Critical Illness Plan

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Your Critical Illness Plan

Chevron Phillips Chemical Company LP (Chevron Phillips Chemical or the Company) offers eligible employees and their dependents employee-paid critical illness insurance through MetLife. Critical illness insurance provides valuable protection by helping pay out-of-pocket costs associated with serious health conditions, such as heart attack, stroke, coronary artery bypass surgery, kidney failure, organ transplants, Alzheimer's disease and certain cancers.

If you or an enrolled family member is diagnosed with a covered condition, the Critical Illness Plan provides a lump-sum benefit for you to use however you choose. Coverage is voluntary and you pay 100% of the premiums on an after-tax basis through payroll deductions. Since contributions for coverage are after-tax, any benefit payments you receive from the plan are not subject to taxes.

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

The Critical Illness Plan is separate from the medical plan, so benefits are payable whether or not you have met your medical deductible or out-of-pocket maximum. The plan is available to all eligible employees, but it may be especially helpful to provide "stopgap" coverage for *Value CDH Plan* participants because of that option's relatively higher out-of-pocket costs.

How the Plan Works

Under the Critical Illness Plan, you can choose coverage for yourself and your eligible dependents. You can elect coverage amounts of $10,000, $20,000 or $30,000. When you or a covered dependent is diagnosed with a covered condition, you will receive a lump-sum benefit (called an "initial benefit" for the first occurrence). The requirements for coverage are indicated in the following table.

CRITICAL ILLNESS INSURANCE COVERAGE REQUIREMENTS

Eligible Individual	Initial Benefit	Requirements
Employee	$10,000, $20,000 or $30,000	Coverage is guaranteed provided you are actively at work on the effective date of coverage.
Spouse	100% of the employee's initial benefit	Coverage is guaranteed provided the employee is actively at work and the spouse is not hospitalized or under a medical restriction* on the effective date of coverage.
Dependent Child(ren)	100% of the employee's initial benefit	Coverage is guaranteed provided the employee is actively at work and the dependent child is not hospitalized or under a medical restriction* on the effective date of coverage.

** Hospitalized and/or medical restriction means a person is (1) confined at home under a physician's care; (2) receiving or applying for disability benefits from any source; (3) an inpatient at a hospital; (4) receiving care in a hospice, intermediate care, or long-term care facility; or (5) receiving chemotherapy, radiation therapy or dialysis.*

What the Plan Pays

Depending on the coverage amount you choose, your initial benefit provides a lump-sum payment of $10,000, $20,000 or $30,000 upon the first diagnosis of the covered conditions listed in the ***Covered Conditions and Benefit Amounts*** chart on page E-3. Your plan also pays a recurrence benefit for certain covered conditions as indicated in the chart. A recurrence benefit is only available if an initial benefit has been paid for the covered condition.

There is a benefit suspension period of six months between recurrences. You cannot receive a recurrence benefit for any condition that recurs during the six-month benefit suspension period, and you must continue to pay premiums during the six-month period to be eligible for any future benefits. In addition, the plan will not pay a recurrence benefit for either a full benefit cancer or a partial benefit cancer unless you have not, for a period of 180 days, had symptoms of, or been treated for, the full benefit cancer or partial benefit cancer for which the plan paid an initial benefit.

You may increase your benefit amount at specific times, such as during open enrollment or if you experience a qualified status change (see ***Qualified Status Changes*** on page A-11), as long as the eligibility requirements listed in ***Critical Illness Insurance Coverage Requirements*** on this page are met.

COVERED CONDITIONS AND BENEFIT AMOUNTS

The table below shows the initial benefit and recurrence benefit percentage for each covered condition.

Covered Conditions	Initial Benefit	Recurrence Benefit
Full benefit cancer[1]	100% of initial benefit	100% of initial benefit
Partial benefit cancer[1]	25% of initial benefit	25% of initial benefit
Heart attack	100% of initial benefit	100% of initial benefit
Stroke ***(or severe stroke in some states)***	100% of initial benefit	100% of initial benefit
Coronary artery bypass graft ***(Coronary artery disease in New Jersey)***	100% of initial benefit	100% of initial benefit
Kidney failure	100% of initial benefit	Not applicable
Alzheimer's disease[2]	100% of initial benefit	Not applicable
Major organ transplant	100% of initial benefit	Not applicable
22 listed conditions ***(see box below)***	25% of initial benefit	Not applicable

[1] *Not all types of cancer are covered. Some cancers are covered at less than the initial benefit amount. See* ***What's Covered*** *beginning on page E-4 for definitions of full benefit cancer and partial benefit cancer.*

[2] *See* ***What's Covered*** *on page E-4 for a definition of Alzheimer's disease and* ***What's Not Covered*** *beginning on page E-5 for a list of specific exclusions relating to a diagnosis of Alzheimer's disease.*

22 Listed Conditions

The Critical Illness Plan will pay 25% of the initial benefit amount for the following 22 listed conditions until you or your covered dependent's lifetime maximum (total benefit) amount is reached. You and your covered dependents may receive only one payment for each listed condition in your or your covered dependent's lifetime.

