Chevron Phillips CHEMICAL

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2024 EMPLOYEE BENEFITS HANDBOOK

Introduction

As an eligible employee or retiree of Chevron Phillips Chemical Company LP (Chevron Phillips Chemical or the Company), you have the opportunity to participate in comprehensive health, income and survivor protection group benefit plans. You may also be able to participate in the 401(k) Savings and Profit-Sharing Plan. These Summary Plan Descriptions (also collectively referred to as the "Benefit Handbook") provide information about eligibility requirements, enrollment procedures, benefits coverage, when coverage begins and ends, and when coverage may be continued under the following plans:

- Medical Plan and Behavioral Health Plan
- Prescription Drug Plan
- Employee Assistance Program (EAP)
- Critical Illness Plan
- Dental Plan
- Vision PLUS Plan
- Health Care Flexible Spending Account (HCFSA)
- Dependent Care Flexible Spending Account (DCFSA)
- Limited-Purpose Flexible Spending Account (LPFSA)
- Health Savings Account (HSA)
- Retiree Reimbursement Account (RRA)
- Basic Life Insurance Plan
- Supplemental Life Insurance Plan
- Basic Accidental Death and Personal Loss Insurance Plan
- Supplemental Accidental Death and Personal Loss Insurance Plan
- Occupational Accidental Death and Personal Loss Insurance Plan
- Business Travel Accident Plan
- Long-Term Disability Plan
- 401(k) Savings and Profit-Sharing Plan

This handbook does not describe the benefit plans that Chevron Phillips Chemical maintains for its Puerto Rico employees or for employees of a collective bargaining unit whose agreement does not provide these benefits. Participants in those plans receive separate summary plan descriptions. For more information on eligibility for the plans described in this handbook, see ***Who's Eligible*** on page A-1.

For the latest version of this **Summary Plan Description**, visit www.mycpchembenefits.com.

This handbook contains summaries of the formal documents that govern the Chevron Phillips Chemical Company LP benefit plans. More complete rules addressing the benefits summarized in this handbook are contained in the governing plan document. If there are any discrepancies between this handbook and the official plan documents, the plan documents will govern.

If you are covered by a collective bargaining agreement that provides for participation in the plans described in this handbook, your entitlement to a benefit and the terms and conditions of your participation are subject to discussions between the parties under the terms of that agreement and applicable labor laws.

Participation in these plans does not imply a contract between you and Chevron Phillips Chemical or a commitment by Chevron Phillips Chemical to continue employment, compensation or benefits for any employee for any period. The plans do not give you a right to any benefit or interest in the plans except as specifically provided in the plan documents.

Chevron Phillips Chemical reserves the right to amend or terminate any of its benefit plans at any time.

What's Inside

(Performance Pipe Hourly Employees)

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Who's Eligible

Employees

As an employee of Chevron Phillips Chemical Company LP (Chevron Phillips Chemical or the Company), you are eligible to participate in the health and income and survivor protection plans described in this handbook if you are:

- On a U.S. dollar payroll, and
- Designated as:
  - A full-time employee (working at least 30 hours a week),
  - A part-time employee (working at least 20 hours a week),
  - An employee on an approved disability leave of absence,
  - A summer college student hire (intern), or
  - A co-op employee (working at least 20 hours a week).

You are **not** eligible to participate in the plans described in this handbook if you are:

- A leased employee,
- A contract employee,
- A part-time employee (working less than 20 hours a week),
- A member of a collective bargaining unit whose agreement does not provide these benefits,
- In the case of the medical plan, covered by another medical plan to which the Company contributes,
- A represented hourly employee at any Performance Pipe location, or
- A union employee at the Bloomfield, Iowa or Fairfield, Iowa location.

Retirees

As a retiree, you may elect to participate in the medical, prescription drug, dental and vision plans if you:

- Have 25 or more years of continuous service at retirement,
- Are age 55 or older and have at least 10 years of continuous service at retirement, or
- Are age 65 or older and have at least 3 years of continuous service at retirement.

If you satisfy the requirements listed above, you are eligible for the Retiree Reimbursement Account (RRA), unless you are:

- An employee whose last hire or rehire date was on or after January 1, 2017,
- A Fairfield, Iowa or Bloomfield, Iowa hourly employee,
- A Puerto Rico Core employee,
- A Knoxville, TN, Reno, NV, Brownwood, TX, Hagerstown, MD, Pryor, OK, Startex, SC or Williamstown, KY hourly employee hired on or after January 1, 2004, or
- A former retirement-eligible Chevron Phillips Chemical employee who transferred to Americas Styrenics.

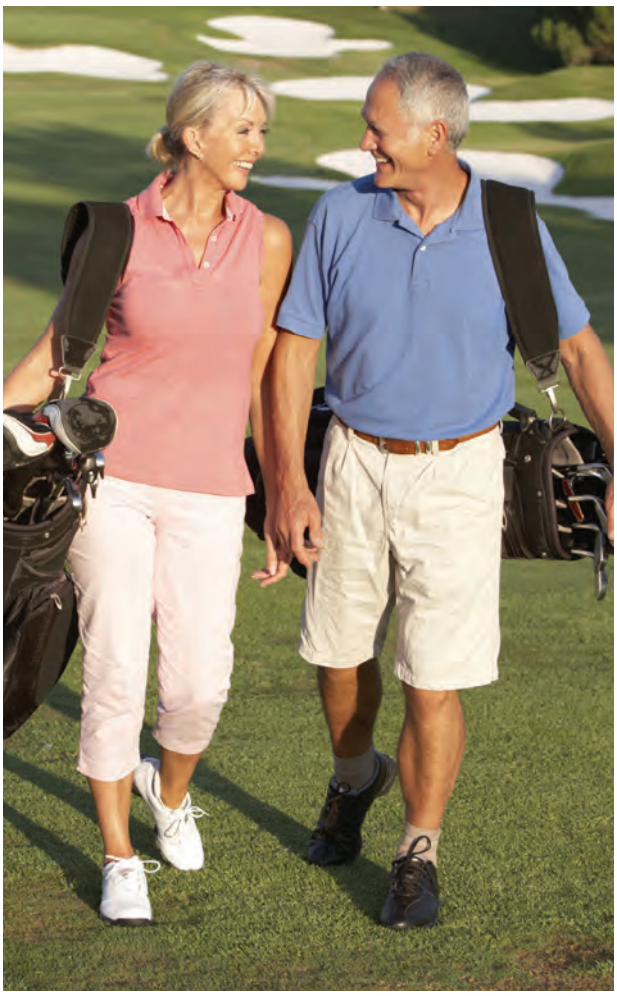
IF YOU AND YOUR SPOUSE ARE BOTH CHEVRON PHILLIPS CHEMICAL EMPLOYEES OR RETIREES

If you and your spouse are both Chevron Phillips Chemical employees or retirees, and you're both eligible for the health and income and survivor protection plans described in this handbook:

- You may each be covered as an employee/retiree under the plans, or
- One of you may be covered as an employee/retiree and the other may be covered as a dependent.
- You and your spouse will not be subject to the spousal surcharge for medical coverage as described on page A-4.

Only one of you may elect coverage for your eligible dependent children.

If you have been a Chevron Phillips Chemical employee continuously since January 1, 2001, your prior employment with Chevron Corporation or ConocoPhillips is included in calculating your continuous service at retirement.



For information about the ***Retiree Reimbursement Account (RRA)***, see page J-1.

Certain benefit plan amendments were made specifically in relation to employees who terminated employment with Chevron Phillips Chemical on the closing date of the Ryton business sale to Solvay Specialty Polymers USA, LLC ("Solvay") and became employed by Solvay on the closing date or the next following day ("Ryton Member(s)"). Certain benefit plan amendments were also made specifically in relation to employees who terminated employment with Chevron Phillips Chemical on the closing date of the K-Resin business sale to INEOS Styrolution America LLC ("INEOS Styrolution") and became employed by INEOS Styrolution on the closing date or the next following day ("K-Resin Member(s)"). Please see the ***Retiree Reimbursement Account (RRA)*** chapter (page J-1) and ***401(k) Savings and Profit-Sharing Plan*** chapter (page O-1) for more information on these benefit plan amendments in relation to Ryton Members and K-Resin Members.

Dependents

If you enroll in a benefit plan described in this handbook, you may also enroll your eligible dependents as outlined in the chart below. Note that the chart also lists certain exclusions.

Type of Dependent(s)	Eligible for Coverage	Not Eligible for Coverage
Your legally married spouse (excluding common-law spouses) in any jurisdiction, regardless of gender or state of residence	X	
Your spouse who is a common-law spouse or domestic partner, even if such relationship is recognized in the state in which he/she resides, and children of your common-law spouse or domestic partner who do not otherwise meet the definition of a dependent child[3]		X
Your dependent children — including biological children, stepchildren, foster children, legally adopted children, children legally placed for adoption and/or children under permanent legal guardianship or permanent sole managing conservatorship — if they are one of the following: ▪ under the age of 26, regardless of marital[1], student or employment status, ▪ your mentally or physically disabled children[2] age 26 or older who were covered under the plan before they reached the applicable age limits (newly hired employees with incapacitated or disabled children beyond the applicable age may be enrolled for coverage if they had prior medical coverage. You will need to contact the CPChem Benefits Service Center at 1-833-964-3575), or ▪ for purposes of the health care plans, a child who is the subject of a valid Qualified Medical Child Support Order, as determined by the plan administrator (for more information, see ***Qualified Medical Child Support Order (QMCSO)*** on page P-23)	X	
A dependent who is on active military duty		X
A dependent already covered as an employee of the Company		X
For retirees, any dependent who did not meet the definition of an eligible dependent on your retirement date. For avoidance of doubt, however, dependents who were eligible dependents as of your retirement date remain eligible for coverage, regardless of whether they were covered under a Chevron Phillips Chemical health plan on your retirement date, as long as they continue to meet the definition of an eligible dependent		X

[1] For supplemental child life insurance, the dependent child must be unmarried to be considered an eligible dependent.

[2] The definition of children includes biological children, stepchildren, foster children, legally adopted children, children legally placed for adoption and/or children under permanent legal guardianship or permanent sole managing conservatorship.

[3] Common-law spouses covered under the ConocoPhillips plan and domestic partners covered under the Chevron Texaco plan as of December 31, 2000, who became participants in the plans described in the Employee Benefits Handbook on January 1, 2001, are considered dependents. Anyone grandfathered under this plan provision who later loses coverage cannot reenter these plans.

Michelle's Law

Enacted on October 9, 2008, Michelle's Law allows seriously ill college students who are covered as dependents under self-funded and insured health plans — and who would otherwise lose coverage due to loss of dependent status — to retain coverage while on a medically necessary leave of absence. Effective January 1, 2010, the law applies to dependent coverage provisions under the Chevron Phillips Chemical group health plan as follows:

- Coverage for dependents who qualify under Michelle's Law must continue until the earlier of: (i) one year from the start of the medically necessary leave of absence, or (ii) the date on which such coverage would otherwise be terminated under the terms of the health plan.
- To qualify for the coverage extension, the child must be enrolled as an eligible dependent under a health plan and must be a student at a post-secondary educational institution immediately before the first day of the medically necessary leave of absence. The child's treating physician must provide certification that the child is suffering from a serious illness or injury that necessitates the leave of absence.

If You Enroll an Ineligible Dependent

If you enroll a dependent who doesn't meet the plan's eligibility requirements or don't cancel coverage within 31 calendar days of when a dependent ceases to meet the plan's dependent eligibility requirements, he or she will be considered an ineligible dependent and will be removed from coverage. The plan has the right to request reimbursement of any claims or expenses paid for an ineligible dependent. If canceling your ineligible dependent's coverage reduces your cost for coverage, any amounts you have overpaid will not be refunded. In addition, you may be subject to disciplinary action — up to and including termination of employment.

Certification of Eligible Dependents/ Required Documentation

When you enroll your dependents in benefits for the first time, you will be required to provide documentation to verify they are eligible dependents as defined by the plan. Failure to provide these documents when requested will delay the dependents' coverage and/or result in termination of existing coverage, retroactive to the date you added your dependents to coverage. Each year during open enrollment, you certify that the dependent(s) currently on your benefits continue to meet the criteria of an eligible dependent.

SPOUSAL SURCHARGE

If you choose Employee + Spouse or Employee + Family coverage under the medical plan, you will be asked to make an attestation regarding your spouse's access to other medical coverage when you complete your enrollment. If your working spouse has access to other employer-sponsored medical coverage but you choose to enroll him or her in Chevron Phillips Chemical's medical plan, you will be assessed a $100/month pre-tax spousal surcharge. The spousal surcharge does not apply if your spouse is employed by Chevron Phillips Chemical.

To waive the surcharge, you will have to confirm that your spouse does not have other medical coverage available through his or her employer (other than Chevron Phillips Chemical).

Since the spousal surcharge is associated with medical coverage, the treatment of the spousal surcharge with respect to coverage periods and "qualified status changes" is generally the same as for the medical plan.

How to Enroll

If you're eligible to enroll in the benefits described in this handbook, you can enroll using the procedure in effect at the time. If you have questions about the enrollment procedure, please contact the CPChem Benefits Service Center at 1-833-964-3575. When you enroll, you will:

- Choose from the plan options available at your location,
- Authorize any required payroll deduction premium payments for the coverage you select, and
- Decide which of your eligible dependents you wish to cover, if any.

When you enroll, you can elect the following coverage levels:

Health Care (includes medical, behavioral health, prescription drug, dental and vision coverage), Critical Illness and Supplemental Life	**Supplemental Accidental Death and Personal Loss (AD&PL)**	**Basic Life, Basic AD&PL, OAD&PL, Business Travel Accident and Long-Term Disability Insurance**	**Flexible Spending Accounts (FSAs)**	**Health Savings Account (HSA)**	**Group Legal Plan**
Employee-Only	Employee-Only	Employee-Only; automatic enrollment for all coverages	Employee makes contributions; money in your FSAs must be spent by the end of the plan year or you lose it	Employee enrolls in the *Value CDH Plan* and makes contributions; eligible expenses for employee and any eligible dependents are reimbursable up to the balance available in the account at the time of reimbursement	Enrollment in the plan covers the employee, spouse and eligible dependents
Employee + Spouse	Family coverage (includes employee and all eligible dependents)				
Employee + Child(ren)					
Employee + Family (includes spouse and children)					

DEFAULT COVERAGE

You must actively enroll or waive coverage within 31 days of your date of hire. If you don't, **you'll automatically be enrolled in the following**:

- Medical: Value CDH Plan — Employee-Only,
- Dental: Comprehensive Dental Plan — Employee-Only, and
- 401(k) Savings Plan (6% for the first year with 1% increases each year to a maximum of 8%).

If you don't want to be enrolled in medical and/or dental benefits, you must log on to digital.alight.com/cpchem or contact the CPChem Benefits Service Center at 1-833-964-3575 within 31 days of your date of hire to waive coverage. If you don't want to be enrolled in the 401(k) Savings Plan, you must contact the Chevron Phillips Pension and Savings Service Center at 1-866-771-5225 to waive enrollment.

WHEN EVIDENCE OF INSURABILITY (EOI) IS REQUIRED

In some cases, MetLife, the claims administrator for the income and survivor protection benefits, requires EOI — a statement of proof of your and/or your dependents' physical condition and other factual information — to apply for supplemental life insurance.

The amount of supplemental life insurance you can buy without EOI is called the "guaranteed issue" amount. You and/or your dependents must provide EOI acceptable to MetLife to apply for coverage in the following situations:

- After the first 31 days of eligibility, if a late entrant,
- Within 31 days of eligibility, if you enroll in supplemental life insurance coverage over three times your annual base pay or $400,000, whichever is less,
- Within 31 days of eligibility, if you enroll in spouse supplemental life insurance coverage over $50,000, and
- For a voluntary increase in supplemental life insurance for you or your spouse after the first 31 days of eligibility.

If you elect a supplemental life insurance coverage amount that requires Evidence of Insurability, complete an online form for yourself and/or your spouse through the CPChem Benefits Service Center website at digital.alight.com/cpchem. When required, a separate Evidence of Insurability form must be completed for you and your spouse. The insurance company must approve your application before the coverage begins or increases. For coverage to be effective, the employee must be actively at work.

You can also request a paper EOI form by calling the CPChem Benefits Service Center at 1-833-964-3575.

When to Enroll

You can enroll for coverage:

- When you first join Chevron Phillips Chemical, you must enroll within 31 days of your date of hire,
- If you become eligible because your employment status changes (for more information, see ***Who's Eligible*** on page A-1),
- During open enrollment, or
- If you have a qualified status change, you must enroll within 31 days of the qualified status change; for more information, see ***Qualified Status Changes*** on page A-10.

Generally, the choices you make are in effect for the plan year unless you have a qualified status change. For more information, see ***Qualified Status Changes*** on page A-10.

If you don't enroll a dependent within 31 days of that dependent's eligibility date, you will not be able to enroll that dependent until the next open enrollment period or a qualified status change occurs. For enrollment in certain benefits, evidence of his or her good health that is acceptable to MetLife may be required (see ***When Evidence of Insurability (EOI) Is Required*** on page A-6).

If you do not enroll yourself or your eligible dependents in medical and dental coverage because you have other coverage, you may be able to enroll in the future. For more information, see ***Special Enrollment*** on page A-12.

When Coverage Begins

For new hires and rehires, your benefits coverage begins on your date of hire or rehire.

If Evidence of Insurability is required for supplemental life insurance, coverage will begin when approval is received from the insurance company.

The date your coverage begins depends on when you enroll:

If You Enroll ...	Health Care, Critical Illness and Group Legal Plan Coverage Begins ...	Basic Life, Basic AD&PL, OAD&PL, Business Travel Accident and Long-Term Disability Coverage Begins ...	Supplemental Life and Supplemental AD&PL Coverage Begins ...
When you first join Chevron Phillips Chemical	As of your date of hire.	As of your date of hire, but only if you're actively at work on that day. Otherwise, coverage begins after you complete one full day of work once you return to your regular work schedule.	As of your date of hire, but only if you're actively at work on that day. Otherwise, coverage begins after you complete one full day of work once you return to your regular work schedule. Supplemental life insurance may require EOI before it is effective. For more information, see ***When Evidence of Insurability (EOI) Is Required*** on page A-6.
When you become eligible due to a change in your employee status	As of the effective date of the status change, provided you timely enroll.	As of the effective date of the status change, but only if you're actively at work on that day. Otherwise, coverage begins after you complete one full day of work once you return to your regular work schedule.	As of the effective date of the status change, but only if you're actively at work on that day. Otherwise, coverage begins after you complete one full day of work once you return to your regular work schedule.
During open enrollment	As of the effective date of coverage, which is typically January 1 of the new plan year.		On the later of: ▪ The effective date of coverage, which is typically January 1 of the new plan year, or ▪ The date your — or your dependent's — EOI, if required, is approved by MetLife.
When you have a qualified status change due to any life event other than birth/ adoption of a child (including marriage, spouse loses other coverage, spouse gains other coverage, after-tax insurance decrease, etc.)	▪ As of the first calendar day of the month following your qualified status change event, if the qualified status change event occurs on any day other than the first calendar day of the month. ▪ As of the date of the qualified status change event, if the qualified status change event occurs on the first calendar day of the month.		For your spouse and associated dependents as of the first day of the month following your date of marriage, or your date of marriage if it is the first day of the month, provided you timely enroll.
When you have a qualified status change due to birth or adoption of an eligible child	As of the date of the qualified status change, provided you timely enroll.	As of the date of the qualified status change.	As of the date of the qualified status change, provided you timely enroll.

Health Savings Account

If you elect medical plan coverage under the *Value CDH Plan*, you are eligible to open a Health Savings Account (HSA). To take advantage of these pre-tax savings, you need to decide how much you want to contribute and make your HSA election through the CPChem Benefits Service Center website at digital.alight.com/cpchem or by calling 1-833-964-3575. If you read and agree to Fidelity's HSA terms and conditions on the Alight site during enrollment, Alight will set up an HSA account with Fidelity for you. **You must authorize Alight to set up an HSA with Fidelity for you in order to receive the Company's annual contribution to your account, even if you choose not to make your own pre-tax contributions.** For further detailed information, see the ***Health Savings Account (HSA)*** chapter beginning on page I-1.

If you are a retiree, you are not eligible to make contributions to an HSA if:

- You currently have an outstanding balance in your Retiree Reimbursement Account (RRA) with Chevron Phillips Chemical,
- You or your spouse (if applicable) have a balance in a Retirement Health Reimbursement Account (Retirement HRA),
- You are enrolled in Medicare Parts A and/or B, or
- You and your covered dependents are otherwise covered by any other medical insurance that is not an IRS-qualified high-deductible medical plan.

What Coverage Costs

When you are first eligible for benefits, and each year at open enrollment, you will receive enrollment materials that show the cost of the various benefit plan options available to you. Depending on the benefit, either you or the Company pays for your coverage, or you share the cost.

- If you are an active employee, any amount that you pay for benefits is deducted from your paycheck.
- If you are a retiree, a survivor, have COBRA coverage or are on an unpaid leave for greater than 31 days, you are required to make periodic premium payments. If you are a retiree eligible for the RRA, you may be able to use your RRA to obtain reimbursement for your medical, dental and vision premium payments. For more information, see the ***Retiree Reimbursement Account (RRA)*** chapter beginning on page J-1.

Health Care Coverage

As an active employee, you and the Company share the cost of your medical and dental coverage, while coverage under the Vision PLUS Plan is fully employee-paid. The amount of your premium payments depends on the plan options you select and the dependents you cover. **You will pay a $100/month pre-tax surcharge if your working spouse has access to other employer-sponsored medical coverage (other than as an employee of Chevron Phillips Chemical) and you enroll him or her in Chevron Phillips Chemical's medical plan.** You make your premium payments for medical, dental and vision coverage with pre-tax dollars. This means that your taxable pay is lower and, as a result, so is the amount you pay for Social Security tax, Medicare tax, federal income tax, and in most areas, state and local income tax.

As a retiree, you pay 100% of your medical, dental and vision coverage. The amount of your premium payments depends on the plan options you select and the dependents you cover. If you're eligible for the RRA, you may be able to use your RRA to obtain reimbursement for your medical, dental and vision premium payments.

The medical plan (which includes prescription drug and behavioral health coverage) and dental plan are both self-insured by Chevron Phillips Chemical, which means the Company pays the claims. However, Chevron Phillips Chemical has contracted with insurance companies to serve as claims administrators to handle processing of all claims under the plans. VSP provides the Vision PLUS Plan and pays all claims under that plan. For more information on claims administrators, see pages P-28 – P-30.

Income and Survivor Protection Coverage for Actives

The Company currently pays the entire cost of your coverage for:

- Basic Life Insurance,
- Basic Accidental Death and Personal Loss Insurance (AD&PL),
- Occupational Accidental Death and Personal Loss Insurance (OAD&PL),
- Business Travel Accident Insurance, and
- Long-Term Disability (LTD).

You pay for any voluntary coverages with after-tax dollars. Voluntary coverages include:

- Critical Illness,
- Supplemental Life Insurance, and
- Supplemental Accidental Death and Personal Loss Insurance (AD&PL).

Premiums for your critical illness coverage are based on the level of coverage you elect, the amount of coverage and your age as of January 1 of the current year.

Premiums for your supplemental life and supplemental AD&PL coverage are based on the level of coverage you elect, your current pay and your age as of January 1 of the current year.

Premiums for your family for supplemental life and supplemental AD&PL coverages are based on who is covered and the level of coverage and are determined as follows:

Family Member	Premiums
Your spouse	Based on his/her age and level of coverage.
Your children	The same no matter how many eligible children you have.

For a list of rates, log on to the CPChem Benefits Service Center website at digital.alight.com/cpchem.

Income and Survivor Protection Coverage for Retired Employees

As a retiree, you can decide whether to convert or port your current Chevron Phillips Chemical life insurance coverage into an individual policy through MetLife. You can contact MetLife directly at 1-877-275-6387 to complete the transaction within 31 days of your retirement date*.

* Last day on the Chevron Phillips Chemical payroll.

Flexible Spending Accounts and Health Savings Account for Actives

If you choose to participate in the Flexible Spending Accounts or the Health Savings Account, your contributions are made with pre-tax dollars.

Group Legal Plan

If you elect Group Legal Plan coverage, your premium payments are deducted from your pay on an after-tax basis. Premiums for the Group Legal Plan cover you, your spouse and your eligible dependents.

When You Can Change Coverage

After your initial enrollment, you may change your plan options and whom you cover:

- During open enrollment,
- Within 31 days of a qualified status change, or
- If you are eligible for a special enrollment.

Qualified Status Changes

During the year, you may make certain changes to your benefit elections if you have a "qualified status change" and notify the CPChem Benefits Service Center at 1-833-964-3575, of that change within 31 days. Otherwise, you may have to wait until the next open enrollment period to make any changes. For more information, see ***Special Enrollment*** on page A-12.

"Qualified status changes" include:

- Your marriage* or divorce,
- Your spouse's or dependent's death,
- A change in your child's eligible dependent status,
- Addition of a child* through birth, adoption, placement for adoption, permanent legal guardianship or permanent sole managing conservatorship,
- A Qualified Medical Child Support Order that requires you to provide medical coverage for a child (for more information, see ***Qualified Medical Child Support Order (QMCSO)*** on page P-23),
- A change in employment status by you, your spouse or your dependent, resulting in a gain or loss of other health plan coverage by you, your spouse or your dependent,
- A change in work schedule resulting in a gain or loss of other health plan coverage by you, your spouse or your dependent, including a reduction or increase in hours of employment, a switch between part-time and full-time, a strike or lockout, or commencement of, or return from, an unpaid leave of absence,
- A change in the place of residence or work site by you, your spouse or your dependent,
- Your and/or your family member's becoming eligible or losing eligibility for Medicare or Medicaid,
- Your and/or your spouse's or your dependent's becoming entitled to COBRA,
- The taking of, or return from, a leave under the Family Medical Leave Act of 1993 or the Uniformed Services Employment and Reemployment Rights Act of 1994, or
- For the Dependent Care FSA only, a substantive change in your cost of care, such as an increase in the fee rate of your day care center.

* Addition of new spouse or child applies to active employees only and does not apply to retirees, unless the spouse or child met the definition of an eligible dependent on the retiree's retirement date.

You may also make certain changes to your benefit elections if your spouse or another dependent experiences a significant change in the cost (increase or decrease) or coverage level of their employer-sponsored benefit plan, and their open enrollment period does not coincide with Chevron Phillips Chemical's open enrollment period. For example, if your spouse is covered by his/her employer-offered HMO plan and that plan is eliminated, that change would be considered "significant" and would allow you to add your spouse to your Chevron Phillips Chemical health coverage outside of the open enrollment period.

You can only make changes to your elections during the plan year that are consistent with the qualified status change that you or your dependents experience. You may not reduce your Health Care Flexible Spending Account (HCFSA) or Limited-Purpose Flexible Spending Account (LPFSA) contribution election to an amount lower than the amount for which you have already been reimbursed for the plan year. The plan administrator has the exclusive authority to determine if you are entitled to change a benefit election as a result of a qualified status change, and its determination shall be binding on all persons. If your premium payments for coverage change as the result of a qualified status change, you will not be retroactively reimbursed any premium payments already paid.

Other Permissible Changes

Reduction in Hours

You may revoke an election of coverage under a Chevron Phillips Chemical group health plan if you have a reduction in hours and are reasonably expected to average less than 30 hours of service per week after the reduction. Your revocation election for you and your eligible dependents must accompany your intended enrollment in another plan that provides minimum essential coverage, with the new coverage effective no later than the first day of the second month following the month in which your coverage under the Chevron Phillips Chemical group health plan is revoked.

Eligibility for Exchange Coverage

You may also revoke an election of coverage under a Chevron Phillips Chemical group health plan due to enrollment in a qualified health plan offered through the Health Insurance Marketplace (Exchange Coverage). In order to revoke an election due to enrollment in Exchange Coverage, you must be eligible to enroll in Exchange Coverage as a special enrollee or during the Marketplace's annual enrollment period. In addition, the revocation election must accompany your intended enrollment for you — and any related individuals who cease coverage due to the revocation — in Exchange Coverage with an effective date no later than the day immediately following the date that coverage under the Chevron Phillips Chemical group health plan is revoked.

Special Enrollment

*Newly Acquired Dependent**

If you and/or your eligible dependents are not covered under any of the group health care plans described in this handbook, you and/or your eligible dependents may have special enrollment rights under certain of the group health care plans described in this handbook if you add a dependent as a result of birth, legal adoption, permanent legal guardianship, permanent sole managing conservatorship or marriage. In order to take advantage of this special enrollment right, you must enroll yourself and your eligible dependents within 31 days of the event giving rise to the special enrollment right. If the event giving rise to your special enrollment right is the birth, legal adoption, permanent legal guardianship or permanent sole managing conservatorship of a dependent, coverage for you and your eligible enrolled dependents will be effective on the date of the event, provided you timely enroll. If the event giving rise to your special enrollment right is your marriage, coverage for you and your eligible enrolled dependents will be effective on the first day of the month following your date of marriage, or your date of marriage if it is the first day of the month, provided you timely enroll.

* Addition of new spouse or child applies to active employees only and does not apply to retirees, unless the spouse or child met the definition of eligible dependent on the retiree's retirement date.

Children's Health Insurance Program Reauthorization Act of 2009 (CHIP)

On April 1, 2009, the Children's Health Insurance Program Reauthorization Act of 2009 (CHIP) was signed into law, extending additional enrollment rights to eligible employees and dependents. Under this law, Chevron Phillips Chemical will allow a special enrollment opportunity if you or your eligible dependents:

- Lose Medicaid or CHIP coverage because you are no longer eligible, or
- Become eligible for a state's premium assistance program under Medicaid or CHIP.

You have **60 days** from the date of the Medicaid/CHIP eligibility change to request enrollment in the Chevron Phillips Chemical group health plan. *Please note that the 60-day enrollment window applies **only** to enrollment opportunities under Medicaid/CHIP; the enrollment window for qualified status changes remains 31 days.* If you are eligible for a special enrollment opportunity through Medicaid or CHIP, please contact the CPChem Benefits Service Center at 1-833-964-3575, within 60 days of your eligibility to request coverage. Coverage for you and your eligible enrolled dependents will be effective on the date you are no longer covered by Medicaid or CHIP, provided you timely enroll.

Loss of Other Coverage

You and/or your eligible dependents may have special enrollment rights under certain group health care plans described in this handbook if you did not enroll yourself and/or your eligible dependents in the group health care plans when you were first eligible to enroll because:

- You and/or your eligible dependents had existing health coverage under another plan at the time you had an opportunity to enroll, and
- Coverage under the other employer's health benefit plan ended because of any of the following:
  - Loss of eligibility (including without limitation, legal separation, divorce or death), but not as a result of a failure to make any required premium payment toward the cost of the coverage.
  - The employer stopped paying the contributions.
  - In the case of COBRA continuation coverage, the coverage ended, but not as a result of a failure to make any required premium payment toward the cost of the coverage.

In order to take advantage of this special enrollment right, you must enroll yourself and your eligible dependents within 31 days of the event giving rise to the special enrollment right. Coverage will be effective on the date of the event, provided you timely enroll.

Making a Change

If you believe you are eligible to make a mid-year election change for one of the special enrollment reasons listed in this section, you must request an election change (and provide proof of your status change) by notifying the CPChem Benefits Service Center at 1-833-964-3575, or, for certain types of qualified status changes, by logging on to digital.alight.com/cpchem within 31 days (or 60 days in the case of a Medicaid/CHIP eligibility change) of the relevant event. Otherwise, you have to wait until the next open enrollment period to make any changes.

When You're on a Leave of Absence

For more information about the leaves discussed below, and any other leaves, please contact your local Human Resources Department.

Personal Leave

If you are on a paid personal leave of absence, all of your benefits will continue throughout your leave. If you are on a scheduled unpaid personal leave *for 31 days or less*, your benefits will continue during your leave and any missed premium payments will be deducted from your pay during the first pay period after you return to work.

If you are on an unpaid scheduled personal leave *for more than 31 days*, your benefits will be affected as follows:

Medical (includes behavioral health and prescription drug), Dental and Vision coverage	Basic Life, Basic AD&PL, OAD&PL, Business Travel Accident and LTD coverage	Critical Illness, Supplemental Employee Life, Supplemental Dependent Life, Supplemental AD&PL and Group Legal Plan coverage	Flexible Spending Accounts (FSAs)	Health Savings Account (HSA)
▪ Coverage ends on the last day of the calendar month in which your leave begins. ▪ You may continue coverage during your leave for up to 18 months through COBRA. You must make your COBRA elections within 60 days after being notified of your eligibility to elect COBRA continuation coverage. ▪ You must re-enroll in coverage within 30 days of your return to work. If you do not re-enroll after you return to work, you will be automatically enrolled in the plan(s) in which you were enrolled before your leave began.	▪ Coverage ends on the day your leave begins. ▪ Coverage will be reinstated when you return to work.	▪ Coverage continues as long as you make the required timely premium payments. ▪ If you do not make timely premium payments, coverage ends and will be reinstated when you return to work.	▪ Your participation ends on the last day of the calendar month in which your leave begins. However, you may continue to submit reimbursement claims for eligible expenses incurred before the start of your leave. ▪ You may continue participation in the HCFSA or LPFSA by making after-tax contributions until the end of the calendar year through COBRA. You must make your COBRA elections within 60 days after being notified of your eligibility to elect COBRA continuation coverage. ▪ If you want to resume participation after your leave, you must re-enroll within 30 days of your return to work.	▪ You may continue to make payments or withdrawals from your HSA for eligible health care expenses during your leave. ▪ You may make after-tax contributions to your HSA.

Long-Term Disability Leave and Disability Leave Without Pay

If you are on an approved Long-Term Disability leave or a disability leave without pay, your benefits will be affected as follows:

Medical (includes behavioral health and prescription drug), Dental and Vision coverage	Basic Life and Basic AD&PL coverage	OAD&PL, Business Travel Accident and LTD coverage	Critical Illness, Supplemental Employee Life, Supplemental Dependent Life, Supplemental AD&PL and Group Legal Plan coverage	Flexible Spending Accounts (FSAs)	Health Savings Account (HSA)
▪ Coverage continues during your approved leave (up to 24 months) as long as you make the required timely premium payments. ▪ Coverage will terminate at the end of your approved leave (maximum of 24 calendar months from the effective date of your first monthly installment of LTD benefit payments (your "LTD Benefit Start Date")). ▪ If you do not make timely premium payments, coverage ends and will be reinstated when you return to work.	▪ Coverage continues during your approved leave (up to 24 months). ▪ Coverage will terminate at the end of your approved leave (maximum of 24 calendar months from your LTD Benefit Start Date).	**Long-Term Disability Leave** ▪ Coverage ends on the day your leave begins. ▪ Coverage will be reinstated when you return to work, provided you return to work within 24 months from your LTD Benefit Start Date. **Disability Leave Without Pay** ▪ OAD&PL and Business Travel Accident coverage end on the day your leave begins. ▪ Coverage will be reinstated when you return to work, provided you return to work within 24 months from the initial date of your disability leave.	▪ Coverage continues during your approved leave (up to 24 months) as long as you make the required timely premium payments. ▪ Coverage will terminate at the end of your approved leave (maximum of 24 calendar months from your LTD Benefit Start Date). ▪ If you do not make timely premium payments, coverage ends and will be reinstated when you return to work.	▪ Your participation ends on the last day of the calendar month in which your leave begins. However, you may continue to submit reimbursement claims for eligible expenses incurred before the start of your leave. ▪ You may continue participation in the HCFSA or LPFSA by making after-tax contributions until the end of the calendar year through direct bill and pay through Inspira. ▪ If you want to resume participation after your leave, you must re-enroll within 30 days of your return to work.	▪ You may continue to make payments or withdrawals from your HSA for eligible health care expenses during your leave. ▪ You may make after-tax contributions to your HSA. ▪ You will not be eligible for Company HSA contributions while on long-term disability leave or disability leave without pay.

Military Leave

If you are on an approved leave of absence under the Uniformed Services Employment and Reemployment Rights Act (USERRA) *for less than 31 days*, any benefit plans you are enrolled in will continue during your leave. When you return from leave, any missed premium payments will be deducted from your pay during the first pay period after you return to work.

