultations rendered by anyone other than a physician are **not** covered.
- Convalescent Facility Care (also called Skilled Nursing Facility) — must be precertified. Benefits are paid only for approved days, to a maximum of 100 days per calendar year. The following services and supplies are covered provided that recovery is expected and care is not custodial:
  - semi-private room and board charges, including charges for nursing services,
  - use of special treatment rooms,
  - X-ray and lab work,
  - physical, speech or occupational therapy,
  - oxygen and other gas therapy, and
  - medical supplies.

  Convalescent facility charges are **not** covered in connection with any of the following conditions:
  - drug addiction,
  - chronic brain syndrome,
  - alcoholism,
  - senility,
  - mental retardation, or
  - any other mental disorder.
- Cosmetic Surgery — covered expenses include charges by a physician, hospital or surgery center for cosmetic or reconstructive services and supplies, including:
  - surgery needed to improve a significant functional impairment of a body part,
  - surgery to correct the result of an accidental injury, including subsequent related or staged surgery, as long as the surgery occurs within 24 months of the original injury. For a covered child, the time period for coverage may be extended through age 18,
  - surgery to correct an injury that occurred during a covered surgery provided that the reconstructive surgery occurs within 24 months of the original injury. ***(Note: Injuries that occur as a result of a medical (i.e., non-surgical) treatment are not considered accidental injuries, even if unplanned or unexpected)***,
  - surgery to correct a gross anatomical defect present at birth or appearing after birth (but not the result of an illness or injury) when:
    - the defect results in severe facial disfigurement, or
    - the defect results in significant functional impairment and the surgery is needed to improve function, and

Specific Covered Expenses *(continued)*

- morbid obesity surgery. Covered expenses include charges made by a physician, licensed or certified dietician, nutritionist or hospital for the non-surgical treatment of obesity for the following outpatient weight management services:
  - an initial medical history and physical exam, and
  - diagnostic tests given or ordered during the first exam.

  Gastric bypass surgery is covered. Lap band procedures are covered only if the patient is not a candidate for gastric bypass for medical reasons.

  Only one morbid obesity surgery is covered every two-year period, beginning with the date of the first surgery, unless a multi-stage procedure is planned. Under the *Select EPO Plan* option, morbid obesity surgery is only covered when provided by an in-network provider. Under the *Choice PPO Plan* option or *Value CDH Plan* option, morbid obesity surgery is covered when provided by either an in-network or an out-of-network provider.

Medically necessary treatment of varicose veins is covered.

Breast enlargement or reduction surgery is **not** covered unless it is medically necessary or is performed in connection with a mastectomy.

Ultraviolet therapy, dermabrasion, wrinkle removal, face lifts, tucks and fatty tissue removal are **not** covered.

- Dental Services — most dental services are covered under the dental plan; however, the following services are covered under the medical plan:
  - dental treatment and/or appliances required for treatment of an accidental injury caused by an outside force only to sound and natural teeth,
  - surgery needed to:
    - treat a fracture, dislocation or wound,
    - cut out cysts, tumors or other diseased tissues which are not dental in origin, or
    - alter the jaw, jaw joints or bite relationships by a cutting procedure when appliance therapy alone cannot result in functional improvement,
  - non-surgical treatment of infections or diseases, when infections or diseases do **not include** those of, or related to, the teeth, and
  - dental work, surgery and orthodontic treatment needed to remove, repair, replace, restore or reposition:
    - natural teeth damaged, lost or removed due to injury, provided such teeth were free from decay and firmly attached to the jaw bone at the time of injury, or
    - other body tissues of the mouth fractured or cut due to injury.

  Treatment to repair or replace natural teeth damaged in an accident must be done in the calendar year of the accident or the following calendar year. Repair or replacement of a crown, denture, bridgework or in-mouth appliance installed to correct an accidental injury is **not** covered. If crowns, dentures, bridgework or in-mouth appliances are installed to correct an injury, covered medical expenses include only charges for:
  - the first denture or fixed bridgework to replace lost teeth,
  - the first crown needed to repair each damaged tooth, and
  - an in-mouth appliance used in the first course of orthodontic treatment after the injury.

  Dental surgical admissions for the removal of impacted teeth or multiple extractions are covered only if a hazardous medical condition exists. The inpatient admission must be considered necessary to safeguard the patient's life during the dental surgery.
- Diagnostic Procedures — MRIs and CAT scans in connection with specific diagnoses must be precertified. When required for the diagnosis of an illness or injury and prescribed by a physician, covered services include facility and provider charges in connection with ultrasound, X-rays, EKGs, EMGs, EEGs, thyroid function tests and nerve conduction studies. Services may be performed in the outpatient department of a hospital or a physician's office. Laboratory and pathology services required in the diagnosis of an illness or injury and billed by a physician are also covered. Services provided during an inpatient hospital stay are also covered.
- Drugs — medicines prescribed and given during a hospital admission are covered. Prescription drugs taken on an outpatient basis are covered under the Prescription Drug Plan. For more information, see ***Prescription Drug Plan*** beginning on page C-1.
- Durable Medical Equipment — rental or purchase (whichever is less expensive) and repair of medical equipment appropriate for home use and prescribed by a physician are covered. Coverage is limited to one item of equipment for the same or similar purpose and the accessories needed to operate the item. Covered equipment must be suited for use in the home and medically necessary for the treatment of an illness or injury or used to improve functioning. The following are **not** covered:

Specific Covered Expenses *(continued)*

- equipment used primarily for comfort or convenience, including overbed tables, communication aids, vision aids, telephone alert systems and elevators,
- environmental control equipment, including air conditioners, air filters or purifiers, humidifiers, dehumidifiers, vaporizers, water filters or purifiers and similar equipment,
- blood pressure kits, diet scales and other monitoring devices,
- exercise equipment, whirlpool baths, portable whirlpool pumps, sauna baths and massage devices,
- dentures,
- rental charges in excess of the purchase price of the same equipment, and
- maintenance and repairs of purchased equipment needed due to misuse or abuse.

- Emergency Care — the *Select EPO Plan* option pays 90% of emergency room charges after the applicable copayment. The copayment is waived if you are admitted to the hospital as an inpatient as the result of an accidental injury or medical emergency. The *Choice PPO Plan* option pays 80% of emergency room charges. The *Value CDH Plan* pays 70% of emergency room charges.

  Charges made by a hospital for emergency room treatment of a recent and severe medical condition are covered. Aetna defines an emergency condition as severe pain or other symptoms that would lead a layperson to believe that his or her condition could result in death or a serious impairment of bodily function, a body part or an organ. Physician charges in connection with the treatment of an emergency condition are also covered.

  Hospital and physician charges in connection with a non-emergency condition are **not** covered. If your medical problem does not meet Aetna's definition of an emergency condition, none of the medical plan options will cover any emergency room charges. In other words, you will be required to pay 100% of the charges for emergency room services, including physician's charges.

