



Insured and/or administered by:  
Cigna Health and Life Insurance Company

## Chevron Phillips Chemical Company LP

Benefits at a Glance  
Global Plan for all covered US Expats  
Policy #09899A004-A006, A011  
Plan Start Date January 1, 2025

### This plan provides minimum essential coverage.

NOTE: This information is a general description of benefits and is not a contract. Refer to your certificate booklet for complete details of coverage and exclusions. If there is any difference between this summary and the certificate, the information in the certificate will apply. Please note that your plan does not cover expenses for services which are not medically necessary.

### Cigna Global Customer Service

<b>Toll Free Telephone Number:</b>	1.800.441.2668	
<b>Direct Telephone:</b>	1.302.797.3100 (collect calls accepted)	
<b>Toll Free Fax Number:</b>	1.800.243.6998	
<b>Direct Fax Number:</b>	001.302.797.3150	
<b>Secure Website:</b>	<a href="http://www.CignaEnvoy.com">www.CignaEnvoy.com</a> . Registration is Required (See member kit for registration information.) Secure email available at this site.	
<b>Mail Delivery:</b>	Cigna Global Health Benefits P.O. Box 15050 Wilmington DE 19850-5050 U.S.A.	Cigna Global Health Benefits 300 Bellevue Parkway Wilmington DE 19809 U.S.A.

### General Plan Provisions - All Amounts in U.S. Dollars

#### Global Medical Plan

	International (Outside of the U.S.)	U.S. In-Network	U.S. Out-of-Network
<b>Area of Cover</b>	Worldwide		
<b>U.S. Medical Network</b>	OAP		
<b>Eligibility</b>	Refer to eligibility definition in the certificate		
<b>Lifetime Maximum</b>	Unlimited		
<b>Calendar Year Deductible</b> · Per Individual	\$0	\$0	\$200
· Per Family	\$0	\$0	\$400
<b>Coinsurance</b> (The percentage of covered expenses the plan pays)	100%	80%	60%
<b>Out-of-Pocket Maximum (Includes Deductible)</b> · Per Individual	\$0	\$1,500	\$3,000
· Per Family	\$0	\$4,500	\$9,000



## Global Medical Plan

### Deductible Calculation

Claims for a family member are covered at plan coinsurance:

- When that family member satisfies the Individual Deductible

-OR-

- When the Family Deductible is satisfied regardless of whether or not the Individual Deductible is satisfied.

### Out-of-Pocket Calculation

Claims for a family member are covered at 100% coinsurance:

- When that family member satisfies the Individual Out-of-Pocket Maximum

-OR-

- When the Family Out-of-Pocket Maximum is satisfied regardless of whether or not the Individual Out-of-Pocket Maximum is satisfied.

Out-of-Pocket will: Include deductible payments; Include copay payments; Include pharmacy copays; Include pharmacy coinsurance payments; Exclude Pre-Admission Certification/Continued Stay Review penalties.

### Network Accumulation

Plan Deductible, Out-of-Pocket, maximums and service specific maximums (dollar and occurrence) will cross-accumulate across international and domestic networks.

## Certification Requirements - For services rendered inside the United States

Precertification for inpatient and outpatient services received in the U.S. may be required.

- Providers must call our toll-free number, 1.800.441.2668 to pre-certify services.
- You or your dependents are responsible for ensuring that Out-of-Network providers pre-certify services.
- Failure to obtain precertification may affect Out-of-Pocket costs.
- This is a summary only and further details can be found in the certificate booklet.