If your USERRA leave lasts *31 days or longer*, your benefits will be affected as follows:

Medical (includes behavioral health and prescription drug), Dental and Vision coverage	Basic Life, Basic AD&PL, OAD&PL, Business Travel Accident and LTD coverage	Critical Illness, Supplemental Employee Life, Supplemental Dependent Life, Supplemental AD&PL and Group Legal Plan coverage	Flexible Spending Accounts (FSAs)	Health Savings Account (HSA)
▪ Coverage ends on the last day of the calendar month in which your leave begins. ▪ You may continue coverage during your leave for up to 24 months. You must make your USERRA elections within 60 days from the date you are notified of your eligibility to elect USERRA continuation coverage. ▪ You may be required to pay up to 102% of the full cost of coverage under the plan. ▪ You must re-enroll in coverage within 30 days of your return to work.	▪ Coverage ends on the day your leave begins. ▪ Coverage will be reinstated when you return to work.	▪ You may continue coverage for the first 12 months of your leave by making the required timely premium payments. ▪ After 12 months, you may convert your coverage to an individual policy by contacting the claims administrator. ▪ If you do not make timely premium payments or your leave has been longer than 12 months and you do not convert your coverage to an individual policy, coverage ends and will be reinstated when you return to work.	▪ Your participation ends on the last day of the calendar month in which your leave begins. However, you may continue to submit reimbursement claims for eligible expenses incurred before the start of your leave. ▪ You may continue participation in the HCFSA or LPFSA by making after-tax contributions until the end of the calendar year. You must make your USERRA elections within 60 days from the date you are notified of your eligibility to elect USERRA continuation coverage. ▪ If you want to resume participation after your leave, you must re-enroll within 30 days of your return to work.	▪ You may continue to make payments or withdrawals from your HSA for eligible health care expenses during your leave. ▪ You may make after-tax contributions to your HSA.

For more information about your benefits while on military leave and your rights under USERRA, contact your local Human Resources Department.

FMLA Leave

The Family and Medical Leave Act (FMLA) of 1993 provides for continuation of certain health care benefits coverage during an unpaid leave of absence. If you take a leave under FMLA, you may elect to continue your coverage under some of the health care plans described in this handbook.

While on an FMLA leave, the Company will continue to make the same contributions on your behalf that it would have made had you not taken leave. You must also continue any required timely premium payments.

Paying for Coverage During Your Leave

The method for making required premium payments for benefits coverage during your leave depends on whether you are on a paid or unpaid leave:

- If you are on a paid leave, your premium payments will continue to be deducted from your pay.
- If you are on an unpaid leave, you must arrange to pay your premium payments on an after-tax basis, unless you receive any taxable compensation during your leave. The plan administrator will set the schedule for payments.

When Coverage Ends

Employees

As an employee, your coverage under the Chevron Phillips Chemical benefit plans ends on the earliest of these dates:

- The end of the month in which your employment with the Company ends,
- The end of the month in which you waive coverage,
- The last day of the month in which you are no longer an eligible employee (for more information, see ***Who's Eligible*** on page A-1),
- The date you die,
- The date the Company no longer offers the coverage (or, in the case of insured plans, the policy terminates),
- The date certain coverages continued during a leave of absence end (for more information, see ***When You're on a Leave of Absence*** on page A-13), or
- The date any required premium payment is not made.

For life insurance coverages, the benefit ends the date you terminate from the Company. For Flexible Spending Accounts (FSAs), the coverage end date depends on the type of FSA account. For details, see the ***Flexible Spending Accounts*** chapter beginning on page H-1.

Retirees

As a retiree, your coverage ends on the earliest of these dates:

- The date the Company no longer offers the coverage (or, in the case of insured plans, the policy terminates),
- The end of the month in which you waive coverage,
- The date any required premium payment is not made,
- The month you turn age 65 (for the medical plans only), or
- The date you die.

Dependents

Coverage for your dependents ends on the earliest of these dates:

- The last day of the month in which your coverage ends,
- The date you die (except as described under ***Survivor Coverage*** on page A-17),
- The last day of the month in which the dependent is no longer eligible (for more information, see ***Who's Eligible*** on page A-1),

- The date the Company no longer offers the coverage (or, in the case of insured plans, the policy terminates),
- The last day of the month in which any required premium payment is not made,
- The last day of the month in which a divorce or legal separation becomes effective,
- The last day of the month in which a dependent begins active military duty, or
- The last day of the month in which a dependent becomes covered as an employee of the Company.

Survivor Coverage

If you die while a participant in the medical, dental and/or vision plans, your dependents' coverage may continue in the same plan and at the same rates that employee/retiree dependents pay.

Your surviving spouse's coverage will end on the date he or she:

- Remarries,
- Does not make the necessary premium payments,
- Becomes covered as an employee of the Company,
- Waives coverage,
- Becomes eligible for Medicare,
- Attains age 65, or
- Dies.

Surviving spouses who lose coverage due to becoming eligible for Medicare or attaining age 65 will be eligible to continue dental and vision coverage at retiree rates as long as they continue to pay timely premiums.

Your surviving dependent children's coverage continues as long as they meet the dependent eligibility requirements and will end on the last day of the month when the earliest of the following occurs:

- The child attains age 26,
- The child becomes eligible for Medicare or Medicaid, or
- With respect to a child enrolled under family coverage, the deceased employee's or retiree's surviving spouse waives coverage or otherwise ceases to be eligible for coverage.

Once coverage is waived, a member cannot re-enroll in the plan.

How to Continue Coverage

Health Care

The Federal Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) entitles you and any covered dependents to continue group health care benefits under certain circumstances and subject to your payment of the required premiums when coverage would otherwise end. You and your dependents who are eligible for COBRA coverage because you were covered under the group health care plan on the date of a qualifying event are referred to as **qualified beneficiaries**. In addition, any child born to you, adopted by you or under your permanent legal guardianship or permanent sole managing conservatorship during your period of COBRA coverage is also a qualified beneficiary and is eligible for COBRA coverage for the remainder of the continuation period.

NOTICE REQUIREMENTS

Under the law, you or a family member has the responsibility to inform the CPChem Benefits Service Center of a divorce, legal separation or a child losing dependent status under the plan within 60 days from the later of: (i) the date of the qualifying event, or (ii) the date benefits would be lost as a result of the qualifying event. If notice is received by the CPChem Benefits Service Center more than 60 days from the later of: (i) the date of the qualifying event, or (ii) the date benefits would be lost as a result of the qualifying event, you may not be entitled to elect COBRA continuation coverage.

The length of COBRA coverage depends on the type of qualifying event causing your loss of coverage as follows:

Employee Qualifying Event	Dependent Qualifying Event
You and Your Dependents are Eligible for 18 Months of COBRA Coverage if:	**Your Dependents are Eligible for 36 Months of COBRA Coverage if:**
You terminate employment for reasons other than gross misconduct	They no longer qualify as dependents under the plan
Your work hours are reduced and that reduction in your work hours affects your eligibility for benefits	You die
You reach the last day of leave under the Family and Medical Leave Act (FMLA) and do not return to work	You divorce or legally separate
In the event you are out on FMLA leave and you inform your employer that you do not intend to return to work	You become entitled to Medicare and your entitlement to Medicare would, absent the first qualifying event, have resulted in your dependents losing coverage

In addition, special COBRA rules apply to retirees if Chevron Phillips Chemical goes into bankruptcy. In the unlikely event such a bankruptcy occurs, affected persons will receive notice of their COBRA rights.

A qualifying event occurs on the date of the qualifying event — not the date on which coverage ends because of the qualifying event.

If you are enrolled in a Health Care Flexible Spending Account (HCFSA) or the Limited-Purpose Flexible Spending Account (LPFSA) (if you are enrolled in the *Value CDH Plan*), you may also be able to continue your participation in the HCFSA or LPFSA for the remainder of the plan year under COBRA rules. For more information about your options under COBRA, go to www.dol.gov.

Electing COBRA Coverage

You or your dependent is responsible for notifying the CPChem Benefits Service Center at 1-833-964-3575, of a divorce, legal separation or loss of dependent eligibility. You are responsible for notifying Human Resources if you intend not to return after an FMLA leave. Chevron Phillips Chemical will notify the Benefits Service Center of your death, termination, leave of absence, or a reduction in your hours of employment which affects your right to benefits. You are responsible for notifying Inspira, the COBRA administrator, at 1-888-678-7835 if you become eligible for Medicare for any reason other than age.

In turn, Inspira, the COBRA administrator, will notify you and/or your dependents of your eligibility for continuation of coverage. Under the law, you have 60 days from the later of the date: (i) you would otherwise lose coverage or (ii) you are provided with the notice advising you of your right to elect COBRA coverage. You or your dependents will need to agree to pay the required premium payments.

If you do not elect COBRA continuation coverage, your coverage ends in accordance with plan provisions.

In the Event of Marriage or the Birth, Adoption, Permanent Legal Guardianship or Permanent Sole Managing Conservatorship of a Child

During the COBRA continuation period, you and all other qualified beneficiaries have the same rights as active employees to cover a new spouse, newborn or adopted child(ren) or children newly under your permanent legal guardianship or permanent sole managing conservatorship. However, only a child born to or adopted by you or placed under your permanent legal guardianship or permanent sole managing conservatorship will be a qualified beneficiary for COBRA coverage purposes. You or your eligible dependent must notify Inspira, the COBRA administrator, at 1-888-678-7835 within 31 days after the marriage, or birth, adoption, permanent legal guardianship or permanent sole managing conservatorship of a child to cover the spouse or child as a dependent under COBRA. Additional premium payments for continuation coverage for a new dependent must be paid on a timely basis. If COBRA coverage ends for a former employee, that employee's newborn or adopted child(ren) or those under permanent legal guardianship or permanent sole managing conservatorship can individually continue their coverage under COBRA.

Extending COBRA Coverage

Your dependents may extend their 18-month coverage to 36 months from the date of the initial qualifying event if a subsequent dependent qualifying event occurs during the original 18-month period of coverage. Specifically:

- Your covered spouse may elect to continue coverage for up to 36 months in the event of your death; your and your covered spouse's divorce or legal separation; or your entitlement to Medicare, if it otherwise would have resulted in your dependents losing coverage.
- Your covered dependent child(ren) may elect to continue coverage for up to 36 months in the event of your death; your and your covered spouse's divorce or legal separation; your entitlement to Medicare, if it otherwise would have resulted in your dependents losing coverage; or if a child no longer qualifies as a dependent child under the health care group plans.
- If you become entitled to Medicare while still employed with the Company and within 18 months you terminate employment for reasons other than gross misconduct, or your work hours are reduced and that reduction in your hours results in your loss of coverage, your dependents will be eligible for COBRA continuation coverage for up to 36 months from the date you became entitled to Medicare.

In the Event of Disability

An 18-month continuation period may be extended to 29 months if:

- You or a dependent are considered totally disabled under Social Security rules at the time you qualify for COBRA coverage or you or a dependent become disabled during the first 60 days of the 18-month COBRA continuation coverage period,
- The disability continues throughout the continuation period, and
- You or a qualified beneficiary provide evidence to Inspira of the Social Security Administration's determination of your or a qualified beneficiary's disability within 60 days after the date of the determination and before the end of the initial 18-month COBRA continuation coverage period.

Your non-disabled family members who currently have COBRA coverage are also entitled to this extension of coverage, regardless of whether the disabled individual elects the disability extension.

You or your covered dependents are responsible for paying the premium payments for months 19 through 29 of COBRA continuation coverage.

If Social Security determines that you or your disabled dependent are no longer totally disabled, you or your dependent must notify Inspira within 30 days. However, coverage cannot terminate before the later of: (i) the first of the month which begins more than 30 days after the determination that you or your dependent are no longer disabled, or (ii) the end of the initial 18-month COBRA coverage period.

Paying for COBRA Continuation Coverage

The cost of continuation coverage is the full cost (including both employee and employer costs) to provide the benefit plus a two percent administrative fee or other costs as permitted by law. If coverage is being continued due to disability, the cost during months 19 through 29 is determined based on who elects the disability extension and the nature of the coverage elected. If the disabled individual is part of the coverage group then the cost during months 19 through 29 is 150% of the full cost of coverage. If the disabled individual is not part of the coverage group then the cost during months 19 through 29 is 102% of the full cost of coverage. Chevron Phillips Chemical does not subsidize the cost in any way. The cost of coverage may change annually.

You are direct billed by Inspira for COBRA coverage after you enroll. COBRA premiums, payable to Chevron Phillips Chemical, are due on the first day of each month of coverage.

You have a 30-day grace period for payment of the regularly scheduled premium and 45 days from the date you elect COBRA coverage for the first payment. If premium payments are not made on a timely basis, COBRA coverage ends as of the last day of the month for which such premium payments were made.

Dependent Care

If you terminate employment and have an outstanding balance in your DCFSA, you may submit claims through the end of the year in which you terminate. This includes expenses incurred after termination of employment, provided you are working elsewhere (or looking for work) at the time the expense was incurred. You may **not** make additional contributions to your DCFSA after termination of employment.

When COBRA Coverage Ends

COBRA coverage may be terminated for any of the following reasons:

- The maximum COBRA continuation coverage period ends. (Coverage for a newly acquired dependent who has been added for the balance of a continuation period would end at the same time your continuation period ends, if he or she is not disabled nor eligible for an extended maximum).
- The premium is not paid on time.
- After the date of your COBRA election, you or your dependent receives health care coverage under another group plan that does not exclude coverage because of any pre-existing condition or under which any such pre-existing condition exclusion does not apply to you because of prior creditable coverage.
- After the date of your COBRA election, you or your dependent becomes entitled to Medicare (including Medicare entitlement due to end-stage renal disease).
- Chevron Phillips Chemical no longer provides group health benefits to its employees.
- The disability ends (or it is determined that the individual no longer is disabled) and you or your covered dependent received extended coverage due to disability (coverage in excess of 18 months up to 29 months). In this case, coverage ends as of the later of: (i) the first day of the first month that is more than 30 days after final determination under the Social Security Act that you or your covered dependent are no longer disabled, or (ii) the end of the initial 18-month COBRA coverage period. You have a duty to notify Chevron Phillips Chemical or Inspira, the COBRA administrator, within 30 days of any final determination. Inspira will cancel coverage at the end of the month when notification is made.
- You or your dependent dies.

How Health Care Coordination of Benefits Works

If You Are Covered by More Than One Plan

You or a covered dependent may be entitled to benefits from another source that pays all or part of the expenses incurred for health care (medical, dental or vision). If this is the case, benefits from Chevron Phillips Chemical plans may be reduced to an amount which, together with all benefits payable by other group plans, would not exceed the amount the Chevron Phillips Chemical plans would have paid if no other plans existed.

Another source of benefits means any group insurance or group-type coverage, whether insured or uninsured. This includes:

- Group or blanket insurance,
- Franchise insurance that terminates upon cessation of employment,
- Group hospital or medical service plans and other group prepayment coverage,
- Any coverage under labor-management trustee arrangements, union welfare arrangements or employer organization arrangements, or
- Governmental plans, or coverage required or provided by law.

This plan does not coordinate benefits with the following:

- Any coverage held by the participant for hospitalization and/or medical-surgical expenses which is written as a part of or in conjunction with any automobile casualty insurance policy,
- A policy of health insurance that is individually underwritten and individually issued,
- School accident-type coverage, or
- A state plan under Medicaid (Title XIX, Grants to States for Medical Assistance Programs, of the United States Social Security Act, as amended).

Under the plan, an "allowed expense" refers to the health care service or expense, including deductibles, co-insurance or copayments, that is covered in full or in part by any of the plans covering you or your covered dependent, except as set forth in this section or where a statute requires a different definition. Any expense or service or a portion of an expense or service that is not covered by any of the plans is not an "allowed expense."

When the plan provides benefits for an expense incurred for care provided by a network provider or an advanced procedure designated facility, the allowed expense is limited to the payment that the provider agreed to accept. For more information, see ***What's Covered*** on page B-21.

Order of Payment

If the Chevron Phillips Chemical plan is primary, its benefits are determined before those of another plan. The benefits of the other plan are not considered. When the Chevron Phillips Chemical plan is secondary, its benefits are determined after those of the other plan. In such a case, this plan's benefits may be reduced because of the other plan's benefits. When there are more than two plans, the Chevron Phillips Chemical plan may be primary to one and secondary to another.

If this coordination of benefits provision applies to benefits to which you or your family members are entitled, the bills must be filed with the "primary" carrier before being filed with the "secondary" carrier. A copy of the primary plan's explanation of benefits should be included with the secondary plan claim.

The Chevron Phillips Chemical plan determines the order of benefits by following the first of the following criteria that applies:

- A plan that does not coordinate with other plans is always the primary plan.
- The benefits of the plan that covers the person as an employee, member or subscriber (other than a dependent) is the primary plan; the plan that covers the person as a dependent is the secondary plan.
- The primary plan is the plan that covers the person as an employee who is neither laid off nor retired (or as that employee's dependent). The secondary plan is the plan that covers that person as a laid-off or retired employee (or as that employee's dependent). If the other plan does not have this rule and if, as a result, the plans do not agree on the order of benefits, this rule does not apply.
- In the case of a dependent child whose parents are not legally separated or divorced:
  - The primary plan is the plan of the parent whose birthday (month and day) falls earlier in the year. The secondary plan is the plan of the parent whose birthday falls later in the year.
  - If both parents have the same birthday, the plan that covered a parent longer is the primary plan; the plan that covered a parent for the shorter time is the secondary plan.
  - If the other plan has the male/female rule instead of the birthday rule and if, as a result, the plans do not agree on the order of benefits, the rule of the other plan determines the order of benefits.
- If a dependent child whose parents are legally separated or divorced and who is covered by the plans of both parents has a claim, the primary payer is the plan covering the parent who has financial responsibility for the child's health care under the terms of the court decree. In the absence of a court order, the payment order is:
  - The plan of the natural parent with custody, then
  - The plan of the spouse of the natural parent with custody, then
  - The plan of the natural parent without custody.

If none of the above rules determine the order of benefits, the primary plan is the plan that covered an employee, member or subscriber longer. The secondary plan is the plan that covered that person the shorter time.

Rules Regarding Processed Claims Transactions

Benefits otherwise payable under the Chevron Phillips Chemical plan for all expenses processed during a single "processed claim transaction" will be reduced by the total benefits payable under all "other plans" for the same expenses. An exception to this rule is that when the coordination of benefits rules of this plan and any "other plan" both agree that this plan is primary, the benefits of the other plan will be ignored in applying this rule. As used in this paragraph, a "processed claim transaction" is a group of actual or prospective charges submitted to the relevant claims administrator for consideration, that have been grouped together for administrative purposes as a "claim transaction" in accordance with the relevant claims administrator's then current rules.

Under the Chevron Phillips Chemical plan, medical, dental and vision coverages will be considered separate plans. The medical/pharmacy coverage will be coordinated with other medical/pharmacy plans, dental coverage will be coordinated with other dental plans and vision coverage will be coordinated with other vision plans.

Coordination With COBRA Continuation Coverage

If you have COBRA continuation coverage through another employer's medical, dental or vision plan, the Chevron Phillips Chemical plan is primary to your COBRA coverage. If you have COBRA continuation coverage under Chevron Phillips Chemical's medical, dental or vision plan in addition to coverage under another employer's plan, the COBRA coverage under Chevron Phillips Chemical's medical, dental or vision plan is secondary to coverage provided by the other employer's plan.

Coordination With Medicaid

The Chevron Phillips Chemical plan is primary and Medicaid is secondary for you or your covered dependent. Benefit payments are made by the plan in accordance with any assignments made by you or on your covered dependent's behalf as required by the state Medicaid plan.

Your or your covered dependent's qualification for Medicaid does not affect eligibility for coverage under this plan. This plan honors any subrogation rights acquired by the state by having paid Medicaid benefits to you or your covered dependent.

Coordination With Medicare

The Chevron Phillips Chemical plan pays primary and Medicare pays secondary if you or your covered dependent is Medicare-eligible and eligibility for Medicare is due to:

- **Age** — the covered **active** employee or covered spouse of an **active** employee is age 65 or older (**Note:** Chevron Phillips Chemical's COBRA coverage pays secondary to Medicare. If you or your spouse is eligible for Medicare, whether enrolled or not, COBRA coverage will always pay secondary as if you or your spouse had Medicare coverage),
- **Disability** — you or your covered dependent is less than age 65 and you have "active employment status" with Chevron Phillips Chemical in accordance with federal law and as determined by Chevron Phillips Chemical, or
- **End-stage renal disease (ESRD)** — this plan is primary only during the first 30 months of eligibility for Medicare due to ESRD, or as otherwise required by federal law. After 30 months, Medicare is primary and the plan is secondary.

Please note that Medicare remains the primary payer and the plan is secondary if:

- You or your covered dependent is already entitled to Medicare on the basis of age or disability when he/she becomes eligible for Medicare on the basis of ESRD, and
- The plan was properly paying secondary to Medicare based on the rules for age or disability.

Medicare pays primary to Chevron Phillips Chemical's health plans in regard to all other participants and dependents eligible for Medicare to the extent permitted by law.

Understanding the Health Insurance Portability and Accountability Act (HIPAA)

The federal law, HIPAA:

- Requires group health plans, such as Chevron Phillips Chemical's plans, to protect the privacy and security of your confidential health information, and
- If you leave Chevron Phillips Chemical, restricts your new employer's option to limit your coverage for pre-existing conditions, provided you had medical coverage with Chevron Phillips Chemical.

Privacy Rules

Chevron Phillips Chemical's health plans will not use or disclose your protected health information without your authorization, except if required for treatment, payment, health care operations, plan administration, or as required or permitted by law.

You can review a description of your protected health information and your rights and protections under HIPAA in the Notice of Privacy Practices. For more information, see ***Notice of Privacy Practices*** on page P-17.

Naming a Beneficiary

The following plans described in this handbook require you to name a beneficiary when you initially enroll or when you add or change your benefit elections:

- Basic and Supplemental Life Insurance,
- Basic and Supplemental Accidental Death and Personal Loss (AD&PL) Insurance,
- Business Travel Accident Insurance,
- Occupational Accidental Death and Personal Loss (OAD&PL) Insurance,
- Long-Term Disability (LTD) Insurance, and
- Critical Illness Insurance.

You may name anyone as your beneficiary for these plans during the benefit enrollment process with the CPChem Benefits Service Center. To begin this process, either call the CPChem Benefits Service Center at 1-833-964-3575, or log on to the CPChem Benefits Service Center website at digital.alight.com/cpchem to complete the process online.

You may change your beneficiary at any time by following a similar process. Log on to digital.alight.com/cpchem and select the "Manage Beneficiaries" tab. The change becomes effective after the process is completed.

If more than one beneficiary is designated without their respective interests being specified, the beneficiaries share equally. The interest of any beneficiary who predeceased you terminates and his or her share is payable equally to the surviving beneficiaries, unless the beneficiary designation specifically provides otherwise.

If there is an amount for which there is no designated beneficiary at your death, or if the named beneficiary does not survive you, the benefits are payable to the surviving person or persons in the first of the following classes that survives you.

For all benefits listed above other than LTD:

- Your spouse,
- Your children, including legally adopted children,
- Your parents,
- Your brothers and sisters, or
- Your estate.

For LTD:

- Your legally married spouse at the date of your death,
- If there is no such spouse, your biological or legally adopted child(ren) who, when you died, is(are) not married, and is(are) under age 25, or
- Your estate, if there is(are) no such surviving child(ren).

Note: For Basic and Supplemental Life Insurance, Accidental Death and Personal Loss Insurance (including Occupational Accidental Death and Personal Loss Insurance), and Business Travel Accident Insurance, if a beneficiary or a payee is a minor or incompetent to receive the benefit payment, MetLife will pay that person's guardian. If a person of legal age has petitioned the court, and has been appointed as guardian of the "property" or "estate" of the minor, the proceeds may be released to that person in his/her capacity as guardian.

Without such court authorization, MetLife's standard procedure when presented with a claim by a minor is to deposit the proceeds into a "blocked" Total Control Account® (TCA). The monies will remain in this interest-bearing account until the earliest of:

- The attainment of the age of majority by the minor, or
- MetLife receiving a certified court-issued document naming a guardian of the "property" or "estate" of the minor.

The fact that a minor child resides with a parent does not make that parent a legal guardian. The parent is the custodial guardian, but MetLife is unable to release any funds until a guardian of the property or estate of the minor is appointed by the court. This process ensures that the proceeds designated to the minor are used for the benefit of the minor, as the insured intended.

Note: The 401(k) Savings Plan also requires you to name one or more beneficiaries. This beneficiary designation can be made through Fidelity's Online Beneficiaries Service, available through Fidelity NetBenefits. Simply log on to NetBenefits at www.netbenefits.com and click on "Beneficiaries" under the "Your Profile" tab. If you do not have access to the Internet or prefer to complete your beneficiary process by paper form, please contact Fidelity at 1-866-771-5225.

(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 BlueCross BlueShield (BCBS):

- The *Value CDH Plan*,
- The *Choice PPO Plan*, or
- The *Select EPO 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 Cigna Global Health Benefits program. A separate Cigna Global 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, administered by CVS Caremark. 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 Health Advocate. 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 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 2024, 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 BCBS Blue Choice PPO 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 for services from most providers and 20% co-insurance for cardiac care, knee or hip replacement, spine surgery or maternity care services from BCBS's Blue Distinction Centers (BDCs) and Blue Distinction Centers+ (BDC+).

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% after deductible 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.

ABOUT PARTICIPATING PROVIDERS

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

- Accept BCBS'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 BCBS. For more information, see ***How to File a Claim*** on page B-22.
- Comply with BCBS'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 *Value CDH Plan*, *Choice PPO Plan* or *Select EPO Plan* network. If you have questions about network doctors and hospitals, call BCBS at 1-800-240-6430 or visit www.bcbstx.com.

ABOUT OUT-OF-NETWORK PROVIDERS

Out-of-network providers do not have signed agreements with BCBS. Because the benefit amounts BCBS 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 BCBS 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 BCBS Blue Choice PPO 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 and out-of-pocket maximums 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 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.

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 for services from most providers and 10% co-insurance for cardiac care, knee or hip replacement, spine surgery or maternity care services from BCBS's Blue Distinction Centers (BDCs) and Blue Distinction Centers+ (BDC+).

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 this page).

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. See ***Your Medical Plan Options: A Comparison Chart*** on page B-11 for the annual deductibles and out-of-pocket maximums.

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 (BCBS Blue Choice PPO network) 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, MDLIVE phone or online video consultations, specialist office visits, spinal manipulation 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 for services from most providers and 0% co-insurance (no out-of-pocket cost after deductible) for cardiac care, knee or hip replacement, spine surgery or maternity care services from BCBS's Blue Distinction Centers (BDCs) and Blue Distinction Centers+ (BDC+). 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*** on page B-3.

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 Provider Finder feature by logging on to www.bcbstx.com.

Under "Doctors & Hospitals":

- Click "Find a Doctor or Hospital."
- Enter a name, provider type, condition or procedure and your location.

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.

BCBS BLUE DISTINCTION® CENTERS

With the Blue Distinction Centers (BDCs) and Blue Distinction Centers+ (BDC+), you have access to designated specialty care facilities that have met national measures for quality and cost-efficient care. When you use a BDC, you will receive the most from your benefits and know that the facility has a record of providing proven, effective specialty care.

You are required to use a BDC or BDC+ for bariatric surgery and transplants, and you will pay a 10% lower co-insurance rate under all three medical plan options for cardiac care, knee or hip replacement, spine surgery and maternity care when you receive services at a BDC or BDC+.

To find a BDC or BDC+ near you, log on to www.bcbstx.com and choose "Doctors & Hospitals" then click the link for "Blue Distinction Centers for Specialty Care."

Recognized Charges

When you use an out-of-network provider, BCBS 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: 75% of the Medicare allowable rate in the state of Texas and 105% of the Medicare allowable rate in all other states.
- For services of hospitals and other facilities: 75% of the Medicare allowable rate in the state of Texas and 140% of the Medicare allowable rate in all other states.
- For prescription drugs: 110% of the Average wholesale price (AWP).

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

BCBS has the right to apply BCBS'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.

BCBS's reimbursement policies are based on BCBS'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.

BCBS 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 BCBS).
- **Geographic area:** The Geographic area made up of the first three digits of the U.S. Postal Service ZIP codes. If BCBS determines that BCBS needs more data for a particular service or supply, BCBS 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. BCBS updates its systems with these revised rates within 180 days of receiving them from CMS. If Medicare does not have a rate, BCBS 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 BCBS's negotiated fees for each covered service as payment in full.

Precertification

Certain medical services, procedures and treatments must be approved in advance by BCBS. 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 any 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 *Value CDH Plan* option or *Choice PPO 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, BCBS 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.

BCBS 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 BCBS'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, BCBS 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. BCBS 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 or Habilitation 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.

eviCore healthcare

eviCore healthcare (eviCore) is a radiology management company that works with BCBS to help achieve appropriate and effective diagnostic imaging procedures for patients. eviCore 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 eviCore 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 *Choice PPO Plan* and *Select EPO 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 *Choice PPO Plan* and the *Select EPO 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 *Choice PPO Plan* and *Select EPO 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 $3,200/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

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

[1] For the ***Value CDH Plan*** and the ***Choice PPO 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

	Value CDH Plan		Choice PPO Plan		Select EPO Plan
	In-Network[1]	Out-of-Network[2]	In-Network[1]	Out-of-Network[2]	In-Network Only[1]
Primary care office visits (surgical & non-surgical)	Preventive: 0% — deductible waived Non-preventive: 30% after annual deductible	Preventive: 50% after annual deductible Non-preventive: 50% after annual deductible	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: $35 copayment
Specialist office visits (surgical & non-surgical)	30% after annual deductible	50% after annual deductible	20% after annual deductible	40% after annual deductible	$50 copayment
MDLIVE phone or online video consultation	30% after annual deductible	N/A	20% after annual deductible	N/A	$20 copayment
Other physician services	30% after annual deductible	50% after annual deductible	20% after annual deductible	40% after annual deductible	10% after annual deductible
Outpatient services and hospital inpatient/outpatient services at BDC/BDC+ locations (certain services)[3]	20% after deductible	N/A	10% after deductible	N/A	0% after deductible
Inpatient and outpatient hospital services (not BDC/BDC+)[3]	30% after annual deductible	50% after annual deductible	20% after annual deductible and $250 copayment per admission[4]	40% after annual deductible and $250 copayment per admission[4]	10% after annual deductible and $250 copayment per admission[4]
Hospital emergency room	30% after annual deductible	30% after annual deductible	20% after annual deductible	20% after annual deductible	$150 copayment (waived if admitted), then 10%[5]

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

[2] **If you're enrolled in the Value CDH Plan option or Choice PPO 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] Eligible services at Blue Distinction Centers (BDCs) and Blue Distinction Centers+ (BDC+) include cardiac care, knee/hip replacement, spine surgery and maternity care.

[4] For the ***Choice PPO Plan*** and ***Select EPO 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.

[5] 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

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

[1] For the ***Value CDH Plan*** and the ***Choice PPO 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 BCBS,
- Non-covered services,
- 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 and/or habilitation therapy, spinal manipulation, autism treatment (speech, occupational 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 *Value CDH Plan* option or *Choice PPO Plan* option, you can protect yourself even further by using in-network doctors and hospitals.

If you are enrolled in the *Choice PPO Plan* option or *Select EPO 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-2, 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 and/or habilitation therapy	60 visits per calendar year for treatment of acute conditions only (maintenance care is not covered)
Autism treatment — speech, occupational and physical therapy	60 visits per calendar year for speech therapy, 60 visits per calendar year for occupational 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:

	Value CDH Plan[1]		Choice PPO Plan[1]		Select EPO Plan
	In-Network[2]	Out-of-Network[2]	In-Network[2]	Out-of-Network[2]	In-Network Only[2]
BCBS network	Blue Choice PPO Network		Blue Choice PPO Network		Blue Choice PPO Network
Deductible ▪ EE Only ▪ EE + Spouse ▪ EE + Child(ren) ▪ EE + Family	 $ 1,600 $ 3,200[3] $ 3,200[3] $ 3,200[3]	 $ 2,250 $ 4,500[3] $ 4,500[3] $ 4,500[3]	 $ 600 $ 1,200 $ 1,800 $ 1,800	 $ 900 $ 1,800 $ 2,700 $ 2,700	 $ 400 $ 800 $ 1,200 $ 1,200
Out-of-pocket maximum ▪ EE Only ▪ EE + Spouse ▪ EE + Child(ren) ▪ EE + Family	 $ 4,500 $ 9,000 $ 9,000 $ 9,000	 $ 6,750 $13,500 $13,500 $13,500	 $ 3,000 $ 6,000 $ 9,000 $ 9,000	 $ 4,000 $ 8,000 $12,000 $12,000	 $ 2,000 $ 4,000 $ 6,000 $ 6,000
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	50%	100% — deductible waived	60%	100% — deductible waived
Annual well-woman exam (includes labs)	100% — deductible waived	50%	100% — deductible waived	60%	100% — deductible waived
Mammograms (routine for women ages 39 and over)	100% — deductible waived	50%	100% — deductible waived	60%	100% — deductible waived
Well-child care (includes labs)	100% — deductible waived	50%	100% — deductible waived	60%	100% — deductible waived
Physician Office Visits					
Primary care office visits (surgical & non-surgical)	Preventive: 100% — deductible waived Non-preventive: 70%	Preventive: 50% Non-preventive: 50%	Preventive: 100% — deductible waived Non-preventive: 80%	Preventive: 60% Non-preventive: 60%	Preventive: 100% — deductible waived Non-preventive: 100% after $35 copay[5]
Specialist office visits (surgical & non-surgical)	70%	50%	80%	60%	100% after $50 copay[5]
MDLIVE phone or online video consultation	70%	N/A	80%	N/A	100% after $20 copay — deductible waived
Lab & X-ray	Preventive: 100% — deductible waived Non-preventive: 70%	Preventive: 50% Non-preventive: 50%	Preventive: 100% — deductible waived Non-preventive: 80%	Preventive: 60% Non-preventive: 60%	Preventive: 100% — deductible waived Non-preventive: 90%[5]
Maternity care	Prenatal office visits: 100% — deductible waived[6]. All other visits/ services covered at 70%	50%	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 90%[5]

Please see the footnotes on page B-14.

(continued)

	Value CDH Plan[1]		Choice PPO Plan[1]		Select EPO Plan
	In-Network[2]	Out-of-Network[2]	In-Network[2]	Out-of-Network[2]	In-Network Only[2]
Emergency Services					
Hospital emergency room	70%	70%	80%	80%	90% after $150 copay (waived if admitted)[7]
Urgent care	70%	50%	80%	60%	100% after $75 copay — deductible waived
Non-emergency use of the emergency room	Not covered	Not covered	Not covered	Not covered	Not covered
Ambulance	70%	70%	80% — deductible waived	80% — deductible waived	100% — deductible waived[7]
Outpatient Services					
BDC/BDC+ locations (certain services)[8]	80%	N/A	90%	N/A	100%
Outpatient surgery	70%	50%	80%	60%	90%
Physician/surgeon and related professional fees (non-office visits)	70%	50%	80%	60%	90%
Hospital Services					
Per confinement copay	Not applicable	Not applicable	$250	$250	$250
BDC/BDC+ locations (certain services)[8]	80%	N/A	90%	N/A	100%
Inpatient and outpatient (not BDC/BDC+)[8]	70%	50%	80%	60%	90%
Other Covered Services					
Spinal manipulation (limits apply)[9]	70%	50%	80%	60%	100% after $50 copay
Assisted Reproductive Technology (ART), including in vitro fertilization (limits apply)[10]	70%	50%	80%	60%	90%
Sterilization (tubal ligation/vasectomy)	Tubal ligation, including ancillary services: 100% — deductible waived; vasectomy covered at 70%	50%	Tubal ligation, including ancillary services: 100% — deductible waived; vasectomy covered at 80%	60%	Physician services covered at 100% after $100 copay; other services, such as hospital and lab, covered at 90%
Short-term rehabilitation (limits apply)[11]	70%	50%	80%	60%	100% after $50 copay if received in doctor's office or special rehabilitation facility; otherwise, covered at 90%

Please see the footnotes on page B-14.