- Family Planning Services and Treatment of Infertility, including:
  - Tubal ligation — $100 copayment required under the *Select EPO Plan* option. In-network tubal ligation, including ancillary services, are covered at 100% (deductible waived) under the *Choice PPO Plan* and the *Value CDH Plan*.
  - Vasectomy — $100 copayment required under the *Select EPO Plan* option.
  - Basic Infertility Expenses — covered expenses include charges made to diagnose and to surgically treat the underlying medical cause of infertility. Under the *Select EPO Plan* option, basic infertility is covered only when provided by an in-network provider.
  - Comprehensive Infertility Expenses — only employees and covered spouses are eligible for benefits if all of the following tests are met:
    - the infertility has been recognized by a gynecologist, or an in-network infertility specialist, and your physician who diagnosed you as infertile, and it has been documented in your medical records,
    - the procedures are done while not confined in a hospital or any other facility as an inpatient,
    - your FSH levels are less than 19 miU on day three of the menstrual cycle,
    - the infertility is not caused by voluntary sterilization of either one of the partners (with or without surgical reversal) or a hysterectomy, and
    - a successful pregnancy cannot be attained through less costly treatment for which coverage is available under the plan.

    If you meet the eligibility requirements above, the following comprehensive infertility service expenses are payable when provided by an in-network infertility specialist:
    - artificial insemination (AI), to a maximum of six cycles per lifetime (covered only when provided by an in-network provider), and
    - ovulation induction services (if done in conjunction with intercourse or AI) including consultation, bloodwork, ultrasound and monitoring, when conducted with the use of menotropins (note that the cost of menotropins and other injectable fertility medications is excluded from coverage under Appendix B and is not payable under the plan). Ovulation induction services are covered to a maximum of six cycles per lifetime and are payable as any other covered expense (covered only when provided by an in-network provider).

Important Note

Treatment of infertility must be precertified by Aetna. Treatment received without precertification or treatment from an out-of-network provider will not be covered. You will be responsible for full payment of the services.

Specific Covered Expenses *(continued)*

- Gender reassignment — any treatment, drug, service or supply related to changing gender or gender characteristics, including:
  - surgical procedures to alter the appearance or function of the body,
  - hormones and hormone therapy,
  - prosthetic devices, and
  - medical or psychological counseling.
- Hearing Care — covered hearing care expenses include:
  - charges for electronic hearing aids (monaural and binaural), installed in accordance with a prescription written during a covered hearing exam when medically necessary, for injury or non-injury related hearing loss. The maximum benefit is $3,000 every three years (with no age limit). Expenses incurred for hearing aids within 30 days of termination of coverage will be covered if during the 30 days before the date coverage ends:
    - The prescription for the hearing aid was written, and
    - The hearing aid was ordered.
  - routine hearing exam, covered once per calendar year. Services must be performed by an otolaryngologist or otologist. Services provided by an audiologist are also covered if the audiologist is legally qualified in audiology or holds a certificate of Clinical Competence in Audiology from the American Speech and Hearing Association, and performs the exam at the written direction of a legally qualified otolaryngologist or otologist.
- Hemodialysis — individuals diagnosed with end-stage renal disease (ESRD) must apply for Medicare benefits, regardless of age, because coverage for dialysis services is coordinated with Medicare. The following are covered at in-network facilities only:
  - services to treat acute kidney failure and ESRD in the outpatient department of a hospital or a licensed facility, and
  - treatment in the home if the home is occupied by the patient or a member of the patient's family. Home hemodialysis must be arranged by a physician. Covered charges include the cost of equipment, installation, training and necessary hemodialysis supplies.
- Home Health Care — visits are limited to 100 each calendar year. Home health care services must be prescribed by a physician and precertified by Aetna.

  Covered expenses include charges by a home health care agency when the care is given under a home health care plan and is given to you in your home while you are homebound. Includes charges for:
  - part-time or intermittent care by an R.N. or by an L.P.N. if an R.N. is not available,
  - part-time or intermittent home health aide services provided in conjunction with and in direct support of care by an R.N. or an L.P.N.,
  - physical, occupational and speech therapy,
  - part-time or intermittent medical social services by a social worker when provided in conjunction with, and in direct support of care by, an R.N. or an L.P.N., and
  - medical supplies, prescription drugs and lab services by or for a home health care agency to the extent they would have been covered if you had continued your hospital stay.

  Each visit by a nurse or therapist counts against the calendar year maximum as one visit. Each visit of up to four hours is one visit.

  This maximum will not apply to care given by an R.N. or L.P.N. when:
  - care is provided within 10 days of discharge from a hospital or skilled nursing facility as a full-time inpatient, and
  - care is needed to transition from the hospital or skilled nursing facility to home care.

  When the above criteria are met, covered expenses include up to 12 hours of continuous care by an R.N. or L.P.N. per day.

  If the covered person is a minor or an adult who is dependent upon others for non-skilled care (e.g., bathing, eating, toileting), coverage for home health services will only be provided during times when there is a family member or caregiver present in the home to meet the person's non-skilled needs.
- Hospice Services — your attending physician must refer you for hospice care, and services must be precertified by Aetna.
  - Inpatient care — charges made by a hospice facility, a hospital or a convalescent center for semi-private room and board and other services furnished to a person while a full-time inpatient for pain control and acute symptom management.
  - Outpatient care — nursing services for up to eight hours per day, psychological and dietary counseling, medical social services, medical supplies, home health aide services for up to eight hours a day, physical and occupational therapy services and consultation or case management services by a physician.

Specific Covered Expenses *(continued)*

- The following services are **not** covered:
  - funeral arrangements,
  - pastoral counseling,
  - financial and legal counseling,
  - homemaker and caretaker services, and
  - daily room and board charges over the semi-private room rate.

- Hospital — all inpatient hospital admissions must be precertified by Aetna; no benefits are paid for non-approved days. You pay a $250 copayment/deductible per hospital admission.
  - The following are covered when needed during an inpatient hospital admission and billed by a hospital:
    - a semi-private room,
    - use of special units such as intensive care, burn and cardiac care,
    - special treatment rooms, including operating, delivery and recovery rooms,
    - meals and special diets,
    - general nursing care,
    - anesthesia when billed as a hospital service,
    - blood services — blood derivatives, whole blood, blood plasma and supplies used in administering blood services,
    - diagnostic tests — EKGs, EMGs, EEGs, thyroid function tests and nerve conduction studies required to diagnose an illness or injury,
    - CAT and MRI scans,
    - laboratory and pathology tests — procedures required to diagnose a condition or injury, when billed as a hospital service,
    - drugs prescribed and administered during a hospital admission,
    - durable medical equipment, such as oxygen tents, wheelchairs and other equipment used during a hospital stay,
    - medical and surgical supplies,
    - prosthetic and orthotic appliances — items that are implanted surgically, such as heart valves,
    - therapeutic radiology — treatment of malignancy by X-ray, isotopes or cobalt, and
    - physician and surgeon visits.
  - Unless a hazardous medical condition exists, charges for non-emergency weekend hospital admissions and inpatient hospital days prior to the day before a scheduled surgery are **not** covered.
  - Hospital charges made for most services and supplies provided by the outpatient department of a hospital are also covered expenses.
  - The plan will only pay for nursing services that are provided by the hospital as part of its charge — nursing services billed separately will **not** be covered.
  - In addition to charges made by the hospital, certain physicians and other providers may bill you separately.
  - Services and supplies furnished in connection with an outpatient surgery are covered if the surgery is in an office-based surgical facility, a surgery center or the outpatient department of a hospital. Benefits for outpatient surgery are described in the "Outpatient Surgery" section on page B-31.

- Mastectomies — as required by the Women's Health and Cancer Rights Act of 1998, the medical plan options cover the following breast reconstruction procedures in connection with mastectomies:
  - reconstruction of the breast on which the mastectomy was performed including an implant and areolar reconstruction,
  - surgery on and reconstruction of the other breast to produce a symmetrical appearance, and
  - treatment of physical complications, including lymphedemas, at all stages of the mastectomy.