The 22 listed conditions are: Addison's disease (adrenal hypofunction); amyotrophic lateral sclerosis (Lou Gehrig's disease); cerebrospinal meningitis (bacterial); cerebral palsy; cystic fibrosis; diphtheria; encephalitis; Huntington's disease (Huntington's chorea); Legionnaire's disease; malaria; multiple sclerosis (definitive diagnosis); muscular dystrophy; myasthenia gravis; necrotizing fasciitis; osteomyelitis; poliomyelitis; rabies; sickle cell anemia (excluding sickle cell trait); systemic lupus erythematosus (SLE); systemic sclerosis (scleroderma); tetanus; and tuberculosis.

LIFETIME MAXIMUM

The maximum lifetime amount you can receive through the Critical Illness Plan is called the "total benefit" and is five times the coverage amount you choose (also called your "initial benefit"). This means that you can receive multiple initial benefit and recurrence benefit payments, as long as you continue to be enrolled in the plan, until you reach the maximum of five times your initial benefit ($50,000, $100,000 or $150,000). The initial benefit and total benefit amounts apply to each covered person separately.

What's Covered

The Critical Illness Plan pays benefits upon the first diagnosis of the following conditions:

- Alzheimer's disease, defined as the development of multiple, progressive cognitive deficits manifested by memory impairment (impaired ability to learn new information or to recall previously learned information) and one or more of the following cognitive disturbances:
  - Aphasia (language disturbance),
  - Apraxia (impaired ability to carry out motor activities despite intact motor function),
  - Angosia (failure to recognize or identify objects despite intact sensory function), and
  - Disturbance in executive functioning (i.e., planning, organizing, sequencing, abstracting).
- Coronary artery bypass graft, defined as the undergoing of open heart surgery performed by a physician to bypass a narrowing or blockage of one or more coronary arteries using venous or arterial grafts. The procedure must be deemed medically necessary by a physician and be supported by pre-operative angiographic evidence. Coronary artery bypass graft does not include:
  - Angioplasty (percutaneous transluminal coronary angioplasty),
  - Laser relief,
  - Stent insertion,
  - Coronary angiography, or
  - Any other intra-catheter technique.
- Full benefit cancer, defined as the presence of one or more malignant tumors characterized by the uncontrollable and abnormal growth and spread of malignant cells with invasion of normal tissue provided that a physician has determined that:
  - Surgery, radiotherapy or chemotherapy is medically necessary,
  - There is metastasis, or
  - The patient has terminal cancer, is expected to die within 24 months or less from the date of diagnosis and will not benefit from, or has exhausted, curative therapy.
- Heart attack (myocardial infarction), defined as the death of a portion of the heart muscle as a result of obstruction of one or more coronary arteries due to artherosclerosis, spasm, thrombus or emboli.
- Kidney failure, defined as the total, end stage, irreversible failure of both kidneys to function, provided that a physician has determined that such failure requires either:
  - Immediate and regular kidney dialysis (no less often than weekly) that is expected by such physician to continue for at least six months, or
  - A kidney transplant.
- Listed conditions, defined as any of the following diseases:
  - Addison's disease (adrenal hypofunction),
  - Amyotrophic lateral sclerosis (Lou Gehrig's disease),
  - Cerebrospinal meningitis (bacterial),
  - Cerebral palsy,
  - Cystic fibrosis,
  - Diphtheria,
  - Encephalitis,
  - Huntington's disease (Huntington's chorea),
  - Legionnaire's disease,
  - Malaria,
  - Multiple sclerosis (definitive diagnosis),
  - Muscular dystrophy,
  - Myasthenia gravis,
  - Necrotizing fasciitis,
  - Osteomyelitis,
  - Poliomyelitis,
  - Rabies,
  - Sickle cell anemia (excluding sickle cell trait),
  - Systemic lupus erythematosus (SLE),
  - Systemic sclerosis (scleroderma),
  - Tetanus, and
  - Tuberculosis.
- Major organ transplant, defined as:
  - The irreversible failure of a covered person's heart, lung, pancreas, entire kidney or any combination thereof, for which a physician has determined that the complete replacement of such organ with an entire organ from a human donor is medically necessary, and either the covered person has been placed on the Transplant List or the transplant procedure has been performed,

What's Covered *(continued)*

- The irreversible failure of a covered person's liver for which a physician has determined that the complete or partial replacement of the liver with a liver or liver tissue from a human donor is medically necessary, and either the covered person has been placed on the Transplant List or the procedure has been performed, or
- The replacement of a covered person's bone marrow with bone marrow from the covered person or another human donor, and replacement is determined to be medically necessary by a physician in order to treat irreversible failure of the covered person's bone marrow.