(continued)

	Value CDH Plan[1]		Choice PPO Plan[1]		Select EPO Plan
	In-Network[2]	Out-of-Network[2]	In-Network[2]	Out-of-Network[2]	In-Network Only[2]
Autism treatment (inpatient/outpatient services, medication management and diagnostic services, and Applied Behavioral Analysis (ABA); speech, occupational and physical therapy, each up to 60 visits/year)	70%	50%	80%	60%	100% after $50 copay
Hearing aids (maximum benefit of $3,000 every 36 months)	70%	50%	80%	60%	90%
Routine eye exam[4]	100% — deductible waived	50%	100% — deductible waived	60%	100% — deductible waived
Routine hearing exam[4]	100% — deductible waived	50%	100% — deductible waived	60%	100% — deductible waived
Gym membership	$19 initiation fee and $19/month to $99/month access charge, based on gym tier	Not covered	$19 initiation fee and $19/month to $99/month access charge, based on gym tier	Not covered	$19 initiation fee and $19/month to $99/month access charge, based on gym tier
Travel Expense Reimbursement	100% of travel and lodging expenses to obtain covered services not available within 100 miles of the patient's home. Maximum of $50/day per person for patient and one approved caregiver (or two approved caregivers for a child). Annual limit of $10,000/year per patient.				
Prescription Drug Coverage					
For covered prescription drugs, you pay:					
Deductible	N/A — Prescription costs other than the $10/$20 generic preventive drug copays are subject to the *Value CDH Plan* medical deductible		N/A		
Retail (30-day supply)	*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%		*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.		
Specialty Drugs (30-day supply)	$0 copay (after deductible) if enrolled in PrudentRx[12] If not enrolled in PrudentRx: 30% (deductible applies)[13]		$0 copay if enrolled in PrudentRx[12] If not enrolled in PrudentRx: 30%		
Mail Order and CVS Retail (90-day supply)	*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%		*Generic Preventive Drugs:* $20 copay from a designated list of drugs and conditions *Other Drugs:* – Generic: $ 25 – Preferred Brand: $ 68 – Non-Preferred Brand: $125		

Please see the footnotes on page B-14.

[1] For the ***Value CDH Plan*** and the ***Choice PPO 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 Guidelines on www.mycpchembenefits.com/health.

[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] Eligible services at Blue Distinction Centers (BDCs) and Blue Distinction Centers+ (BDC+) include cardiac care, knee/hip replacement, spine surgery and maternity care.

[9] 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.

[10] Assisted Reproductive Technology (ART), including in vitro fertilization and artificial insemination, benefit limited to $10,000/lifetime for medical and $5,000/lifetime for associated prescription drugs.

[11] 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.

[12] You must enroll in PrudentRx to participate. A list of eligible specialty drugs is available online at www.mycpchembenefits.com/health under "CVS Caremark." If you are not enrolled in PrudentRx, you will pay 30% co-insurance for specialty drugs.

[13] Under the True Accumulator program, manufacturer's coupon payments for specialty drugs will not count toward your medical plan deductible, co-insurance or out-of-pocket maximum.

Behavioral Health Plan

The Behavioral Health Plan is administered by BCBS. 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 BCBS. 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 ***BCBS 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.

BCBS Behavioral Health Plan Covered Services Chart

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

IMPORTANT REMINDER:

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

Additional Programs

Virtual Visits through MDLIVE

When you enroll in any of the medical plan options, you can take advantage of a low-cost telemedicine feature available through MDLIVE.

Getting sick after hours or on weekends used to mean a lengthy, costly trip to the emergency room or urgent care center. But with your virtual visits benefit, provided by BCBS and powered by MDLIVE, the doctor is in 24/7/365 — and you don't have to leave the comfort of your own home. Virtual visits allow you to consult a doctor for non-emergency situations by phone, mobile app or online video anytime, anywhere. Speak to a doctor or schedule an appointment at a time that works best for you.

With virtual visits, you get:

- 24/7 access to an independently contracted, board-certified doctor,
- Access via online video, mobile app or telephone, and
- If necessary, an e-prescription sent to your local pharmacy.

Virtual visit doctors can treat a variety of health conditions, including:

- Allergies,
- Ear problems (ages 12+),
- Pink eye,
- Asthma,
- Fever (ages 3+),
- Rash,
- Cold/flu,
- Nausea,
- Sinus infections,
- And more.

You can also speak with a licensed counselor, therapist or psychiatrist for support through virtual visits, available by appointment. You can choose who you want to work with regarding issues such as anxiety, depression, trauma and loss or relationship problems.

With virtual visits, you will pay a lower copayment or co-insurance than a non-preventive physician office visit. For example, the typical cost for an MDLIVE consultation is $44 before insurance, compared to a primary care physician office visit of approximately $100.

To activate your MDLIVE account or schedule a virtual visit:

- Log on to the "Blue Access for Members" website at www.bcbstx.com or visit www.MDLIVE.com/bcbstx,
- Download the MDLIVE app from the Apple App Store or the Google Play Store,
- Call MDLIVE at 1-888-680-8646, or
- Text BCBSTX to 635-483, and MDLIVE's online assistant Sophie will help you activate your account.

Blue365® Member Discount Program

We want to help you take care of yourself, every day of the year. That's why BCBS health plan members have access to Blue365, an online destination for health-focused discounts. With discounts on health-related products, health and fitness clubs, weight-loss programs and so much more, you can decide what choices are right for you while saving money.

With Blue365, you can:

- Receive discounts and offers from national and local health and wellness companies that encourage mind and body wellness,
- Share the health — Blue365 can make living well a family activity with gym discounts, well-balanced meal ideas and more, and
- After you register, you'll get weekly deals delivered straight to your inbox, helping you focus on your health.

Start enjoying the discounts and deals today by visiting http://www.blue365deals.com/BCBSTX/. You will be asked to register to receive discounts, so be sure to have your medical ID card handy.

24/7 Nurseline

Employees and their family members enrolled in any of the medical plan options have around-the-clock access to reliable health information through BCBS's 24/7 Nurseline.

The 24/7 Nurseline is staffed by registered nurses who are available 24 hours a day, 7 days a week. When a health problem pops up late in the day or in the middle of night, it can be hard to know how serious it is. Should you go to the emergency room or urgent care? Or can it wait until you can see your regular doctor? The 24/7 Nurseline can help answer your health questions, day or night.

Plus, when you call, you can access an audio library of more than 300 health topics — from allergies to surgeries — available in English and Spanish.

Call the 24/7 Nurseline anytime at 1-800-581-0368.

Women's and Family Health

Whether you are pregnant or planning to get pregnant, you should prepare as much as you can. BCBS has several support services that provide you with maternity health care information and help guide you through pregnancy.

Be sure to take advantage of these specialized women's and family health resources:

- Ovia Health™ apps feature health trackers and provide videos, tips, coaching and more. Ovia Fertility, Ovia Pregnancy and Ovia Parenting apps can be downloaded from the Apple App Store or Google Play Store. During sign-up, make sure to choose "I have Ovia Health as a benefit." Then select BCBSTX as your health plan and enter your employer name (Chevron Phillips Chemical),
- Well onTarget® has self-guided courses about pregnancy that you can take online, covering topics such as healthy foods, body changes and labor. Find information in the Well onTarget portal on the "Blue Access for Members" website at www.bcbstx.com, and
- If your pregnancy is high risk, BCBS's maternity specialists will support you by phone from early pregnancy until six weeks after delivery. Call 1-888-421-7781 to be connected to a maternity specialist.

Connect With a Cancer Specialist

Cancer can be a scary word. The Cancer Services and Support program, provided by BCBS in collaboration with AccessHope, wants to make it a little less scary. They can help you understand your care options and your health benefits. And they'll be there to support you throughout your journey — from finding a provider through treatment and beyond. You can even ask a medical expert to review your case. This specialist will keep in touch with your doctor and refer you for a second opinion or provide information on possible clinical trials, if needed. Call the BCBS Customer Service Line at 1-800-240-6430 to learn more.

Point Solutions for Diabetes and Musculoskeletal

Medical plan participants with diabetes are eligible for a diabetes management program through Livongo. Participants can receive a glucose meter, testing supplies, a connected app that tracks your numbers and 24/7 access to expert diabetes coaches — all at no cost. To register, visit join.livongo.com/CPChem/hi and use Registration Code "CPCHEM" or call Livongo 1-800-945-4355.

Medical plan participants with musculoskeletal/joint pain and conditions can receive a personalized diagnosis and treatment through Airrosti. Airrosti assists individuals with acute or chronic pain and injuries such as back/neck, knee, shoulder, foot, wrist and more. You'll receive an accurate diagnosis, personalized recovery plan and effective injury recovery. Treatment plans include an assessment, orthopedic testing and provider-guided treatments and rehab solutions to restore function, increase mobility, reduce pain and prevent future injuries. For more information, call Airrosti at 1-800-404-6050 or visit www.airrosti.com.

Well onTarget®

Well onTarget provides tools and resources to help you manage your health. Visit the Well onTarget portal by logging on to www.bcbstx.com and clicking on "My Health." There you'll find:

- A Health Assessment to help you measure the status of your health,
- Digital self-management programs, lessons and challenges to help you reach your wellness goals,
- The Blue Points℠ program, where you can earn points and redeem them in the online shopping mall by completing specific activities and achieving goals, and
- Tools to track healthy behaviors and sync your fitness and nutrition devices with the Well onTarget portal or mobile app.

My Care Profile

Set up your My Care Profile to access information about your medical conditions, hospital and doctor visits, medications, test results and other key health information in one convenient, easy-to-access location. You can view information over time and validate recent updates. Access your My Care Profile by logging on to www.bcbstx.com and clicking on the "My Health" tab.

Fitness Program

All medical plan participants age 16 and older have the opportunity to enroll in an affordable Fitness Program offered by BlueCross BlueShield. You pay a $19 initiation fee and $19/month to $129/month (based on gym tier) for access to a nationwide network of fitness locations, or a digital content-only option for $10/month. For more information, see the "BCBS Fitness Program Flyer" at www.mycpchembenefits. com/wellness or call 1-888-762-2583.

Weight Management Program — Wondr

Medical plan participants ages 18 and older who meet basic screening requirements are eligible to participate in a weight management point solution through Wondr at no additional cost. Wondr is a virtual program that includes a mailed welcome packet, a simple self-paced mobile app for 24/7 support, on-call health coaches and an online community for social support. The personalized program is designed to change behaviors that allow you to lose weight and improve your physical and mental well-being. For more information, visit wondrhealth.com/cpchem.

BCBS Mobile Messaging

With BCBS mobile messaging, health information is right in the palm of your hand. You can text "keywords" to **33633** to receive information or resource links on health-related information.

Use the "keywords" in all caps below to receive information about the following:

- Digital Member ID Card = TXID,
- Find a Doctor = TXDOC,
- Find an Urgent Care = URGENTTX,
- 24/7 Nurseline = NURSE,
- Virtual Visits = MDLIVETX,
- Mobile app = BCBSTXAPP,
- Update Preferences = CONTACTTX,
- Weekly Health Tips = TXFIT, TXDIET and TXHEART, and
- Special Beginnings = NEWBABY (weekly tips), BABY (general information) and NEWBORN (NICU).

What's Covered

Medically Necessary Expenses

The plan pays benefits for services and supplies that are "medically necessary" (as determined by BCBS) for the diagnosis, care or treatment of an illness or injury. BCBS 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 BCBS 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,
- BCBS 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 clinical trial services are provided in connection with a phase I, phase II, phase III or phase IV clinical trial, and
  - the clinical trial is conducted in relation to the prevention, detection or treatment of cancer or other life-threatening disease or condition and recognized under state and/or federal law.

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 Value CDH Plan Option or Choice PPO Plan Option

Value CDH Plan and *Choice PPO 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 *Value CDH Plan* or *Choice PPO 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. BCBS 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 BCBS 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 BCBS at 1-800-240-6430, and on the Internet at www.bcbstx.com under "Forms & Documents" 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.

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 BCBS at 1-800-240-6430.

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-14.
- If a benefit payment is made by the plan, to you or on your behalf, which exceeds the benefit amount that you are entitled to receive, the plan has the right to require the return of the overpayment. The plan has the right to reduce, by the amount of the overpayment, any future benefit payment made to or on behalf of a participant in the plan. Another way that overpayments are recovered is by reducing future payments to the provider by the amount of the overpayment. These future payments may involve this plan or other health plans that are administered by BCBS. Under this process, BCBS reduces future payments to providers by the amount of the overpayments they received, and then credits the recovered amount to the plan that overpaid the provider. Payments to providers under this plan are subject to this same process when BCBS recovers overpayments for other plans administered by BCBS. This right does not affect any other right of recovery the plan may have with respect to overpayments.
- 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-16.

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 *Value CDH Plan* or *Choice PPO 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 generally recognized services prescribed in relation to Autism Spectrum Disorder by the participant's physician or behavioral health practitioner in a treatment plan recommended by that physician or behavioral health practitioner for a covered participant. Individuals providing treatment prescribed under the plan must be a health care practitioner:
  - who is licensed, certified or registered by an appropriate agency in their respective field, or
  - an individual acting under the supervision of a health care practitioner as described above.

  For purposes of this section, generally recognized services may include the following:
  - evaluation and assessment services,
  - screening at 18 and 24 months,
  - Applied Behavior Analysis,
  - behavior training and behavior management,
  - speech therapy (limited to 60 visits per calendar year),
  - occupational therapy (limited to 60 visits per calendar year),
  - physical therapy (limited to 60 visits per calendar year), and
  - medications used to address symptoms of Autism Spectrum Disorder.

  Visits for speech, occupational and physical therapy for Autism Spectrum Disorder will not apply towards the annual limits for speech, occupational and physical therapy for short-term rehabilitation and habilitation therapy for conditions other than Autism. Applied Behavioral Analysis therapies will not apply towards the visit limit maximums for speech therapy, occupational therapy and physical therapy. Preauthorization will be required to assess whether services meet coverage requirements. See ***Precertification*** on page B-6 for more information about preauthorization.
- 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,
  - intellectual disability, or
  - any other mental disorder.

Specific Covered Expenses *(continued)*

- 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
  - 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. Morbid obesity surgery is only covered when provided by a BCBS Blue Distinction® Center.

  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.

- COVID-19 testing and treatment — FDA-approved COVID-19 diagnostic testing, including items and services related to the testing and the associated provider visit (which may be in a doctor's office, through MDLIVE or teledoc/telehealth services, urgent care or in an emergency room).
- 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.

Specific Covered Expenses *(continued)*

- 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:
  - 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 *Value CDH Plan* option pays 70% of emergency room charges. The *Choice PPO Plan* option pays 80% of emergency room charges. 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.
- Family Planning Services and Treatment of Infertility, including:
  - Tubal ligation — In-network tubal ligation, including ancillary services, are covered at 100% (deductible waived) under the *Value CDH Plan* and the *Choice PPO Plan*. $100 copayment required under the *Select EPO Plan* option.
  - Vasectomy — $100 copayment required under the *Select EPO Plan* option.
  - Basic Family Planning and 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 family planning and infertility is covered only when provided by an in-network provider.
  - Comprehensive Family Planning and Infertility Expenses (Assisted Reproductive Technology) — only employees and covered spouses are eligible for benefits if all of the following tests are met:
    - the procedures are done while not confined in a hospital or any other facility as an inpatient,
    - 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, expenses for the following comprehensive family planning and infertility services, also referred to as Assisted Reproductive Technology (ART), are payable when provided by an in-network family planning and infertility specialist:
    - in vitro fertilization,
    - gamete intrafallopian tube transfer and zygote intrafallopian tube (only if less costly procedures have not been successful and limited to four completed oocyte retrievals and two more oocyte retrievals after a live birth),
    - uterine embryo lavage,
    - embryo transfer,

Specific Covered Expenses *(continued)*

- artificial insemination, and
- low tubal ovum transfer.

The medical plan lifetime maximum for ART is $10,000/lifetime and the Prescription Drug Plan lifetime maximum for associated covered prescription drugs is $5,000/lifetime.

IMPORTANT NOTE

Family planning services and treatment of infertility must be precertified by BCBS (see ***Precertification*** on page B-6). 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.

- 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 BCBS.

  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.

Specific Covered Expenses *(continued)*

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 BCBS.
  - 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.
  - 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 BCBS; no benefits are paid for non-approved days. You pay a $250 copayment/deductible per hospital admission under the *Select EPO Plan* and *Choice PPO* Plan options.
  - 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.

Specific Covered Expenses *(continued)*

- 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,
  - initial exam of a newborn child when performed by a doctor other than the doctor who delivered the child, and
  - one breast pump per plan year covered at 100% of allowed amount for in-network provider.

  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.

Specific Covered Expenses *(continued)*

- 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. BCBS 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.

  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.
- 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:
  - 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 this page.) 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:

Specific Covered Expenses *(continued)*

- 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 12 months thereafter
    - Includes immunizations
  - Adults:
    - One exam every 12 months (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.

  The 10 consecutive days of skilled observation are included in the maximum of 70 eight-hour shifts that are covered per calendar year.

Specific Covered Expenses *(continued)*

- 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 BCBS's Clinical Policy Bulletin on "Proton Beam and Neutron Beam Radiotherapy." It is also covered when medically necessary for head, neck and throat cancer.

- 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 45 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 and/or habilitation treatment — benefits are limited to 60 visits per calendar year for physical, occupational, speech and cognitive therapy services (separate limits apply for treatment of autism spectrum disorders as outlined in the "Autism Treatment" section on page B-25).

  The *Value CDH Plan* option pays 70% for in-network services and 50% for out-of-network services, subject to the applicable deductible 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 *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. 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.

Specific Covered Expenses *(continued)*

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 — tobacco cessation counseling and covered prescription and over-the-counter medications for tobacco cessation.
- 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 — BCBS 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 BCBS. 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),
  - 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).

Specific Covered Expenses *(continued)*

The in-network level of benefits is paid only for a treatment received at a facility designated by the plan as a BCBS Blue Distinction® Center (BDC) for the type of transplant being performed. Each BDC facility has been selected to perform only certain types of transplants. If you are a participant in the BDC 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 BDC for the transplant being performed will be covered as out-of-network, even if the facility is an in-network facility or BDC 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 BDC 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.

When significant travel is required to use a BCBS Blue Distinction® Center (BDC) 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 BCBS.

  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,

Specific Covered Expenses *(continued)*

  - 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 BCBS to provide urgent care, and
  - is, with BCBS'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 *Value CDH Plan* option or *Choice PPO 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, or
  - **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.

  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.
- Wigs — for hair loss due to injury or disease or treatment of a disease (alopecia, burns, chemotherapy, fungal infections, lupus and radiation therapy). Coverage includes one wig per calendar year, up to a maximum of $1,000.

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-36.
- 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.

Specific Non-Covered Expenses *(continued)*

- 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.
- Behavioral Health Services, as follows:
  - treatment of impulse control disorders such as pathological gambling, kleptomania, pedophilia or caffeine use,
  - treatment of antisocial personality disorder,
  - treatment in wilderness programs or other similar programs,
  - treatment of intellectual disability, defects and deficiencies. This exclusion does not apply to the treatment of mental disorders under the Behavioral Health Plan or to medical treatment of intellectually disabled participants as outlined under ***Specific Covered Expenses*** on pages B-24 – B-36, 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 and/or habilitation 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.

Specific Non-Covered Expenses *(continued)*

- 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.
- Dental — any dental service or supplies that are covered under the Chevron Phillips Chemical Dental Plan or under any other Company benefits plan including 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.
- 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, except EpiPens, and
  - any prescription drugs, injectables, medications or supplies provided by the customer or through a third party vendor contract with the customer.

Specific Non-Covered Expenses *(continued)*

- 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 educational testing and training related to behavioral (conduct) problems, learning disabilities and delays in developing skills.
- 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-36, 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 BCBS's negotiated charge for a particular service or supply.
- For out-of-network providers — the portion of a charge that exceeds BCBS'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.

Specific Non-Covered Expenses *(continued)*

- 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.
- 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.
- Family planning services and infertility treatments, except as specifically described in the "Family Planning Services and Treatment of Infertility" section under ***Specific Covered Expenses*** beginning on page B-27.
- 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.

  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.

Specific Non-Covered Expenses *(continued)*

- 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 BCBS, 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 BCBS 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.
- Short-term rehabilitation and habilitation therapy — charges for the following are not covered:
  - services provided while confined as an inpatient in a hospital or other medical care facility,
  - special functional communication training, including sign language lessons, for a person whose speech was impaired or lost,
  - 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,

Specific Non-Covered Expenses *(continued)*

  - treatment covered as part of spinal manipulation treatment as outlined in the "Spinal Manipulation Treatment" section under ***Specific Covered Expenses*** on page B-34, 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.
- 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-34.
- 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 BCBS.
- 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 BCBS 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 page B-26. This includes, but is not limited to:
  - 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.

(Performance Pipe Hourly Employees)

Prescription Drug Plan

Contents

Your Prescription Drug Plan

When you enroll in any of the medical plan options offered by Chevron Phillips Chemical Company LP (Chevron Phillips Chemical or the Company), you're automatically enrolled in the Prescription Drug Plan, administered by CVS Caremark. The plan enables you to purchase the medication you need from:

- A participating or non-participating retail pharmacy,
- CVS Caremark Mail Service Pharmacy (mail-order service) or the CVS Retail Maintenance Choice Program, or
- CVS Specialty pharmacy.

The amount you pay is based on:

- The medical plan option in which you are enrolled,
- Where you purchase the drug (at retail, at a CVS Pharmacy or through mail-order),
- The type of drug (preventive, maintenance or specialty), and
- Whether the drug is generic, preferred brand (formulary) or non-preferred brand (non-formulary).

Typically, your prescription will be filled with a generic drug, if available, unless your doctor specifies otherwise.

EXPATRIATE EMPLOYEES

Health care benefits, including prescription drug benefits, are provided to Chevron Phillips Chemical's expatriate employees and their dependents through the Cigna Global Health Benefits program. A separate Cigna Global packet will be provided to new expatriate employees.

Retirees and spouses age 65 and older (or Medicare-eligible) are not eligible for the Chevron Phillips Chemical Prescription Drug Plan, but will receive a **UnitedHealth Rx for Groups** enrollment packet 90 days prior to their 65th birthday (see page C-8).

How the Plan Works

For the *Choice PPO Plan* and the *Select EPO Plan*, you do not have to meet a deductible (including your medical plan deductible) before the plan begins to pay benefits for prescription drugs. You simply pay the copayment or co-insurance for your retail or mail-order prescription as outlined on pages C-3 – C-5.

The *Value CDH Plan* is different in that prescription drug costs do apply to the *Value CDH Plan* medical deductible. For the purposes of this plan, the family deductible can be met by one covered family member or a combination of covered family members if you have Employee + Spouse, Employee + Child(ren) or Employee + Family coverage. **Designated preventive drugs (see below) are not subject to the deductible, but all non-preventive medications are subject to the *Value CDH Plan* medical deductible.** Once your annual medical deductible is satisfied, you will pay 30% co-insurance for covered non-preventive drugs.

Lower Copays for Certain Generic Preventive Drugs

All three medical plan options — the *Value CDH Plan*, the *Choice PPO Plan* and the *Select EPO Plan* — feature a lower copay for designated generic preventive drugs. When these drugs are prescribed for listed conditions, you'll pay only:

- $10 for a 30-day supply (retail), or
- $20 for a 90-day supply (mail-order or CVS retail).

The designated preventive drugs must be purchased in 30-day or 90-day supply quantities. **The *Value CDH Plan* medical deductible is also waived** for these selected drugs.

Effective, early management of certain conditions using moderate-cost medications can help prevent future serious complications and reduce future medical costs. Some of the conditions and drugs that are included are:

- For cardiovascular conditions — such as lisinopril, atenolol, and amlodipine,
- For high cholesterol — such as simvastatin,
- For diabetes — insulin, drugs such as glyburide and metformin HCL, and supplies such as meters and One Touch strips, and
- For asthma — designated inhalers.

In addition, a few designated preventive drugs are covered at 100% — when prescribed by a physician — with no deductible, copay or co-insurance, as follows:

- For iron deficiency in children — iron supplements,
- For pregnancy — folic acid supplements,
- For birth control — designated over-the-counter and single source brand contraceptives,
- As prescribed to prevent cardiovascular disease — aspirin,
- For children aged 6 months through 5 years — oral fluoride supplements,
- For participants over age 65 — vitamin D,
- For participants ages 40 through 75 — certain generic cholesterol medications,
- Colonoscopy preparation medications,
- For breast cancer prevention — Exemestane and Anastrozole,
- For HIV prevention — Truvada and Descovy, and
- Designated Monkeypox vaccination and oral antivirals.

For more information on the preventive drugs covered at 100%, see the CVS Caremark No Cost Preventive List at www.mycpchembenefits.com under "Health & Wellness," then "Health."

Certain prescription drugs are excluded from coverage as listed in the CVS Caremark Medications Requiring Prior Authorization document at www.mycpchembenefits.com under "Health & Wellness," then "Health."

You can access and print the CVS Caremark Preferred Drug Guide (formulary), also referred to as the Performance Drug List, for the *Value CDH Plan*, the *Choice PPO Plan* and the *Select EPO Plan* at www.mycpchembenefits.com under "Health & Wellness," then "Health." All three medical plan options use one single, inclusive formulary. You can also find lists of prescription drugs that are included in each pharmacy management program, including the Preventive Drug List, No Cost Preventive List, Maintenance Drug List, PrudentRx Specialty Drug List, Medications Requiring Prior Authorization and more at www.mycpchembenefits.com under "Health & Wellness," then "Health."

Also, high-level categories of covered and non-covered prescription drugs can be found in the ***Medical Plan and Behavioral Health Plan*** chapter under ***Specific Covered Expenses*** beginning on page B-24 and ***Specific Non-Covered Expenses*** beginning on page B-36.

Participating Retail Pharmacies

You may purchase up to a 30-day supply of a prescription medicine at a participating retail pharmacy and pay the following amounts:

Participating Pharmacy Benefits — What You Pay for Up to a 30-Day Supply

	Value CDH Plan	Choice PPO and Select EPO Plans
Retail* (30-day supply)	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%	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.

* Penalties may apply after your second 30-day fill of maintenance medications. See ***Incentivized Mail-Order Program*** below for more information.

Maintenance Medications

A maintenance drug is one that must be taken on a regular basis. The plan allows you to obtain your first two 30-day fills of a maintenance drug at any retail pharmacy. After that, you have the option of obtaining up to a 90-day supply of your maintenance medications either through the mail-order pharmacy (CVS Caremark Mail Service Pharmacy) or at a local retail CVS Pharmacy through the Maintenance Choice Program. No matter which option you choose, you pay the same mail-order copayment/co-insurance.

You get the benefit of discounted rates from participating pharmacies even when you are paying all the cost (i.e., before the *Value CDH Plan* deductible is satisfied).

You may want to consider contributing to a Health Care Flexible Spending Account (HCFSA) or a Health Savings Account (HSA) (the HSA is for *Value CDH Plan* participants only) so you can cover your out-of-pocket prescription drug costs with pre-tax dollars.

Incentivized Mail-Order Program

If you continue to use a retail pharmacy (including CVS) for 30-day supplies of maintenance drugs after your second 30-day fill, then you will pay the following surcharge ***in addition to your standard copayment/co-insurance***:

- Generic Drug: $15
- Preferred Brand-Name Drug: $30
- Non-Preferred Brand-Name Drug: $45

Any surcharges you pay for continued use of a retail pharmacy for maintenance drugs do not count toward your medical plan annual out-of-pocket maximum. However, in no event will you pay more than the pharmacy's cash price for your maintenance medication. This will allow you to continue to take advantage of any special low-price drug promotions at your retail pharmacy for 30-day supplies. Effective February 23, 2023, Oklahoma residents are not subject to surcharges under the Incentivized Mail-Order Program due to changes in Oklahoma state law.

Receiving Benefits

To receive benefits, simply show your BCBS medical ID card to the pharmacist when you purchase prescriptions.

To find an in-network retail pharmacy, you can call CVS Caremark at 1-855-305-3028, or log on to www.caremark.com and search as follows:

- Under "Plan & Benefits" — choose "Pharmacy Locator"
- Enter the ZIP code, address or name of the pharmacy you are searching for
- Click "Search" to view a list of in-network pharmacies meeting your criteria

Non-Participating Retail Pharmacies

You may buy up to a 30-day supply of a prescription medicine at a non-participating pharmacy; however, you'll pay considerably more than if you use a participating pharmacy.

You must pay the full, non-discounted cost of the prescription at the time of purchase, and then submit an original receipt and a reimbursement claim form to CVS Caremark. Your final cost will be the difference between the non-discounted and discounted cost of the prescription drug (the ineligible cost) plus your copayment or co-insurance. The amounts above your normal copayment or co-insurance do not count toward the *Value CDH Plan* deductible or the annual out-of-pocket maximum under all three medical plan options.

Non-Participating Pharmacy Benefits — What You Pay for Up to a 30-Day Supply

Covered Prescriptions*	Value CDH Plan	Choice PPO and Select EPO Plans
Generic Preventive Drug	$10 copay from a designated list of drugs and conditions (deductible waived)	$10 copay from a designated list of drugs and conditions
Generic Drug**	Difference between discounted and non-discounted cost PLUS 30% of discounted cost; after *Value CDH Plan* deductible is met	Difference between discounted and non-discounted cost PLUS a $10 copayment
Preferred Brand-Name Drug**	Difference between discounted and non-discounted cost PLUS 30% of discounted cost; after *Value CDH Plan* deductible is met	Difference between discounted and non-discounted cost PLUS a $25 copayment
Non-Preferred Brand-Name Drug**	Difference between discounted and non-discounted cost PLUS 30% of discounted cost; after *Value CDH Plan* deductible is met	Difference between discounted and non-discounted cost PLUS a $50 copayment

* Precertification is required for certain prescriptions. For more information, see ***Precertification*** on page C-7.

** A penalty may apply after your second 30-day retail fill of maintenance medications. See ***Incentivized Mail-Order Program*** on page C-3.

Reimbursement claim forms are available by calling CVS Caremark at 1-855-305-3028 or by logging on to www.caremark.com and clicking "Plan & Benefits" then "Print Plan Forms" or at www.mycpchembenefits.com under "Forms."

Mail-Order Service

With the mail-order service, you may purchase up to a 90-day supply of prescription medication. If you take maintenance medication for a chronic or long-term condition — such as diabetes, arthritis, heart condition or high blood pressure — this service is ideal for you. CVS Caremark Mail Service Pharmacy can ship your mail-order prescription to any of the 50 states or to any U.S. territory. Effective February 23, 2023, Oklahoma residents are not eligible for the Mail-Order Service program due to changes in Oklahoma state law. Please note that federal law prohibits CVS Caremark Mail Service Pharmacy from shipping your order to a foreign country.

Mail-Order Service Benefits — What You Pay for Up to a 90-Day Supply

	Value CDH Plan	Choice PPO and Select EPO Plans
Mail-Order and CVS Retail (90-day supply)	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%	Generic preventive drugs: $20 copay from a designated list of drugs and conditions Other Drugs: ▪ Generic: $ 25 ▪ Preferred Brand: $ 68 ▪ Non-Preferred Brand: $125

To fill a new prescription using CVS Caremark Mail Service Pharmacy:

1. Ask your doctor for a 90-day prescription (with up to one year of refills, if appropriate).
2. Complete a CVS Caremark Mail Service Order Form. You can get a form from CVS Caremark at 1-855-305-3028 or by logging on to www.caremark.com and clicking on "Prescriptions" then "Start Mail Service" or at www.mycpchembenefits.com under "Forms."
3. Complete your order in one of these ways:

   Order by Mail — Mail the order form, your prescription and payment to the address shown on the form.

   Order by Fax (Doctor Only) — Have **your doctor**, or a member of your doctor's staff, fax your order form to the fax number shown on the form. Faxes must be sent from **your doctor's office**. Faxes from other locations (such as your home or workplace) cannot be accepted.

Note: For your protection, a doctor's signature is required on all prescriptions.

Maintenance Choice Program

You have the option to fill your 90-day supply of maintenance medications at a retail CVS Pharmacy through the Maintenance Choice Program. Just take your prescription to any retail CVS Pharmacy and you can receive a 90-day supply for the cost of mail-order. Effective February 23, 2023, Oklahoma residents are not eligible for the Maintenance Choice Program due to changes in Oklahoma state law.

Specialty Drugs

Specialty drugs are high-cost injectable, infused, oral or inhaled drugs that need close supervision and monitoring and often require special handling and storage.

All fills and refills of specialty prescriptions, including the first 30-day supply, must be obtained from CVS Specialty pharmacy. CVS Specialty pharmacy can fill your prescription specialty medicine and deliver it right to your mailbox. Designated specialty drugs are subject to precertification requirements (see ***Precertification*** on page C-7). For questions, call CVS Specialty pharmacy at 1-800-237-2767.

Participating Pharmacy Benefits — What You Pay for Up to a 30-Day Supply

	Value CDH Plan	Choice PPO and Select EPO Plans
Specialty Drugs (30-day supply)	$0 copay (after deductible) if enrolled in PrudentRx* If not enrolled in PrudentRx: 30% (deductible applies)	$0 copay if enrolled in PrudentRx* If not enrolled in PrudentRx: 30%

* You must enroll in PrudentRx to participate. A list of eligible specialty drugs is available online at www.mycpchembenefits.com/health under "CVS Caremark." If you are not enrolled in PrudentRx, you will pay 30% co-insurance for specialty drugs.

PrudentRx Specialty Drug Program

The PrudentRx Copay Program will cover all specialty drugs on the plan's formulary at 100% ($0 copay) by maximizing the value of the manufacturer's coupons on your behalf. Under the *Value CDH Plan*, you must satisfy the annual deductible before the plan will pay 100% under the PrudentRx program. If you don't enroll in PrudentRx, you will pay 30% co-insurance (after deductible under the *Value CDH Plan*) for specialty drugs.

If you or a covered family member are not currently taking, but will start a new medication covered under the PrudentRx Copay Program, you can reach out to PrudentRx or they will proactively contact you so that you can take full advantage of the PrudentRx Copay Program. You can reach PrudentRx at 1-800-578-4403 to address any questions.

Generics Preferred Program

Generic drugs have the same active ingredients as brand-name drugs but cost much less. This is because the companies that make generics don't spend large sums of money on advertising or research. By using generic drugs, you can save money and still achieve the same therapeutic outcome because every generic drug must undergo the same U.S. Food and Drug Administration (FDA) review as its equivalent band-name drug.

This is why Chevron Phillips Chemical utilizes the Generics Preferred Program. If you fill a prescription with a non-preferred brand-name drug when a generic drug is available, you are required to pay the non-preferred brand-name copayment or co-insurance, plus the difference in cost between the generic drug and the non-preferred brand-name drug. Please note that this cost difference is not applied to the *Value CDH Plan* deductible or the annual out-of-pocket maximum under all three medical plan options.

EXAMPLE OF HOW THE GENERICS PREFERRED PROGRAM WORKS

An employee with the *Choice PPO Plan* or *Select EPO Plan* has a prescription for a non-preferred brand-name drug that costs $180, while a generic is available for $60.

Under the Generics Preferred Program, the employee could choose to fill the prescription with a non-preferred brand-name drug, but he or she would be responsible for paying the difference between the non-preferred brand-name price and the generic price ($120) as well as the non-preferred brand-name drug minimum copay of $50. The employee would be responsible for $170, with Chevron Phillips Chemical paying the remaining $10. However, the employee could instead fill the prescription with a generic and pay only a $10 copay, with Chevron Phillips Chemical paying the remaining $50.

Rx Savings Solutions (RxSS)

Rx Savings Solutions (RxSS) is a unique program that can identify ways to help you save money on prescription drugs by searching for savings opportunities for you. Based on your prescriptions, RxSS may recommend lower cost alternative medicines, purchase channel substitutes or coupons for certain drugs. RxSS will contact you (typically by email or text) and, if you choose to participate, they will contact your physician and the pharmacy on your behalf to make any needed changes. You have to enroll to receive the savings, and you can opt out at anytime.

Caremark Cost Saver Program

The Caremark Cost Saver program will ensure you get the best available price for many commonly prescribed generic drugs. You'll receive automatic access to GoodRx's prescription pricing so you will pay lower prices, when available, on generic medications. Cost Saver automatically searches across multiple resources to find the lowest available price, while ensuring that your out-of-pocket prescription drug costs are included in your deductible (for the *Value CDH Plan* only) and out-of-pocket maximums. The program is applied automatically when you present your BCBS medical ID card.

Medically Necessary Substitution of Brand-Name Drugs

CVS Caremark has a review process that may allow you to receive a non-preferred brand-name drug at lower rates when a generic drug is available, if you can demonstrate that the non-preferred brand-name drug is medically necessary. If your request is approved, you may obtain prescriptions for the following copayment or co-insurance per prescription:

- *Value CDH Plan*
  - Retail (up to a 30-day supply) and Mail-Order (up to a 90-day supply): 30% co-insurance after deductible.
- *Choice PPO Plan* and *Select EPO Plan*
  - Participating retail pharmacy (up to a 30-day supply): 30% of the total cost or a $50 copayment, whichever is greater, or
  - Non-participating retail pharmacy (up to a 30-day supply): difference between the discounted and non-discounted cost PLUS a $50 copayment, or
  - Mail-Order (up to a 90-day supply): $125 copayment.

To start the review process, have your physician call CVS Caremark at 1-800-294-5979 or fax a letter of medical necessity to CVS Caremark at 1-888-487-9257. CVS Caremark may approve a lower rate for up to one year. Your physician may request an approval for a longer period for maintenance medications.