  Benefits are also provided for a breast implant or an initial external breast prosthesis following mastectomy when prescribed by a physician and furnished by an accredited supplier. Coverage includes up to four initial post-mastectomy surgical bras. The first breast prosthesis and bras must be purchased within one year after the mastectomy is performed.

  Replacements are also covered when required as the result of a significant change in body weight which renders the prosthesis unusable.

- Maternity Care — covered charges include:
  - pre- and post-natal care provided by a physician or a certified nurse midwife performing under the supervision of a physician,
  - delivery services provided in a hospital or a licensed birthing center by a physician or a certified nurse midwife performing under the supervision of a physician,
  - ultrasound and other medically necessary testing,
  - inpatient room and board and delivery room services,
  - nursery care for the newborn during the mother's hospital stay, and
  - initial exam of a newborn child when performed by a doctor other than the doctor who delivered the child.

Specific Covered Expenses *(continued)*

These services are **not** covered:

- education classes, including childbirth instruction,
- ultrasound procedures performed only to determine the sex of the fetus, and
- genetic testing, except when medically necessary.

- Medical Supplies — covered items include gauze, cotton, solutions, dressings, plaster and oxygen prescribed by a physician during an inpatient hospital admission or a covered outpatient visit. Medical supplies prescribed for use outside a hospital setting are also covered when furnished by a medical supplier. Supplies provided and billed by a physician's office are **not** covered.
- Newborn Care — the medical plan covers ordinary hospital nursery care during the mother's hospital stay **if the newborn is enrolled within 31 days following birth**. Other necessary hospital and physician services (tests, medication, incubators, neonatal intensive care, etc.) are also covered.

  Your newborn child is covered as a dependent if you enroll him or her within 31 days following the date of birth. A newborn grandchild is **not** eligible for coverage as a dependent unless you have legally adopted the child.

Important!

Don't forget to enroll your newborn child. If you fail to enroll a newborn child within 31 days of the date of birth, you won't be able to enroll him or her for medical benefits until the next open enrollment period, unless you have another qualified status change.

In accordance with federal law, Chevron Phillips Chemical's medical plan provides specific minimum benefits for any length of hospital stay in connection with childbirth.

- Following a normal vaginal delivery, the minimum hospital length of stay for the mother and newborn child is 48 hours.
- For a cesarean section, the minimum length of hospital stay for the mother and newborn child is 96 hours following delivery.
- A doctor or hospital is not required to obtain authorization for delivery-related hospital stays that are within these minimum time periods.
- If the mother, her attending physician and the hospital agree that a shorter length of stay is sufficient, the mother and the newborn child may leave the hospital before the minimum 48- or 96-hour stay prescribed by federal law.

- Office Visits — visits to a physician for examination, diagnosis and treatment of general medical conditions are covered. Covered services include medical care, consultations, medications and injections.
- Out-of-Country Health Care Services — when you are in a foreign country and require medical services, most hospitals and doctors will ask you to pay for services directly. Ask for itemized receipts for all services, preferably written in English.

  When you submit your claim, indicate whether the charges shown on your receipts are in U.S. or a foreign currency. Aetna will pay up to the approved amount for each covered service at the rate of exchange in effect on the date services were provided, less any deductibles or copayments that may apply. Out-of-country health care claims are subject to the guidelines of your domestic plan option.

  If your plan option does not cover out-of-network services, then services out-of-country are limited to true emergency services only. Most providers outside of the country are out-of-network. Follow-up care and routine care by out-of-network providers are not covered. Non-emergency services received in an emergency room are not covered.

  If your plan option covers in-network and out-of-network services, then true emergency services are covered at the in-network level of coverage. Follow-up care and routine care by out-of-network providers is covered at the out-of-network level of coverage. Most providers out of the country are out-of-network. Non-emergency services received in an emergency room are not covered.
- Outpatient Infusion Therapy — covered expenses include charges made on an outpatient basis for infusion therapy by:
  - a free-standing facility,
  - the outpatient department of a hospital, or
  - a physician in his/her office or in your home.

  Infusion therapy is the intravenous or continuous administration of medications or solutions that are a part of your course of treatment. Charges for the following are covered expenses:

Specific Covered Expenses *(continued)*

- the pharmaceutical supplies when administered in connection with infusion therapy and any medical supplies, equipment and nursing services required to support the infusion therapy,
- professional services,
- total parenteral nutrition (TPN),
- chemotherapy,
- drug therapy (includes antibiotic and antivirals),
- pain management (narcotics), and
- hydration therapy (includes fluids, electrolytes and other additives).

Charges incurred for the following are **not** covered under this infusion therapy benefit:

- enteral nutrition,
- blood transfusions and blood products,
- dialysis, and
- insulin.

- Outpatient Surgery — if you use out-of-network providers, certain medical expenses require precertification even when they are performed on an outpatient basis. For more information, see ***Precertification*** on page B-6.

  Services and supplies for outpatient surgery are covered if the surgery is in an office-based surgical facility, a surgery center or the outpatient department of a hospital. (Benefits for surgery services performed in a physician's office are described under the "Office Visits" section on page B-30.) The following are covered:

  - services and supplies provided by the hospital or surgery center on the day of the procedure,
  - the surgeon's services for performing the procedure, related pre- and post-operative care and administration of anesthesia, and
  - services of another physician for related post-operative care and administration of anesthesia. This does not include a local anesthetic.

  Outpatient surgical benefits do not include the services of a physician or other health care provider who renders technical assistance to the surgeon, a stay in the hospital or facility charges for an office-based surgery.

- Pathology and Laboratory Services — diagnostic services prescribed by a physician and performed in a physician's office, the outpatient department of a hospital or an independent laboratory are covered.

- Podiatric Treatment — medically necessary inpatient and outpatient treatment, including surgery, is covered.

- Pre-Admission Testing — prior to a scheduled covered surgery, covered expenses include charges made for tests performed by a hospital, surgery center, physician or licensed diagnostic laboratory, provided the charges for the surgery are covered expenses and the tests are:

  - related to your surgery, and the surgery takes place in a hospital or surgery center,
  - completed within 14 days before your surgery,
  - performed on an outpatient basis,
  - covered if you were an inpatient in a hospital,
  - not repeated in or by the hospital or surgery center where the surgery will be performed, and
  - part of your medical record (including results) kept by the hospital or surgery center where the surgery is performed.

  The plan does **not** cover diagnostic complex imaging expenses under this part of the plan if such imaging expenses are covered under any other part of the plan. If your tests indicate that surgery should not be performed because of your physical condition, the plan will pay for the tests, however surgery will **not** be covered.

- Preventive Care — designated preventive care services are covered at 100%, with no copayments, across all three medical plan options if an in-network provider is used.

  Covered expenses include charges for routine physical exams. A routine exam is a medical exam given by a physician for a reason other than to diagnose or treat a suspected or identified illness or injury (certain care in relation to pregnancy is covered at 100%), and also includes:

  - limited radiological services, lab and other tests given in connection with the exam,
  - immunizations for infectious diseases and the materials for administration of immunizations, and
  - testing for tuberculosis.

  Covered expenses for children from birth to age 18 also include an initial hospital check-up and well-child visits in accordance with the prevailing clinical standards of the American Academy of Pediatric Physicians.