	International (Outside of the U.S.)	U.S. In-Network	U.S. Out-of-Network
<b>Physician's Services</b>			
· Physician's Office Visit	100%	80%	60% after deductible
· Surgery Performed In the Physician's Office	100%	80%	60% after deductible
<b>Preventive Care</b>			
· Routine Preventive Care - Adult	100%	100%	60% after deductible
· Immunizations - Adult	100%	100%	60% after deductible
· Routine Preventive Care - Child	100%	100%	60% after deductible
· Immunizations - Child	100%	100%	60% after deductible
<b>Travel Immunizations</b> (Immunizations as required for travel)	100%	100%	60% after deductible
<b>Mammograms, PSA, PAP Smear and Colorectal Cancer Screenings</b>	100%	100%	60% after deductible
<b>Inpatient Hospital</b>			
· Inpatient Hospital - Facility Services (Limited to the Semi-Private Room Rate)	100%	80%	60% after deductible
· Inpatient Hospital Physician Visits/Consultations	100%	80%	60% after deductible
· Inpatient Professional Services (Surgeon, Radiologist, Pathologist, Anesthesiologist)	100%	80%	60% after deductible
<b>Outpatient Services</b>			
· Outpatient Facility Services	100%	80%	60% after deductible
· Outpatient Professional Services	100%	80%	60% after deductible
<b>Emergency Room</b>	100%	80%	80%
<b>Urgent Care Services</b>	100%	80%	60% after deductible
<b>Ambulance</b>	100%	100%	100% after deductible



Global Medical Plan			
	International (Outside of the U.S.)	U.S. In-Network	U.S. Out-of-Network
<b>Laboratory Services</b>			
· Physician Office Visit	100%	80%	60% after deductible
· Outpatient Facility	100%	80%	60% after deductible
· Laboratory Services at an Independent Lab facility	100%	80%	60% after deductible
<b>Radiology Services</b>			
· Physician Office Visit	100%	80%	60% after deductible
· Outpatient Facility	100%	80%	60% after deductible
<b>Advanced Radiology</b> (i.e., MRIs, MRAs, CAT Scans, PET Scans)			
· Physician Office Visit	100%	80%	60% after deductible
· Inpatient Facility	100%	80%	60% after deductible
· Outpatient Facility	100%	80%	60% after deductible
<b>Outpatient Therapy Services</b>			
· Physician Office Visit	100%	80%	60% after deductible
· Outpatient Hospital Facility	100%	80%	60% after deductible
Calendar Year Maximum:	60 Days	60 Days	60 Days
<p>The limit is not applicable to Mental Health and Substance Use Disorder conditions.</p> <p><b>Note:</b> The Outpatient Therapy Services maximum does not apply to the treatment of Autism  <i>Includes:</i> Cardiac and Pulmonary Rehab, Speech, Occupational and Cognitive Therapy</p>			



Global Medical Plan			
	International (Outside of the U.S.)	U.S. In-Network	U.S. Out-of-Network
<b>Outpatient Therapy Services - Physical Therapy / Physiotherapy</b> • Physician Office Visit • Outpatient Hospital Facility Calendar Year Maximum: Unlimited for all Therapies Combined	100% 100%	80% 80%	75% after deductible 75% after deductible
<b>Chiropractic Care</b> Calendar Year Maximum: Unlimited	100%	80%	75% after deductible
<b>Maternity Care Services</b> • Initial Visit to Confirm Pregnancy • All subsequent Prenatal Visits, Postnatal Visits and Physician's Delivery Charges (i.e. global maternity fee) • Physician's Office Visits in addition to the global maternity fee when performed by an OB/GYN or Specialist • Delivery – Facility • Inpatient Hospital • Birthing Center	100% 100% 100% 100% 100%	80% 80% 80% 80% 80%	60% after deductible 60% after deductible 60% after deductible 60% after deductible 60% after deductible

Global Medical Plan			
	International (Outside of the U.S.)	U.S. In-Network	U.S. Out-of-Network
<b>Infertility, Fertility and Conception Services</b>  • Physician Office Visit and Counseling • Lab and Radiology Tests • Inpatient Facility • Outpatient Facility	Coverage will be provided for the following services:  • GIFT, ZIFT, etc. • In-vitro • Artificial Insemination		
	100%	80%	60% after deductible
	100%	80%	60% after deductible
	100%	80%	60% after deductible
	100%	80%	60% after deductible
<b>Hearing Exam</b> • 1 Exam Every 24 Months	100%	80%	60% after deductible
<b>Hearing Device / Aids</b> • Limited to Dependent Children Under 24 Years • 1 Per Ear Every 36 Months up to \$3,000	100%	80%	60% after deductible
<b>Mental Health</b> • Physician Office Visit • Inpatient Facility Maximum: (combined with Substance Use Disorder) • Outpatient Facility Maximum: (combined with Substance Use Disorder)	100%	80%	75% after deductible
	100%	80%	60% after deductible
		Unlimited	
	100%	80%	75% after deductible
<b>Substance Use Disorder</b> • Physician Office Visit • Inpatient Facility Maximum: (combined with Mental Health) • Outpatient Facility Maximum: (combined with Mental Health)		Unlimited	
	100%	80%	75% after deductible
	100%	80%	60% after deductible
	100%	80%	75% after deductible
<b>Important Note on Mental Health &amp; Substance Use Disorder Coverage:</b> Covered medical services listed above, which are received to diagnose or treat a Mental Health or Substance Use Disorder condition will be payable according to the sections titled "Mental Health" and "Substance Use Disorder".			