What's Covered

The list of drugs covered by the plan is called the formulary. An expert panel of physicians and pharmacists has carefully reviewed all of the medications on the formulary for safety, quality, effectiveness and cost. The formulary also includes generic drugs which the Food and Drug Administration approves as bioequivalent — meaning they perform in your body the same way as a brand-name drug.

The formulary is not company-specific or all-inclusive and does not guarantee coverage — there may be minor differences in preferred and non-preferred classifications between the formulary and Chevron Phillips Chemical's prescription drug coverage. All three medical plan options use CVS Caremark's Preferred Drug Guide (formulary), also referred to as the Performance Drug List. When appropriate, your doctor should use the formulary to prescribe drugs for you.

For information on the formulary or specific questions on covered drugs, please call CVS Caremark at 1-855-305-3028. You can access and print the 2024 CVS Caremark Preferred Drug Guide (formulary) at www.mycpchembenefits.com under "Health & Wellness," then "Health."

Precertification

If you take certain prescription drugs regularly for a designated ongoing condition like psoriasis, fungal infections, seizure disorders/migraines or rheumatoid arthritis, you may need precertification (also called prior authorization) and will be asked to have your physician provide a statement of medical necessity for those drugs.

Precertification ensures that a medicine is being prescribed to treat a covered medical condition. Many drugs have numerous uses and can be prescribed to treat multiple medical conditions. Most of these conditions are covered under the medical plan, but a few are not. For example, a drug that treats certain eye disorders may also be used to reduce wrinkles. When prescribed to treat the eye disorder, the drug would be covered. If it is prescribed to reduce wrinkles, it would not be covered.

In this program, your own medical professionals are consulted. When your pharmacist tells you that your prescription needs precertification, it simply means that more information is needed to see if the plan will cover the drug. Only your doctor (or sometimes a pharmacist) can provide this information.

Precertification is a program that helps you get prescription drugs you need with safety, savings and — most importantly — your good health in mind. It helps you get the most from your health care dollars with prescription drugs that work well for you **and** that are covered by the Prescription Drug Plan.

CVS Caremark will notify you if this requirement applies to you.

Prescription Drug Management Programs

Chevron Phillips Chemical's prescription drug coverage includes several prescription management programs to give you better care at a lower cost. If any of these specific programs apply to you, you'll receive information directly from CVS Caremark:

- **Specialty Care Management** — This program is intended to better manage the high cost of biotech injectable drugs.
- **Drug Quantity Management** — This safety program is designed to ensure that the quantity of units supplied in each prescription remains consistent with clinical dosing guidelines. This helps encourage the safe, effective and economical use of drugs.
- **Specialty Utilization Management Program** — Designated specialty drugs are high-cost injectable, infused, oral or inhaled drugs that need close supervision, monitoring and/or precertification. Specialty drugs are typically prescribed for rare conditions and applications such as inflammatory conditions, multiple sclerosis, growth hormones and pulmonary arterial hypertension.

Medicare Prescription Drug Benefits

For retirees and their spouses who are age 65 or older, or Medicare-eligible, UnitedHealthcare offers a Medicare Part D prescription drug plan called *UnitedHealth Rx for Groups* through UnitedHealthcare Insurance Company. Eligible participants will receive information directly from UnitedHealthcare approximately 90 days before their 65th birthday. Highlights of the Medicare prescription drug coverage available to you include:

- No annual deductible.
- Predictable and affordable flat copays.
- A formulary that includes 100% of the drugs covered by Medicare Part D.
- A national pharmacy network with over 60,000 convenient locations.
- A mail service pharmacy to fill your 90-day maintenance drug needs.

For more information about *UnitedHealth Rx for Groups* coverage options, call UnitedHealthcare Customer Service at 1-888-556-6648, 24 hours a day, seven days a week. Just be sure to identify yourself as a retiree of Chevron Phillips Chemical Company (Group #309).

Coordination of Benefits

The coordination of benefits provisions described in ***How Health Care Coordination of Benefits Works*** on page A-20 do not apply to the Prescription Drug Plan. Accordingly, prescriptions covered by another group medical plan cannot be submitted for reimbursement under the Chevron Phillips Chemical Prescription Drug Plan. You may want to consider contributing to the Health Care Flexible Spending Account (HCFSA) or the Health Savings Account (HSA) (the HSA is for *Value CDH Plan* participants only) so you can cover the additional cost of any prescription covered by another group medical plan.

Situations That Affect Your Benefits or Coverage

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 P-16.

(Performance Pipe Hourly Employees)

Employee Assistance Program (EAP)

Contents

Your Coverage

Chevron Phillips Chemical Company LP (Chevron Phillips Chemical or the Company) offers an Employee Assistance Program (EAP), administered by Health Advocate for U.S. employees and by Cigna Global EAP for U.S. payroll expatriate employees. The EAP is provided to all U.S. employees and their dependents regardless of their participation in a Chevron Phillips Chemical BlueCross BlueShield of TX medical plan. The EAP is provided all expats and their covered dependents who are enrolled in the Cigna Global medical plan. All employees are automatically enrolled in the EAP from their first day of employment.

How the Program Works

The EAP is a **Company-paid** program that offers confidential support and work/life services designed to help you balance the demands of work, life and personal issues. Employees, an employee's spouse or domestic partner, dependents, parents and mothers-in-law and fathers-in-law (collectively "members") in the U.S. are entitled to receive up to 10 counseling sessions per person, per incident in a 12-month period. Employees and their covered dependents who are enrolled in the Cigna Global medical plan are also entitled to receive up to 10 counseling sessions per person, per incident in a 12-month period through Cigna Global EAP.

EAP counselors can provide assistance with a wide range of things that may be causing problems in your work or home life, including:

- Stress or anxiety,
- Time management,
- Conflict resolution,
- Child care,
- Parenting and child development,
- Elder care,
- Legal services,
- Adoption,
- Marital and family problems,
- Financial difficulties,
- Self-improvement,
- Education,
- Grief, or
- Violence prevention.

EAP counselors are available by phone 24 hours a day, every day of the year. They can provide you with resources and referrals or arrange face-to-face counseling with a provider in your area. In a crisis situation, they will help you to access emergency care immediately.

If you require emergency inpatient services, extended counseling sessions or other mental health treatment, the EAP can coordinate that care through the Behavioral Health Plan, which is part of the medical plan. The EAP will coordinate with BlueCross BlueShield (BCBS) Behavioral Health Services for U.S. employees or through Cigna Global for U.S. payroll expatriate employees. If you are not covered by the Behavioral Health Plan (meaning you are not enrolled in a Chevron Phillips Chemical medical plan option), the EAP can refer you to community-based resources. You will be financially responsible for any follow-up care.

U.S. employees can call Health Advocate at 1-866-799-2691 to talk to an EAP counselor at any time. You also may reach the EAP by calling 1-800-446-1422 (option 8) or by logging into www.healthadvocate.com/cpchem.

Expatriate Employees

EAP benefits are provided to Chevron Phillips Chemical's U.S. payroll expatriate employees and their dependents through the Cigna Global EAP program. You can reach the International Employee Assistance Program (IEAP) online or by phone. Call the member services number located on the back of your member ID card or go online to www.CignaEnvoy.com.

Work/Life Services

The EAP can provide support to help you meet everyday challenges. By calling the phone numbers or visiting the websites listed above, you can get assistance with:

- Child care and parenting — referrals for child care, information on parenting, child safety and more.
- Adult care and aging — care options, referrals for caregiving, transportation, meals, retirement communities, etc.
- Academic programs — information about everything from preschool to college, financial aid, scholarships and special needs programs.
- Legal and financial assistance — expert consultation to help with your legal, financial and identity theft needs. Includes a prepaid initial in-person or telephonic consultation with a lawyer (or telephonic consultation with a financial expert) who can then give an estimate for continued paid legal services, if needed (discounts apply to some services). Access a free online library with resources for identity theft resolution, budgeting, debt management, family law, wills and more.

- Personal services — whether it's finding a pet sitter or a plumber, referrals to providers who can help you better manage your life at home.
- Well-being assistance — guidance for issues like managing stress, resolving conflict, dealing with substance abuse and more.
- Additional work/life services — save time and money on some of life's most important needs. Specialists provide expert guidance and personalized referrals to service providers including child and adult care, education, home improvement, consumer information, emergency preparedness and more.

Situations That Affect Your Benefits or Coverage

No benefits are payable for treatment you or a dependent receives before coverage begins or after coverage ends.

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 P-16.

When Coverage Ends

Coverage ends for you and your dependents at the end of the month in which your employment with the Company terminates.

(Performance Pipe Hourly Employees)

Critical Illness Plan

Contents

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),
  - Any non-melanoma skin cancer unless there is metastasis, or
  - Any malignant tumor classified as less than T1N0M0 under TNM staging.

What's Not Covered *(continued)*

- 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, 2020. You are diagnosed with cancer in December 2019. 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, 2020. You have a heart attack on December 31, 2019. 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, 2020 — 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 P-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. Critical Illness Plan coverage ends at the end of the month in which your employment with the Company ends. Under certain circumstances, you can continue your coverage when your employment with Chevron Phillips Chemical ends. You must make a request in writing on a form approved by MetLife within 31 days after your active employee coverage ends. You can request a coverage continuation form by calling MetLife at 1-800-438-6388. After enrolling in coverage continuation, you must pay premiums for coverage directly to the insurance carrier. Contact MetLife for more information, including details regarding when coverage continuation is or is not available and when continued coverage ends.

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 P-16.

(Performance Pipe Hourly Employees)

Dental Plan

Contents

Your Dental Plan Options

Chevron Phillips Chemical Company LP (Chevron Phillips Chemical or the Company) offers eligible employees a choice of dental plans, each administered by Aetna:

- The Preventive Dental Plan (Dental PPO/PDN with PPO II and Extend℠ Network), which covers routine preventive care and diagnostic services only, or
- The Comprehensive Dental Plan (Dental PPO/PDN with PPO II and Extend℠ Network), which covers a broad range of dental services, including routine and diagnostic services, fillings, dental surgery, major restorations and orthodontia.

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

EXPATRIATE EMPLOYEES

Dental benefits are provided to Chevron Phillips Chemical's expatriate employees and their dependents through the Cigna Global Health Benefits program. A separate Cigna Global packet will be sent to expatriate employees.

How the Plans Work

Preventive Dental Plan

The Preventive Dental Plan is designed for employees who expect to have few dental problems. It pays 100% of recognized charges for covered routine preventive and diagnostic care expenses, with no deductible. It does not provide any other benefits. You may use dentists who participate in the Aetna dental network or out-of-network providers. For more information, see ***Recognized Charges*** on page F-3.

When you use an Aetna participating provider, you save money because these participating dentists have agreed to provide their services at discounted rates.

Comprehensive Dental Plan

The Comprehensive Dental Plan (default coverage if you don't actively enroll upon hire) offers you a choice when you receive dental care. This plan will pay the same level of benefits for care received from any licensed dental provider — regardless of whether they participate in the dental plan provider network.

Because participating dentists have agreed to provide their services at discounted rates, you'll **save** money when you choose to receive care from a participating dentist.

If You Use Non-Participating Dentists

If you use a non-participating dentist, Aetna's payment is based on the fee charged or the recognized charge amount, whichever is less. You're responsible for any costs that exceed the recognized charge. You may also be required to pay a non-participating dentist directly and then submit a claim for reimbursement to Aetna. For more information, see ***Recognized Charges*** on page F-3 and ***How to File a Claim*** on page F-11.

ABOUT PARTICIPATING PROVIDERS

The dentists that participate in Aetna's dental network agree to:

- Accept Aetna's negotiated fee — which is usually lower than the fee charged by non-participating dentists — along with your deductible, as payment in full, and
- Handle claim filing for you and receive payment directly from Aetna. You receive an explanation of benefits (EOB) form showing the portion of the charges paid by Aetna and any amount you owe.

Your dentist's office can tell you if he or she participates in the Dental PPO/PDN with PPO II and Extend℠ Network. If you have questions about in-network dentists, call Aetna at 1-800-269-5314 or visit the Aetna website at www.aetna.com/docfind/.

FINDING DENTAL PLAN PROVIDERS

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

Under "Provider Types" — Choose **"Dentists (Primary Care)"** or **"Dental Specialists"**

Under "Plan" — Choose **"Dental PPO/PDN with PPO II and Extend℠"**

Important Features

Recognized Charges

The benefit amount Aetna pays when you see a non-participating dentist is based on the recognized charge. Only that part of a charge which is less than or equal to the recognized charge is a covered benefit. The recognized charge for a service or supply is the lowest of:

- The provider's usual charge for furnishing it,
- The charge Aetna determines to be appropriate, based on factors such as the cost of providing the same or a similar service or supply and the manner in which charges for the service or supply are made, billed or coded, or
- The charge Aetna determines to be the usual charge level made for it in the geographic area where it is furnished.

In determining the recognized charge for a service or supply that is unusual, or is not often provided in a certain area or is provided by only a small number of providers in the geographic area, Aetna may take into account factors such as:

- The complexity,
- The degree of skill needed,
- The type of specialty of the provider,
- The range of services or supplies provided by a facility, and
- The recognized charge in other geographic areas.

In some circumstances, Aetna may have an agreement with a provider (either directly, or indirectly through a third party) which sets the rate that Aetna will pay for a service or supply. In these instances, the recognized charge is the rate established in such agreement.

The benefit paid by the plan after seeing a non-participating dentist (using the recognized charges logic above) may be less than the amount charged by that dentist. If this happens, you are responsible for the difference between the Aetna benefit payment and the dentist's actual charges.

Predetermination of Benefits

If you are enrolled in the Comprehensive Dental Plan and your dentist recommends treatment for you or a covered dependent (other than routine care) that is expected to cost more than $350, you should ask him or her to request a predetermination of benefits from Aetna. This lets you and the dentist know in advance what services are covered, the dental benefits that will be paid and how much you will have to pay.

To request a predetermination, ask your dentist to complete a claim form describing the planned services and charges and submit the form to Aetna before treatment begins. Both you and your dentist will be notified of the results of the predetermination.

Alternate Treatment Provision

Sometimes more than one type of dental service can treat the same problem. ***If you are enrolled in the Comprehensive Dental Plan,*** Aetna may decide to authorize coverage only for a less costly service provided that all of the following terms are met:

- The service selected must be deemed to be an appropriate method of treatment by the dental profession,
- The service selected must meet broadly accepted national standards of dental practice, and
- The service selected must customarily be used nationwide for treatment.

You should review the differences in cost of the alternate treatment with your dental provider. Of course, you and your dental provider can still choose the more costly treatment method. However, you are responsible for any charges in excess of what the plan will cover.

What the Plans Pay

Although each dental plan pays much or most of covered charges, you share in the cost of covered services through deductibles and applicable co-insurance.

Deductible

The deductible is the amount you pay each plan year for covered dental services before the dental plan begins to pay benefits.

Under the Comprehensive Dental Plan, your deductible is based on the coverage level you elect. There is no deductible under the Preventive Dental Plan.

Your Annual Deductible

	Comprehensive Dental Plan	Preventive Dental Plan
Employee-Only	$ 50	None
Employee + Spouse*	$100	None
Employee + Child, one child*	$100	None
Employee + Children, two or more children*	$150	None
Employee + Family*	$150	None

* All covered participants can contribute toward the deductible to a maximum of $50 per person.

Co-insurance

When you incur a covered dental expense, you and the plan share the cost, called co-insurance. After you meet any applicable deductible, the plan pays a percentage of eligible dental charges and you are required to pay the remaining charges. To see how co-insurance is applied to various covered services, see ***Your Dental Plan Options: A Comparison Chart*** on page F-5.

Benefit Maximums

The Comprehensive Dental Plan limits the amount of benefits for covered services paid in any plan year and has a lifetime maximum for orthodontia coverage.

Your Benefit Maximums

	Comprehensive Dental Plan	Preventive Dental Plan
Plan year maximum benefit	$2,000 per person	None
Lifetime maximum orthodontia benefit	$2,000 (adult or child) per person	Not applicable

Your Dental Plan Options: A Comparison Chart

	Comprehensive Dental Plan	Preventive Dental Plan
General Information		
Deductible	$ 50/Employee-Only $100/Employee + Spouse* $100/Employee + Child, 1 child* $150/Employee + Children, 2+ children* $150/Employee + Family*	None
Plan year maximum	$2,000/person	None
For the following treatments and services, the dental plan options pay:		
Covered Services		
Diagnostic and preventive care	100%	100%
Basic services**	80%	Not covered
Major services**	50%	Not covered
Orthodontia		
▪ **Adults**	50%	Not covered
▪ **Children**	50%	Not covered
▪ **Lifetime maximum**	$2,000 per person	Not covered

* All covered participants can contribute toward the deductible to a maximum of $50 per person.

** Benefits are paid after the deductible is met.

What's Covered

Dental expenses are divided into four types:

- Type A expenses are for preventive dental services such as oral exams, cleanings and X-rays. To encourage good dental care, Chevron Phillips Chemical's dental benefits cover 100% of diagnostic and preventive services. The deductible does not apply to these services. **The Preventive Dental Plan covers only Type A expenses.**
- Type B expenses are for basic dental services, which include fillings, as well as basic periodontal and some oral surgery services. These expenses are covered under the Comprehensive Dental Plan at 80% after the deductible is met.
- Type C expenses are for major dental services, which include prosthodontics and major surgical and restorative services. These expenses are covered under the Comprehensive Dental Plan at 50% after the deductible is met.
- Orthodontia expenses include those for treatment of dependent children and adults. Benefits for orthodontia expenses are covered under the Comprehensive Dental Plan at 50%, up to the lifetime maximum orthodontia benefit. The deductible does not apply to orthodontia expenses.

Benefit Schedule

The following schedule shows what the plan pays for the specific services covered under Chevron Phillips Chemical's dental plans. Claim payments to participating dentists are based on a negotiated schedule of discounted fees. If you use a non-participating dentist, dental benefits are based on recognized charge determinations. For more information, see ***Recognized Charges*** on page F-3.

Covered Service	Plan Benefit	
	Comprehensive Dental Plan	Preventive Dental Plan
Type A — Diagnostic & Preventive Care — No Deductible Applies		
Routine oral exams, limited to two per year	100%	100%
X-rays and pathology ▪ Full mouth (including bitewing, if necessary) or panoramic, limited to one set every three years ▪ Bitewing, limited to two sets per year ▪ Periapical X-rays (single films up to 13) ▪ Intra-oral, occlusal view, maxillary or mandibular ▪ Upper or lower jaw, extra-oral	100%	100%
Prophylaxis (cleaning, scaling and polishing), limited to two per year	100%	100%
Fluoride treatments, for children to age 17, limited to two per year	100%	100%
Sealants, for children to age 15, one application every three years; permanent molars only	100%	100%
Space maintainers for children to age 17, unilateral or bilateral, fixed or removable, including adjustments within six months of installation	100%	100%
Type B — Basic Services — Subject to Deductible		
Visits ▪ Professional visit after-hours ▪ Emergency palliative treatment (to temporarily relieve pain)	80%	Not covered
Histopathologic exam of oral tissue	80%	Not covered
Oral surgery ▪ Extractions (uncomplicated; surgical removal of erupted tooth or root tip) ▪ Removal of impacted tooth (soft tissue impaction)	80%	Not covered
Other surgical procedures ▪ Alveoloplasty, per quadrant ▪ Closure of oral fistula ▪ Removal of extostosis ▪ Frenectomy ▪ Transplantation of tooth or tooth bud ▪ Crown exposure to aid eruption	80%	Not covered
Minor restorative services ▪ Amalgam and composite restorations — primary and permanent teeth ▪ Resin restorations ▪ Sedative fillings ▪ Pins, in addition to amalgam, composite or resin restoration ▪ Crowns, when tooth cannot be restored with a filling material ▪ Prefabricated stainless steel ▪ Prefabricated resin ▪ Recementation of inlays, crowns or bridges	80%	Not covered

(continued)

Covered Service	Plan Benefit	
	Comprehensive Dental Plan	Preventive Dental Plan
Type B — Basic Services — Subject to Deductible *(continued)*		
Periodontics ▪ Emergency treatment ▪ Occlusal adjustment, other than with an appliance or by restoration ▪ Subgingival curettage or root planing and scaling, per quadrant, limited to four separate quadrants every two years ▪ Gingivectomy treatment per quadrant, including post-surgical visits, limited to once per quadrant every three years ▪ Gingivectomy treatment per tooth, fewer than three teeth, limited to one per site every three years ▪ Gingival flap procedure per quadrant, including root planing, limited to one per quadrant every three years ▪ Periodontal maintenance procedures, limited to two per year in addition to the two regular cleanings	80%	Not covered
Endodontics ▪ Pulp capping ▪ Apexification/recalcification ▪ Pulpotomy ▪ Apicoectomy ▪ Root canal therapy, anterior or bicuspid teeth, including X-rays	80%	Not covered
Type C — Major Services — Subject to Deductible		
Oral surgery to remove a tooth partially or completely impacted in bone ▪ Typical removal of impacted wisdom teeth	50%	Not covered
Bridge abutments	50%	Not covered
Periodontics ▪ Osseous surgery per quadrant, including post-surgical visits, limited to once per quadrant every three years	50%	Not covered
Endodontics ▪ Root canal therapy, molars, including X-rays	50%	Not covered
Inlays/onlays, resin, metallic or porcelain/ceramic ▪ Inlay, one or more surfaces ▪ Onlay, two or more surfaces	50%	Not covered
Labial veneers ▪ Laminate — chairside ▪ Resin laminate — laboratory ▪ Porcelain laminate — laboratory	50%	Not covered
Crowns ▪ Resin or porcelain with noble or base metal ▪ Full cast, base or noble metal ▪ 3/4 cast, metallic ▪ Post and core ▪ Crown build-ups	50%	Not covered
Pontics: full porcelain, porcelain/resin processed to metal, full cast	50%	Not covered
Removable bridge, unilateral	50%	Not covered

(continued)

Covered Service	Plan Benefit	
	Comprehensive Dental Plan	Preventive Dental Plan
Type C — Major Services — Subject to Deductible *(continued)*		
Dentures and partial dentures, including an interim partial denture, relines, rebase, special tissue conditioning, adjustments and repairs; specialized techniques and characterizations are not eligible; limited to one reline or rebase in any 36 consecutive month period	50%	Not covered
Dental implants	50%	Not covered
Dental bone grafts	50%	Not covered
Non-surgical Temporomandibular Joint Disorder (TMJ) services	50%	Not covered
Occlusal guard for bruxism, limited to one every three years	50%	Not covered
General anesthesia and intravenous sedation when provided in connection with a covered surgical procedure	50%	Not covered
Orthodontia — No Deductible Applies		
Comprehensive orthodontics of adult or adolescent dentition, including post-treatment stabilization; interceptive and limited orthodontics and orthodontic treatment of transitional dentition (baby teeth)	50%	Not covered
Removable or fixed inhibiting appliance to correct thumbsucking	50%	Not covered

Dental/Medical Integration Program

The following additional dental expenses will be considered covered expenses for you if you have medical coverage and have at least one of the following conditions:

- Pregnancy,
- Coronary artery disease/cardiovascular disease,
- Cerebrovascular disease, or
- Diabetes.

The additional covered dental expenses include:

- One additional prophylaxis (cleaning) per year,
- Scaling and root planing (four or more teeth), per quadrant,
- Scaling and root planing (limited to 1 – 3 teeth), per quadrant,
- Full mouth debridement,
- Periodontal maintenance (one additional treatment per year), and
- Localized delivery of antimicrobial agents (not covered for pregnancy).

For the additional prophylaxis, the benefit is payable the same as other covered prophylaxis treatments.

For all other covered dental expenses listed above, the plan pays 100% and the additional services will not be subject to any frequency limits (except as listed above) or any plan year maximums.

If you have one of these conditions or are pregnant and would like to enroll in these enhanced benefits, call Aetna at 1-800-779-3357 (TTY: 711), Monday through Friday, 8 a.m. to 6 p.m. ET. A dental care coordinator will be happy to assist you.

Limitations

The replacement of, addition to, or modification of crowns, inlays, onlays and veneers, complete dentures, removable partial dentures, fixed partial dentures (bridges) and other prosthetic services is covered only if one of the following criteria is met:

- The replacement or addition of teeth is required to replace one or more teeth extracted after the existing denture or bridgework was installed. Comprehensive Dental Plan coverage must have been in force for the covered person when the extraction took place.
- The existing dentures, crown, bridgework, inlay, onlay or veneer cannot be made serviceable and was installed at least five years before its replacement.
- The existing denture is an immediate temporary one to replace one or more natural teeth extracted while the person is covered, it cannot be made permanent and replacement by a permanent denture is required. The replacement must take place within 12 months from the date of initial installation of the immediate temporary denture.

Tooth-Missing-But-Not-Replaced Rule

Coverage for the first installation of removable dentures, removable bridges and fixed bridgework is subject to the requirements that such dentures, removable bridges and fixed bridgework are:

- Needed to replace one or more natural teeth that were removed while this contract was in force for the covered person, and
- Not abutments to a partial denture, removable bridge or fixed bridge installed during the prior five years.

The extraction of a third molar does not qualify. Any such appliance or fixed bridge must include the replacement of an extracted tooth or teeth.

What's Not Covered

Chevron Phillips Chemical's dental plans do not cover the following expenses:

- Any services not listed in the ***Benefit Schedule*** on pages F-6 – F-8.
- Basic, Major and Orthodontic services which are not covered under the Preventive Dental Plan.
- Services that are not medically necessary, as determined by Aetna. This applies even if they are prescribed, recommended or approved by your dental provider.
- Charges submitted for services that are not rendered, or rendered to a person not eligible for coverage under the plan.
- Treatment by other than a licensed dentist, except for prophylaxis (cleaning and scaling of teeth) and topical application of fluoride performed by a licensed dental hygienist under the supervision and direction of a dentist.
- Charges submitted for services by an unlicensed provider or a provider not operating within the scope of his/her license.
- Cosmetic surgery, dentistry to correct congenital malformations, plastic surgery, reconstructive surgery, personalization or characterization of dentures or other services or supplies that improve, alter or enhance appearance, augmentation and vestibuloplasty, and other substances to protect, clean, whiten, bleach or alter the appearance of teeth; whether or not for psychological or emotional reasons, except to repair an injury. Surgery must be performed in the calendar year of the accident that caused the injury or in the next calendar year. Facings on molar crowns and pontics will always be considered cosmetic.
- Services or appliances, including crowns, bridges, restoration and root canal therapy, that commenced or were provided before the date the person became covered under the plan or after termination of plan coverage, unless coverage is continued as outlined under ***Benefits for Treatment in Progress After Coverage Terminates*** on page F-12.
- First installation of a denture or fixed bridge, and any inlay and crown that serves as an abutment to replace congenitally missing teeth or to replace teeth all of which were lost while the person was not covered under the plan.
- Charges for an orthodontic procedure if an active appliance for that procedure was installed before the person was covered under the plan.

- Prescription drugs, laboratory tests and/or exams, pre-medications and relative analgesia (prescription drugs are covered under Chevron Phillips Chemical's prescription drug benefits).
- Hospitalization.
- General anesthesia and/or intravenous sedation except when provided in connection with a covered surgical procedure.
- Charges for completion of claim forms.
- Charges for canceled or missed dental appointments.
- Charges for instructions regarding diet, plaque control and oral hygiene.
- Charges for any dental examinations:
  - Required by a third party, including examinations and treatments required to obtain or maintain employment, or which an employer is required to provide under a labor agreement,
  - Required for securing school admissions or professional or other licenses,
  - Required to travel, attend a school, camp or sporting event or to participate in a sport or other recreational activity, and
  - Any special dental reports not directly related to treatment except when provided as part of a covered service.
- Appliances, surgical procedures or restorations used for the purpose of splinting, to alter vertical dimension, to restore occlusion or to replace tooth structure loss resulting from attrition, abrasion or erosion.
- Replacement of a device or appliance that is lost, missing or stolen, and for the replacement of damaged appliances due to abuse, misuse or neglect and for an extra set of dentures.
- Services that are experimental or investigational in nature, as determined by Aetna.
- Services and supplies for which the patient is not legally obligated to pay or for which no charge would be made in the absence of dental coverage.
- Services and supplies to diagnose or treat a disease or injury that is an occupational disease or injury related to employment or self-employment including injuries that arise out of (or in the course of) any work for pay or profit.
- Services to treat a dental disease, defect or injury due to an act of war, declared or undeclared.
- Treatment of work-related injuries to sound, natural teeth or services that are covered under workers' compensation or employers' liability laws.
- Certain services related to the treatment of a jaw joint disorder, including but not limited to, Temporomandibular Joint Disorder (TMJ), except as specifically provided.
- Space maintainers, except when needed to preserve space resulting from the premature loss of deciduous teeth.
- A crown, a cast or a processed restoration, unless:
  - It is for the treatment of decay or traumatic injury, and teeth cannot be restored with a filling material, or
  - The tooth is an abutment to a covered partial denture or fixed bridge.
- Pontics, crowns, cast or processed restorations made with high noble metals (gold or titanium).
- Surgical removal of impacted wisdom teeth only for orthodontic reasons.
- Dental services or supplies provided where there is no evidence of pathology, dysfunction or disease, other than covered preventive services.
- Services provided by any government agency, community agency, foundation or similar entity, including programs provided under Title XIX of the Social Security Act or Medicaid.
- Court ordered services, including those required as a condition of parole or release.
- Services and supplies provided for your personal comfort or convenience, or the convenience of any other person, including a provider.
- Services needed in connection with non-covered services.
- Services that are covered under Chevron Phillips Chemical's medical plan or any other plan provided by Chevron Phillips Chemical. The following services are typically medical in nature and, therefore, are not covered under the dental plan:
  - Biopsy of oral tissue,
  - Incision and drainage of abscess,
  - Removal of cysts or tumors that are dental in origin,
  - Closure of salivary or oral fistula,
  - Sequestrectomy,
  - Suture of soft tissue injury,
  - Removal of salivary calculus,
  - Excision of tissue, and
  - Removal of foreign body from soft tissue.

- The following orthodontic services and supplies:
  - Replacement of broken appliances,
  - Re-treatment of orthodontic cases,
  - Changes in treatment necessitated by an accident,
  - Maxillofacial surgery,
  - Myofunctional surgery,
  - Treatment of micrognathia,
  - Treatment of cleft palate,
  - Treatment of macroglossia,
  - Invisalign (ceramic/clear braces), except if the patient chooses these instead of conventional orthodontic appliances (metal braces). In this case, the patient is responsible for the co-insurance amount plus the difference between the normal fee for the conventional appliance and the dentist's fee for the ceramic/clear lingual Invisalign appliance, and
  - Removable acrylic aligners (i.e., "invisible aligners").

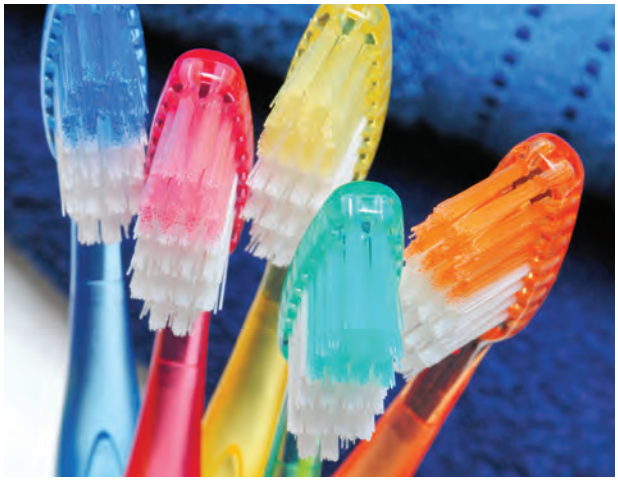
How to File a Claim

If You Use Participating Dentists

You don't have to file claim-related paperwork. Simply make sure that your dentist knows you are enrolled in an Aetna plan and show your dental ID card. Your dentist's office will verify your eligibility and benefits and handle all claim filing on your behalf.

Aetna reimburses participating dentists directly for covered services. Typically, the dentist's office bills you for your deductible and co-insurance percentage, as well as any non-covered services or supplies.

When your claim is processed, Aetna sends you and your dentist a written explanation of benefits.



If You Use Non-Participating Dentists

The plan prohibits any assignment of benefit claims or any other types of claims or ERISA rights to a non-participating dentist 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.

Although many dental offices will submit charges to Aetna for reimbursement, you should always check first. If the dentist's office handles claim filing for you, Aetna may pay benefits directly to the dentist. Otherwise, payments will be made directly to you, and you will be responsible for paying the dentist. In the event that Aetna pays the dentist directly, such payment shall in no way be interpreted as a waiver of the plan's prohibition on assignment of benefits.

In some cases, non-participating dentists may ask you to pay up front for dental services and handle claim filing on your own. When this happens, Aetna pays benefits directly to you.

A claim must be submitted to Aetna in writing within 90 days of receiving services. 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 it as soon as possible. Unless you are legally incapacitated, late claims for dental benefits will not be covered if they are filed more than two years after the deadline.

Benefits are based on recognized charge determinations. For more information, see ***Recognized Charges*** on page F-3. You are responsible for paying the difference between your dentist's actual charges and the amounts recognized by Aetna, in addition to deductibles and your co-insurance.

When your claim is processed, Aetna sends you and your dentist a written explanation of benefits.

Coordination of Benefits

Many people are covered by more than one dental plan. When this happens, coverage under Chevron Phillips Chemical's dental plan is coordinated with other dental plan coverage you may have. For more information, see ***How Health Care Coordination of Benefits Works*** on page A-20.

Situations That Affect Your Benefits or Coverage

Dental benefits may be affected in the following situations:

- No benefits are payable for treatment you or a dependent receives before coverage under the Chevron Phillips Chemical dental plan becomes effective or after coverage ends, except in the specific situations described here.
- If you decline dental coverage, no benefits are payable.
- If you use a non-participating dentist, you may have to pay the dentist directly for dental services and file a claim for reimbursement.
- If you use a non-participating dentist, you are responsible for paying the difference between what Aetna pays and the dentist's actual charge, in addition to your deductible and/or co-insurance.
- If all or part of your claim is denied, you are entitled to a complete and fair review. For more information on the review process, see the ***Claims*** section beginning on page P-2.
- If a benefit larger than the amount allowed by the plan is paid, the plan has the right to require the return of the overpayment. The plan also has the right to reduce any future benefit payments made to or on behalf of the plan participant by the amount of the overpayment. For more information, see ***Recovery of Excess Payments*** on page P-15.
- 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 P-16.

Coverage for Dental Work Begun Before You Were Covered by the Plan

Dental services that were provided before you or a covered dependent were covered by the plan are not covered. This means that the following dental services are not covered:

- An appliance, or modification of an appliance, if an impression for it was made before plan coverage began.
- A crown, bridge, or cast or processed restoration, if a tooth was prepared for it before plan coverage began.
- Root canal therapy, if the pulp chamber for it was opened before plan coverage began.

Benefits for Treatment in Progress After Coverage Terminates

Dental services provided after coverage terminates are not covered. However, when treatment starts while you are covered under the plan, the plan covers "ordered" inlays, onlays, crowns, removable bridges, cast or processed restorations, dentures, fixed bridgework and root canals if the item is installed or delivered within 30 days following coverage termination.

For purposes of this continuation coverage, "ordered" means that, prior to the date coverage ends:

- For a denture: impressions for the denture were taken.
- For a root canal: the pulp chamber was opened.
- For any other service listed above: the teeth that are being restored, or that will serve as support or retainers for a bridge or other restoration, were fully prepared to receive the item, and impressions for the item were taken.

(Performance Pipe Hourly Employees)

Vision PLUS Plan

Contents

Your Vision PLUS Plan

Chevron Phillips Chemical Company LP (Chevron Phillips Chemical or the Company) offers employees and their dependents vision benefits provided through VSP. The Vision PLUS Plan covers eye exams, eyeglass frames, eyeglass lenses and contact lenses, subject to certain limits.

Under the plan, you can see an in-network VSP provider or an out-of-network provider, but the plan will pay a higher level of benefits if you see an in-network provider.

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

Keep in mind that the medical plan options still cover an annual in-network non-corrective eye exam. However, if you enroll in the Vision PLUS Plan, you will also have coverage for a corrective eye exam, eyeglass lenses, eyeglass frames and contact lenses.

Vision PLUS Plan Summary Chart

The following chart shows the services covered under the Vision PLUS Plan.