  Covered expenses for all three plans are limited as follows:

  - Children:
    - Seven exams in the first 12 months of life
    - Three exams in the second 12 months of life
    - Three exams in the third 12 months of life
    - One exam every year thereafter
    - Includes immunizations

Specific Covered Expenses *(continued)*

- Adults:
  - One exam per calendar year (vision and hearing exams are covered once per calendar year)
  - Includes immunizations
- Well woman:
  - Annual gynecological examination
  - Prenatal doctor's office visits (does not include inpatient admissions, high risk specialist visits, ultrasounds, amniocentesis, fetal stress tests, certain diagnostic lab tests or delivery, including anesthesia)
  - Lab tests for gestational diabetes screenings
  - Breast feeding support, supplies and counseling

Unless specified above, the following charges are not covered by this benefit:

- Services which are covered to any extent under any other part of this plan,
- Services which are for diagnosis or treatment of a suspected or identified illness or injury (except certain care in relation to pregnancy as outlined above),
- Exams given during your stay for medical care,
- Services not given by a physician or under his or her direction, and
- Psychiatric, psychological, personality or emotional testing or exams.

- Private Duty Nursing — charges made by an R.N., L.P.N. or nursing agency are covered up to a maximum of 70 eight-hour shifts in any calendar year. Private duty nursing services include:
  - visiting nurse care by an R.N. or L.P.N. if each visit lasts four hours or less and is for the purpose of performing specific skilled nursing tasks, and
  - private duty nursing by an R.N. or L.P.N. if the patient's condition requires skilled nursing care and visiting nursing care is not adequate.

  The plan also covers skilled observation for up to one four-hour period per day, for up to 10 consecutive days following:
  - a change in your medication,
  - treatment of an urgent or emergency medical condition by a physician,
  - the onset of symptoms indicating a need for emergency treatment,
  - surgery, or
  - an inpatient hospital stay.
- Prosthetic and Orthotic Appliances — covered expenses include charges made for internal and external prosthetic devices and special appliances, if the device or appliance improves or restores body part function that has been lost or damaged by illness, injury or congenital defect. Covered expenses also include instruction and incidental supplies needed to use a covered prosthetic device.

  The plan covers the first prosthesis that temporarily or permanently replaces all or part of an internal body part, organ or external body part that is lost or impaired as a result of disease, injury or congenital defect. Covered expenses also include replacement of a prosthetic device if:
  - the replacement is needed because of a change in your physical condition, or normal growth or wear and tear,
  - it is likely to cost less to buy a new one than to repair the existing one, or
  - the existing one cannot be made serviceable.

  Covered devices include but are not limited to:
  - artificial arm, leg, hip, knee or eye,
  - eye lens,
  - external breast prosthesis and up to four surgical bras made solely for use with it after a mastectomy (must be purchased within one year after the mastectomy is performed),
  - breast implant after a mastectomy,
  - ostomy supplies, urinary catheters and external urinary collection devices,
  - speech generating device,
  - cardiac pacemaker and pacemaker defibrillators,
  - durable brace that is custom made for and fitted for you, and
  - orthopedic shoes, therapeutic shoes, orthotics or other devices to support the feet, or if the orthopedic shoe is an integral part of a covered leg brace.

  The plan will **not** cover expenses and charges for, or expenses related to trusses, corsets and other support items.
- Radiation Therapy — radiation therapy performed in the physician's office or the outpatient department of a hospital is covered when performed and billed by a physician. Covered services include radiological treatment for a malignancy by X-ray, isotopes or cobalt. Regarding Proton Beam Therapy (PBT), a specific type of radiation therapy, PBT is covered when medically necessary for the types of cancers outlined in Aetna's Clinical Policy Bulletin on "Proton Beam and Neutron Beam Radiotherapy." It is also covered when medically necessary for head, neck and throat cancer.

Specific Covered Expenses *(continued)*

- Routine Cancer Screenings — covered expenses include charges incurred for routine cancer screenings as follows:
  - one mammogram every calendar year for covered females age 39 and over,
  - one Pap smear every calendar year,
  - one gynecological exam every calendar year,
  - one fecal occult blood test every calendar year, and
  - one digital rectal exam and one prostate specific antigen (PSA) test every calendar year for covered males age 40 and older.

  The following tests are covered expenses if you are age 50 and older when recommended by your physician:
  - one Sigmoidoscopy every five years for persons at average risk, **or**
  - one Double contrast barium enema (DCBE) every 5 years for persons at average risk, **or**
  - one Colonoscopy every 5 years for persons at average risk for colorectal cancer.
- Short-Term Rehabilitation — benefits are limited to 60 visits per calendar year for physical, occupational, speech and cognitive therapy services. A "visit" consists of no more than one hour of therapy.

  The *Select EPO Plan* option pays 100% of covered charges after the applicable copayment for treatment received in a doctor's office or special rehabilitation facility. All other covered services, including treatment received in a hospital or hospital-type facility will be subject to the applicable deductible and co-insurance amounts. The *Choice PPO Plan* option pays 80% for in-network services and 60% for out-of-network services, subject to the applicable deductible amounts. The *Value CDH Plan* option pays 70% for in-network services and 50% for out-of-network services, subject to the applicable deductible amounts. For information on cardiac and pulmonary rehabilitation benefits as part of a hospital inpatient stay, see the "Cardiac and Pulmonary Rehabilitation Benefits" section on page B-25.

  Charges made by a hospital, physician or licensed or certified physical, occupational or speech therapist for the treatment of acute illnesses and injuries are covered, as follows:
  - physical and occupational therapy must be expected to significantly improve, develop or restore physical functions lost or impaired as a result of an acute illness, injury or surgical procedure,
  - speech therapy is expected to restore speech that was lost or impaired due to an injury, illness or congenital defect, and
  - cognitive therapy is covered when needed as a result of neurological impairment due to trauma, stroke or encephalopathy, and when the therapy is part of a treatment plan intended to restore previous cognitive function.
- Smoking and Tobacco Cessation Services — counseling visits (limited to eight visits per calendar year), smoking cessation treatment and smoking cessation classes.
- Spinal Manipulation Treatment — covered visits are limited to 20 each calendar year. Manipulative and other physical treatment of any condition caused by or related to biomechanical or nerve condition disorders of the spine are covered on an outpatient basis.
- Sterilization Procedures — voluntary sterilization procedures for both male and female patients are covered regardless of medical necessity. Reversal of voluntary sterilization procedures is **not** covered.
- Surgery — if you use out-of-network providers, certain medical expenses must be precertified. For more information, see ***Precertification*** on page B-6. Inpatient hospital days in connection with a surgical procedure must be precertified.

  The following services are covered:
  - procedures for the diagnosis and treatment of diseases and injuries,
  - all related pre- and post-operative medical care by the attending physician, and
  - technical surgical assistance by another physician when requested by the operating surgeon, provided that an intern or hospital physician is not available, and the surgery is considered a major procedure.
- Transplants — Aetna covers solid organ, stem cell, bone marrow and tissue transplants based on a case-by-case review. All transplant-related services must be precertified in advance by Aetna. For more information, see ***Precertification*** on page B-6. The following will be considered one transplant occurrence:
  - heart,
  - lung,
  - heart/lung,
  - simultaneous pancreas/kidney (SPK),

Specific Covered Expenses *(continued)*

- pancreas,
- kidney,
- liver,
- intestine,
- bone marrow/stem cell,
- multiple organs replaced during one transplant surgery,
- tandem transplants (stem cell),
- sequential transplants,
- re-transplant of same organ type within 180 days of the first transplant, and
- any other single organ transplant, unless otherwise excluded under the plan.