## Prescription Drug Benefits

### International (Outside of the U.S.)

<b>Purchased outside the United States</b>	No Charge, not subject to plan deductible
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Certain preventive care medications covered under this plan and required as part of preventive care services (detailed information is available at [www.healthcare.gov](http://www.healthcare.gov)) are payable at 100% with no copayment or deductible, when purchased from a Network Pharmacy. A written prescription is required.

### Purchased Inside the United States Only

<b>Benefit Highlights</b>	<b>Network Pharmacy (U.S. In-Network)</b>	<b>Non-Network Pharmacy (U.S. Out-of-Network)</b>
<b>Prescription Drug Products at Retail Pharmacies</b>	<b>The amount you pay for up to a consecutive 30-day supply</b>	
<b>Tier 1 - Generic Drugs on the Prescription Drug List</b>	You pay 25% not subject to plan deductible \$50 maximum	You pay 40% after plan deductible
<b>Tier 2 – Brand Drugs designated as preferred on the Prescription Drug List</b>	You pay 25% not subject to plan deductible \$100 maximum	You pay 40% after plan deductible
<b>Tier 3 – Brand Drugs designated as non-preferred on the Prescription Drug List</b>	You pay 25% not subject to plan deductible \$125 maximum	You pay 40% after plan deductible
<b>Prescription Drug Products at Home Delivery Pharmacies</b>	<b>The amount you pay for up to a consecutive 90-day supply</b>	
<b>Tier 1 - Generic Drugs on the Prescription Drug List</b>	You pay 25% not subject to plan deductible \$150 maximum	In-Network coverage only
<b>Tier 2 – Brand Drugs designated as preferred on the Prescription Drug List</b>	You pay 25% not subject to plan deductible \$300 maximum	In-Network coverage only
<b>Tier 3 – Brand Drugs designated as non-preferred on the Prescription Drug List</b>	You pay 25% not subject to plan deductible \$375 maximum	In-Network coverage only



Pharmacy Plan Features for Prescriptions Drugs Purchased Inside the United States Only	
<b>Prescription Drug List</b>	Performance 3-Tier
<b>Dispense As Written</b>	If you request to fill a brand name drug that has a generic equivalent available, you will be financially responsible for the difference in cost between the brand name and the generic drug, plus any required brand name drug copayment and/or coinsurance, if applicable. However, if your doctor has determined a generic drug is not an acceptable alternative for you, you will only be responsible for payment of the appropriate brand name drug copayment and/or coinsurance, if applicable
<b>Utilization Management</b>	Your plan features drug management programs and edits to ensure safe prescribing, and access to medications proven to be the most reliable and cost effective for your medical condition
<b>Step Therapy</b>	Certain drugs are subject to step therapy requirements. To identify whether a particular drug is subject to step therapy, please refer to your prescription drug list.
<b>Prior Authorization</b>	Coverage for certain drugs require your Physician to obtain prior authorization from Cigna. To identify whether a particular drug requires prior authorization, please refer to your prescription drug list.
<b>Quantity Limits</b>	Includes maximum daily dose edits, quantity over time edits, duration of therapy edits, and dose optimization edits
<b>Patient Assurance Program</b>	Your plan includes the Patient Assurance Program, which waives the deductible, if applicable, and reduces the amount you owe for certain medications used to treat chronic conditions included in the program. Additionally: <ul style="list-style-type: none"> <li>•Any amount you pay for these medications only count toward meeting your out-of-pocket maximum, if applicable.</li> <li>•Any discount provided by a pharmaceutical manufacturer for these medications only count toward meeting your out-of-pocket maximum, if applicable.</li> </ul>
To see if your medication is covered, you can view Cigna's Prescription Drug List by going to <a href="http://www.Cigna.com/druglist">www.Cigna.com/druglist</a> and select "Performance 3-Tier"	