	In-Network	Out-of-Network
Eye exam, including corrective exam and contact lens fitting and evaluation (once per calendar year)	Covered 100%	Reimbursed up to $45
Eyeglass frames* (once every two calendar years)	Covered up to $150; 20% discount on any amount over $150	Reimbursed up to $70
Eyeglass lenses (once per calendar year)		
▪ Single	Covered 100%	Reimbursed up to $30
▪ Bifocal	Covered 100%	Reimbursed up to $50
▪ Trifocal	Covered 100%	Reimbursed up to $65
▪ Lenticular	Covered 100%	Reimbursed up to $100
Progressive lenses (once per calendar year)		
▪ Standard	VSP member cost: $55	Reimbursed up to $50
▪ Premium	VSP member cost: $95 – $105	Reimbursed up to $50
▪ Custom	VSP member cost: $150 – $175	Reimbursed up to $50
Contacts (once per calendar year; in lieu of eyeglass lenses; applies to all three items below)		
▪ Elective	Covered up to $130	Reimbursed up to $105
▪ Medically necessary	Covered 100%	Reimbursed up to $105
▪ Contact lens fitting and evaluation	Covered 100%	Included in eye exam reimbursement above
Second annual eye exam related to diabetic eye disease, glaucoma or age-related macular degeneration (AMD)	$20 copay	Not covered
VSP Essential Medical Eye Care *(see page G-5)*	$20 copay	Not covered

* Eyeglass frames are not covered in a year in which you utilize the contact lens benefit under this plan.

DISCOUNTED LASER VISION CORRECTION SURGERY

If you enroll in the Vision PLUS Plan, you are eligible for the VSP Laser VisionCare Program.

- You'll save an average of 15% off the regular price or 5% off the promotional price of laser vision correction surgery at a VSP participating laser center.
- The screening and consultation with your VSP Laser VisionCare doctor are complimentary. If you have a preoperative exam and don't proceed with the surgery, your VSP doctor may charge an exam fee of up to $100.

CONTACT LENS FITTING AND EVALUATION

Contact lens fitting and evaluation coverage at 100% in-network is a customized feature of our plan. If your in-network provider does not apply the 100% coverage with no copay or coinsurance, please call VSP at 1-800-877-7195 for an adjustment to your bill or to request and receive a refund.

How the Plan Works

Under the Vision PLUS Plan, you and your dependents are reimbursed for a portion of your eligible vision expenses. You may obtain services from any provider, but the plan will pay a higher level of benefits when you see a VSP provider.

When You Use a VSP Network Provider

Step 1

Find a participating network provider by calling VSP at 1-800-877-7195 or visit their website at www.vsp.com for a list of providers in your area.

Step 2

When you make an appointment, identify yourself as a VSP member. Your provider will contact VSP to verify your eligibility for benefits and authorized services. If your provider does not receive approval for authorized services from VSP, your benefits will be reduced to the out-of-network amounts.

Step 3

At your appointment, the doctor will provide an eye exam and determine if eyewear is necessary. You pay the required copays at the time of your visit, as well as any amount above covered allowances. VSP will pay your network provider directly for all covered services and eyewear or contact lenses.

YOU DO NOT NEED AN ID CARD

You will not receive an ID card, and one is not required to see an in-network provider. However, it is important that you remember to tell the doctor that you are a VSP member. The doctor's office can contact VSP to verify benefits. If your doctor does not receive approval for authorized services from VSP before you receive services, your benefits will be reduced to the out-of-network level. If desired, you can print an ID card at www.vsp.com to take to your doctor.

Out-of-Network Providers

When you go to an out-of-network provider, you pay the provider the full cost of the services provided and then you file a claim with VSP for reimbursement of eligible charges. See ***How to File a Claim*** on page G-4.

What's Covered

The Vision PLUS Plan covers an annual eye exam, eyeglass lenses, eyeglass frames and contact lenses (in lieu of eyeglass lenses and frames), subject to certain limits. See the chart on page G-2 for details.

What's Not Covered

The following list of exclusions and limitations does not include everything that's not covered. If you're not sure about whether something is covered, contact VSP before you incur the expense.

Patient Options

The Vision PLUS Plan covers visual needs rather than cosmetic materials. You are responsible for paying the additional cost of any of the following options:

- Certain coatings, including:
  - Anti-reflective,
  - Color,
  - Mirror, and
  - Scratch,
- Certain types of lenses, including:
  - Blended,
  - Cosmetic,
  - Laminated,
  - Oversize,
  - Polycarbonate,
  - Photochromic or tinted, except Pink #1 and #2,
  - Progressive multifocal, and
  - UV (ultraviolet) protected,
- Contact lenses (except as noted elsewhere in this document),
- Expenses beyond low vision care limits,
- Frames that cost more than the plan allowance, and
- Optional cosmetic processes.

Other Exclusions

The following services and materials are not covered:

- Corrective vision treatment of an experimental nature,
- Costs for services or materials above plan benefit allowances,
- Medical or surgical treatment of the eyes,
- Orthoptics or vision training and associated testing,
- Plano lenses,
- Replacement of lenses and frames furnished under this policy which are lost or broken, except at the normal intervals when services are otherwise available, and
- Two pairs of glasses instead of bifocals.

How to File a Claim

If You Use Participating Providers

You don't have to file claim-related paperwork if you receive services from an in-network VSP provider. Just tell the provider that you are a VSP member at the time you make the appointment. The provider's office will verify your eligibility and benefits and handle all claims filing on your behalf. VSP will reimburse the provider directly.

If you're enrolled in the Health Care Flexible Spending Account (HCFSA) or Limited-Purpose Flexible Spending Account (LPFSA), you may file a claim for reimbursement of out-of-pocket vision expenses not covered by the plan from your FSA, or if your vision provider is a Inspira-certified merchant, you can use your Inspira card to pay for your eligible vision expenses at the point of sale. See the ***Flexible Spending Accounts*** chapter starting on page H-1 for more information.

If You Use Non-Participating Providers

If you receive services from an out-of-network provider, you must submit a claim form to VSP within one year of service. You pay the provider for services and eyewear or contacts at the time of your appointment, and then submit your itemized receipt, along with a Member Reimbursement Form, to VSP. The VSP claim form is available at www.mycpchembenefits.com/forms. You can also find claim forms and instructions at www.vsp.com.

Some non-network providers may submit your claim to VSP for you, but you should always check first.

VSP Essential Medical Eye Care

Eye care is a key part of preventive health care, which is why the Vision PLUS Plan includes VSP Essential Medical Eye Care. This program goes beyond routine vision expenses and provides additional coverage for medical and urgent eye care. Plus, you have the reassurance and convenience of visiting the same expert eye care provider who knows your eyes best.

Covered Services

The VSP Essential Medical Eye Care program covers the following:

- Retinal screening for participants with diabetes,
- Medical exams and services for the diagnosis, evaluation, treatment and management of chronic conditions such as diabetic eye disease, glaucoma and age-related macular degeneration,
- Treatment for urgent conditions such eye infections, foreign body and abrasions, eye injuries and chemical exposure to the eye or eyelid,
- Medical tests to diagnose and treat sudden changes in vision, such as eye flashes, floaters and sudden vision loss, and
- Other medical services to help support optimal vision and eye health if you're experiencing an eye disorder or disease.

Coverage Details

- Essential Medical Eye Care is supplemental medical eye care coverage. Your medical insurance plan should be billed as the primary payer when you use an in-network VSP provider who is also in-network under your medical plan.
- You may be able to coordinate with Vision PLUS Plan benefits to help reduce your out-of-pocket costs under your medical plan.
- If you use an in-network VSP provider who is not in-network under your medical plan, you will pay only the $20 copay as detailed below.

Copay

- When you receive care from a participating VSP network provider, a $20 copay applies to medical exams only.
- A copay does not apply to additional non-exam services covered by the plan, such as retinal screenings.

(Performance Pipe Hourly Employees)

Flexible Spending Accounts

Contents

Your Flexible Spending Account (FSA) Options

A SPECIAL NOTE...

Participation in flexible spending accounts is an annual election that does not roll over from one year to the next. This means that if you do not make an active election during each open enrollment period, you cannot participate in a flexible spending account the following year unless you have a qualified status change during the year.

Eligible employees of Chevron Phillips Chemical Company LP (Chevron Phillips Chemical or the Company) have the opportunity to participate in the following tax-advantaged flexible spending accounts:

- The Health Care Flexible Spending Account (HCFSA) — if you are enrolled in the *Choice PPO Plan* or the *Select EPO Plan* or if you have waived medical coverage,
- The Limited-Purpose Flexible Spending Account (LPFSA) — if you are enrolled in the *Value CDH Plan* or another IRS-qualified high deductible medical plan, and/or
- The Dependent Care Flexible Spending Account (DCFSA).

By using the flexible spending accounts, you can save tax dollars on eligible health care and dependent care expenses.

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

DEADLINES FOR INCURRING EXPENSES AND FILING CLAIMS

All eligible expenses must be incurred by **December 31** of the plan year in which you are making contributions to your FSA. However, you have until **March 31** of the following year to file claims for reimbursement. Any funds remaining in your account(s) after the March 31 deadline will be forfeited.

Your participation in the HCFSA, LPFSA and/or DCFSA ends when the earliest of these occurs:

- December 31,
- You are no longer an eligible employee,
- You terminate employment,
- You retire,
- The plan is terminated, or
- Certain leaves of absence occur (for more information, see ***When You're on a Leave of Absence*** on page A-13).

Note, however, that you can elect to continue your participation in the HCFSA or LPFSA after your termination date through COBRA coverage as detailed beginning on page A-17.

How the Accounts Work

Flexible spending accounts allow you to set aside pre-tax dollars to reimburse yourself for eligible health care and/or dependent care expenses. You or your eligible dependents don't have to be enrolled in a Chevron Phillips Chemical medical plan in order to use these accounts. When you're first eligible to enroll, and each year during open enrollment thereafter, you decide if you want to participate in the FSAs:

- The Health Care Flexible Spending Account (HCFSA) — for certain medical, dental, prescription drug, vision and hearing expenses not reimbursed by other health plans. You are eligible to enroll in the HCFSA if you enroll in the *Choice PPO Plan* or the *Select EPO Plan* or if you waive medical coverage.
- The Limited-Purpose Flexible Spending Account (LPFSA) — for eligible expenses, such as dental and vision expenses, when you enroll in the *Value CDH Plan* or another IRS-qualified high deductible medical plan. You can also use the account for HCFSA-eligible expenses after you have met your annual deductible under the *Value CDH Plan* or another IRS-qualified high deductible medical plan.
- The Dependent Care Flexible Spending Account (DCFSA) — for qualified dependent care expenses incurred so that you (or, if you are married, so that you and your spouse) can work or attend school full-time. This account is for dependent care expenses for children under age 13 and disabled dependents, not for expenses relating to a dependent's health care.

TAX SAVINGS

FSAs can help lower the taxes you pay. When you participate, your contributions are taken out of your pay before federal income taxes, Social Security taxes, Medicare taxes and, in most states, state income taxes are calculated and withheld. This means you lower your taxable income — so you pay less tax.

Because this is a pre-tax benefit, your participation may slightly reduce your future Social Security benefits when you retire. You should consult a tax advisor to determine the tax consequences, if any, for you personally.

For information on enrollment eligibility, see page A-1 of the ***How to Participate*** chapter.

Though the accounts cover different types of expenses, they operate in much the same way. The process for using the flexible spending accounts is as follows:

Step 1

During your enrollment period, estimate your expected eligible expenses for health care and/or dependent care for the plan year (which is the current year during new hire enrollment and the next calendar year during open enrollment). Remember that all expenses claimed for reimbursement from either account must be for services received between the date you begin participation in the FSA and **December 31** of the plan year in which you are making contributions. Enroll in the account(s) as described in your enrollment materials.

Note: If you are enrolled in an IRS-qualified high deductible medical plan other than the *Value CDH Plan* and want to enroll in the LPFSA, call the CPChem Benefits Service Center at 1-833-964-3575 during your enrollment period.

Step 2

The amount you authorize to contribute is automatically deducted pre-tax from your paycheck. Your contributions are then deposited in the flexible spending account(s) that you selected. For information on the maximums that apply to each of the accounts, see pages H-4 and H-8.

Step 3

When you incur an eligible expense during your coverage period, you file an FSA claim for reimbursement, unless you use your Inspira Card to pay for eligible health care expenses.

- For the HCFSA or LPFSA, you can be reimbursed at any time during the year up to the entire amount you agreed to set aside for the calendar year, less any amount already reimbursed to you.
- For the DCFSA, you can be reimbursed only up to the amount you have actually contributed to your account at the time your claim is processed. Any balance due to you is paid to you as funds become available in your account during that calendar year.

You have until March 31 following the end of the calendar year to file a claim for eligible expenses you incurred during the year in which you were making contributions to your FSAs. If Inspira does not receive your request for reimbursement by March 31, any money remaining in your account(s) is forfeited. For this reason, careful budgeting is very important. Amounts in your HCFSA or LPFSA will also be forfeited if the plan is unable to locate you to make a payment within one year after you file a claim for reimbursement. Any money forfeited from the accounts is used by Chevron Phillips Chemical to offset administrative costs of the plan.

There are several ways to determine your account balance:

- Each time you receive a reimbursement check, the stub shows your balance.
- You may contact Inspira, the flexible spending account claims administrator, at 1-888-678-8242 or login to www.inspirafinancial.com and find your account balance.
- Check your account balance on the Inspira Mobile™ app. The free app is available on iOS and Android devices. You can download the Inspira Mobile™ app from your mobile app store and use your www.inspirafinancial.com username and password to login.

Special IRS Rules

Because the flexible spending accounts operate under Internal Revenue Service guidelines, special rules apply.

- Once you sign up for a flexible spending account, you cannot change your election for the period January 1 through December 31 unless you have a qualified status change. For more information, see ***Qualified Status Changes*** on page A-11. In addition to a qualified status change, you may change your DCFSA election if the cost of child care changes (for example, if your day care changes its rates).
- Any change to your election must apply to the specific person or situation affected and must be made within 31 days of the qualified status change.
- If you are participating in more than one FSA, you cannot transfer money from one account to the other, or use money in one account to pay expenses related to another account.
- Certain information is required when you file a claim for reimbursement. For more information, see ***How to File a Claim*** on page H-9.
- You cannot take a federal tax deduction or credit on your income taxes for expenses reimbursed through these accounts. For more information, see ***Tax-Free vs. Tax-Deductible*** on page H-5 and ***Dependent Care FSA (DCFSA) vs. Federal Tax Credit*** on page H-9.

Using the Health Care FSA (HCFSA) or Limited-Purpose FSA (LPFSA)

You can use your HCFSA to pay certain health care expenses incurred by you, your spouse or your eligible dependents as long as you aren't enrolled in a high-deductible plan like the *Value CDH Plan*. You (or your dependents) do not have to be enrolled in a Chevron Phillips Chemical medical plan to use this account. If you enroll in the *Value CDH Plan*, you cannot participate in the HCFSA, but you have the option to participate in the LPFSA. You can use the LPFSA to set aside pre-tax dollars and reimburse yourself for eligible expenses, such as dental and vision expenses. You may also use your LPFSA to reimburse yourself for eligible medical, prescription drug and hearing expenses after you have met your annual deductible under the *Value CDH Plan* or another IRS-qualified high deductible medical plan.

IF YOUR EMPLOYMENT ENDS FOR ANY REASON

Your pre-tax contributions to your flexible spending accounts will stop when your employment ends. However, you may receive reimbursement for eligible expenses:

- From the HCFSA or LPFSA — up to the contribution amount you specified at the beginning of the plan year for expenses that were incurred during that plan year on or before the date you terminate employment. You may be eligible to continue participating in the HCFSA or LPFSA under the provisions of the Consolidated Omnibus Budget Reconciliation Act (COBRA). Your contributions to an HCFSA or LPFSA while you are on COBRA must be made on an after-tax basis. For more information, see ***How to Continue Coverage*** beginning on page A-17.
- From the DCFSA — up to the amount credited to your account prior to your termination for expenses that are incurred during the plan year, whether incurred before or after you terminate employment.

Contribution Amount

You decide how much money to contribute to your HCFSA or LPFSA based on the health care expenses you expect you and your family to incur during the year. Contributions are deducted from your paycheck pre-tax in equal installments throughout the year. The maximum annual contribution for the Chevron Phillips Chemical HCFSA or LPFSA is $3,200 for 2024. If you and your spouse are both Chevron Phillips Chemical employees and have access to a Chevron Phillips Chemical HCFSA or LPFSA, you can each contribute $3,200 for a total of $6,400 per family.

Reimbursement

When you have unreimbursed expenses related to eligible health care (medical, dental, prescription drug, vision or hearing care), you file a claim for reimbursement from your FSA. For information on filing a claim, see ***How to File a Claim*** on page H-9.

You receive reimbursement from your flexible spending account for the amount of your approved claim expense. You may submit claims for up to the total amount you elected to contribute to your HCFSA or LPFSA for the calendar year.

You can set up direct deposit reimbursements to your bank account. For instructions, see ***Direct Deposit of Reimbursements*** on page H-11.

Reimbursement for Eligible Health Care Expenses

- **Use your Inspira Card:** You may use your Inspira Card, which is an HCFSA and LPFSA debit card, at time of service or purchase to pay for eligible health care expenses at any Inspira-certified merchant. Merchants include doctor and dental offices, hospitals, pharmacies and hearing and vision care centers. You can also use your card at some discount and grocery stores or to purchase mail-order prescriptions.
- **Pay at time of service or purchase, then submit a claim:** You may pay for eligible health care expenses at time of service or purchase, or pay a bill received after the service, then submit a claim for reimbursement. Claims for eligible health care expenses not previously reimbursed by your medical coverage may be reimbursed through the HCFSA or LPFSA (see restrictions under ***Limited-Purpose Flexible Spending Account (LPFSA) Expenses Allowed by the IRS*** on page H-6). For information on filing a claim, see ***How to File a Claim*** on page H-9.

Note for LPFSA Members

The LPFSA is designed with pre- and post-deductible phases. This means that before you meet your *Value CDH Plan* deductible, funds must be used only for vision and dental expenses. Then, once you meet your *Value CDH Plan* deductible, you can use LPFSA funds to pay for all eligible health care expenses.

INSPIRA CARD EXPENSE DOCUMENTATION

There may be times when Inspira requests documentation from you to verify your Inspira debit card was used to pay for an eligible health care item or service. If you do not provide a timely response to these requests, your Inspira Card may be suspended.

To help stay up to date on your Inspira Card transactions, log in to www.inspirafinancial.com and sign up for Inspira Card account notifications.

Health Care Flexible Spending Account (HCFSA) Expenses Allowed by the IRS

Only allowable expenses that are adequately documented and are not covered by insurance are eligible for reimbursement from your HCFSA. The following is a partial list of expenses that may be eligible for reimbursement from the HCFSA if not paid by insurance.

- Acupuncture,
- Automobile equipment to help any physically disabled eligible dependent,
- Birth-control-related expenses,
- Braille books and magazines,
- Certain schooling for a disabled eligible dependent (with proof of medical necessity),
- Charges in excess of recognized charges limits under the medical plan and/or dental plan, or any other health plan under which you have coverage,
- Childbirth preparation classes,
- Chiropractic care,
- Cost of a note-taker for a hearing-impaired child while in school,
- Crutches,
- Deductibles/co-insurance/copayments under the medical plan, dental plan and/or vision plan, or any other health plan under which you have coverage, with the exception of the *Value CDH Plan*,
- Dental cleanings and fillings,
- Detoxification and treatment at a center for alcohol or drug abuse,
- Diabetic supplies,
- Diathermy,
- Elevators (in home) for any disabled eligible dependent,
- Expenses for services connected with donating an organ,
- Eye exams, eyeglasses, contact lenses and supplies,
- Fees to use a swimming pool for exercises prescribed by a doctor to alleviate a specific medical condition,
- Feminine hygiene products,
- Guide or guide dog for any eligible dependent who is visually or hearing-impaired,
- Hearing aids and batteries,
- Home pregnancy tests,
- Infertility treatment,
- Medically necessary mattresses,
- Orthodontia,
- Orthopedic shoes when medically necessary,
- Orthotics (including inserts, orthotics or supports designed to treat an injured or weakened body part),
- Over-the-counter medications used to treat illness,
- Physical therapy,
- Prescription drugs,
- Psychotherapy,
- Radial keratotomy or LASIK surgery,
- Radiation treatments,
- Ramp, wheelchair lift or installation of other equipment when medically necessary,
- Routine physical exams,
- Smoking-cessation programs,
- Specialized equipment for any disabled eligible dependent when medically necessary,
- Speech therapy,
- Sterilization and reverse-sterilization surgery,
- Surgical stockings and compression socks,
- Well-baby and well-child care,
- Wheelchairs,
- Wigs for hair loss due to disease, and
- X-rays.

TAX-FREE VS. TAX-DEDUCTIBLE

You may approach the tax treatment of your health care dollars in one of two ways:

- The federal government offers a federal income tax deduction for unreimbursed eligible health care expenses that exceed 10% of your adjusted gross income.
- The HCFSA or LPFSA offers tax-free reimbursement from the first dollar of your eligible expenses.

Since the government will not allow two tax breaks on the same expense, you cannot claim a tax deduction for expenses reimbursed from the HCFSA or LPFSA.

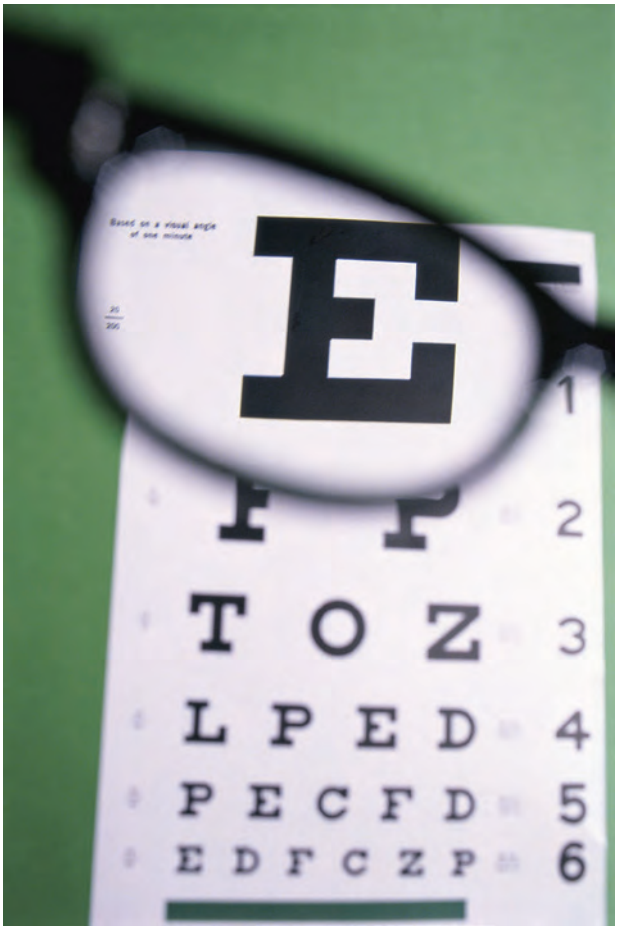
Most people find the HCFSA or LPFSA offers greater tax advantages. However, because tax laws are complicated and change from time to time, you should consult your personal tax advisor to find out which approach is best for you.

Limited-Purpose Flexible Spending Account (LPFSA) Expenses Allowed by the IRS

Only allowable expenses that are adequately documented and are not covered by insurance are eligible for reimbursement from your LPFSA. The following is a partial list of expenses that may be eligible for reimbursement under the LPFSA if not paid by insurance.

- Dental care and orthodontia, such as fillings, X-rays, braces, caps and mouth guards,
- Vision care, including eye exams, eyeglasses, contact lenses, solutions and supplies, and LASIK eye surgery, and
- Prescriptions and eligible over-the-counter items for dental and vision care only.

In addition, after you have met your annual deductible under the *Value CDH Plan* or another IRS-qualified high deductible medical plan, you are eligible for reimbursement of all HCFSA-qualified expenses, as listed on page H-5, from your LPFSA.



Expenses Not Allowed for Reimbursement by the IRS Under the HCFSA or LPFSA

The following are examples of expenses not eligible for reimbursement from the HCFSA or LPFSA. These include, but are not limited to:

- Cosmetic surgery and procedures (except to improve a deformity or repair injury),
- Cosmetics and toiletries,
- Custodial care in an institution,
- Expenses claimed on your income tax return,
- Expenses for which you receive reimbursement under the medical plan, dental plan, or any other health plan under which you have coverage,
- Expenses incurred before the date you began participating in the FSA,
- Funeral or burial expenses,
- Health club fees and dues,
- Household help,
- Insurance premiums, including premiums for plans maintained by the employer of your spouse or other dependent,
- Long-term care expenses,
- Meals,
- Mileage in your own car,
- Transportation to/from work for the handicapped,
- Vacation travel for health programs,
- Vitamins, and
- Weight loss programs (except in the case of proven medical necessity).

For more information about eligible expenses, see www.inspirafinancial.com or *IRS Publication 502, Medical and Dental Expenses*, available online at http://www.irs.gov/publications/p502/index.html. However, the IRS list includes some things, such as insurance premiums, that aren't eligible expenses.

Using the Dependent Care FSA (DCFSA)

The DCFSA allows you to use pre-tax dollars to pay dependent care expenses that are necessary so that you — and your spouse if you are married — can work, or so that your spouse can go to school full-time. Eligible dependents include the following:

- Your children under age 13 whom you can claim as dependents on your income tax return (if you are divorced and the custodial parent, you may participate in the DCFSA even if, by agreement, you may not claim your child as a dependent on your income tax return),
- Your spouse, if physically or mentally incapable of self care, and
- Any other person considered a dependent for tax purposes who is physically or mentally incapable of self care, regardless of age.

The cost of care rendered outside of your home for your spouse or for dependents of any age who are mentally or physically disabled is reimbursable only if that person spends at least eight hours in your home each day.

If you are divorced or legally separated, child care expenses are eligible for reimbursement only if you have custody of the child for a longer period during the plan year than does the other parent.

PLEASE NOTE ...

The DCFSA is not an "employee welfare benefit plan" under Title I of ERISA.

DEPENDENT CARE EXPENSES WHILE JOB HUNTING

If your spouse is actively searching for gainful employment, you may be reimbursed for dependent care expenses through the DCFSA in certain circumstances. Under IRS guidelines, the determination of whether such an expense is eligible is based on the facts and circumstances of each situation. You may want to consult your personal tax advisor or *IRS Publication 503, Child and Dependent Care Expenses* at http://www.irs.gov/publications/p503/index.html. The plan administrator (or its designated claims administrator) has the authority to determine the eligibility of these types of expenses for reimbursement.

Contribution Amount

You may contribute up to $5,000 a year to pay for dependent care expenses. Your contribution is deducted from your paycheck pre-tax in equal installments throughout the year. If you are married, the IRS puts additional limits on your contributions:

- If you and your spouse both work, you are limited to the lesser of $5,000, or your spouse's annual pay. For example, if your spouse works part-time and has an earned income of $1,200, you cannot contribute more than $1,200 for the whole year into the DCFSA.
- If you file separate income tax returns, the most you can contribute is $2,500.
- If your spouse has a similar account with his or her employer, your limit is $5,000 a year for both accounts combined.
- Generally, both you and your spouse must be working in order for expenses to be eligible for reimbursement. However, if your spouse is either disabled and unable to provide self care, or is a full-time student for at least five months during the year and has no income, you still may participate in this account. In this case, you can contribute up to $250 per month for one child or $500 per month for two or more children for each of the months your spouse is disabled or enrolled in school full-time.

Reimbursement

With the DCFSA, you pay the expense first and then file a claim for reimbursement from your account. The process for filing a claim is discussed in ***How to File a Claim*** on page H-9.

You receive a reimbursement check from your DCFSA for the amount of your approved claim expense, up to your current account balance as of the date your claim was processed.

You can set up direct deposit reimbursements to your bank account. For instructions, see ***Direct Deposit of Reimbursements*** on page H-11.

Dependent Care Expenses Allowed by the IRS

The following is a partial list of expenses that may be eligible for reimbursement through a DCFSA:

- A qualified day care center, nursery school or summer day camp,
- A housekeeper whose duties include day care,
- Someone who cares for an elderly or incapacitated dependent,
- A baby-sitter or nanny inside or outside your home,
- After-school care, or
- A relative who cares for your dependents, as long as that relative is not one of your dependents or one of your children under age 19.

NO REIMBURSEMENT FOR HEALTH CARE EXPENSES

Keep in mind that the DCFSA is designed to help you pay for certain child care or elder care expenses only. You cannot use the account for reimbursement of any health care expenses for yourself or your dependents.

Dependent Care Expenses Excluded by the IRS

The following are examples of expenses not eligible for reimbursement through a DCFSA. These include, but are not limited to:

- Baby-sitting expenses for reasons other than to enable you to work,
- Cleaning and cooking services not provided by a caregiver,
- Expenses incurred before the date you began participating in the FSA,
- Overnight camp,
- Child support payments,
- Food, clothing and entertainment,
- Activity fees and late payment fees, and
- Education, including tuition for private schools.

You may also refer to *IRS Publication 503, Child and Dependent Care Expenses*, available from the IRS or through the IRS website at http://www.irs.gov/publications/p503/index.html.

DEPENDENT CARE FSA (DCFSA) VS. FEDERAL TAX CREDIT

The federal government allows you to take a tax credit for eligible dependent care expenses. Under the Internal Revenue Code, the tax credit is an amount equal to a percentage of your dependent care expenses, limited to $3,000 for one dependent or $6,000 for two or more dependents. This amount may change from year to year and you should request this information annually from your tax advisor.

If you are considering using the DCFSA, you might want also to consider the effect of your participation on taking the tax credit. Here are your options:

- You may take the full tax credit allowed by the IRS,
- You may pass your expenses through the DCFSA, or
- You may use the DCFSA for a portion of your dependent care expenses and take the tax credit for the remaining amount. If you use the DCFSA, the amount you contribute to your account offsets dollar-for-dollar the amount you can take as a tax credit.

The payment method that is best for you depends on your individual situation. In some cases, using the DCFSA saves you more. In other cases, you may save more by taking the credit on your tax return. In most cases, if your family income is over $30,000 or you spend more than $3,000 on care for one dependent, your savings will be greater through a DCFSA.

To help you determine whether the DCFSA or the tax credit is better in your particular situation, you should consult a tax specialist or contact the IRS to obtain *Publication 503, Child and Dependent Care Expenses.*

How to File a Claim

The process for filing a claim is the same for the HCFSA, LPFSA and DCFSA. You have until March 31 following the end of the calendar year to file claims for reimbursement. Any funds remaining in your account(s) after March 31 will be forfeited. You have several options for filing a claim:

- Login to www.inspirafinancial.com and select "File a Spending Account Claim." Complete the online claims information and upload, mail or fax any required documentation to Inspira. You can either elect reimbursement for already paid expenses or request that the provider is paid directly from your account.
- Use the Inspira Mobile™ app on your smartphone or other mobile device. You can download the Inspira Mobile™ app from your mobile app store and login using your www.inspirafinancial.com username and password. From "My Dashboard" select "Financial Center" then "File a Claim." Then enter the expense type, date, name and amount paid and upload any required documentation to submit your claim.
- Complete a flexible spending account claim form. Claim forms can be obtained at www.mycpchembenefits.com/forms or www.inspirafinancial.com or by calling Inspira at 1-888-678-8242. Attach any required documentation and fax it to 1-888-238-3539 or mail it to:

  Inspira Financial
  P.O. Box 2495
  Omaha, NE 68103

All eligible expenses must be incurred by **December 31** of the plan year in which you are making contributions to your FSA. An expense is incurred when the service is rendered — not when you are charged or billed, or when you pay the expense.

MANAGE YOUR ACCOUNTS WITH THE INSPIRA MOBILE™ APP

The Inspira Mobile™ app makes it easy for you to manage your FSA accounts 24/7. The free app is available on iOS and Android devices. The Inspira Mobile™ app lets you:

- Check your account balances, deposits and payments.
- View your account alerts.
- Verify Inspira Card purchases.
- Pay providers directly from your account.
- Request reimbursement of eligible expenses.

For more information about the Inspira Mobile™ app, go to www.mycpchembenefits.com/health and look for Inspira documents in the "Flexible Spending Accounts" section.

Documentation Required for Claims Processing

A charge card receipt, cancelled check or balance due statement are not sufficient evidence to request a reimbursement from your FSAs. Acceptable documentation is one of the following

- ***If the claim first goes through your medical, dental or vision plan,*** you must first submit the expenses for reimbursement to the insurance plan that pays benefits, even if your expenses only apply toward your deductible. You will receive an Explanation of Benefits (EOB) indicating expenses not covered or not paid by the insurance plan. This is the best form of documentation.
- ***If the claim is not run through a health care insurance plan (for example, an OTC medicine or product),*** you can use the itemized receipt or statement. The receipt must show the date of purchase or date the service is incurred, the amount for which you are financially responsible, a description of the item or service and the name of the merchant or provider.
- ***If you are sending in a prescription drug receipt, it must contain the pharmacy name,*** patient name, drug name (if listed), date the prescription was filled and amount you paid.

- ***If the claim is for dependent care,*** the dependent care provider must sign the completed claim form or provide an itemized receipt including the dates of service, name of the dependent, cost of care and the care provider's name.

USE INSPIRA'S ONLINE TOOLS

The FSAs are administered by Inspira, which offers many convenient online features to track and manage your accounts. Visit www.inspirafinancial.com to use the following tools:

- **Account Details:** View your account balance and manage your funds.
- **My Resources:** View educational materials, forms and IRS publications.
- **Savings calculator:** Estimate your health care and dependent care expenses.
- **FAQs:** Review frequently asked questions about your FSAs.

On www.inspirafinancial.com, click "Log In" under "Manage your HSA, FSA, or other benefits" and enter your username and password to log on. If you haven't registered, click on "Set up account" to get started.

When You Can Expect a Reimbursement

Claims for reimbursement are processed on a daily basis by Inspira and are mailed to your home weekly. If your home address changes, it is your responsibility to update it on MySphere under "Contact Info." If you are not an active employee, you can call the CPChem Benefits Service Center at 1-833-964-3575 to update your home address.

Direct Deposit of Reimbursements

You can elect to have your flexible spending account reimbursements directly deposited into your bank account. With this service, claims for reimbursement of health care expenses and/or dependent care expenses are processed daily and your savings or checking account will be credited three business days after the claim is processed.

To enroll in direct deposit of your FSA reimbursements, login to www.inspirafinancial.com and select "Financial Center" then "Enroll in Direct Deposit." Or download the "Direct Deposit Authorization Form" from "My Resources" and submit the completed form with a voided check or savings deposit slip by fax or mail using the contact information indicated on the form. Your direct deposits will begin approximately 10 business days after you complete the enrollment process.

Claims Assistance

For assistance with questions or problems concerning benefits under this plan, call Inspira at 1-888-678-8242.

All decisions concerning the payment of claims under the plan are at the sole discretion of the plan administrator (or its designated 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 P-2.

Your ERISA Rights

As a participant in the HCFSA or the LPFSA, 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-16.

(Performance Pipe Hourly Employees)

Health Savings Account (HSA)

Contents

Your Health Savings Account (HSA)

Eligible employees of Chevron Phillips Chemical Company LP (Chevron Phillips Chemical or the Company) who elect medical coverage under the *Value CDH Plan* have the opportunity to participate in a tax-advantaged Health Savings Account (HSA) that lets them save tax dollars on eligible health care expenses.

To be eligible to enroll in an HSA:

- You must be enrolled in the *Value CDH Plan*,
- You must not be covered by any other medical plan other than an IRS-qualified high deductible medical plan, even if it is another family member's coverage. If you are covered by any other non-high deductible medical insurance, such as your spouse's employer's PPO or HMO plan, you cannot contribute to an HSA, even if you are enrolled in the *Value CDH Plan*,
- You must not be enrolled in, be eligible for reimbursement under, or receive reimbursement from a Health Care Flexible Spending Account (HCFSA), including as a dependent under your spouse's HCFSA. However, you or your spouse can be enrolled in a Limited-Purpose Flexible Spending Account (LPFSA) (see the ***Flexible Spending Accounts*** chapter starting on page H-1 for more information),
- If you are a retiree, you must not have an outstanding balance in your Retiree Reimbursement Account (RRA),
- You and your spouse must not have a Retirement Health Reimbursement Account (Retirement HRA, similar to an RRA) with another employer that covers you,
- You must not be enrolled in Medicare,
- You must not be enrolled in TRICARE or TRICARE for Life (military),
- You must not be claimed as dependent on anyone else's tax return, and
- You must not have received Veterans Administration (VA) benefits within the past three months (preventive care, dental and vision services are permitted).

Please refer to IRS Publication 969, Health Savings Accounts and Other Tax-Favored Health Plans, available at http://www.irs.gov/pub/irs-pdf/p969.pdf, for more information about eligibility for HSAs.

Enrolling in the *Value CDH Plan* as your medical plan option doesn't automatically open your HSA. You must authorize Alight to open an HSA with Fidelity as a separate step. For more information, see ***How the HSA Works*** below.