The following will be considered to be **more than one** transplant occurrence:

- autologous blood/bone marrow transplant followed by allogenic blood/bone marrow transplant (when not part of a tandem transplant),
- allogenic blood/bone marrow transplant followed by an autologous blood/bone marrow transplant (when not part of a tandem transplant),
- re-transplant more than 180 days after the first transplant,
- pancreas transplant following a kidney transplant,
- a transplant needed because of an additional organ failure during the original transplant surgery/process, and
- more than one transplant when not performed as part of a planned tandem or sequential transplant (e.g., a liver transplant with subsequent heart transplant).

The in-network level of benefits is paid only for a treatment received at a facility designated by the plan as an Institute of Excellence™ (IOE) for the type of transplant being performed. Each IOE facility has been selected to perform only certain types of transplants. If you are a participant in the IOE program, the program will coordinate all solid organ and bone marrow transplants and other specialized care you need. Services and supplies obtained from a facility that is not designated as an IOE for the transplant being performed will be covered as out-of-network, even if the facility is an in-network facility or IOE for other types of services.

The plan covers:

- charges made by a physician or transplant team,
- charges made by a hospital, outpatient facility or physician for the medical and surgical expenses of a live donor, but only to the extent not covered by another plan or program,
- related supplies and services provided by the IOE facility during the transplant process, which may include: physical, speech and occupational therapy; bio-medicals and immunosuppressants; home health care expenses and home infusion services,
- charges for activating the donor search process with national registries,
- compatibility testing of prospective organ donors who are immediate family members, defined as your biological parents, siblings or children, and
- inpatient and outpatient expenses directly related to a transplant.

A transplant occurrence begins at the point of evaluation for a transplant and ends either 180 days from the date of the transplant; **or** on the date you are discharged from the hospital or outpatient facility, whichever is later. The four phases and covered expenses of one transplant occurrence are:

1. Pre-transplant evaluation/screening — includes all professional and technical components required for assessment, evaluation and acceptance into a facility's transplant program.
2. Pre-transplant/candidacy screening — includes HLA typing/compatibility testing of prospective organ donors who are immediate family members.
3. Transplant event — includes:
   - services and supplies provided to you and a donor during the one or more surgical procedures or medical therapies for a transplant,
   - prescription drugs provided during your inpatient stay or outpatient visit(s), including bio-medical and immunosuppressant drugs,
   - physical, speech or occupational therapy provided during your inpatient stay or outpatient visit(s), and
   - cadaveric and live donor organ procurement.
4. Follow-up care — includes all covered transplant expenses rendered within 180 days from the date of the transplant:
   - home health care services,
   - home infusion services, and
   - transplant-related outpatient services.

Specific Covered Expenses *(continued)*

When significant travel is required to use an Institutes of Excellence (IOE) facility, the transplant recipient may be eligible for reimbursement of travel and lodging expenses.

- Urgent Care — coverage is provided for urgent care. An urgent condition is a sudden illness, injury or condition that:
  - requires prompt medical attention to avoid serious deterioration of your health,
  - can't be adequately managed without urgent care or treatment,
  - does not require the level of care provided in a hospital emergency room, and
  - requires immediate outpatient medical care that can't wait for your physician to become available.

  Call your physician if you think you need urgent care. If you can't reach your physician, you may contact any physician or urgent care provider. If you need help finding an urgent care provider, call Aetna.

  If you seek care from an urgent care provider for a non-urgent condition, the plan won't cover your expenses. Follow-up care is not considered urgent and is **not** covered as part of any emergency or urgent care visit. Once you have been treated and discharged, you should contact your physician for any necessary follow-up care.

  Covered expenses are charges made by an urgent care provider to evaluate and treat you, including:
  - use of urgent care facilities,
  - physicians' services,
  - nursing staff services, and
  - radiologists' and pathologists' services.

  The following are considered urgent care providers:
  - a free-standing medical facility that meets all of the following requirements:
    - is not the emergency room or outpatient department of a hospital,
    - provides unscheduled medical services to treat an urgent condition if the person's physician is not reasonably available,
    - routinely provides ongoing unscheduled medical services for more than eight consecutive hours,
    - makes charges,
    - is licensed and certified as required by any state or federal law or regulation,
    - keeps a medical record on each patient,
    - provides an ongoing quality assurance program. This includes reviews by physicians other than those who own or direct the facility,
    - is run by a staff of physicians. At least one physician must be on call at all times, and
    - has a full-time administrator who is a licensed physician, or
  - a physician's office, but only one that:
    - has contracted with Aetna to provide urgent care, and
    - is, with Aetna's consent, included in the directory as an in-network urgent care provider.
- Vision Care — routine vision exams are covered provided that services are rendered by an ophthalmologist or optometrist, as follows:
  - **if you are enrolled in the *Select EPO Plan* option,** one complete eye exam, including refraction, by an in-network provider is covered once per calendar year, or
  - **if you are enrolled in the *Choice PPO Plan* option or *Value CDH Plan* option,** one complete eye exam, including refraction, is covered once per calendar year. Coverage levels vary depending on whether you use an in-network or out-of-network provider.

  Vision acuity testing and vision correction, other than cataract removal, by any means, including surgery, exercise, orthopedic training, eyeglasses and contact lenses, are **not** covered.
- Walk-in Clinic — visits to walk-in clinics are covered. Walk-in clinics are in-network, free-standing health care facilities. They are an alternative to a physician's office visit for treatment of unscheduled, non-emergency illnesses and injuries and the administration of certain immunizations. It's not an alternative for emergency room services or the ongoing care provided by a physician. Neither an emergency room, nor the outpatient department of a hospital, shall be considered a walk-in clinic.

Appendix B

SPECIFIC NON-COVERED EXPENSES

The Chevron Phillips Chemical medical plan options do not cover the following:

- Acupuncture, acupressure and acupuncture therapy, except as described in the "Acupuncture" section under ***Specific Covered Expenses*** on page B-24.
- Allergy — specific non-standard allergy services and supplies, including but not limited to, skin titration (wrinkle method), cytotoxicity testing (Bryan's Test), treatment of non-specific candida sensitivity and urine autoinjections.
- Ambulance — transportation by ambulance is not covered under these conditions:
  - if an ambulance service is not required by your physical condition,
  - if the type of ambulance service provided is not required for your physical condition, or
  - by any form of transportation other than a professional ambulance service.
- Annual charges or other charges to be in a physician's practice or charges to have preferred access to a physician's services such as boutique or concierge physician practices.
- Any charges in excess of the benefit, dollar, day, visit or supply limits as stated under ***Specific Covered Expenses*** on pages B-24 – B-35.
- Any drugs or supplies used in the treatment of erectile dysfunction, impotence or sexual dysfunction or inadequacy, or to enhance sexual performance or increase sexual desire, including:
  - surgery, drugs, implants, devices or preparations to correct or enhance erectile function, enhance sensitivity or alter the shape or appearance of a sex organ, and
  - sex therapy, sex counseling, marriage counseling or other counseling or advisory services.
- Any drugs, services, devices or supplies used to enhance performance, strength, endurance, athletic performance or lifestyle, including:
  - exercise equipment, memberships in health or fitness clubs, training, advice or coaching,
  - drugs or preparations to enhance strength, performance or endurance, and
  - treatments, services and supplies to treat illnesses, injuries or disabilities related to the use of performance-enhancing drugs or preparations.
- Any of the following therapies and tests:
  - aromatherapy,
  - bio-feedback and bioenergetic therapy,
  - carbon dioxide therapy,
  - chelation therapy (except for heavy metal poisoning),
  - computer-aided tomography (CAT) scanning of the entire body,
  - educational therapy,
  - gastric irrigation,
  - hair analysis,
  - hyperbaric therapy, except for the treatment of decompression or to promote healing of wounds,
  - hypnosis and hypnotherapy, except when performed by a physician as a form of anesthesia in connection with covered surgery,
  - lovaas therapy,
  - massage therapy,
  - megavitamin therapy,
  - primal therapy,
  - psychodrama,
  - purging,
  - recreational therapy,
  - rolfing,
  - sensory or auditory integration therapy,
  - sleep therapy,
  - thermograms and thermography, and
  - visual perception training.
- Any non-emergency charges incurred outside of the United States if:
  - you traveled to such location to obtain prescription drugs or supplies, even if otherwise covered under the plan,
  - such drugs or supplies are unavailable or illegal in the United States, or
  - the purchase of such prescription drugs or supplies outside the United States is considered illegal.
- Applied Behavioral Analysis, the LEAP, TEACCH, Denver and Rutgers programs.
- Behavioral Health Services, as follows:
  - treatment of impulse control disorders such as pathological gambling, kleptomania, pedophilia, caffeine or nicotine use,
  - treatment of antisocial personality disorder,

Specific Non-Covered Expenses *(continued)*

- treatment in wilderness programs or other similar programs,
- treatment of mental retardation, defects and deficiencies. This exclusion does not apply to the treatment of mental disorders under the Behavioral Health Plan or to medical treatment of mentally retarded participants as outlined under ***Specific Covered Expenses*** on pages B-24 – B-35, and
- treatment of a covered health care provider who specializes in the mental health care field and who receives treatment as a part of his or her training in that field.

- Blood, blood plasma, synthetic blood, blood products or substitutes, including the provision of blood (other than blood-derived clotting factors). Any related services are also not covered, including processing, storage or replacement costs, and the services of blood donors, apheresis or plasmapheresis. For autologous blood donations, only administration and processing costs are covered.
- Canceled or missed appointment charges or charges to complete claim forms.
- Charges for inpatient hospital accommodations that are in excess of the charge for a semi-private room.
- Charges in excess of benefit limits for convalescent facility treatment, home health care, hospice treatment, spinal manipulation and short-term rehabilitation therapy.
- Charges submitted for services that are not rendered, or rendered to a person not eligible for coverage under the plan.
- Charges that a covered person is not legally obligated to pay or the charges would not be made if the recipient did not have coverage (to the extent the exclusion is permitted by law), including:
  - care in charitable institutions,
  - care for conditions related to current or previous military service,
  - care while in the custody of a governmental authority,
  - any care a public hospital or other facility is required to provide, or
  - any care in a hospital or other health care facility owned or operated by any federal, state or other governmental entity, except to the extent coverage is required by applicable laws.
- Contraception — over-the-counter contraceptive supplies including but not limited to condoms, contraceptive foams, jellies and ointments. These may be covered under the Prescription Drug Plan (see ***Prescription Drug Plan*** beginning on page C-1).
- Cosmetic surgery or plastic surgery: services or supplies solely for the purposes of altering, improving or enhancing the shape or appearance of the body, whether or not for psychological or emotional reasons, including:
  - face lifts, body lifts, tummy tucks, liposuction, removal of excess skin, removal or reduction of non-malignant moles, blemishes, varicose veins, cosmetic eyelid surgery and other cosmetic surgical procedures,
  - procedures to remove healthy cartilage or bone from the nose (even if the surgery may enhance breathing) or other parts of the body,
  - chemical peels, dermabrasion, laser or light treatments, bleaching, creams, ointments or other treatments or supplies to alter the appearance or texture of the skin,
  - insertion or removal of any implant that alters the appearance of the body (such as breast or chin implants), except removal of an implant, which is covered when medically necessary,
  - removal of tattoos (except for tattoos applied to assist in covered medical treatments, such as markers for radiation therapy),
  - repair of piercings and other voluntary body modifications, including removal of injected or implanted substances or devices,
  - surgery to correct gynecomastia,
  - breast augmentation, and
  - otoplasty.
- Court ordered services, including those required as a condition of parole or release.
- Custodial care.

Specific Non-Covered Expenses *(continued)*

- Dental — any dental service or supplies that are covered under the Chevron Phillips Chemical Dental Plan or under any other Company benefits plan. This includes any treatment, services or supplies related to the care, filling, removal or replacement of teeth and the treatment of injuries and diseases of the teeth, gums and other structures supporting the teeth. This includes, but is not limited to:
  - services of dentists, oral surgeons, dental hygienists and orthodontists including apicoectomy (dental root resection), root canal treatment, soft tissue impactions, removal of bony impacted teeth, treatment of periodontal disease, alveolectomy, augmentation and vestibuloplasty and fluoride and other substances to protect, clean or alter the appearance of teeth,
  - dental implants, false teeth, prosthetic restoration of dental implants, plates, dentures, braces, mouth guards and other devices to protect, replace or reposition teeth, and
  - non-surgical treatments to alter bite or the alignment or operation of the jaw, including treatment of malocclusion or devices to alter bite or alignment.
- Developmental delays — services, evaluation, treatment, educational testing or training related to developmental delays, minimal brain dysfunction, developmental learning, communication disorders or behavioral disorders; or cognitive rehabilitation, regardless of the underlying cause (except as outlined in the "Autism Treatment" section under ***Specific Covered Expenses*** on page B-25).
- Disposable outpatient supplies: any outpatient disposable supply or device, including sheaths, bags, elastic garments, support hose, bandages, bedpans, syringes, blood or urine testing supplies, and other home test kits; and splints, neck braces, compresses and other devices not intended for reuse by another patient.
- Drugs, medications and supplies, as follows:
  - over-the-counter drugs, biological or chemical preparations and supplies that may be obtained without a prescription including vitamins,
  - any services related to the dispensing, injection or application of a drug,
  - any prescription drug purchased illegally outside the United States, even if otherwise covered under this plan within the United States,
  - immunizations related to work,
  - needles, syringes and other injectable aids, except as covered for diabetic supplies,
  - drugs related to the treatment of non-covered expenses,
  - performance-enhancing steroids,
  - injectable drugs if an alternative oral drug is available,
  - bulk chemical compound medications, except for designated covered pediatric compounding,
  - self-injectable prescription drugs and medications, and
  - any prescription drugs, injectables, medications or supplies provided by the customer or through a third party vendor contract with the customer.
- Durable Medical Equipment — the following are not covered:
  - equipment used primarily for comfort or convenience, including overbed tables, communication aids, vision aids, telephone alert systems and elevators,
  - environmental control equipment, including air conditioners, air filters or purifiers, humidifiers, dehumidifiers, vaporizers, water filters or purifiers and similar equipment,
  - blood pressure kits, diet scales and other monitoring devices,
  - exercise equipment, whirlpool baths, portable whirlpool pumps, sauna baths and massage devices,
  - dentures,
  - rental charges in excess of the purchase price of the same equipment, and
  - maintenance and repairs of purchased equipment needed due to misuse or abuse.
- Education, special education, job training and job hardening programs, whether or not provided in a facility that also provides medical treatment. This includes the evaluation or treatment of learning disabilities; minimal brain dysfunction; developmental, learning and communication disorders; behavioral disorders (including pervasive developmental disorders) and training; or cognitive rehabilitation, regardless of the underlying cause. The plan also excludes services, treatment and educational testing and training related to behavioral (conduct) problems, learning disabilities and delays in developing skills.
- Emergency room facility charges in connection with the treatment of a condition that does not meet Aetna's definition of an emergency condition.