Global Evacuation Plan	
<b>Toll Free telephone number</b>	1.800.441.2668
<b>Emergency Medical Evacuation</b>	100% of covered expenses for approved services.
<b>Family Travel Arrangements</b>	Roundtrip Airfare at Economy Rates to the place of hospitalization for 1 Family Member for hospitalizations in excess of 7 Days
<b>Return of Dependent Children</b>	One-way Airfare at Economy Rates to return dependent children to country of residence
<b>Repatriation of Mortal Remains</b>	100% coverage





## International Employee Assistance Program (IEAP)

Toll Free:	1.888.851.7032 or 1.877.857.2952
Reverse Charge Number:	+44 208 987 6230
Level 3 International EAP Assist & Work/Life	Direct dial 24/7 immediate access to confidential services for behavioral issues. Services include telephonic triage for emergent and urgent referrals, crises intervention and referrals to community resources. Referrals for 6 face-to-face sessions with licensed behavioral professional. Includes work-life referrals for childcare, eldercare, legal and financial situations.

## Global Telehealth

<b>Teladoc Health International</b>	Available 24/7 via the Cigna Wellbeing App and Envoy <a href="https://cignaenvoy.com">Home Page (cignaenvoy.com)</a> , Global Telehealth gives you access to licensed doctors around the world. <ul style="list-style-type: none"><li>• Video or phone consultations with licensed doctors when medically necessary</li><li>• Prescriptions for common health concerns when medically necessary and permitted</li><li>• Treating medical conditions like fever, rash, pain and more</li><li>• Assistance with preparations for an upcoming consultation</li><li>• Discussing medication plan and potential side effects</li><li>• Diagnosing non-emergency health issues ranging from acute conditions to complex chronic conditions</li></ul>
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## Global Vision Plan

	International (Outside of the U.S.)	U.S. In-Network	U.S. Out-of-Network
<b>Examinations</b> One every Calendar Year	100%	100%	
<b>Lenses and Frames or Contacts</b> One every Calendar Year	100%	80%	



Global Dental Plan		
<b>Calendar Year Maximum</b> Combined for: Class I Class II Class III		\$2,000
<b>Lifetime Class IV Maximum</b>		\$2,000
<b>Calendar Year Deductible</b> Combined for: Class II Class III		\$50 Individual / \$150 Family
<b>Class I</b>	<b>Preventive Care</b> For diagnostic and preventative services including: <ul style="list-style-type: none"> <li>• Oral Exam -2 Per Person Per Year</li> <li>• Cleanings -2 Per Person Per Year</li> <li>• Bitewing X-rays -2 Per Person Per Year</li> <li>• Fluoride Applications -1 Per Person Per Year (Up to age 19)</li> <li>• Sealants -1 Treatment per Posterior Tooth per 3 Years</li> <li>• Diagnostic X-rays –Unlimited</li> <li>• Full Mouth / Panoramic X-rays -1 Per Person Per 3 Years</li> </ul>	100% not subject to deductible
<b>Class II</b>	<b>Basic Restorative</b> For Basic Restorations: <ul style="list-style-type: none"> <li>• Endodontics</li> <li>• Periodontics</li> <li>• Prosthodontics Maintenance</li> <li>• Oral Surgery</li> <li>• Fillings</li> <li>• Root Canal</li> <li>• Periodontal Scaling and Root Planing</li> <li>• Repair to Bridgework and Dentures</li> </ul>	80% after deductible
<b>Class III</b>	<b>Major Restorative</b> For Major Restorations: <ul style="list-style-type: none"> <li>• Dentures</li> <li>• Bridgework</li> <li>• Crowns</li> </ul>	50% after deductible
<b>Class IV</b>	<b>Orthodontia</b> Children and Adults	50% not subject to deductible