NOTE:

Health Savings Accounts (HSAs) do not constitute "employee welfare benefit plans" for purposes of the provisions of Title I of ERISA. For more information on HSAs, please contact Fidelity at www.netbenefits.com or 1-866-771-5225 and/or refer to IRS Publication 969.

How the HSA Works

The HSA, administered by Fidelity, allows you to set aside pre-tax dollars to reimburse yourself for eligible health care expenses. You must be enrolled in the *Value CDH Plan* to contribute to an HSA; however, the reverse is not true. You do not have to open an HSA with Fidelity to be enrolled in the *Value CDH Plan* but if you don't, you will lose out on the Company's contributions to your HSA. In 2024, for active employees who enroll in the *Value CDH Plan* and who open or already have an HSA with Fidelity, the Company will contribute money to their HSA — $500 for Employee-Only coverage and $1,000 for Employee + Spouse, Employee + Child(ren) or Employee + Family coverage. An employee and any dependent spouse or children, who are enrolled in family coverage as dependents at any time during a plan year, are limited to a combined $1,000 HSA Company contribution for that plan year.

ADVANTAGES OF THE FIDELITY HSA

You can decline to open the HSA that is offered through Fidelity, or you can go to any bank that offers an HSA. However, when you open an HSA through Fidelity:

- Chevron Phillips Chemical's annual contributions are deposited into your Fidelity HSA.
- You can make contributions through automated payroll deductions.
- Chevron Phillips Chemical will pay your monthly account maintenance fee for a Fidelity HSA as long as you remain an employee or retiree.

You will not receive these benefits from Chevron Phillips Chemical if you open an account elsewhere.

In order to receive the Company's contributions, you must read and agree to Fidelity's HSA terms and conditions on the Alight site during enrollment, which authorizes Alight to set up an HSA with Fidelity for you. The process for setting up and contributing to the HSA is as follows:

Step 1

Decide how much you want to contribute to your HSA. Then make your election through the CPChem Benefits Service Center website at digital.alight.com/cpchem or by calling 1-833-964-3575.

Step 2

Read and agree to Fidelity's HSA terms and conditions on the Alight site during enrollment, authorizing Alight to set up an HSA account with Fidelity for you.

You will receive a New Account Profile from Fidelity Personal Investments confirming that your HSA has been approved. At that time, you will be able to view your account at www.netbenefits.com.

Contribution Amount

You decide how much to contribute to the account based on the health care expenses you expect to have during the year. When you open an HSA through Fidelity, contributions are deducted from your paycheck in equal installments throughout the year. The IRS establishes an annual dollar limit on total contributions each year. If your pre-tax contributions, when combined with the Company's contributions, reach the dollar limit during the year, your contributions are automatically suspended. The maximum combined employer and employee HSA contribution limits for 2024 are:

Employee-Only	$4,150
Employee + Spouse, Employee + Child(ren) or Employee + Family	$8,300

In addition to the maximum amounts listed above, you may contribute an additional $1,000 in any year you are age 55 or older, including the year you turn age 55.

During open enrollment, you can enter an amount to be contributed each paycheck and/or an amount to be contributed as a one-time lump sum in January. The total of these two elections cannot exceed the IRS annual contribution limits. Also, if you do not plan to work a full year, you should consider how that will affect your contribution limits as outlined in ***Prorated Contributions*** on page I-3.

As long as you're covered by the *Value CDH Plan* on December 1 of a given year, you may contribute up to the maximum annual amount specified in the chart on page I-2, regardless of the month you establish your HSA. Please refer to IRS Publication 969, available at www.irs.gov/publications/p969, for more information about eligibility and maximum annual contribution amounts.

It's a good idea to open your account promptly so the Company contributions can be deposited and your contributions can begin with the first eligible pay period.

You may start, stop, increase or decrease the amount of your HSA contribution at any time, and regardless of whether or not you have experienced a qualified status change event — for example, if you start your contributions late or if your estimated medical expenses increase — as long as you don't exceed the annual maximum. Your change request will be effective as soon as administratively feasible, typically the first or the second pay period following the date you submit your request. To make a change, log on to the CPChem Benefits Service Center website at digital.alight.com/cpchem or call 1-833-964-3575.

The amount you authorize to contribute to your Fidelity HSA is automatically deducted on a pre-tax basis from your paycheck. You can also make contributions by check.

Your money is held in a Fidelity brokerage account that includes a core FDIC bank account through which deposits and withdrawals are made. You can leave your money in the core account or choose to invest your funds in a wide variety of options, including Fidelity and non-Fidelity mutual funds, ETFs, CDs, and individual stocks and bonds. You must meet certain minimums to invest in mutual funds. Any earnings on your Fidelity investments are automatically invested and grow tax-free — although your account is also subject to possible market losses.

HEALTH SAVINGS ACCOUNTS AND TAX SAVINGS

A Health Savings Account can help lower the taxes you pay. When you participate in an HSA through Fidelity, your contributions are taken out of your pay before federal income taxes, Social Security taxes and, in most states, state income taxes are calculated. This means you lower your taxable income — so you pay less tax.

Because this is a pre-tax benefit, your participation may slightly reduce your Social Security benefits. You should consult your personal tax advisor to determine the tax consequences for you personally.

Prorated Contributions

If you end coverage under the *Value CDH Plan* during the year, your pre-tax, lump-sum and catch-up contributions to the HSA must be prorated based on the number of months during the year that you were covered under the *Value CDH Plan* as of the first day of the month. Please refer to IRS Publication 969, available at www.irs.gov/publications/p969, for more information.

Excess Contributions

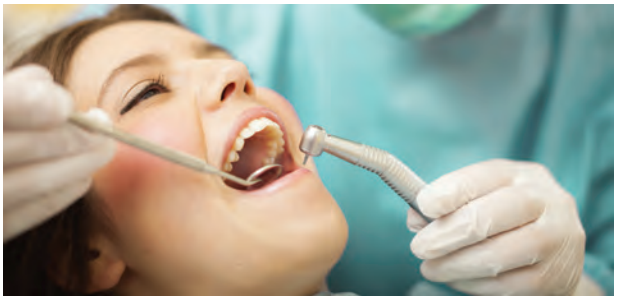
If you contribute more than the annual IRS maximum to your HSA, the additional funds will be considered taxable income and you may need to make adjustments on your annual tax filings. These funds are subject to standard income tax rates, plus a 6% penalty unless the excess contributions (and any earnings on these excess contributions) are withdrawn by your federal tax filing deadline (including any extensions) for the applicable year. Please refer to IRS Publication 969, available at www.irs.gov/publications/p969, for more information.

Note: Although the Chevron Phillips Chemical payroll system will automatically suspend your HSA contributions for the rest of the plan year when you reach the annual IRS family maximum contribution limit, you are responsible for monitoring and adjusting your contributions throughout the year to ensure compliance with federal laws and limitations that apply to HSAs.

Special IRS Rules

Because HSAs operate under Internal Revenue Service guidelines, special rules apply:

- **No enrollment in Health Care Flexible Spending Account (HCFSA):** You cannot enroll in an HSA if you are enrolled in, are an eligible dependent under, or receive reimbursement from an HCFSA, other than a Limited-Purpose Flexible Spending Account (LPFSA). Because it is considered a health plan, enrollment in an HCFSA makes you ineligible for an HSA, but you can be enrolled in an LPFSA and an HSA.
- **No account balance in your Retiree Reimbursement Account (RRA) or Retirement Health Reimbursement Account (Retirement HRA):** If you are a retiree, you cannot contribute to an HSA if you have an outstanding balance in your RRA or a Retirement HRA.
- **No "use it or lose it":** Unlike a flexible spending account, your HSA is not "use it or lose it." Any money remaining in your HSA at the end of the year rolls over, and you can add more money or spend the money on eligible expenses in future years. The funds in your HSA are always yours even if you change medical plans, leave the Company or retire. For detailed information about the Fidelity HSA, see "Your Guide to Understanding a Health Savings Account" at www.mycpchembenefits.com/health.
- **Rollovers from other HSAs:** Rollovers from other HSAs are permitted with the following restrictions:
  - You are permitted to make only one rollover of an HSA during a one-year period,
  - Rollovers to your HSA must be completed within 60 days of the date you receive the distribution from the other HSA, and
  - Direct rollovers to or from retirement accounts, such as 401(k), 403(b) and 457 plans, are not permitted.
- **Transfer funds to another HSA:** You can transfer your funds to another HSA administrator at any time, but transfer fees apply. Please contact Fidelity at www.netbenefits.com or 1-866-771-5225 for more information.



Using the HSA

You can use your HSA to pay certain health care expenses incurred by you or any of your dependents. You (or your dependents) do not have to be enrolled in a Chevron Phillips Chemical medical plan to receive reimbursements from this account for eligible expenses. Also, you can receive reimbursement for your dependents' eligible health care expenses even if they are enrolled in a non-high deductible health plan. However, you must be enrolled in the *Value CDH Plan* to make contributions to your HSA.

Please note that the definition of a child dependent for HSA purposes uses a different "age test" than other Chevron Phillips Chemical health plan dependent definitions, generally ending at age 19 if not a student and at age 24 if a student, unless disabled. Refer to IRS Publication 501 for the full IRS child dependent definition.

YOUR HSA IS PORTABLE

Your HSA is still your account even if you:

- Change jobs or become unemployed,
- Change your medical coverage,
- Move to another state, or
- Change your marital status.

Although your pre-tax contributions will stop if your employment with Chevron Phillips Chemical ends or you drop your coverage under the *Value CDH Plan*, you may continue to receive reimbursement for eligible expenses.

Accessing Your HSA Funds

If you want to use your HSA funds to pay for eligible health care expenses, you can:

- Use your HSA debit card to pay for services when you receive them,
- Write an HSA check to the provider or to yourself (if you have an HSA checkbook),
- Use Fidelity's online bill paying service to make payments directly to health care providers, and
- Distribute money from your HSA by requesting an Electronic Funds Transfer (EFT) to your personal bank account or request that a distribution check be mailed directly to you.

You can make payments or withdrawals from your HSA only up to your current account balance.

Note that you must keep your own records of eligible medical expenses — you don't submit claims documentation to Fidelity.

Health Care Expenses Allowed by the IRS

Only allowable expenses that are adequately documented and are not covered by insurance are reimbursed. The following is a partial list of expenses that may be eligible for reimbursement if not paid by insurance.

- Abdominal supports,
- Acupuncture,
- Automobile equipment to help any physically disabled eligible dependent,
- Back supports,
- Birth-control-related expenses,
- Bone marrow transplants,
- Braille books and magazines,
- Certain schooling for any disabled eligible dependent,
- Charges in excess of recognized charges limits under the medical plan and/or dental plan, or any other health plan under which you have coverage,
- Childbirth preparation classes,
- Chiropractic care,
- Cost of a note-taker for a hearing-impaired child while in school,
- Cost of a special diet when medically necessary and only to the extent that cost exceeds that of a normal diet,
- Crutches,
- Deductibles/co-insurance/copayments under the medical plan, dental plan and/or vision plan, or any other health plan under which you have coverage,
- Dental cleanings and fillings,
- Detoxification or drug abuse centers,
- Diabetic supplies,
- Diathermy,
- Elevators (in home) for any disabled eligible dependent,
- Expenses for services connected with donating an organ,
- Eye exams, eyeglasses, contact lenses and supplies,
- Fees to use a swimming pool for exercises prescribed by a doctor to alleviate a specific medical condition,
- Feminine hygiene products,
- Guide or guide dog for any eligible dependent who is visually or hearing-impaired,
- Hearing aids,
- Home pregnancy tests,
- Household visual-alert systems for any hearing-impaired eligible dependent,
- Infertility treatment,
- Limited types of insurance premiums, including premiums for Medicare if you are age 65 or older, qualified long-term care insurance, and health care continuation coverage (such as COBRA),
- Medically necessary mattresses and boards,
- Orthodontia,
- Orthopedic shoes,
- Over-the-counter medications used to treat illness,
- Physical therapy,
- Prescription drugs,
- Psychotherapy,
- Radial keratotomy or LASIK surgery,
- Radiation treatments,
- Respirators,
- Routine physical exams,
- Smoking-cessation programs and products,
- Special devices, such as tape recorders and computers, for any eligible dependent who is visually impaired,
- Specialized equipment for any disabled eligible dependent,
- Speech therapy,
- Sterilization and reverse-sterilization surgery,
- Surgical stockings,
- Well-baby and well-child care,
- Wheelchairs,
- Wigs for hair loss due to disease, and
- X-rays.

Limited Health Insurance Premium Expenses Allowed by the IRS

Certain premiums are eligible expenses for reimbursement under the HSA. These include:

- Qualified long-term care insurance premiums,
- Medicare premiums, if you are age 65 or over, and
- Premiums for health care continuation insurance, such as COBRA.

Health Care Expenses Not Allowed by the IRS

The following are examples of expenses not eligible for reimbursement. These include, but are not limited to:

- Cosmetic surgery and procedures (except to improve a deformity or repair injury),
- Cosmetics and toiletries,
- Custodial care in an institution,
- Expenses claimed on your income tax return,
- Expenses for which you receive reimbursement under the medical plan, dental plan, or any other health plan under which you have coverage,
- Funeral or burial expenses,
- Health club fees and dues,
- Household help,
- Meals,
- Mileage in your own car,
- Most insurance premiums, including premiums for plans maintained by the employer of your spouse or other dependent,
- Transportation to/from work for the handicapped,
- Vacation travel for health programs,
- Vitamins, and
- Weight loss programs (except in the case of proven medical necessity).

For more information about eligible expenses under HSAs, see IRS Publication 502, Medical and Dental Expenses. This publication is available online at http://www.irs.gov/pub/irs-pdf/p502.pdf.

Using Your HSA for Non-Qualified Medical Expenses

Distributions from your Fidelity HSA that are used to pay for or reimburse non-qualified medical expenses will be included in your gross income for tax purposes and are subject to an additional 20% penalty. The 20% penalty does not apply to distributions made if you become disabled, once you reach age 65 or after your death.

An expense is incurred when the service is rendered — not when you are charged or billed, or when you pay the expense.

(Performance Pipe Hourly Employees)

Retiree Reimbursement Account (RRA)

Contents

Your Retiree Reimbursement Account (RRA)

Chevron Phillips Chemical provides the Retiree Reimbursement Account (RRA) to help eligible retirees pay medical, dental and vision premiums and out-of-pocket health care expenses. The RRA is administered by Inspira.

Who's Eligible

You do not have to be enrolled in Chevron Phillips Chemical benefits at the time of retirement to be eligible for the RRA. You are eligible for the RRA if your last hire or rehire date was before January 1, 2017, AND you meet any of the following criteria at retirement:

- You have 25 or more years of continuous service,
- You have 10 or more years of continuous service AND are at least 55 years of age, OR
- You have 3 or more years of continuous service AND are 65 years of age or older.

However, the following employees are NOT eligible for the Chevron Phillips Chemical RRA:

- Employees whose last hire or rehire date was on or after January 1, 2017,
- Fairfield, Iowa and Bloomfield, Iowa hourly employees,
- Puerto Rico Core employees,
- Knoxville, TN, Reno, NV, Brownwood, TX, Hagerstown, MD, Pryor, OK, Startex, SC and Williamstown, KY hourly employees hired on or after January 1, 2004, and
- Former retirement-eligible Chevron Phillips Chemical employees who transferred to Americas Styrenics (AmSty).

Ryton Members, as defined on page A-2 of the ***How to Participate*** chapter, were provided an RRA upon the closing of the Ryton business sale transaction regardless of their age and continuous service at that time. An RRA was also provided to K-Resin Members, as defined on page A-2 of the ***How to Participate*** chapter, upon the closing of the K-Resin business sale transaction regardless of their age and continuous service at that time.

Dependent Coverage

You may submit reimbursement claims for eligible dependents based on the same dependent eligibility rules applicable to active employees. For more information on dependent eligibility, see pages A-3 – A-4 of the ***How to Participate*** chapter. If you should die, the spouse you were married to at the time of your retirement will continue to have access to your RRA. However, if he or she remarries, the RRA will be forfeited. If you are not married at retirement or if you marry a new spouse after the date of your retirement, your RRA funds will be forfeited upon your death.

THE RRA AND CHEVRON CORPORATION/ CONOCOPHILLIPS RETIREE HEALTH CARE BENEFITS

If you transferred to Chevron Phillips Chemical on January 1, 2001, and you were eligible for retiree health care benefits from either Chevron Corporation or ConocoPhillips as of December 31, 2000, you may have the option to receive retiree health care benefits under the parent company's plan. If you elect retiree medical coverage from Chevron Corporation or ConocoPhillips, subsidized pre-65 and/or post-65 retiree medical premiums through the parent company's retiree health plan are ***not*** eligible for reimbursement from your RRA. However, you can use your RRA for other out-of-pocket health care expenses.

How the Plan Works

If your last hire or rehire date was before January 1, 2017 and you retire on or after January 1, 2007, Chevron Phillips Chemical will credit to your Retiree Reimbursement Account (RRA) an amount equal to:

- $1,300 times your years of continuous service if you are single at retirement, or
- $2,500 times your years of continuous service if you are married at retirement.

Continuous service is the period, calculated in number of days, from your continuous service date (typically your most recent hire date for regular or full-time employment) to your termination date. For the purpose of determining the amount that Chevron Phillips Chemical will credit to your RRA, your service with Chevron Corporation and/or ConocoPhillips will be included when calculating your years of continuous service as long as you transferred to Chevron Phillips Chemical on January 1, 2001. Service recognized under the AmSty retiree health reimbursement account plan will also be included for RRA eligibility and benefit purposes if you transfer back to the Company directly from AmSty. Your account earns a market rate of interest once it is established.

The Company will deduct from your RRA balance any contribution or premium amounts paid by the Company for health plan coverage on your or your dependents' behalf billed to you, but unpaid by you, between your last day as an active employee and the date on which your RRA is set up.

KEEP YOUR MARITAL STATUS UP-TO-DATE

The amount of money that the Company credits to your RRA is based on your years of continuous service and your marital status at retirement. Therefore, it is important that Chevron Phillips Chemical has your correct marital status prior to your retirement date.

Generally, accounts are opened and funded within 14 business days of the date the Company is notified of your retirement. Chevron Phillips Chemical makes no additional contributions other than monthly interest credits. If you think there has been an error in the Company's contributions to your RRA, you must notify Chevron Phillips Chemical within 12 months of your retirement date. Unless it is the result of an error by the Company when calculating your RRA funds, no interest will be paid on any retroactive deposits into your RRA (for example, if you did not update your marital status prior to retirement).

Using Your RRA Money

You may use the money in your account to reimburse yourself for the cost of benefits coverage under the Chevron Phillips Chemical COBRA and/or retiree medical, dental and/or vision plans, or to reimburse yourself for the cost of coverage from private health care plans, including Medicare premiums, Mercer Marketplace 365 plans or AARP Medicare supplement coverage, and qualified out-of-pocket health care expenses such as deductibles, copays, co-insurance and other expenses that are not covered by your retiree medical, dental and vision plans — and the reimbursements are all non-taxable to you. You will have to pay your health care premiums and other health care expenses out-of-pocket and submit a claim to Inspira for reimbursement.

Note: Unless you are enrolled as a dependent, subsidized retiree medical premiums for coverage through a parent company's retiree medical and dental plans (Chevron Corporation or ConocoPhillips) are ***not*** eligible for reimbursement from your RRA. Contributions to Medi-Share and similar medical expense-sharing programs are also ***not*** eligible for reimbursement from your RRA.

OTHER SOURCES OF RETIREE HEALTH CARE FUNDS

Your RRA may only cover part of your Chevron Phillips Chemical retiree benefit costs. You may want to supplement the RRA by making contributions while you're an active employee to the 401(k) Savings Account or a Health Savings Account (HSA), if eligible.

Coordination With Medicare

Following your retirement, as soon as you or a covered dependent are eligible for benefits under Medicare, the person must enroll in Medicare Parts A and B in order to remain eligible for benefits under the RRA. If you or a covered dependent fail to enroll in Medicare Parts A and B when first eligible following your retirement, your or your dependent's coverage under the RRA will be suspended effective as of the date you or your dependent should have enrolled in Medicare. You may also be subject to a penalty imposed by the Social Security Administration for not timely enrolling in Medicare after your retirement.

How to File a Claim

There are two ways to request reimbursement from your RRA. Reimbursement forms can be found at www.mycpchembenefits.com/forms or at www.inspirafinancial.com. Inspira also supports one-time claims submissions online at www.inspirafinancial.com.

Submitting a One-Time Claim for Reimbursement

You can request a one-time reimbursement for all eligible health care premiums and out-of-pocket health care expenses either by completing the "Inspira Retiree Reimbursement Account (RRA) Claim Form" available at www.mycpchembenefits.com/forms or by logging into www.inspirafinancial.com and electronically uploading your claim information.

Submitting a Recurring Claim for Premium Reimbursement

For recurring (i.e., monthly) health care premiums, you also have the option to set up recurring reimbursement for a period of up to 12 months by completing the "Inspira RRA Recurring Premium Reimbursement Claim Form" available at www.mycpchembenefits.com/forms. Submit the form with the required supporting documentation by fax or by mail using the contact information indicated on the form.

RRA Reimbursement Direct Deposit

To have your premium and out-of-pocket health care reimbursements directly deposited into your bank account, complete the "Inspira Direct Deposit Authorization Form" available at www.mycpchembenefits.com/forms. Submit the form with a voided check or savings deposit slip by fax or by mail.

When You Can Expect a Reimbursement

Inspira processes claims for reimbursement on a daily basis, and reimbursements are mailed to your home address. If your home address changes, it is your responsibility to update it on MySphere under "Contact Info." If you are not an active employee, you can call the CPChem Benefits Service Center at 1-833-964-3575 to update your address. If you elect to have reimbursements directly deposited into your bank account, the deposit will be credited approximately three business days after the claim is processed.

Please note that any amounts due and payable to you under the RRA will be forfeited within one year if Inspira is unable to locate you to make a payment, subject to reinstatement of the full amount (exclusive of any interest) if a claim is made within the time period set by the Benefits Committee or applicable claims procedures.

Other Important Information

Plan Funding

The RRA is an unfunded plan. Benefits under the RRA are payable solely from the Company's general assets and are subject to the claims of the Company's general creditors in the event of the Company's insolvency. While benefits under the RRA are generally payable solely from the general assets of the Company, the Company has established a 401(h) account under the Retirement Plan to assist in funding its obligation under the RRA. In addition, the Company may pre-fund accounts under the Health and Welfare Benefit Trust to assist it in meeting its obligation under the RRA. Any benefits (or claims) paid directly from the 401(h) account established under the Retirement Plan, or any pre-funded account under the Health and Welfare Benefit Plan Trust or the general assets of the Company, shall reduce the balance available in your RRA.

Claims Assistance

For assistance with questions or problems concerning benefits under this plan, call Inspira at 1-888-678-8242.

All decisions concerning the payment of claims under the plan are at the sole discretion of the plan administrator (or its designated 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 P-2.

Your ERISA Rights

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 P-16.

When Coverage Ends

Coverage under the RRA for you and your covered dependents will end on the earlier of:

- the date your account funds are exhausted,
- the date you transferred directly from the Company to AmSty, or
- the later of the following three dates:
  - the date of your death,
  - the date of the death of your surviving spouse if your surviving spouse was covered under the RRA, or
  - the date your surviving spouse remarries if your surviving spouse was covered under the RRA.

Any remaining amounts credited to your RRA will be forfeited as of your transfer to AmSty, your or your surviving spouse's death or your surviving spouse's remarriage.

Please note, however, that survivor rights to your RRA balance do not transfer to a spouse who you marry after your retirement date. If you divorce after you retire, you can no longer receive reimbursement for your ex-spouse's expenses. A widowed spouse forfeits the remaining RRA balance upon remarriage.

For administrative reasons, if your RRA balance is less than $100 and there has been no claims activity on your account during a given plan year, the amount remaining in your RRA shall be forfeited at the end of the last day of that plan year.

(Performance Pipe Hourly Employees)

Life Insurance Plans

Contents

Your Life Insurance Options

Life insurance provides financial resources to your beneficiaries in case of your death. Chevron Phillips Chemical Company LP (Chevron Phillips Chemical or the Company) offers eligible employees:

- Company-paid basic life insurance, and
- The opportunity to purchase supplemental life insurance for yourself and your eligible family members, if you wish.

FROZEN AGE

Life insurance premiums are based on an employee's age as of January 1st of the current calendar year (e.g., calendar year 2024 benefits are based on age as of January 1, 2024).

You are automatically enrolled in basic life insurance coverage. You must enroll if you want to elect supplemental life insurance coverage. For information on eligibility and enrollment, see pages A-1 – A-7 of the ***How to Participate*** chapter. In some cases, Evidence of Insurability may be required. For more information, see ***When Evidence of Insurability (EOI) Is Required*** on page A-6 of the ***How to Participate*** chapter.

BASE PAY

Base pay for purposes of the Chevron Phillips Chemical health and welfare plans is defined as total regular base pay. Regular base pay includes regularly scheduled overtime for employees who are normally scheduled to work more than 40 hours per week. All other types of pay that are not considered to be part of regular base pay or regularly scheduled overtime are not eligible earnings under the health and welfare plans.

If your pay increases during the calendar year, your life insurance coverage will increase accordingly, effective on the first of the month following your increase in base pay or on the date specified, if Evidence of Insurability is submitted and approved.

How the Plans Work

Basic Life Insurance

The Company-paid coverage provides your beneficiary with a benefit of one times your annual base pay — with a minimum benefit of $10,000 and a maximum benefit of $300,000. Your coverage amount is rounded up to the next higher $1,000, if it is not already a multiple of $1,000.

Supplemental Life Insurance

For Yourself

You may elect supplemental life insurance for yourself equal to one to eight times your annual base pay rounded up to the next higher $1,000, if it is not already a multiple of $1,000. The minimum coverage is $10,000 and the maximum is $600,000. The maximum amount of life insurance you may have through Chevron Phillips Chemical (basic and supplemental life insurance combined) is $900,000.

During your initial enrollment for supplemental life insurance, there is a guaranteed issue amount, which is the lesser of three times your annual base pay or $400,000. If you wish to enroll in supplemental life coverage of more than the guaranteed issue amount during your initial eligibility period, or you do not elect coverage within 31 days of when you are initially eligible, Evidence of Insurability will be required if you wish to enroll or increase coverage at a later date.

For Your Dependents

If you elect supplemental life insurance for yourself, you may also buy supplemental life insurance coverage for your spouse and eligible dependent children.* You can elect spouse coverage in $10,000 increments. The minimum is $10,000 and the maximum is the lesser of $250,000 or 100% of the combined total of your basic and supplemental life insurance coverage amounts. Changes to your pay do not affect your spouse's coverage amount.

* Dependent children include biological children, stepchildren, foster children, legally adopted children, children legally placed for adoption and/or children under permanent legal guardianship or permanent sole managing conservatorship.

LIFE INSURANCE AND TAXES

According to federal tax law, up to the first $50,000 of Company-provided life insurance is available to you tax-free. However, once the face amount of your coverage exceeds $50,000, the value of the Company-provided insurance in excess of $50,000, known as imputed income, is reported as income to the Internal Revenue Service (IRS) and added to your taxable pay. Imputed income for life insurance is determined using IRS cost tables.

For example, if you are eligible for basic life insurance in the amount of $70,000, the value of the amount exceeding $50,000 ($20,000 of coverage) will be added to your W-2 earnings. Your imputed income is determined by using the IRS tables.

Your beneficiary will not pay taxes on any death benefits he or she receives from the plan. However, interest on the death benefits, if any, will be taxable.

For information about imputed income, see page P-30.

During your initial enrollment for spouse coverage, there is a guaranteed issue amount equal to $50,000. If you do not elect coverage within 31 days of when you or your spouse is initially eligible, Evidence of Insurability will be required if you wish to enroll or increase spouse coverage at a later date.

For your dependent children, you have three options to choose from:

- **Option 1:** $5,000 of coverage for each child,
- **Option 2:** $10,000 of coverage for each child, or
- **Option 3:** $15,000 of coverage for each child.

One premium for child life insurance covers all eligible children, up to age 26, no matter how many children you enroll. Evidence of Insurability is not required for dependent child life insurance.

If both you and your spouse work at Chevron Phillips Chemical, you may not be covered both as an employee and dependent. Also, your children may be enrolled only once under the plan.

Accelerated Death Benefit

The Chevron Phillips Chemical life insurance plans offer an accelerated death benefit if you or your covered spouse becomes terminally ill. You (or your spouse) can receive up to 80% of your (or your spouse's) life insurance benefit (basic and supplemental combined) in advance to help with expenses.

A person is considered terminally ill if the person, due to injury or sickness, is expected to die within 24 months.

To apply for accelerated benefits, you or your covered spouse must provide the insurance company with a completed accelerated benefit claim form and a signed physician's certification that you are terminally ill. The insurance company may also require you or your spouse to be examined by a doctor of its choice, at its expense.

Amount of the Accelerated Death Benefit

The amount of the accelerated death benefit is determined at the time the insurance company approves payment. You may receive no more than 80% of your basic and supplemental life insurance coverage amount, not to exceed a maximum of $200,000 for basic life insurance and $400,000 for supplemental life insurance. Your covered spouse may receive no more than 80% of their spouse life insurance coverage amount, not to exceed a maximum of $200,000.

An accelerated benefit for each eligible life benefit is payable only once.

Upon your or your covered spouse's death, your beneficiaries receive your coverage amount less the amount paid to you as an accelerated death benefit plus any interest that is applicable.

Benefits payable under the accelerated death benefit provision may be taxable. If so, you or your beneficiaries may incur a tax obligation. As with all tax matters, you should consult with a personal tax advisor to assess the impact of this benefit. Accelerated death benefits are not payable if:

- The life insurance coverage under the policy is not in force, or is expected to end within 12 months of the date that an accelerated benefit is requested,
- You or your spouse have less than $10,000 of coverage,
- You or your spouse have already received an accelerated benefit on the eligible life benefit under the policy, or
- You have assigned your benefits.

Who Receives Plan Benefits

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.

You are the beneficiary of your dependent's life insurance benefits. The insurance company pays the proceeds of your dependent's life insurance in effect on the date your covered dependent dies. Benefits are paid as soon as possible after the insurance company receives proof to support the claim.

ESTATE RESOLUTION SERVICES

This service provides your beneficiaries the personal support of a MetLife Legal Plans' attorney either in-person or via telephone. By participating in MetLife Estate Resolution Services℠, the participating plan attorney's fees are covered for the administrator or executor of your estate for the following probate services:

- Telephone and office consultations to discuss matters related to probating the insured's estate,
- Preparation of documents and representation at court proceedings needed to transfer the probate assets from the insured's estate to the insured's heirs,
- The completion of correspondence necessary to transfer non-probate assets such as proceeds from insurance policies, joint bank accounts, stock accounts or a house, and
- Associated tax filings.

When your supplemental life insurance becomes effective, you will automatically become eligible for this service. Beneficiaries will receive an explanation of this service included with their claim form.

WILL PREPARATION SERVICE

To help ensure that your assets are distributed according to your wishes, Chevron Phillips Chemical offers a will preparation service, provided by MetLife Legal Plans. The service provides eligible employees who have elected supplemental life insurance and their spouse access to MetLife Legal Plans' network attorneys who prepare or update wills, living wills or powers of attorney at no additional charge.

When you choose a participating MetLife Legal Plans attorney, the attorney's fees are fully covered and there are no claim forms to file. You also have the flexibility of using a non-network attorney and being reimbursed for covered services according to a set fee schedule.

To access the service or for any questions, contact MetLife Legal Plans at 1-800-821-6400.

A MetLife Legal Plans Representative will:

- Ask you to provide your company name or group number (0116910) and the last four digits of your Social Security number or employee number,
- Help you locate a participating plan attorney in your area,
- Provide you with case numbers to give to the attorney you choose, and
- Answer any questions you have.

You contact the attorney's office and make an appointment at a time convenient for you.

GRIEF COUNSELING SERVICES

MetLife provides grief counseling services to all life insurance participants, including those with Company-paid basic life insurance only. You and your immediate family members are eligible for the following support services following a loss:

- Up to five in-person or telephonic counseling sessions per event,
- Funeral assistance services, including locating local funeral homes, identifying backup care for children or older adults and finding specific support groups, and
- Access to financial and legal consultations to make informed decisions following a loss.

How to File a Claim

In the event of your or a covered dependent's loss, MetLife must receive notice of the loss and any required proof within 90 days — or as soon as reasonably possible — after the loss occurs. Notice can be given by calling the CPChem Benefits Service Center at 1-833-964-3575. You will be asked to provide information such as your name, address, employee identification number and/or Social Security number.

Claim Assistance

For assistance with questions or problems concerning benefits under this plan, call MetLife at 1-800-638-6420. If additional assistance is needed, you also may contact MetLife at the address shown in the ***General Information*** chapter on page P-29.

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

Your ERISA Rights

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 P-16.

How to Continue Coverage If You Become Disabled

If you become disabled, you may continue your basic and supplemental life insurance coverages. The insurance will continue as long as you pay your supplemental and dependent life insurance premiums and are considered disabled under the terms of the Company's Long-Term Disability Plan. Chevron Phillips Chemical will continue to pay for your basic life insurance.

PORTING VS. CONVERTING LIFE INSURANCE COVERAGE

If you are no longer eligible for coverage under the plan, you and your dependents may elect to either port or convert your life insurance coverage to an individual policy within 31 days of when your coverage ends.

You may be eligible to port your supplemental life coverage, which means your coverage becomes a term policy with premiums determined based on your age. When you port coverage, your premiums will increase as you get older.

You may also be eligible to covert your basic and/or supplemental life coverage, which means your policy becomes a permanent life policy with premiums at group rates determined based on your age and benefit amount elected. Your premiums will remain the same for the life of the policy.

How to Port Coverage If You're No Longer Eligible

If you are no longer eligible for supplemental insurance coverage because you terminate employment with the Company, retire or you no longer are in an eligible group of employees, you may continue your coverage through the portability option. Evidence of Insurability is not required.

You must be actively at work on the day your coverage ceases in order to be eligible. For your dependent spouse to be eligible, you must elect coverage for yourself, except in cases of death or divorce.

You may continue coverage for up to (but not more than) the amount you were enrolled in before becoming ineligible for coverage. Your election will need to fall within the ranges specified below.

	Minimum	Maximum
For you	$20,000	$500,000
For your spouse	$ 2,500	$250,000
For your dependent child	$ 1,000	$ 15,000

You must send a written request to MetLife and pay the required premiums within 31 days after your eligibility ends. Please note that some correspondence with respect to porting your MetLife coverage may be with Barnum Financial Group, with whom MetLife has subcontracted for certain portability administration services. Coverage becomes effective at the end of the 31-day period. You are not eligible for this option if:

- Your life insurance will be terminated and replaced by like coverage under another policy,
- Chevron Phillips Chemical goes out of business, or
- Your basic and/or supplemental life insurance was converted to an individual life policy in accordance with the conversion-of-coverage provision.

Coverage under the portability option reduces to 50% of the amount then in force on January 1st of the year in which the insured person turns age 70. Coverage ends on January 1st of the year in which the insured person turns age 80.

Termination of Coverage

Your coverage under the portability option ends:

- At the end of the 31-day period for which required premiums are not paid,
- On the date of your death, or
- On January 1st of the year in which you reach age 80.

Your spouse's and dependents' coverage under the portability option ends:

- With respect to your spouse, on January 1st of the year in which your spouse reaches age 80,
- With respect to your dependent child, when the child reaches age 19, or age 23 if a full-time student (age 25 if a full-time student and Texas resident), or
- On the date your spouse or dependent child no longer is defined as an eligible dependent.

Coverage under the portability option that ends due to attainment of an age limit may be converted to an individual policy. However, the portion of coverage lost when your or your spouse's coverage is reduced by 50% at age 70 may not be converted. Only the portion left after the reduction may be converted.

How to Convert Coverage

You or your insured dependent may convert your basic and supplemental insurance to an individual life insurance policy if any part of your or your insured dependent's life insurance under this plan stops. Evidence of Insurability is not required.

Reasons for Converting

You or your insured dependent may convert to an individual policy if your plan coverage (including coverage continued under the portability option) stops for any of these reasons:

- For your life insurance:
  - Your termination, retirement or disability,
  - Coverage ends for an eligible class of which you are a member and you participated in it for at least five consecutive years,
  - You reach the age limit for coverage,
  - The plan is changed or canceled, and you participated in it for at least five consecutive years, or
  - The coverage you have attempted to port exceeds the maximum allowed under portability, and you would like to continue the remaining coverage.
- For your dependent's life insurance:
  - Your termination, retirement, disability or death,
  - Your marriage is divorced or annulled, so that your dependent no longer is an eligible dependent,
  - Your spouse or child reaches the age limit for coverage, or
  - The plan is changed or canceled, and your spouse or child participated in it for at least five consecutive years.