Specific Non-Covered Expenses *(continued)*

- Eyeglasses, duplicate or spare eyeglasses or lenses or frames, contact lenses and vision examinations for prescribing or fitting glasses or contact lenses, except as described in the "Vision Care" section under ***Specific Covered Expenses*** on page B-35, or for use in treatment following cataract surgery. Note that some of these services may be covered under the Vision PLUS Plan if you enroll in that plan (see ***Vision PLUS Plan*** beginning on page G-1 for details). The plan also does not cover:
  - special supplies such as non-prescription sunglasses and subnormal vision aids,
  - vision services or supplies which don't meet professionally accepted standards,
  - special vision procedures, such as orthoptics, vision therapy or vision training,
  - eye exams during your stay in a hospital or other facility for health care,
  - acuity tests,
  - eye surgery for the correction of vision, including radial keratotomy, LASIK and similar procedures, and
  - services to treat errors of refraction.
- Experimental or investigative — services, care, devices or supplies considered investigative, experimental or research-oriented, except as outlined under ***Experimental or Investigational Services*** on page B-21.
- Food items — any food item, including infant formulas, nutritional supplements, vitamins (including prescription vitamins), medical foods and other nutritional items, even if it is the sole source of nutrition. Some of these items may be covered under the Prescription Drug Plan (see ***Prescription Drug Plan*** beginning on page C-1).
- Foot care — any services, supplies or devices to improve comfort or appearance of toes, feet or ankles including, but not limited to:
  - treatment of calluses, bunions, toenails, hammertoes, subluxations, fallen arches, weak feet, chronic foot pain or conditions caused by routine activities such as walking, running, working or wearing shoes, and
  - shoes (excluding orthopedic shoes), ankle braces, guards, protectors, creams, ointments and other equipment, devices and supplies, even if required following a covered treatment of an illness or injury.
- For in-network providers — the portion of a charge that exceeds Aetna's negotiated charge for a particular service or supply.
- For out-of-network providers — the portion of a charge that exceeds Aetna's recognized charge determination.
- Growth/height — any treatment, device, drug, service or supply (including surgical procedures, devices to stimulate growth and growth hormones), solely to increase or decrease height or alter the rate of growth.
- Hearing services or supplies that do not meet professionally accepted standards and hearing exams given during a stay in a hospital or other facility.
- Home and mobility — any additions or alterations to a home, workplace, other location or vehicle and related equipment/devices, such as:
  - purchase or rental of exercise equipment, air purifiers, central or unit air conditioners, water purifiers, waterbeds and swimming pools,
  - exercise and training devices, whirlpools, portable whirlpool pumps, sauna baths or massage devices,
  - equipment or supplies to aid sleeping or sitting, including non-hospital electric and air beds, water beds, pillows, sheets, blankets, warming or cooling devices, bed tables and reclining chairs,
  - equipment installed in your home, workplace or other location, including stair-glides, elevators, wheelchair ramps or equipment to alter air quality, humidity or temperature,
  - other additions or alterations to your home, workplace or other location, including room additions, changes in cabinets, countertops, doorways, lighting, wiring, furniture, communication aids, wireless alert systems or home monitoring,
  - services and supplies furnished mainly to provide a surrounding free from exposure that can worsen your illness or injury,
  - removal from your home, worksite or other environment of carpeting, hypo-allergenic pillows, mattresses, paint, mold, asbestos, fiberglass, dust, pet dander, pests or other potential sources of allergies or illness, and
  - transportation devices, including stair-climbing wheelchairs, personal transporters, bicycles, automobiles, vans or trucks or alterations to any vehicle or other mode of transportation.
- Home births — any services and supplies related to births occurring in the home or in a place not licensed to perform deliveries.

Specific Non-Covered Expenses *(continued)*

- Home health care — except as described in the "Home Health Care" section under ***Specific Covered Expenses*** on page B-28, the following home health care services are not covered:
  - services or supplies that are not a part of the home health care plan,
  - services of a person who usually lives with you, or who is a member of your or your spouse's family,
  - services of a certified or licensed social worker,
  - services for Infusion Therapy,
  - transportation,
  - services or supplies provided to a minor or dependent adult when a family member or caregiver is not present, and
  - services that are custodial care.
- Home uterine activity monitoring.
- Hospice Care — the following services are not covered:
  - funeral arrangements,
  - pastoral counseling,
  - financial and legal counseling, and
  - homemaker and caretaker services.
- Infertility treatments, except as specifically described in the "Family Planning Services and Treatment of Infertility" section under ***Specific Covered Expenses*** on page B-27, including, but not limited to:
  - drugs related to the treatment of non-covered benefits,
  - injectable infertility medications, including but not limited to menotropins, hCG, GnRH agonists and IVIG,
  - any advanced reproductive technology ("ART") procedures or services related to such procedures, including but not limited to in vitro fertilization ("IVF"), gamete intra-fallopian transfer ("GIFT"), zygote intra-fallopian transfer ("ZIFT") and intra-cytoplasmic sperm injection ("ICSI"),
  - any charges associated with care required to obtain ART services (e.g., office, hospital, ultrasounds, laboratory tests); and any charges associated with obtaining sperm for any ART procedures,
  - infertility services for couples in which one of the partners had a previous sterilization procedure, with or without surgical reversal,
  - procedures, services and supplies to reverse voluntary sterilization,
  - infertility services for females with FSH levels 19 or greater mIU/ml on day three of the menstrual cycle,
  - sperm/egg donor services:
    - the purchase of donor sperm and charges for the storage of sperm,
    - the purchase of donor eggs and charges associated with care of the donor required for egg retrievals,
    - egg transfers, gestational carriers or surrogacy,
    - donor egg retrieval or fees associated with donor egg programs, including but not limited to, fees for laboratory tests,
  - charges associated with cryopreservation or storage of cryopreserved eggs and embryos (e.g., office, hospital, ultrasounds, laboratory tests, etc.) and charges associated with a frozen embryo or egg transfer, including but not limited to, thawing charges,
  - home ovulation prediction kits or home pregnancy tests,
  - any covered services or supplies provided without precertification from Aetna,
  - infertility services that are not reasonably likely to result in success,
  - services and supplies furnished by an out-of-network provider, and
  - ovulation induction and artificial insemination services if you are not infertile as defined by the plan.
- Inpatient/outpatient facility and physician charges in connection with surgical procedures, tests and other services that are not covered.
- Maintenance care.
- Marriage, family, child, career, social adjustment, pastoral or financial counseling.
- Nursing and home health aide services provided outside of the home (such as in conjunction with school, vacation, work or recreational activities).
- Occupational illness or injury — includes any illness or injury that arises out of (or in the course of) any work for pay or profit or results in any way from an illness or injury that does. This exclusion doesn't apply if no other source of coverage or reimbursement is available to you. Sources of coverage or reimbursement may include:
  - your employer,
  - Workers' Compensation, or
  - an occupational illness program or similar program under local, state or federal law.