- Partial benefit cancer, defined as one of the following conditions that meets the TNM staging classification and other qualifications specified below:
  - Carcinoma in situ classified as TisN0M0, provided that surgery, radiotherapy or chemotherapy has been determined to be medically necessary by a physician,
  - Malignant tumors classified as T1N0M0 or greater which are treated by endoscopic procedures alone,
  - Malignant melanomas classified as T1N0M0, for which a pathology report shows maximum thickness less than or equal to 0.75 millimeters using the Breslow method of determining tumor thickness, or
  - Tumors of the prostate classified as T1bN0M0, or T1cN0M0, provided that they are treated with a radical prostatectomy or external beam radiotherapy.
- Stroke, defined as a cerebrovascular accident or incident producing measurable, functional and permanent neurological impairment (not including transient ischemic attacks (TIA) or prolonged reversible ischemic attacks) caused by any of the following, which results in an infarction of brain tissue:
  - Hemorrhage,
  - Thrombus, or
  - Embolus from an extracranial source.

What's Not Covered

The Critical Illness Plan will not pay benefits in certain situations. The following are exclusions and limitations under the plan.

EXCLUSIONS RELATING TO COVERED CONDITIONS

The plan will only pay benefits for specific covered conditions as indicated on pages E-4 – E-5. If you are misdiagnosed with a covered condition — or diagnosed with a similar non-covered condition as indicated in this section — benefits will not be paid. The plan will not pay benefits for:

- A diagnosis of Alzheimer's disease for:
  - Other central nervous system conditions that may cause deficits in memory and cognition (e.g., cerebrovascular disease, Parkinson's disease or normal-pressure hydrocephalus),
  - Systemic conditions that are known to cause dementia (e.g., hypothyroidism, vitamin B12 or folic acid deficiency, niacin deficiency, hypercalcemia or neurosyphilis),
  - Substance-induced conditions, or
  - Any form of dementia that is not diagnosed as Alzheimer's disease.
- Coronary artery bypass graft that:
  - Is performed outside the United States, or
  - Does not involve median sternotomy (a surgical incision in which the sternum, also known as the breastbone, is divided down the middle from top to bottom).
- A diagnosis of full benefit cancer for:
  - Any condition that is partial benefit cancer,
  - Any benign tumor, dysplasia, intraepithelial neoplasia or pre-malignant growth,
  - Any papillary tumor of the bladder classified as Ta under TNM staging,
  - Any tumor of the prostate classified as T1N0M0 under TNM staging,
  - Any papillary tumor of the thyroid that is classified as T1N0M0 or less under TNM staging and is one centimeter or less in diameter unless there is metastasis,
  - Any tumor in the presence of human immuno-deficiency virus (this exclusion is not applicable to Florida residents),

What's Not Covered *(continued)*

  - Any non-melanoma skin cancer unless there is metastasis, or
  - Any malignant tumor classified as less than T1N0M0 under TNM staging.
- A diagnosis of partial benefit cancer for:
  - Any benign tumor, dysplasia, intraepithelial neoplasia or pre-malignant growth,
  - Any papillary tumor of the bladder classified as Ta under TNM staging,
  - Any tumor of the prostate classified as T1N0M0 under TNM staging,
  - Any papillary tumor of the thyroid that is classified as T1N0M0 or less under TNM staging and is one centimeter or less in diameter,
  - Any tumor in the presence of human immuno-deficiency virus (this exclusion is not applicable to Florida residents),
  - Any non-melanoma skin cancer, or
  - Any melanoma in situ classified as TisN0M0 under TNM staging.
- A diagnosis of stroke for:
  - Cerebral symptoms due to migraine,
  - Cerebral injury resulting from trauma or hypoxia, or
  - Vascular disease affecting the eye or optic nerve or vestibular functions.
- A major organ transplant that:
  - Is performed outside the United States,
  - Involves organs received from non-human donors,
  - Involves implantation of mechanical devices or mechanical organs,
  - Involves stem cell-generated transplants, or
  - Involves islet cell transplants.
- The following listed conditions:
  - A diagnosis of multiple sclerosis for clinically isolated syndrome (CIS),
  - A diagnosis of systemic lupus erythematosus (SLE) for any form of Lupus that is not diagnosed as systemic lupus erythematosus (SLE), or
  - A suspected or probable diagnosis of one of the 22 listed conditions under ***What's Covered*** on page E-4.