You or your dependents may convert coverage by applying to MetLife and paying the first premium for an individual policy within 31 days after any part of your or your covered dependent's life insurance stops. MetLife will automatically mail the appropriate forms to you. If you do not receive the forms, call the CPChem Benefits Service Center at 1-833-964-3575, and request conversion forms. Please note that some correspondence with respect to converting your MetLife coverage may be with Barnum Financial Group, with whom MetLife has subcontracted for certain conversion administration services.

If you or your insured dependents die within the 31-day period allowed for making an application to convert, a death benefit is paid to the applicable beneficiary in the amount you or your insured dependent were entitled to convert. This amount is paid whether or not an application to convert was made. Any premium paid for the individual policy is returned.

Termination of Coverage

Your coverage under the conversion option ends as stated on your individual conversion policy.

(Performance Pipe Hourly Employees)

Accidental Death and Personal Loss Insurance Plans

Including Occupational Accidental Death and Personal Loss Insurance Plan

Contents

Your Plan Options

Accidental Death and Personal Loss Insurance

The Accidental Death and Personal Loss (AD&PL) Plan pays benefits if you die or suffer accidental injuries as a result of a covered accident. Chevron Phillips Chemical Company LP (Chevron Phillips Chemical or the Company) offers eligible employees:

- Company-paid basic AD&PL insurance. You are automatically enrolled in basic AD&PL insurance coverage.
- The opportunity to buy additional amounts of AD&PL coverage for yourself and your eligible family members, if you wish. You must enroll if you want to elect supplemental AD&PL insurance coverage.

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

Occupational Accidental Death and Personal Loss Insurance

The Occupational Accidental Death and Personal Loss (OAD&PL) Plan pays benefits if you die or are in a Coma as a result of a covered accident while on the job. Chevron Phillips Chemical provides eligible employees with basic OAD&PL insurance. For information on eligibility, see page A-1 of the ***How to Participate*** chapter.

You are automatically enrolled in Company-paid basic OAD&PL insurance coverage. This coverage requires no Statement of Health.

BASE PAY

Base pay for purposes of the Chevron Phillips Chemical health and welfare plans is defined as total regular base pay. Regular base pay includes regularly scheduled overtime for employees who normally are scheduled to work more than 40 hours per week.

All other types of pay that are not considered to be part of regular base pay or regularly scheduled overtime are not eligible earnings under the health and welfare plans.

If your pay increases during the calendar year, your basic AD&PL coverage will increase accordingly.

How the Plans Work

Basic AD&PL Insurance

Company-paid basic AD&PL insurance provides coverage equal to your annual base pay — with a minimum benefit of $10,000 and a maximum benefit of $300,000. A benefit is paid to you in case of accidental injury and to your beneficiaries in the event of your accidental death. Your coverage amount is rounded up to the next $1,000, if not already a multiple of $1,000.

OAD&PL Insurance

This Company-paid coverage provides a lump-sum payment of $500,000 to your beneficiary in the case of your accidental death while on the job.

This coverage also provides a benefit for Coma, which is 2% of the face value, or $10,000 monthly, beginning on the 5th day of the Coma to a maximum of 50 months.

Coma means a state of deep and total unconsciousness from which the comatose person cannot be aroused. Such state must begin within 30 days of the accidental injury and continue for five consecutive days.

Supplemental AD&PL Insurance

For Yourself

You may elect employee supplemental AD&PL insurance for yourself in $10,000 increments starting at $50,000, up to a maximum of the lesser of 10 times your annual base pay (rounded up to the next $10,000) or $1,000,000.

For Your Dependents

If you have supplemental AD&PL insurance for yourself, you also may cover your dependents. Coverage amounts depend on the make-up of your family, as shown in the following chart.

If You Are...	Dependent AD&PL Covers...	Coverage Amount (% of Employee Supplemental AD&PL Insurance)
Married with no children	Spouse only	65% up to $650,000
Married with children	Spouse and children	55% for spouse up to $550,000; 20% for each child up to $200,000
Single with children	Children only	25% for each child up to $250,000

If both you and your spouse work at Chevron Phillips Chemical, you may not have supplemental AD&PL coverage as an employee **and** as a dependent of your spouse. Your children can also only have supplemental AD&PL coverage under one employee.

Plan Benefits

Benefits are payable for losses directly resulting from a covered accidental injury incurred within one year of an accident. Injury means bodily injury caused by an accident occurring while the plan is in force as it relates to the covered person whose injury is the basis of a claim and resulting directly and independently of all other causes in a covered loss.

OAD&PL Benefit

This Company-paid coverage provides a one-time payment of $500,000 to your beneficiary in the case of an accidental death while on the job.

This coverage also provides a benefit for Coma, which is 2% of the face value, or $10,000 monthly, beginning on the 5th day of the Coma to a maximum of 50 months.

Coma means a state of deep and total unconsciousness from which the comatose person cannot be aroused. Such state must begin within 30 days of the accidental injury and continue for five consecutive days.

Basic AD&PL Benefits

If, within one year from the date of an accident covered by this plan, an injury from the accident results in a loss listed in the chart on the following page, the basic AD&PL coverage pays the benefit shown in the chart. If you suffer more than one covered loss as the result of the same accident, the plan pays for each loss, up to a maximum of the full AD&PL coverage amount. The additional benefits will not be taken into account when determining the maximum amount payable if the amount exceeds the full AD&PL coverage amount.

Supplemental AD&PL Benefits

In addition to Company-provided basic AD&PL, you may elect supplemental AD&PL insurance coverage. In the event of a covered loss, you or your beneficiary receives the amount of supplemental AD&PL you elected plus any amount of basic AD&PL to which you are entitled.

The following chart shows the percentage of your full benefit amount you are eligible to receive.

Covered Loss:	The Plan Pays This Portion of Your Full Amount:
Loss of life	100%
Loss of any combination of hand, foot or sight of one eye	100%
Loss of speech and hearing	100%
Paralysis of both arms and both legs	100%
Brain damage	100%
Loss of one arm or one leg	75%
Loss of one hand or one foot	50%
Loss of sight in one eye	50%
Loss of speech or hearing	50%
Paralysis of both legs	50%
Paralysis of arm and leg on the same side of the body	50%
Paralysis of one arm or one leg	25%
Loss of thumb and index finger of same hand	25%
Coma	2% monthly, beginning on the fifth day of the Coma, to a maximum of 50 months
Third degree burns	% of benefit is equal to % of body surface suffering third degree burns
A benefit equal to two times the child supplemental AD&PL benefit will be paid to each child if the covered loss is due to dismemberment, for all losses as a result of the same accident.	

The covered losses are defined as follows:

- **Loss of hand** means permanently severed at or above the wrist but below the elbow.
- **Loss of foot** means permanently severed at or above the ankle but below the knee.
- **Loss of arm** means permanently severed at or above the elbow.
- **Loss of leg** means permanently severed at or above the knee.
- **Loss of sight** means permanent and unrecoverable loss of sight in the eye. Visual acuity must be 20/200 or worse in the eye or the field of vision must be less than 20 degrees.
- **Loss of thumb and index finger of same hand** means that the thumb and the index finger are permanently severed through or above the third joint from the tip of the index finger and second joint from the tip of the thumb.
- **Loss of speech** means the entire and irrecoverable loss of speech that continues for six consecutive months following the accidental injury.
- **Loss of hearing** means the entire and irrecoverable loss of hearing in both ears that continues for six consecutive months following the accidental injury.
- **Paralysis** means the loss of use of a limb, without severance. A physician must determine the paralysis to be permanent, complete and irreversible.
- **Brain damage** means permanent and irreversible physical damage to the brain causing the complete inability to perform all the substantial and material functions and activities normal to everyday life. Such damage must manifest itself within 30 days of the accidental injury, require a hospitalization of at least five days, and persist for 12 consecutive months after the accidental injury.
- **Coma** means a state of deep and total unconsciousness from which the comatose person cannot be aroused. Such a state must begin within 30 days of the accidental injury and continue for five consecutive days.

Benefits for loss of life are paid in one sum unless you elect an installment method that was agreed to by MetLife. If you die after a benefit of less than 100% of your principal sum has been paid, the remaining unpaid benefit is paid in one lump sum to your beneficiary. The total amount paid for all benefits will not exceed the principal sum.

Additional Benefits

The AD&PL Plan includes additional benefits that are briefly described below.

The following benefit is included at no cost as part of the basic Accidental Death and Personal Loss (AD&PL) Plan:

- **Travel Assistance Coverage** — The coverage provides comprehensive travel services to business and vacation travelers as listed below.
  - Medical Assistance:
    - Referrals to English-speaking doctors and/or hospitals, dentists and specialists,
    - Guaranteed hospital admission and/or advancement of funds when medical insurance cannot be validated,
    - Emergency evacuation service (including transport, equipment and necessary personnel) when medical facilities are not available locally,
    - A critical care team of doctors, nurses and medically trained personnel that will stay in regular communication with local attending physicians to monitor quality of care,
    - Medically supervised repatriation to a rehabilitation facility or your home when you are ready to be discharged from a hospital but still in need of medical assistance,
    - Prescription assistance,
    - Round-trip transportation for a designated family member or friend to join you if you are traveling alone and are hospitalized for more than seven days,
    - One-way transportation (with an attendant if necessary) for a minor child left unattended as a result of accident or illness, and
    - Return of mortal remains.
  - Personal Assistance:
    - Lost document and luggage assistance,
    - Emergency cash advance if wallet is lost or stolen, and
    - Emergency message transmission.
  - Legal Assistance:
    - Legal referrals to English-speaking attorneys and interpreters, and
    - Bail bond assistance.
  - Information Services:
    - Passport and visa,
    - Inoculation requirements and local customs,
    - Exchange rates, and
    - Weather and holiday information.

Certain limitations apply to travel assistance coverage:

- Your actual medical expenses are covered and paid according to the terms of your health insurance. The travel assistance plan covers the extra costs involved in the medical transportation and other travel assistance services detailed on page L-5 and administered by the travel assistance administrator.
- The maximum benefit per person for costs associated with evacuations, repatriation or the return of mortal remains is $200,000 for each service.
- Non-medical services such as hotel, restaurant, taxi expenses or reimbursement for baggage loss while traveling are not covered.
- Coverage applies to participants in traveling status. If a trip exceeds 120 days, the participant is no longer considered in traveling status and coverage ceases.
- Evacuation or repatriation will not be provided without medical authorization; in cases of mild lesions or injuries such as sprains, simple fractures or mild sickness which can be treated by local doctors and do not prevent the person from continuing a trip or returning home; or for infections under treatment and not yet healed.
- Assistance is excluded when travel is undertaken for the specific purpose of obtaining medical treatment; in cases of injuries resulting from suicide, attempted suicide, participation in acts of war or insurrection, or commission of unlawful acts; in cases relating to use of drugs unless prescribed by a physician; and in cases involving mental or nervous disorders unless hospitalization is required.

These services are accessible worldwide, 24 hours a day, 365 days a year, by calling the AXA Travel Assistance Alarm Center at 1-800-454-3679 (within the U.S.) or collect at 1-312-935-3783 (outside the U.S.).

The following benefits apply to both the basic and supplemental Accidental Death and Personal Loss (AD&PL) Plans:

- **Seat Belt Benefit** — This benefit pays an additional benefit equal to 10% of the employee's or dependent's full amount or $25,000 (whichever is less), if a covered person dies as a result of a motor vehicle accident while either operating or riding as a passenger in a private passenger motor vehicle designed for use primarily on public roads, and at the time was wearing a properly fastened seat belt (or child restraint if the person is a child). The minimum benefit payable is $1,000.

  The Seat Belt Benefit will not be paid for loss of life caused by, contributed to, or resulting from a motor vehicle accident in which the operator of the vehicle is intoxicated or under the influence of drugs or narcotics, unless prescribed by a physician for a medical condition other than drug addiction.
- **Air Bag Benefit** — This benefit pays an additional benefit equal to 5% of the employee's or dependent's full amount or $10,000 (whichever is less), if a covered person dies as a result of a motor vehicle accident while either operating or riding as a passenger in a private passenger motor vehicle, and at the time was wearing a properly fastened seat belt and the air bag deployed.

When the Air Bag Benefit and the Seat Belt Benefit both apply, the combined additional benefit will not exceed 15% of the covered person's coverage to a combined maximum of $35,000. The additional benefits apply to both basic and supplemental AD&PL coverage.

- **Exposure and Disappearance Benefit** — The plan will automatically pay 100% of the employee's or dependent's full amount for a covered loss resulting from unavoidable exposure to the elements as a result of a covered accident. Also, if you or your dependent have disappeared for greater than one year as a result of the accidental disappearance, wreckage or sinking of the conveyance in which you were traveling and there is no contradictory evidence, your disappearance will be considered an accidental death.
- **Common Carrier Benefit** — This benefit pays an **additional** benefit equal to 100% of the employee's or dependent's full amount of AD&PL coverage if the covered person dies as a result of an accident while traveling in a common carrier (a government-regulated entity that is in the business of transporting fare-paying passengers, such as an airline, rail line or bus line).

The following benefits apply to only the supplemental Accidental Death and Personal Loss (AD&PL) Plan:

- **Child Education Benefit** — This benefit pays an additional annual benefit equal to the actual tuition charges incurred, up to a maximum of $20,000, for an eligible dependent child* to attend an accredited college, university or vocational school above the 12th grade level for up to four consecutive academic years. There is an overall maximum for all four years of 10% of the employee's/spouse's coverage. The child must be enrolled as a full-time student above the 12th grade level on the date of the employee's/spouse's accidental death, or enroll as a full-time student within one year of the death, and remain enrolled.

  This benefit is payable to the person who pays the tuition on behalf of the child.

  If, at the time of the accident, there are no children who qualify, the plan will pay an additional benefit of $1,000 to the designated beneficiary.

* Dependent children include biological children, stepchildren, foster children, legally adopted children, children legally placed for adoption and/or children under permanent legal guardianship or permanent sole managing conservatorship.

- **Spouse Education Benefit** — This benefit pays an additional annual benefit equal to the actual tuition charges incurred, up to a maximum of $5,000, for an eligible spouse** to attend an accredited school for up to four consecutive academic years. There is an overall maximum for all four years of 5% of the employee's coverage. The spouse must be enrolled in an accredited school on the date of the employee's accidental death, or enroll within one year of the death, and remain enrolled.

  This benefit is payable to the spouse.

  If, at the time of the accident, there is no spouse who qualifies, the plan will pay an additional benefit of $1,000 to the designated beneficiary.

** Your legally married spouse in any jurisdiction, regardless of gender or state of residence.

- **Child Care Benefit** — This benefit pays an additional annual benefit equal to the actual child care center costs incurred, up to a maximum of $7,500 per year, for an eligible dependent child under 12 years of age to attend a licensed child care center for up to four consecutive years. There is an overall maximum for all four years of 5% of the employee's/spouse's coverage. The child must have been enrolled in a licensed child care center at the time of the employee's/spouse's accidental death, or enroll within one year of the death, and remain enrolled.

  This benefit is payable to the person who pays the child care costs on behalf of the child.

  If, at the time of the accident, there are no children who qualify, the plan will pay an additional benefit of $1,000 to the designated beneficiary.

- **COBRA Continuation Benefit** — This benefit pays an additional annual benefit equal to the actual premium costs for surviving family members to continue medical coverage under the Company's medical plan, up to $3,000 per year, for the continuation of the surviving family members' group medical plan premiums for three years following the date of the employee's death. There is an overall maximum for all three years of 3% of the employee's coverage.

  This benefit is payable to the spouse. If there is no spouse on the date of the employee's death, the benefit will be paid to the person who pays the premiums for the child(ren)'s COBRA continuation.

  If, at the time of the accident, there is no dependent who qualifies, the plan will pay an additional benefit of $1,000 to the designated beneficiary.

- **Common Disaster Benefit** — If an employee has elected family coverage under the supplemental AD&PL plan, and both the employee and his/her covered spouse die within 365 days of each other as a result of injury in the same accident, the spouse's coverage amount will be increased to equal the amount of the employee's coverage.

- **Hospital Confinement Benefit** — This benefit pays an additional monthly benefit, up to a maximum of 1% of the insured person's coverage or $2,500 (whichever is less), if the person is confined in a hospital as a result of an accidental injury. Benefits will begin on the fifth day of continuous confinement and are subject to a maximum of 12 consecutive months and the benefit will be prorated for any partial month confinement. Benefits will only be paid for one period of continuous confinement for any accidental injury. That period will be the first period of confinement that qualifies for payment.

  This benefit is payable to the employee.

- **Rehabilitation Benefit** — This benefit pays an additional annual benefit equal to the expenses incurred for rehabilitative training, up to a maximum of 10% of your or your dependent's full amount or $10,000 (whichever is less), for an injury that results in any loss other than loss of life, within 90 days after a covered accident.

  Expenses incurred means the actual cost of the rehabilitative training and any materials or equipment needed for the rehabilitative training incurred within two years of the date of the accident.

  This benefit is payable to the employee.

When Benefits Are Not Paid

No benefit is paid for any loss caused by or resulting from:

- Physical or mental illness or infirmity, or diagnosis of or treatment for the illness or infirmity,
- An infection, other than infection occurring in an external accidental wound,
- Suicide or attempted suicide,
- Injuring oneself on purpose,
- The voluntary intake of any drug, medicine or sedative, unless taken or used as prescribed by a physician, or if an "over-the-counter" drug, medication or sedative, unless taken as directed, or alcohol in combination with any drug, medication or sedative,
- Committing or trying to commit a felony,
- Any poison gas or fumes voluntarily taken, administered or absorbed,
- Service in the armed forces of any country or international authority, except the United States National Guard,
- Any incident related to travel in an aircraft:
  - as a pilot, crew member, flight student or while acting in any capacity other than as a passenger,
  - for the purpose of parachuting or otherwise exiting from such aircraft while it is in flight, except for self preservation, or
  - used for testing or experimental purposes, or by or for any military authority, or for travel or designed for travel beyond the earth's atmosphere, or
- Driving a vehicle or other device while intoxicated as defined by the laws of the jurisdiction in which the vehicle or device was being operated.

Who Receives Plan Benefits

Benefits for loss of life are paid upon receipt of written proof of a loss to your beneficiary. Your beneficiary is the person or persons you designate to receive the proceeds of your insurance on your death. When you enroll for benefits as a new employee or when you add or change your benefit elections, you name a beneficiary. For more information, see ***Naming a Beneficiary*** on page A-23.

For any other loss sustained by you, or for any loss sustained by a dependent, benefits will be paid to you.

How to File a Claim

In the event of your or a covered dependent's death or personal loss, MetLife must receive notice of the loss within 90 days — or as soon as reasonably possible — after the death or injury occurs. Notice can be given by calling the CPChem Benefits Service Center at 1-833-964-3575. You will be asked to provide information such as your name, address, employee identification number and/or Social Security number.

Physical Exam and Autopsy

MetLife has the right to have a physician or dentist of its choice examine any person for whom benefits are requested. This will be done at all reasonable times while a claim for benefits is pending or under review.

Claim Assistance

For assistance with questions or problems concerning benefits under this plan, call MetLife at 1-800-638-6420. If additional assistance is needed, you also may contact MetLife at the address shown in the ***General Information*** chapter on page P-29.

All decisions concerning the payment of claims under the plan are at the sole discretion of MetLife. 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 P-2.

Your ERISA Rights

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 P-16.

(Performance Pipe Hourly Employees)

Business Travel Accident Plan

Contents

Your Business Travel Accident Plan

The Business Travel Accident Plan provides benefits if an eligible employee is seriously injured or dies in an accident while traveling on business for Chevron Phillips Chemical Company LP (Chevron Phillips Chemical or the Company). Chevron Phillips Chemical pays the full cost of your coverage under this plan. Family members traveling with you are not covered.

You are automatically enrolled in business travel accident insurance coverage. For information on eligibility, see page A-1 of the ***How to Participate*** chapter.

How the Plan Works

Business travel accident insurance applies if you are seriously injured or die in an accident while traveling on Chevron Phillips Chemical business anywhere in the world. Your coverage begins when you leave your home or office — whichever you leave last — for a planned business trip and remains in effect until you return to your home or office — whichever place you arrive first. Coverage is not in effect during day-to-day commuting between your home and regular place(s) of work, or while you are on a bona fide leave of absence or vacation.

You are traveling on Chevron Phillips Chemical business when you are on assignment by or at the direction of Chevron Phillips Chemical for the purpose of furthering business for Chevron Phillips Chemical.

Your regular commuting to and from work, including traveling to and from one plant location to another or while at a location, is not covered unless a trip is not part of your normal route and is at the Company's request.

You are covered if you make a personal deviation on a business trip and suffer an accidental covered injury. It must take place while on a business trip for Chevron Phillips Chemical. A personal deviation means:

- Any travel or activity not reasonably related to Chevron Phillips Chemical business, and
- Not incidental to the business trip, and
- Not longer than seven days, and
- Not done during vacation time or leave of absence.

The trip must be more than 100 miles from your primary home or office.

Plan Benefits

The amount of your coverage, or **principal sum**, is equal to your regular annual base pay, rounded to the next higher $1,000, up to a maximum of $500,000.

The combined total coverage, or **maximum aggregate benefit**, payable to all beneficiaries for a single covered accident (or series or combination of accidents arising out of one or more associated events) is $2,500,000. If two or more covered individuals are injured in the same business travel accident and suffer a loss or die as a direct result of the accident, benefits payable to each person may be proportionately reduced so that total benefits paid for all losses from the accident do not exceed the maximum aggregate benefit.

You or your beneficiary will receive benefits for resulting losses within 12 months of a covered accident. Your death from unavoidable exposure to the elements is considered an accidental death if the exposure was a direct result of the accident. Also, if you have disappeared for greater than one year as a result of the accidental disappearance, wrecking or sinking of the conveyance in which you were riding and there is no contradictory evidence, your disappearance will be considered an accidental death.

BASE PAY

Base pay for purposes of the Chevron Phillips Chemical health and welfare plans is defined as total regular base pay. Regular base pay includes regularly scheduled overtime for employees who normally are scheduled to work more than 40 hours per week. All other types of pay that are not considered to be part of regular base pay or regularly scheduled overtime are not eligible earnings under the health and welfare plans.

If your pay increases during the calendar year, the amount of your business travel accident coverage will increase accordingly.

Covered Losses

The benefit amount paid by the plan is based on the extent of your covered loss. If you suffer more than one covered loss as the result of the same accident, the plan pays for each loss, up to a maximum of the full amount. Additional benefits will not be taken into account when determining the maximum amount payable if the amount exceeds the full amount.

Covered Loss:	The Plan Pays This % of Your Full Amount:
Loss of life	100%
Loss of any combination of hand, foot or sight of one eye	100%
Loss of speech and hearing	100%
Paralysis of both arms and both legs	100%
Brain damage	100%
Loss of one arm or one leg	75%
Loss of one hand or one foot	50%
Loss of sight in one eye	50%
Loss of speech or hearing	50%
Paralysis of both legs	50%
Paralysis of arm and leg on the same side of the body	50%
Paralysis of one arm or one leg	25%
Loss of thumb and index finger of same hand	25%
Coma	2% monthly, beginning on the fifth day of the Coma, to a maximum of 50 months
Third degree burns	% of benefit is equal to % of body surface suffering third degree burns

The covered losses are defined as follows:

- **Loss of hand** means permanently severed at or above the wrist but below the elbow.
- **Loss of foot** means permanently severed at or above the ankle but below the knee.
- **Loss of arm** means permanently severed at or above the elbow.
- **Loss of leg** means permanently severed at or above the knee.
- **Loss of sight** means permanent and unrecoverable loss of sight in the eye. Visual acuity must be 20/200 or worse in the eye or the field of vision must be less than 20 degrees.
- **Loss of thumb and index finger of same hand** means that the thumb and the index finger are permanently severed through or above the third joint from the tip of the index finger and second joint from the tip of the thumb.
- **Loss of speech** means the entire and irrecoverable loss of speech that continues for 12 consecutive months following the accidental injury.
- **Loss of hearing** means the entire and irrecoverable loss of hearing in both ears that continues for 12 consecutive months following the accidental injury.
- **Paralysis** means the loss of use of a limb, without severance. A physician must determine the paralysis to be permanent, complete and irreversible.
- **Brain damage** means permanent and irreversible physical damage to the brain causing the complete inability to perform all the substantial and material functions and activities normal to everyday life. Such damage must manifest itself within 30 days of the accidental injury, require a hospitalization of at least five days, and persist for 12 consecutive months after the accidental injury.
- **Coma** means a state of deep and total unconsciousness from which the comatose person cannot be aroused. Such a state must begin within 30 days of the accidental injury and continue for five consecutive days.

Benefits are paid in one lump sum unless you elect an installment method that was agreed to by MetLife. If you die after a benefit of less than 100% of your principal sum has been paid, the remaining unpaid benefit is paid in one lump sum to your beneficiary. The total amount paid for all benefits will not exceed the principal sum.

Seat Belt Benefit

This benefit pays an additional benefit equal to 10% of your full amount or $25,000 (whichever is less), if you die while on Company business as a result of a motor vehicle accident while either operating or riding as a passenger in a private passenger motor vehicle designed for use primarily on public roads, and at the time you were wearing a properly fastened seat belt. The minimum benefit payable is $1,000.

The Seat Belt Benefit will not be paid for loss of life caused by, contributed to, or resulting from a motor vehicle accident in which the operator of the vehicle is intoxicated or under the influence of drugs or narcotics, unless prescribed by a physician for a medical condition other than drug addiction.

Air Bag Benefit

This benefit pays an additional benefit equal to 5% of your full amount or $10,000 (whichever is less), if you die while on Company business as a result of a motor vehicle accident while either operating or riding as a passenger in a private passenger motor vehicle, and at the time you were wearing a properly fastened seat belt and the air bag deployed. The minimum benefit payable is $1,000.

When the Air Bag Benefit and the Seat Belt Benefit both apply, the combined additional benefit will not exceed 15% of your coverage, to a combined maximum of $35,000.

When Benefits Are Not Paid

Plan benefits are not paid if your loss is caused or contributed to by:

- Physical or mental illness or infirmity, or diagnosis of or treatment for the illness or infirmity,
- An infection, other than infection occurring in an external accidental wound or from accidental food poisoning,
- Suicide or attempted suicide,
- Injuring oneself on purpose,
- Participation in hazardous activities such as:
  - scuba diving*,
  - bungee jumping,
  - skydiving,
  - hang gliding,
  - ballooning*,
  - drag racing,
  - driving a car fitted for competitive racing,
  - aerial hunting, or
  - aerial skiing,

* Note: Benefits are paid if a loss is caused while scuba diving or ballooning during a personal deviation on a business trip.

- The use of any drug, medicine or sedative, unless taken or used as prescribed by a physician, or if an "over-the-counter" drug, medication or sedative, unless taken as directed, or alcohol in combination with any drug, medication or sedative,
- War, whether declared or undeclared, or any act of war, insurrection, rebellion, riot, or a terrorist act in Iraq or Afghanistan (note: you can remove this exclusion on a per-trip basis by notifying the Chevron Phillips Chemical Benefits Department at least one week prior to your travel to a war-risk region),
- Committing or trying to commit a felony,
- Any poison, fumes or gas voluntarily taken, administered or absorbed,
- Any nuclear reaction or release of nuclear energy. This includes radioactive, toxic, explosive or other hazardous or contaminating properties or radioactive matter,
- The emission, discharge, dispersal, release or escape of any solid, liquid or gaseous chemical or biological agent,
- Service in the armed forces of any country or international authority, except the United States National Guard,
- Any incident related to travel in an aircraft:
  - as a pilot, crew member, flight student or while acting in any capacity other than as a passenger,
  - for the purpose of parachuting or otherwise exiting from such aircraft while it is in flight, except for self preservation,
  - that does not have a valid Certificate of Airworthiness,
  - that is not flown by a pilot with a valid license to operate that aircraft,
  - which is owned, leased, controlled or chartered by the covered individual, or
  - used:
    - for testing or experimental purposes,
    - by or for any military authority,
    - for travel or designed for travel beyond the earth's atmosphere,
    - for crop dusting, spraying or seeding,
    - for firefighting,
    - for sky diving,
    - for hang gliding,
    - for pipeline or power line inspection,
    - for sky writing,
    - for aerial photography or exploration,
    - for racing, endurance tests, stunt or acrobatic flying, or
    - for any use which requires a special permit from the Federal Aviation Administration, or
- Driving a vehicle or other device while intoxicated as defined by the laws of the jurisdiction in which the vehicle or device was being operated.

Who Receives Benefits

If your accident results in a loss of life, benefits are paid to your beneficiary upon receipt of written proof of a loss. Your beneficiary is the person or persons you designate to receive the proceeds of your insurance on your death. When you enroll for benefits as a new employee or when you add or change your benefit elections, you name a beneficiary. For more information, see ***Naming a Beneficiary*** on page A-23.

For any other loss sustained by you, benefits will be paid to you.

How to File a Claim

In the event of your accidental death or covered injury, the insurance company must receive written notice of the loss within 90 days — or as soon as reasonably possible — after the death or loss occurs. Notice can be given by calling the CPChem Benefits Service Center at 1-833-964-3575. You will be asked to provide information such as your name, address, employee identification number and/or Social Security number.

Physical Exam and Autopsy

The insurance company has the right to have you examined as often as reasonably necessary by a physician of its choice while the claim is pending, at its own expense. An autopsy may be conducted at the insurance company's expense unless prohibited by law.

Claim Assistance

For assistance with questions or problems concerning benefits under this plan, call MetLife at 1-800-638-6420. If additional information is needed, you may also contact MetLife at the address shown in the ***General Information*** chapter on page P-29.

All decisions concerning the payment of claims under the plan are at the sole discretion of MetLife. 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 P-2.

Your ERISA Rights

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 P-16.

(Performance Pipe Hourly Employees)

Long-Term Disability Plan

Contents

Your Long-Term Disability Plan

The Long-Term Disability (LTD) Plan, sponsored by Chevron Phillips Chemical Company LP (Chevron Phillips Chemical or the Company) and administered by Metropolitan Life Insurance Company (MetLife), is designed to provide eligible employees with financial assistance when an injury or illness lasts longer than six months (the first six months is called the "elimination period"). Chevron Phillips Chemical pays the full cost of your coverage under this plan.

You are automatically enrolled in LTD coverage. For information on eligibility, see page A-1 of the ***How to Participate*** chapter.

Important Terms Defined

Disability

You are considered disabled if, due to sickness or as a direct result of accidental injury:

- You are receiving appropriate care and treatment and complying with the requirements of such treatment, and
- During your elimination period and for the next 24 months, you are unable to earn more than 80% of your pre-disability earnings at your own occupation from any employer in your local economy, and
- After such period, you are unable to earn more than 80% of your pre-disability earnings from any employer in your local economy at any gainful occupation for which you are reasonably qualified taking into account your training, education and experience.

If your occupation requires a license, the fact that you lose your license, for any reason, does not in itself constitute disability.

Pre-Disability Earnings

Pre-disability earnings for purposes of the Chevron Phillips Chemical health and welfare plans is defined as gross salary or wages you were earning from the Company as of your last day of active work before your disability began. Pre-disability earnings include commissions you earned averaged over the 12-month period before your disability began. If you had not worked for at least 12 months, commissions are averaged over the period of your employment. Also included are any contributions you were making through a salary reduction agreement with Chevron Phillips Chemical to any of the following:

- An Internal Revenue Code (IRC) Section 401(k), 403(b) or 457 deferred compensation arrangement,
- An executive non-qualified deferred compensation arrangement, and
- Your fringe benefits under an IRC Section 125 plan.

Pay that is not considered part of your pre-disability earnings includes:

- Awards and bonuses,
- Overtime pay,
- Company contributions to any deferred compensation arrangement or pension plan, and
- Any other compensation from Chevron Phillips Chemical.

If your pay increases during the calendar year, your LTD coverage will increase accordingly.

Elimination Period

The elimination period is the period of your disability during which no benefits are paid. The elimination period begins on the day you become disabled and continues for six months or the length of time through which you have exhausted all of your paid leaves of absence (short-term disability, vacation, etc.) from Chevron Phillips Chemical, whichever is later.

If you return to active work before completing your elimination period for a period of 30 days or less, and then become disabled again due to the same or related sickness or accidental injury, you will not be required to complete a new elimination period. MetLife will count those days towards the completion of your elimination period.

If you return to active work for a period of more than 30 days, and then become disabled again, you will have to complete a new elimination period.

For purposes of determining your elimination period, the term “active work” only includes those days you actually work.

Plan Benefits

Benefit Amount

Your LTD coverage amount is equal to 60% of your monthly earnings, with a monthly maximum benefit of $14,000. LTD benefits are coordinated with other disability income benefits you receive (such as Social Security payments); however, your LTD benefit never will be less than $100 a month (subject to overpayments and any rehabilitation incentive benefit).

Other disability income benefits include, but are not limited to, benefits from family Social Security, Workers' Compensation, state disability programs and any other source of disability benefits paid for in whole or in part by Chevron Phillips Chemical. For more information, see ***Coordination With Other Sources of Income*** on page N-5.

Your LTD premiums are paid by the Company from after-tax assets. Therefore, your LTD benefit payments are subject to personal income taxes in the year received.

Maximum Benefit Period

Your maximum benefit period is the later of:

- Your normal retirement age (as defined by the federal Social Security Administration on the date your disability starts), or
- The period shown on the table below.

Age When Disability Occurs	Benefit Period
Less than age 60	to age 65
60	60 months
61	48 months
62	42 months
63	36 months
64	30 months
65	24 months
66	21 months
67	18 months
68	15 months
69+	12 months

Certification

If your doctor believes you will not be able to return to work after six months (the elimination period), MetLife may request additional medical documentation from your doctor. On its receipt, MetLife will review the documentation and determine if you qualify for LTD benefits.

MetLife may require you to undergo a medical examination as often as reasonably needed to make sure your claim is valid.

Period of Disability

A period of disability starts on the first day you are disabled (as defined on page N-2) and you are under appropriate care and treatment by a physician.

Appropriate care and treatment is defined as medical care and treatment that is:

- Given by a physician whose medical training and clinical specialty are appropriate for treating your disability,
- Consistent in type, frequency and duration of treatment with relevant guidance from national medical research, health care coverage organizations and governmental agencies,
- Consistent with a physician's diagnosis of your disability, and
- Intended to maximize your medical and functional improvement.

Date Benefit Payments End

Your period of disability ends on the date the earliest of the following occurs:

- The date you are no longer disabled,
- The date you start work at a reasonable occupation and earn more than 80% of your pre-disability earnings,
- The date you fail to give proof of continuing disability,
- The date you refuse to be examined as requested by MetLife,
- The date you cease to be under the care of a physician,
- The date you reach the expiration of the maximum benefit period shown in the ***Maximum Benefit Period*** section on page N-3,
- The date you are not undergoing treatment for alcoholism or drug abuse in a recovery program recommended by a physician, if your disability is caused to any extent by alcoholism or drug abuse,
- Beginning 24 months after the effective date of your first monthly installment of LTD benefit payments (your "LTD Benefit Start Date"), the date you have income from any employer or from any occupation for compensation or profit equal to more than 80% of your adjusted pre-disability earnings,
- Beginning 24 months after your LTD Benefit Start Date, the date you fail to give proof that you are unable to perform the duties of any occupation for compensation or profit equal to more than 80% of your adjusted pre-disability earnings,
- The date of your death, or
- The date you cease or refuse to participate in a rehabilitation program that MetLife requires.

The period of disability for certain conditions such as mental or nervous conditions and alcohol-related and drug-related illnesses may be limited to a combined total of 36 months for all such conditions. If your disability is due to alcohol, drug or substance addiction, you are required to participate in an alcohol, drug or substance addiction recovery program recommended by a physician in order to receive benefits. This limitation does not apply to a disability resulting from schizophrenia, dementia or organic brain disease.

Approved Rehabilitation Program

If you are disabled as defined on page N-2, but are able to return to work on a modified basis with a goal of resuming employment for which you are reasonably qualified (by training, education, experience and past earnings), you may be eligible to participate in a rehabilitation program that has been approved by MetLife.

The approved rehabilitation program includes, but is not limited to, one or more of the following activities:

- On-site job analysis,
- Job modification/accommodation,
- Training to improve job-seeking skills,
- Vocational training, or
- Restorative therapies to improve functional capacity to return to work.

If approved by MetLife, the plan pays for all services and supplies needed in connection with participation in a rehabilitation program, except those for which you can otherwise receive reimbursement from any third party payer, including any governmental benefits to which you may be entitled.