Specific Non-Covered Expenses *(continued)*

A source of coverage or reimbursement will be considered available to you even if you waived your right to payment from that source. If you're covered under a Workers' Compensation law or similar law and submit proof that you aren't covered for a particular illness or injury under such law, that illness or injury will be considered "non-occupational" regardless of cause.

- Outpatient infusion therapy — charges for the following are **not** covered:
  - enteral nutrition,
  - blood transfusions and blood products,
  - dialysis, and
  - insulin.
- Outpatient prescription drugs (these are covered under the Prescription Drug Plan). For more information, see ***Prescription Drug Plan*** beginning on page C-1.
- Payment for the portion of charges for which Medicare or another party is the primary payer.
- Pre-marital or pre-employment physicals; or examinations required to travel, attend a school, a camp, or a sporting event or to participate in a sport or other recreation activity; or for licensing or for any other regulatory purpose. Includes examinations required by law to secure insurance or school admissions or to obtain employment or licenses.
- Private duty nursing — the following are not covered:
  - nursing care that does not require the education, training and technical skills of an R.N. or L.P.N. Examples include transportation, meal preparation, charting of vital signs and companionship activities,
  - private duty nursing care provided to a person who is an inpatient in a hospital or other health care facility,
  - help with the activities of daily living, such as bathing, feeding, personal grooming, dressing, toileting or getting in or out of bed or a chair,
  - any service provided solely to administer oral medicines, unless applicable law requires administration by an R.N. or L.P.N., and
  - care provided strictly for skilled observation, unless there is a specific need following a change in medication, treatment of an emergency condition, surgery or release from an inpatient confinement.
- Psychiatric, psychological, personality or emotional testing or exams, behavioral health or chemical dependency/substance abuse treatment services (some of these services are covered under the Behavioral Health Plan). For more information on covered treatments for mental disorders, alcoholism or substance abuse, see ***Behavioral Health Plan*** on pages B-15 – B-17.
- Refractive eye surgery.
- Services, care, treatment or referrals rendered by any member of your family (includes spouse, domestic partner, parent, child, step-child, brother, sister or in-law) or any person who resides with you or a covered dependent.
- Services, medical care, supplies or devices that are provided primarily for a patient's personal comfort or convenience, including:
  - telephone, television and internet,
  - barber or beauty services or other guest services,
  - housekeeping, cooking, cleaning, shopping, monitoring, security or other home services,
  - travel, transportation or living expenses,
  - rest cures, and
  - recreational or diversional therapy.
- Services or supplies that are not medically necessary, as determined by Aetna, for the diagnosis, care or treatment of a disease, illness, injury, restoration of physiological functions or covered preventive services. This applies even if they are prescribed, recommended or approved by a physician.
- Services provided before the effective date of coverage or after the coverage termination date under a Chevron Phillips Chemical-sponsored medical plan.
- Services provided by a resident physician or intern rendered in that capacity.
- Services provided where there is no evidence of pathology, dysfunction or disease, except as specifically provided in connection with covered preventive care and cancer screenings.
- Services that are determined by Aetna to be for custodial care, assisted living facilities, care in nursing or rest home facilities, health resorts, spas, sanitariums, or infirmaries at schools, colleges or camps.

Specific Non-Covered Expenses *(continued)*

- Short-term rehabilitation — charges for the following are not covered:
  - services provided while confined as an inpatient in a hospital or other medical care facility,
  - services for the treatment of delayed speech development, unless the condition results from disease, injury or a congenital defect. Speech therapy for the treatment of autism spectrum disorders is covered as outlined in the "Autism Treatment" section under ***Specific Covered Expenses*** on page B-25,
  - special functional communication training, including sign language lessons, for a person whose speech was impaired or lost,
  - services for the treatment of delays in development, unless resulting from acute illness or injury, or congenital defects amenable to surgical repair (such as cleft lip/palate). Speech and physical therapy for the treatment of autism spectrum disorders are covered as outlined in the "Autism Treatment" section under ***Specific Covered Expenses*** on page B-25. Examples of non-covered diagnoses include:
    - Down's Syndrome, and
    - Cerebral Palsy,
  - any services not provided in accordance with a specific treatment plan,
  - services not performed by a physician or under the direct supervision of a physician,
  - treatment covered as part of spinal manipulation treatment as outlined in the "Spinal Manipulation Treatment" section under ***Specific Covered Expenses*** on page B-33, and
  - services provided by a physician or therapist who resides in your home, or who is a member of your family or a member of your spouse's family.
- Speech therapy, unless treatment is expected to restore speech that was lost as the result of illness, injury or congenital defect (except as outlined in the "Autism Treatment" section under ***Specific Covered Expenses*** on page B-25).
- Spinal disorders — treatment for spinal disorders, including care provided for detection and correction by manual or mechanical means of structural imbalance, distortion or dislocation. Includes physical treatments of any condition caused by or related to biomechanical or nerve conduction disorders of the spine, except spinal manipulation treatment as outlined in the "Spinal Manipulation Treatment" section under ***Specific Covered Expenses*** on page B-33.
- Transplants: the transplant coverage does not include charges for:
  - outpatient drugs including bio-medicals and immunosuppressants not expressly related to an outpatient transplant occurrence,
  - services and supplies furnished to a donor when recipient is not a covered person under this plan,
  - home infusion therapy after the end of the transplant occurrence,
  - harvesting and/or storage of organs, without the expectation of immediate transplantation for an existing illness,
  - harvesting and/or storage of bone marrow, tissue or stem cells without the expectation of transplantation within 12 months for an existing illness, and
  - cornea (corneal graft with amniotic membrane) or cartilage (autologous chondrocyte or autologous osteochondral mosaicplasty) transplants, unless otherwise precertified by Aetna.
- Transportation costs, including ambulance services for routine transportation to receive outpatient or inpatient services except as described in the "Ambulance" section under ***Specific Covered Expenses*** on page B-24.
- Treatment, care or other medical services that are furnished, paid for or for which benefits are provided or required by reason of past or present service in the armed forces of a government.
- Treatment, services or supplies that are not prescribed, recommended or approved by an attending physician or dentist, or charges submitted for services by an unlicensed hospital, physician or other provider or not within the scope of the provider's license.
- Unauthorized services, including any service obtained by or on behalf of a covered person without precertification by Aetna when required. This exclusion does not apply in a medical emergency or in an urgent care situation.
- Voluntary termination of pregnancy, including related services.
- Weight — any treatment, drug, service or supply intended to decrease or increase body weight, control weight or treat obesity, including morbid obesity, regardless of the existence of comorbid conditions, except as outlined in the "Cosmetic Surgery" section under ***Specific Covered Expenses*** on pages B-25 – B-26. This includes, but is not limited to:

Specific Non-Covered Expenses *(continued)*

- liposuction, banding, gastric stapling and other forms of bariatric surgery (excluding gastric bypass which is covered),
- surgical procedures, medical treatments, weight control/loss programs and other services and supplies that are primarily intended to treat, or are related to the treatment of, obesity, including morbid obesity,
- drugs, stimulants, preparations, foods or diet supplements, dietary regimens and supplements, food or food supplements, appetite suppressants and other medications,
- counseling, coaching, training, hypnosis or other forms of therapy, and
- exercise programs, exercise equipment, membership to health or fitness clubs, recreational therapy or other forms of activity or activity enhancement.