GENERAL EXCLUSIONS

The plan will not pay benefits for a covered condition that was diagnosed before the effective date of your coverage under the plan. For example, if prior to the date your coverage begins, you have been diagnosed with amyotrophic lateral sclerosis (ALS) or multiple sclerosis (MS), that diagnosis will not be covered. Take a look at two specific examples of how this exclusion works:

- You enroll in the Critical Illness Plan with coverage effective January 1, 2018. You are diagnosed with cancer in December 2017. The cancer diagnosis will not be covered under the plan since it occurred before your effective date of coverage. However, if you receive treatment and are cancer-free for 180 days and then your cancer returns, your second cancer diagnosis is covered as a new condition as long as you are still covered under the plan.
- You enroll in the Critical Illness Plan with coverage effective January 1, 2018. You have a heart attack on December 31, 2017. The heart attack is not covered under the plan since it occurred before your effective date of coverage. However, if you have another heart attack after coverage becomes effective — for example two weeks later on January 14, 2018 — the second heart attack is covered as a new condition.

In addition, the plan will not pay benefits for covered conditions:

- Arising from war or any act of war, even if war was not declared,
- For which a diagnosis is made outside of the United States, unless the diagnosis is confirmed in the United States, in which case the covered condition will be deemed to occur on the date the diagnosis is made outside the United States,
- Caused by, contributed by or resulting from a covered person:
  - Participating in a felony, riot or insurrection,
  - Intentionally causing a self-inflicted injury,
  - Committing or attempting to commit suicide while sane or insane,
  - Voluntarily taking or using any drug, medication or sedative unless it is:
    - Taken or used as prescribed by a physician, or
    - An "over-the-counter" drug, medication or sedative taken according to package directions,

– Engaging in an illegal occupation,
– Serving in the armed forces or any auxiliary unit of the armed forces of any country, or
– Who is involved in an incident where he or she is intoxicated at the time of the incident and is the operator of a vehicle involved in the incident. Intoxicated means that the covered person's alcohol level met or exceeded the level that creates a legal presumption of intoxication under the laws of the jurisdiction in which the incident happened.

How to File a Claim

To make a claim for benefits, complete and submit a Critical Illness Insurance Claim Form, which is available at www.mycpchembenefits.com/forms. Or you can contact a MetLife Customer Service Representative at 1-800-438-6388. Representatives are available Monday through Friday from 8:00 a.m. to 11:00 p.m., Eastern time.

To file a Critical Illness claim, you must give MetLife notice of the claim and submit proof of the claim to MetLife through the following four steps:

- **Step 1:** You must give MetLife notice of your claim in writing or by calling MetLife at 1-800-438-6388 within 30 days of the date of the loss.
- **Step 2:** MetLife will send you a claim form and explain how to complete it. You should receive the claim form within 15 days of giving MetLife notice of claim.
- **Step 3:** When you receive the claim form, you should fill it out as instructed and return it with the required proof described on the claim form. If you do not receive a claim form within 15 days after giving MetLife notice of claim, you may send MetLife proof using any form sufficient to provide MetLife with the required proof.
- **Step 4:** You must give MetLife proof no later than 90 days after the date of the loss. If notice of claim or proof is not given within the time limits described in this section, the delay will not cause a claim to be denied or reduced if such notice and proof are given as soon as is reasonably possible, but in no event, other than in the absence of the legal capacity of the claimant, later than 15 months from the date of the loss.

To be eligible for benefits, a diagnosis of a covered condition must be made by a physician through the use of clinical and/or laboratory findings. For more detailed information, see the Critical Illness Insurance Plan Summary and the Disclosure Document at www.mycpchembenefits.com under "Health & Wellness" then "Voluntary Benefits." You will be required to provide proof of a covered condition, including information from your health care provider, with your claim. MetLife may, at its own expense, request a medical exam or blood and urine tests.

All decisions concerning the payment of claims under the plan are at the sole discretion of the claims administrator. If you disagree with the way your claim is handled, apply for a formal review. For more information, see the ***Claims*** section beginning on page Q-2.

Who Receives Plan Benefits

Regardless of which family members are covered under the plan, if you are alive when a covered claim is paid by the insurer, the insurance proceeds are paid to you. Benefits are paid as soon as possible after the insurance company receives proof to support the claim.

If you die after the diagnosis of a covered condition but before a claim can be filed or before a claim is paid, the claim can be filed by your beneficiary and/or the payment can be made to your beneficiary. Your beneficiary is the person or persons you want to receive the proceeds of your insurance upon your death. When you enroll for benefits as a new employee or when you add or change your benefit elections, you indicate your beneficiary as part of the enrollment process. For more information, see ***Naming a Beneficiary*** on page A-23.

Situations That Affect Your Benefits or Coverage

No benefits are payable for covered conditions diagnosed before coverage begins or after coverage ends. Under certain circumstances, you can continue your coverage when your employment with Chevron Phillips Chemical ends. You must make a request in writing within a specified period after you leave the Company, and you must pay premiums for coverage directly to the insurance carrier. Contact MetLife for more information.

As a participant in a Chevron Phillips Chemical benefit 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 Q-14.