If You Become Disabled After You Return to Work

If you receive LTD benefits, return to active work on a regular basis, and then become disabled again, one of the following applies:

- If your second disability is due to the same or related cause as the first and you returned to active work full-time for 180 days or less, you are immediately eligible for LTD benefits and do not have to satisfy another elimination period. This will be considered part of the original disability, and MetLife will use the same pre-disability earnings and apply the same terms, provisions and conditions that were used in the original disability.
- If the second disability is due to a different cause or if you've been back to active work on a regular work schedule for more than 180 days, this second disability is counted as a new disability. This means you will have to complete a new elimination period before receiving any LTD benefits.

See ***Elimination Period*** on page N-2 for information on how the elimination period is determined.

Coordination With Other Sources of Income

In addition to this LTD plan, other plans and certain laws may provide you with a replacement for the income you lose if you become disabled. To prevent duplicate payments, your benefit under this plan is reduced by the amount of any other income-replacement benefits for which you are eligible. Sources of such benefits include:

- Any disability or retirement benefits which you, your spouse or children receive, or are eligible to receive, because of your disability or retirement under:
  - the federal Social Security Act,
  - the Railroad Retirement Act,
  - any state or public employee retirement or disability plan, or
  - any pension or disability plan of any other nation or political subdivision,
- Any income received for disability or retirement under the Chevron Phillips Chemical Retirement Plan, to the extent that it can be attributed to Chevron Phillips Chemical contributions,
- Any income received for disability under:
  - a group insurance policy to which Chevron Phillips Chemical has made a contribution, such as:
    - benefits for lost time from work due to disability, or
    - installment payments for permanent total disability,
  - a no-fault auto law for loss of income, excluding supplemental disability benefits,
  - a government compulsory benefit plan or program which provides payment for loss of time from your job due to your disability, whether such payment is made directly by the plan or program or through a third party,
  - a self-funded plan, or other arrangement, if Chevron Phillips Chemical has contributed toward it or makes payroll deductions for it,
  - any sick pay, vacation pay or other salary continuation that Chevron Phillips Chemical pays you,
  - Workers' Compensation or a similar law which provides periodic benefits,
  - occupational disease laws,
  - laws providing for maritime maintenance and cure, or
  - unemployment insurance laws or programs,
- Any income that you receive from working while disabled to the extent that such income reduces the amount of your monthly benefit as described under Rehabilitation Incentive below. This includes but is not limited to:
  - salary,
  - commissions,
  - overtime pay, and
  - bonus or other extra pay arrangements from any sources, or
- Recovery amounts that you receive for loss of income as a result of claims against a third party by judgment, settlement or otherwise, including future earnings.

Rehabilitation Incentive

If you participate in an approved rehabilitation program, MetLife will increase your monthly benefit by 10%.

Work Incentive Benefit

If you work while you are disabled and receiving monthly benefits, your adjusted monthly benefit will not be reduced by the amount you earn from working, unless your adjusted monthly benefit plus the amount you earn from working exceeds 100% of your pre-disability earnings.

After the first 12 months following your elimination period, your monthly benefit will be reduced by 50% of the amount you earn from working while disabled.

Family Care Benefit

If you work or participate in a rehabilitation program while you are disabled, you will be reimbursed for up to $400 for monthly expenses you incur for each family member to provide:

- Care for your or your spouse's child, legally adopted child or child for whom you or your spouse are legal guardian and who is:
  - living with you as part of your household,
  - dependent on you for support, and
  - under age 13.

  The child care must be provided by a licensed child care provider and may not be a member of your immediate family or living in your residence, or

- Care to your family member who is:
  - living with you as part of your household,
  - chiefly dependent on you for support, and
  - incapable of independent living, regardless of age, due to mental or physical handicap as defined by applicable law.

  Care for your family member may not be provided by a member of your immediate family.

Moving Expense Incentive

If you participate in a rehabilitation program while you are disabled, you may be reimbursed for expenses you incur in order to move to a new residence if recommended as part of the rehabilitation program. Such expenses must be approved by MetLife in advance. Expenses for services provided by an immediate family member or someone living in your home will not be reimbursed.

Survivor Benefit

If you die while disabled, and you were entitled to receive a monthly benefit under this plan, a single lump-sum benefit is paid to your eligible beneficiary or beneficiaries.

Your beneficiary is the person or persons you want to receive your benefit 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.

If more than one person is eligible to receive payment, MetLife will divide the benefit amount in equal shares.

The beneficiary benefit amount is three times the monthly benefit, not reduced by other income benefits, for which you were eligible in the full month just before the month in which you die.

If you die before you become eligible for one full monthly benefit, the beneficiary benefit amount is three times the monthly benefit, not reduced by other income benefits, for which you would have been eligible if you had not died, for the first full month after the month in which you die.

What Happens to Your Other Company Benefits

Participation in the following benefit plans continues for you and your enrolled dependents for up to 24 months after your LTD Benefit Start Date, provided you make the required contributions while you're on LTD Leave:

- Medical (includes prescription drug and behavioral health), critical illness, dental and vision,
- Basic and supplemental life, including dependent coverage,
- Basic and supplemental accidental death and personal loss (AD&PL) insurance, and
- Group Legal Plan coverage.

Employer contributions continue for up to 24 months after your LTD Benefit Start Date for these plans if applicable.

Participation in the Chevron Phillips Chemical 401(k) Savings and Profit-Sharing Plan also continues for up to 24 months after your LTD Benefit Start Date. However, all employee and Company contributions are suspended while you're on LTD Leave. All monies in the plan at the time of disability continue to achieve gains (and/or experience loss) of principal and earnings. You can continue to request loans and withdrawals. If you are not vested in Company matching contributions to the 401(k) Savings and Profit-Sharing Plan at your LTD Benefit Start Date, you will automatically become 100% vested in Company matching contributions upon approval of disability payments under the plan.

Participation in the following benefit plans is suspended while you're on LTD Leave:

- Occupational accidental death and personal loss (OAD&PL) insurance, and
- Business travel accident insurance.

In addition, your participation in the Health Care Flexible Spending Account (HCFSA), Limited-Purpose Flexible Spending Account (LPFSA) and/or Dependent Care Flexible Spending Account (DCFSA) is canceled effective on the last day of the calendar month in which you begin LTD Leave unless you elect to continue participation through the end of the calendar year through COBRA, which is available for the HCFSA and LPFSA only. You must re-enroll within 30 days of your return to work if you want to participate in the FSAs after your LTD Leave ends.

If eligible, you may continue to make payments or withdrawals from your Health Savings Account (HSA) for eligible health care expenses during your LTD Leave. You may also make after-tax contributions to your HSA.

You don't earn vacation time or receive pay for scheduled holidays that occur while you're on LTD Leave.

If you return on the first workday following your last day of LTD Leave, you're automatically re-enrolled in all benefit plans (except flexible spending accounts) in which you participated before you began LTD Leave.

Note that if you terminate employment for any reason while on LTD Leave, including retirement or voluntary termination to commence your Retirement Plan benefit, you will no longer be considered to be on LTD Leave and will not be eligible for the Company benefits described in this section.

When Benefits Are Not Paid

The LTD plan does not cover any disability that is caused or contributed to by:

- A pre-existing condition, if you have been actively at work for less than 12 months after your LTD coverage started. A pre-existing condition is a sickness or accidental injury for which you:
  - received medical treatment, consultation, care or services,
  - took prescription medication or had medications prescribed, or
  - had symptoms or conditions that would cause a reasonably prudent person to seek diagnosis, care or treatment,

  in the six months before your LTD coverage started,
- Your active participation in a riot,
- Intentionally self-inflicted injury,
- Attempted suicide, or
- Commission of or attempt to commit a felony.

In addition, disability benefits will not be paid for any period of disability during which the employee is incarcerated in a penal or corrections institution.

How to File a Claim

If you remain disabled after the six-month elimination period, MetLife will confirm eligibility and, if approved, begin paying monthly LTD benefits to you. To apply for LTD benefits, you must contact your HR Business Partner.

Payment of Claims

Benefits are paid to you at the end of each calendar month during the period for which benefits are payable. Benefits for a period of less than a month are prorated. This is done on the basis of the ratio, to 30 days, of the days of eligibility for benefits during the month.

Claims Assistance

For assistance with questions or problems concerning benefits under this plan, call MetLife at 1-800-300-4296. If additional assistance is needed, you may also contact MetLife at the address shown in the ***General Information*** chapter on page P-29.

All decisions concerning the payment of claims under the plan are at the sole discretion of MetLife. 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 P-2.

Your ERISA Rights

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 P-16.

(Performance Pipe Hourly Employees)

401(k) Savings and Profit-Sharing Plan

Contents

Overview and Important Features

The Chevron Phillips Chemical Company LP 401(k) Savings and Profit-Sharing Plan (the Plan), provided by Chevron Phillips Chemical Company LP (Chevron Phillips Chemical or the Company), is a long-term savings plan that allows you to enjoy a break on your current taxes while you save for your future.

Subject to certain limits and restrictions, you decide how much of your pay you want to contribute to the Plan and how you want the money in your Plan accounts invested. The Company helps by providing matching contributions. Based on Chevron Phillips Chemical's performance, the Company may also add profit-sharing contributions to your account. Fidelity Investments Institutional Operations Company, Inc. (Fidelity) serves as the Plan's recordkeeper.

If you are eligible, the Plan enables you to:

- Save from 1% to 40% of your eligible earnings, up to federal limits, on a pre-tax basis (Pre-Tax Contribution Account), after-tax basis with Roth contributions (Roth Contribution Account), and/or after-tax basis (Medical Savings Account),
- Receive Company matching contributions on your eligible pre-tax and/or Roth contributions,
- Receive profit-sharing contributions based on the Company's performance,
- Invest your own and the Company's contributions in a wide array of investment funds,
- Accumulate investment earnings on a tax-deferred or tax-free basis,
- Borrow from your 401(k) assets,
- Withdraw funds for qualifying hardship reasons,
- Earn a nonforfeitable right to Company matching and profit-sharing contributions after three years of Vesting Service, and
- Begin saving for retirement medical expenses through after-tax contributions to a Medical Savings Account.

This version of the summary plan description applies if you are an employee of the Company paid on an hourly basis at Performance Pipe in Brownwood, TX; Hagerstown, MD; Pryor, OK; Startex, SC or Williamstown, KY; or an hourly employee of the Company hired on or after January 1, 2004 at Performance Pipe in Knoxville, TN or Reno, NV. Separate versions of the summary plan description apply for other Chevron Phillips employees.

Who's Eligible

Employees of the Company and any of its affiliates that are participating employers in the Plan, including employees who are members of certain collective bargaining groups, are eligible to participate in the Plan as soon as they are hired, provided they are eligible employees. For this purpose, eligible employees generally include all employees of participating employers.

You are **not** eligible for the Plan if any of the following applies to you:

- You are classified by the Company as a leased employee,
- You are covered by a written contract stating that you are an independent contractor rather than an employee (even if the IRS reclassifies you as an employee for tax withholding purposes),
- You belong to a unit covered by a collective bargaining agreement that does not provide for your participation in the Plan,
- You are on the payroll of a third party with whom the Company has contracted for your services,
- You are deemed to be an employee, but you are not on the payroll,
- You are subject to a written agreement that states that you are ineligible to participate in the Plan,
- You are eligible to participate in the Chevron Phillips Chemical Puerto Rico Core LLC Savings Plan, or
- You are classified by the Company as a temporary employee, a seasonal/co-op employee or an intern, and have **not** completed 1,000 hours of service during the one-year period commencing with your date of employment or 500 hours for each of three consecutive one-year periods (excluding one-year periods beginning before January 1, 2021) or during any plan year commencing after your date of employment.

Provided you are an eligible employee, there is no waiting period prior to participation nor is there a minimum age requirement.

How to Enroll

An enrollment package will be mailed to eligible employees. This enrollment package includes an overview of the Plan as well as:

- Information that will help you with the initial enrollment decisions available to you,
- Instructions for generating your Personal Identification Number (PIN), and
- Instructions on how to enroll by contacting the Chevron Phillips Pension and Savings Service Center 24 hours a day at 1-866-771-5225 or through an interactive website, www.netbenefits.com.

You may use the Chevron Phillips Pension and Savings Service Center's automated phone system or www.netbenefits.com to specify:

- The percentage of eligible earnings you wish to contribute, and
- How you want to invest your Plan assets.

IMPORTANT — AUTOMATIC ENROLLMENT!

If you do **not** want to participate in the Plan, you must indicate this preference by calling the Chevron Phillips Pension and Savings Service Center at 1-866-771-5225 or by logging on to www.netbenefits.com. **Otherwise, you will be automatically enrolled for a pre-tax contribution of 6% invested in the applicable BlackRock LifePath® Index Non-Lendable Fund and your contribution will be increased annually by 1% until it reaches 8%.**

CHANGING YOUR ELECTIONS

To change or stop your contributions as of any pay period or to change your investments as of any business day, contact the Chevron Phillips Pension and Savings Service Center at 1-866-771-5225 or log on to www.netbenefits.com.

You have the right to opt out and request a return of your contributions, adjusted for gains and losses, up to 90 days after you have been automatically enrolled in the Plan by calling the phone number above. It is important to note that if you process any fund exchanges within your account, you are no longer eligible for this withdrawal.

You will need your Social Security number and your PIN to access either system. When you use your PIN, you are authorizing transactions to be made on your behalf. **Because your PIN is your electronic signature, be sure to protect it and do not give it to anyone else.**

Your payroll contributions to the Plan become effective with the next available pay cycle after your enrollment request or automatic enrollment is processed.

Your 401(k) Plan Contributions

Pre-Tax Contributions

Most eligible employees may contribute from 1% to 40% of their eligible earnings on a pre-tax basis to the Plan. Your contributions must be in whole number percentages and are subject to annual Internal Revenue Service (IRS) limits. For more information, see ***Annual IRS Contribution Limits*** on page O-6.

ELIGIBLE EARNINGS

For purposes of this Plan and this document, your eligible earnings include your base pay plus any shift differentials, regularly scheduled overtime, unscheduled overtime, holiday pay, sick pay, vacation pay and call-out pay.

Your eligible earnings do **not** include Employee Incentive Plan (EIP) bonuses, any relocation pay, educational reimbursements, premium pay, vacation lump-sum payments and/or cash awards.

In addition, for purposes of the Company match and profit-sharing contributions to the Plan, eligible earnings do not include unscheduled overtime, premium pay or call-out pay.

You won't owe federal income taxes (and, in most states, state income taxes) on your pre-tax contributions or on any earnings associated with them until they are withdrawn from the Plan. Although pre-tax 401(k) contributions reduce your taxable income, they won't affect your future Social Security benefits. That's because your 401(k) contributions are subject to Social Security taxes at the time of contribution. Your 401(k) contributions are also subject to Medicare taxes at the time of contribution.

RETROACTIVE PRE-TAX CONTRIBUTIONS

Retroactive pre-tax contributions may be made to the Plan following a military leave. If this situation applies to you, contact the CPChem Benefits Service Center at 1-833-964-3575.

Pre-tax contributions are made through payroll deductions and are calculated and credited to your account each payroll cycle. All of your pre-tax contributions — plus any related earnings or minus any losses — are maintained in your Pre-Tax Contribution Account. For more information, see ***Participant Accounts*** on page O-14.

You may change your contribution rate and/or the direction of your investments at any time by contacting the Chevron Phillips Pension and Savings Service Center at 1-866-771-5225 or by logging on to www.netbenefits.com.

Roth Contributions

Most eligible employees may contribute from 1% to 40% of their eligible earnings on a Roth after-tax (hereinafter "Roth") basis to the Plan. The combined total of all your pre-tax, Roth and MSA after-tax contributions to the Plan cannot exceed 40% of your eligible earnings. Your contributions must be in whole number percentages and are subject to annual Internal Revenue Service (IRS) limits. For more information, see ***Annual IRS Contribution Limits*** on page O-6.

These contributions are subject to federal and state income taxes, Social Security taxes and Medicare taxes when they are made to the Plan, but you won't owe federal income taxes on any earnings associated with your Roth contributions when they are withdrawn from the Plan, provided you:

- Have held the account for five (5) years or more, and
- Are at least age 59½ before you take a withdrawal.

After-Tax Contributions: Post-Retirement Medical Savings Account

In addition to pre-tax and Roth contributions, you can make other after-tax contributions to the Plan. These contributions, which are earmarked to help pay medical expenses after you retire, do not receive a Company match. Through this type of arrangement — called a Medical Savings Account (MSA) — you are able to defer payment of income taxes on the earnings on your investments within the account. The combined total of all your pre-tax, Roth and MSA after-tax contributions to the Plan cannot exceed 40% of your eligible earnings and are also subject to IRS annual dollar limits as detailed on page O-6.

Although this MSA feature is intended to encourage you to save for medical and other health care expenses (including health care plan premiums) that you'll face during retirement, you may use the proceeds from this account for any purpose after you retire or terminate employment with the Company. If you die and your beneficiary is your spouse, he or she may use this account as an MSA or may elect to receive the value of the account as a cash payment.

These MSA contributions are subject to income taxes when they are made. The contributions are not subject to income taxes when they are distributed to you because you have already paid taxes on them. However, any investment earnings associated with your MSA after-tax contributions are subject to taxation according to the tax laws in effect at the time they are paid to you or to your beneficiary.

Catch-Up Contributions

In addition to pre-tax, Roth and MSA after-tax contributions, the Plan allows employees age 50 and older to make additional pre-tax and/or Roth "catch-up" contributions to the Plan. All employees who turn 50 before the end of the calendar year are eligible to make catch-up contributions beginning with the first pay period of that year. These catch-up contributions do not receive Company matching contributions.

Catch-up-eligible participants can contribute from 1% to 20% of their eligible earnings on a pre-tax catch-up or Roth catch-up basis, subject to the annual dollar limit for catch-up contributions ($7,500 in 2024). Catch-up contributions do not count toward annual IRS contribution limits.

In addition to having to be age 50 or older, in order to be able to make catch-up contributions, you ***must*** also make the combined pre-tax and/or Roth IRS annual maximum contribution ($23,000 in 2024) to the Plan (see page O-6). Otherwise, your catch-up contributions will be recharacterized as pre-tax and/or Roth regular contributions, as applicable.

Rollovers Into the Plan

The Plan accepts distributions rolled over from other eligible sources, including other employers' qualified retirement and savings plans and conduit and non-conduit individual retirement accounts (IRAs). The Plan offers automatic portability services, allowing automatic rollovers of eligible low balance retirement accounts from previous employers into the Plan. To qualify, the rollover must be in the form of cash. In-kind distributions (such as shares of stock) may **not** be rolled over into the Plan.

Rollovers enable you to defer paying taxes on these distributions, provided the money is transferred directly from your prior plan into the Plan, or, if distributed directly to you, rolled over into the Plan within 60 days from the date you received it. The sponsor or administrator of your prior plan must supply satisfactory evidence that your proposed rollover meets IRS requirements.

All rollover contributions are deposited in your Rollover Account, or Roth Rollover Account if the funds are from a Roth 401(k) plan, and you direct how you want to invest them. They are available for fund transfers, loans and withdrawals, as explained later in this summary. Rollover contributions do not count toward annual IRS contribution limits.

Annual Increase Program

The annual increase program allows you to automatically increase your 401(k) Plan contributions each year with very little effort. You just elect the amount of the increase (as a percentage of pay) and the date you want the increase to take effect each year. Then, each year on the designated date, your contributions will automatically increase by the percentage you have elected, up to the 40% of eligible earnings maximum and subject to IRS annual dollar limits as detailed on page O-6.

To enroll in the auto increase program, log on to www.netbenefits.com and select "Contribution Amount." Then click on "Annual Increase Program" and follow the steps to complete your enrollment.

Company Contributions

Matching Contributions

Company matching dollar-for-dollar contributions are based on the first 7% of your eligible earnings (as defined in ***Pre-Tax Contributions*** on page O-3, but excluding unscheduled overtime, call-out pay and premium pay) you contribute to the Plan on a pre-tax and/or Roth basis.

The Company makes a matching contribution of $1 for every $1 of eligible earnings you contribute on a pre-tax or Roth basis — up to the 7% earnings limit per paycheck. In other words, if you contribute 7% of your eligible earnings on a pre-tax or Roth basis, the Company will contribute 7% of your eligible earnings. If you increased your contribution to 10% of your eligible earnings, the Company match would remain at 7%, because the match is based on the first 7% of eligible earnings you contribute.

Like your own contributions, Company matching contributions are calculated based on your pay each pay period and are credited to your account every payroll cycle. It is important to note that Company matching contributions stop if you stop making pre-tax or Roth contributions or if you reach the annual IRS dollar limit. For 2024, this dollar limit is $23,000.

Effective January 1, 2024, the Company will also match student loan payments you make to third party vendors with Company matching contributions to your 401(k), up to the 7% of earnings maximum. You must enroll and allow access to your student loan payment records for the Company matching contributions to be credited to your account. The student loan Company matching contributions will be deposited in a lump sum, typically the February after the end of the plan year. **Note that the 7% of eligible earnings annual maximum for matching contributions applies to pre-tax contributions, Roth contributions and student loan repayments combined.**

Annual True-Up Matching Contributions

The Company makes an annual "true-up matching contribution" for eligible participants who contributed more than 7% of their pay from some paychecks and less than 7% from other paychecks as pre-tax and/or Roth contributions during a given plan year. The true-up matching contribution also applies to student loan repayments.

Soon after the end of the plan year, the Company calculates your Company matching contribution as if all of your earnings, 401(k) contributions and student loan payments were included in a single annual paycheck. If this amount is greater than the Company matching contributions you actually received, the Company makes a true-up matching contribution equal to the difference between those two amounts. The true-up matching contribution is made to your 401(k) account during the first few months of the following year. You are eligible for a true-up matching contribution provided you were an active employee on December 31 of the plan year, or if you were retired, were laid-off, became totally disabled or died during the plan year.

Profit-Sharing Contributions

The profit-sharing feature of the Plan was in place for plan years 2001 through 2020 and was discontinued in 2021.

Profit-sharing contributions to your account were based on the Company's performance. Each year for plan years 2001 through 2020, the Company could, in its sole discretion, decide to make a profit-sharing contribution in an amount that it determined to be appropriate. Profit-sharing contributions ranged from no contribution to up to 5% of your eligible earnings.

For purposes of receiving profit-sharing contributions, your eligible earnings did **not** include unscheduled overtime, call-out pay and premium pay.

Provided you were employed by the Company on December 31 of the plan year, annual profit-sharing contributions, if any, were allocated to your account during the first few months of the following year. Profit-sharing contributions were also allocated to the accounts of employees who retired, were laid-off, became totally disabled or died during the plan year.

Annual IRS Contribution Limits

As discussed previously, the IRS establishes an annual dollar limit ($23,000 in 2024) on combined pre-tax and Roth contributions to 401(k) plans. If your pre-tax and/or Roth contributions reach the dollar limit during the year, these per-paycheck contributions and any per-paycheck Company matching contributions are automatically suspended. Unless you change it, however, your election will remain in place and your pre-tax contributions and/or Roth contributions will automatically restart at the beginning of the next calendar year.

The IRS sets another limit each year on the total amounts that you and the Company can contribute to your 401(k) account ($69,000 in 2024). Total contributions include Roth and MSA after-tax employee contributions (when applicable), pre-tax employee contributions, Company matching contributions and any profit-sharing contributions.

Catch-up contributions do not count toward annual IRS contribution limits.

Please note that your pre-tax and/or Roth contributions and Company matching contributions stop if you reach the $23,000 IRS limit; they are not automatically rolled over to MSA after-tax contributions. MSA after-tax contributions are not affected by the $23,000 limit. Contact the Chevron Phillips Pension and Savings Service Center at 1-866-771-5225 or log on to www.netbenefits.com if you want to make MSA after-tax contributions to the 401(k) Plan once your pre-tax and/or Roth contribution level is reached.

Your account in the Plan is tested each year to see if your contributions plus Company contributions exceed this legal limit. If they do, your excess contributions and their associated investment earnings or losses are automatically refunded to you in the first half of the following year. Corresponding Company matching contributions and associated earnings or losses are forfeited and used to offset administrative expenses or to reduce future Company contributions.

The distribution of any refunded excess contributions and earnings (except for any portion of the refunded excess contributions that is attributable to your after-tax contributions) is taxable to you.

Excess contributions are refunded in the following order:

- After-tax contributions plus associated earnings or losses, then
- Unmatched Roth contributions plus associated earnings or losses, then
- Unmatched pre-tax contributions plus associated earnings or losses, then
- Matched Roth contributions plus associated earnings or losses. Related matching contributions plus associated earnings or losses are forfeited to the Plan and used to offset future Company contributions, then
- Matched pre-tax contributions plus associated earnings or losses. Related matching contributions plus associated earnings or losses are forfeited to the Plan and used to offset future Company contributions.

In addition to the IRS limits on contributions described on page O-6, federal law requires that the Plan satisfy certain non-discrimination standards with respect to pre-tax and matching contributions on an annual basis, which could result in the return of your pre-tax contributions plus associated earnings or losses. Any matching contributions plus associated earnings or losses are forfeited to the Plan and are used to offset administrative expenses or to reduce future Company contributions. You will be notified if this law applies to you.

Investment Options

The Plan allows you to invest your assets in the Plan among a wide variety of investment options. Your choices range from relatively stable, low-risk investments to higher-risk funds that can experience significant increases and decreases in value within short periods of time. You may invest your 401(k) account in one fund or in as many funds as you wish, in whole percentages. Recordkeeping and administrative services for the Plan are provided by Fidelity.

The Plan is intended to fulfill the requirements of section 404(c) of the Employee Retirement Income Security Act of 1974, as amended, and the regulations relating to that section. This means that you have the right to direct the investments of your Plan account in the various investment options. Since you may exercise independent control over investment decisions with respect to your account, the Plan fiduciaries will generally not be liable for losses that are a direct result of your exercise of control over your accounts. It is your responsibility to be aware of your investment decisions. You may want to seek independent investment advice.

The value of your account under the Plan is based on your investment fund elections and the performance of those funds over time. If the funds you choose for your investments increase in value, your account balance increases. If the funds lose value, your account balance decreases.

Choosing Your Investments

Investment education materials are included in the enrollment package mailed to you when you first become eligible to participate in the Plan. Investment education materials will also be sent to you from Fidelity on an ongoing basis. In addition, you can call the Chevron Phillips Pension and Savings Service Center at 1-866-771-5225 or log on to www.netbenefits.com to request the latest information about the 401(k) investment funds.

You can also receive investment advice from Edelman Financial Engines, including online advice (paid by the Plan) or professional management of your account (paid by you through an asset-based fee).

Through Fidelity, you can elect to invest in any or all of the following core investment funds in 2024:

- Vanguard Federal Money Market Fund Investor Shares
- Galliard Stable Return Fund C
- Vanguard Total Bond Market Index Fund Institutional Plus Shares
- Dodge & Cox Income Fund Class I
- Vanguard Short-Term Inflation-Protected Securities Index Fund Institutional Shares
- Spartan® Large Cap Value Index Pool Class D
- Spartan® 500 Index Pool Class D
- Spartan® Extended Market Index Pool Class D
- Fidelity® Contrafund® Commingled Pool Class A
- Snyder Capital Small/Mid Cap Value Collective Investment Fund – R2
- William Blair Small Mid Cap Growth CIT – Class III
- Spartan® Global ex US Index Pool Class D
- Invesco International Growth Trust – Class I
- Vanguard Real Estate Index Fund Institutional Shares
- BlackRock LifePath® Index Non-Lendable Fund M Series:
  - LifePath® Index Retirement Non-Lendable Fund M,
  - LifePath® Index 2025 Non-Lendable Fund M,
  - LifePath® Index 2030 Non-Lendable Fund M,
  - LifePath® Index 2035 Non-Lendable Fund M,
  - LifePath® Index 2040 Non-Lendable Fund M,
  - LifePath® Index 2045 Non-Lendable Fund M,
  - LifePath® Index 2050 Non-Lendable Fund M,
  - LifePath® Index 2055 Non-Lendable Fund M,
  - LifePath® Index 2060 Non-Lendable Fund M, and/or
  - LifePath® Index 2065 Non-Lendable Fund M.

The BlackRock LifePath® Index Non-Lendable Fund M Series offers a blend of stocks, bonds, commodities, real estate and short-term investments within a single fund. They are designed for investors who don't want to go through the process of picking several funds from multiple asset classes but who still want to diversify among stocks, bonds, commodities, real estate and short-term investments. The LifePath Funds offer a long-term savings solution that gradually reduces the risk level of an investment in the fund as the fund's target date draws closer.

For additional information on your investment options, see ***Appendix — 401(k) Savings and Profit-Sharing Plan Investment Options*** beginning on page Q-1.

As previously stated, the Plan has an automatic 6% enrollment provision if you do not make an affirmative election to participate within 31 days from your date of hire. If you do not make an investment election (whether you are automatically enrolled or not), your contributions will automatically be invested in the BlackRock LifePath® Index Non-Lendable Fund that has a target retirement date closest to your estimated year of retirement, based upon your current age and assuming a normal retirement age of 65.

If you aren't a sophisticated investor, it's a good idea to seek the guidance of a competent, independent professional financial planner or investment advisor. Your personal financial planner or investment advisor can help you determine the level of risk that's appropriate for your financial situation.

You can also take advantage of Fidelity's Mutual Fund Window if you desire a broader range of options in creating your investment portfolio. This Mutual Fund Window, which Fidelity calls BrokerageLink®, enables you to invest among thousands of other mutual funds, including asset categories not offered in the core investment options.

BrokerageLink includes Fidelity mutual funds and non-Fidelity mutual funds. Keep in mind that the mutual funds available through BrokerageLink reserve the right to modify or withdraw the exchange privilege. If you invest through BrokerageLink, please refer to the BrokerageLink Kit and accompanying BrokerageLink Fact Sheet, available from Fidelity, for details and limitations on Plan investments. Brokerage-related commissions, fees and loads are deducted by Fidelity Brokerage Services from your account, if applicable, at the time of a transaction.

Your investment instruction for each investment option you elect must be a whole-number percentage (e.g., 10%, 16%, 31%). The total of your investment instructions must equal 100%.

You can monitor your investment performance by logging on to www.netbenefits.com, where you will be able to view an online summary of your account, reallocate your account balance, change your contribution rate, model a loan and use retirement modeling software to estimate your retirement income. This information is designed to help you learn about your investment options and assist you with your investment decisions. As with any investment, you always assume the responsibility of researching, evaluating and tracking each fund in which you plan to invest.

Chevron, ConocoPhillips, and Phillips 66 Stock Funds

If you are a former employee of Chevron Corporation or ConocoPhillips Corporation whose prior 401(k) plan account was transitioned to the Chevron Phillips Chemical 401(k) Plan in connection with the establishment of the Chevron Phillips Chemical 401(k) Plan, certain investments you held in Chevron or ConocoPhillips common stock were moved over to the Chevron Phillips Chemical 401(k) Plan as shares-in-kind. In addition, if you held shares of ConocoPhillips common stock in your 401(k) Plan account as of May 1, 2012, you received one share of Phillips 66 common stock for every two shares of ConocoPhillips stock as a result of the Phillips 66 stock spinoff. If you transferred such an account and/or received Phillips 66 common stock, your balance is frozen — that is, no new contributions may be made to this account. However, you may liquidate all or a portion of the stock and invest the proceeds in one or more of the core investment funds or the Mutual Fund Window.

Dividends will not be automatically reinvested in your account to purchase additional shares of Chevron, ConocoPhillips, or Phillips 66 stock. The value of any dividends declared on Chevron, ConocoPhillips, or Phillips 66 common stock held in your account will be spread among the core funds in which you are currently invested, according to your existing investment instructions.

Selling Chevron, ConocoPhillips, and Phillips 66 Stock

You are able to sell your Chevron, ConocoPhillips, or Phillips 66 stock in "Real-Time." "Real-Time Trading" means that when you make a trade, the order is immediately sent to market during normal market hours[1] and is then eligible for execution.

[1] Response time may be subject to market conditions and systems availability. On rare occasions, market conditions, systems availability or other circumstances, may prevent Fidelity from accepting a plan's real-time company stock exchange requests. In that event, no company stock exchange will be allowed and you will not be able to direct your plan's real-time trade. You will be asked to try again at a later time. Neither the plan, nor your employer, nor Fidelity will be responsible for any losses, damages or missed price opportunities in these circumstances.

How to Sell Your Stock

Step 1: Specify the type of order you want — "Market[2]," "Day Limit[3]" or "Good 'til Canceled (GTC)[4]"

Market	An order to sell the stock at the next available price when the order reaches the marketplace. It's designed to ensure that the sale of all shares specified in the order are actively traded.
Day Limit	An order containing a specific price at which you are willing to sell stock for that day.
Good 'til Canceled	A limit order containing a specific price at which you are willing to sell stock over the next 120 calendar days or sooner, depending on plan rules and corporate action activity. The order remains in effect until it is executed, canceled or 120 days elapse.

[2] **Market** — Be aware that when placing market orders, the price of securities may change sharply during the trading day or after hours. Standard market hours are between 9:30 a.m. and 4:00 p.m. Eastern time when U.S. markets and exchanges are open for trading, unless trading is halted. Market orders to sell stock are allowed when the market is closed and will be placed on the next day.

[3] **Day Limit** — Day Limit orders restrict the price of selling a security to a limit price you specify or better. The limit price is specified in a separate limit field and generally may not exceed two decimal places.

[4] **Good 'til Canceled (GTC)** — GTC orders generally must be for at least 100 shares. GTC orders receive a lower priority in trading than market orders.

Note for "Day Limit" and "Good 'til Canceled (GTC)" orders: After the limit price is triggered, the security's price may continue to rise and fall. As a result, your order may not be executed.

Step 2: Choose the condition[5] — "None" or "All-or-None (AON)" for "Day Limit" orders. "Market" and "Good 'til Canceled (GTC)" orders have specified conditions.

None	A condition that indicates there are no restrictions on the requirements to execute the order and it may be partially filled.
All-or-None (AON)	A condition that indicates that no partial order is to be executed. Either all shares specified in the order will be traded or none will be traded.

Orders	Conditions[5]
Market	PRESET: None
Day Limit	Choose: None (No conditions) All-or-None (AON)
GTC	PRESET: All-or-None (AON)

Step 3: Decide how many shares of company stock you want to sell in whole numbers (for example, "200 shares," not "200.5 shares").

Step 4: Specify the percentage of the proceeds of company stock you want to use to buy (exchange into) other eligible investments.

Tip: You must always enter orders for company stock in whole shares. If you are selling your entire position in whole shares within your plan account or a particular source, any fractional shares will automatically be exchanged at the price determined by the trade you direct.

"Good 'til Canceled" orders generally must be for at least 100 shares. Each night, the system will check to make sure there are enough shares in the account to cover outstanding orders to sell stock. If there is an insufficient stock balance, orders may be canceled.

[5] **Conditions**

During periods of heavy trading or volatility, real-time quotes may not reflect current market prices or quotes.

None — The None condition is also known as No Conditions.

All-or-None (AON) — If a specified price is not available for the entire exchange amount, the trade is not executed but stays open during its prescribed time period. "Received" indicates Fidelity has received the trade, not that it has been executed. All-or-None orders generally must be for at least 100 shares.

Timing of Transactions and Confirmations: Just because an order is placed, there is no guarantee that the order will be executed. The confirmation number received indicates that Fidelity has received the trade request, not that it has been executed. **Please note:** Verbal confirmation is no guarantee that an order will be executed. However, a confirmation notice is proof that an order was executed.

Investment Fees

The general administrative fees associated with the management of the Plan are currently paid from unallocated funds within the trust established by the Company to administer the Plan. However, the trust reserves the right to pass along the cost of such general administrative fees to participants in the Plan.

No load fees are charged on investments in the core investment funds.

Mutual funds pay fees to the recordkeepers who provide administrative services to 401(k) plan participants. These fee credits are received by Fidelity — the Plan's recordkeeper. Chevron Phillips Chemical has chosen to reallocate these fee credits back to the participants who actually hold the funds. Any credit allocated to your account will appear on your quarterly benefits statement and will be invested in the fund to which the credit relates and allocated proportionally to the sources associated with such fund for each participant.

As with many investment options, several factors affect overall expense levels. These include expense ratios — the annual percentage of a particular fund's assets that is paid out in expenses — and expense caps (limitations on expenses). A description of all relevant fees and charges may be found in fund prospectuses, which may be obtained from Fidelity.

Investment Advice

To help manage your account, you can receive investment advice through Edelman Financial Engines, an independent, federally registered investment advisor and manager under a program named "Retirement Help for Life." Edelman Financial Engines serves as a fiduciary and is therefore required to act in your interest. You can use their online advice or professional management services (for an annual fee).

Online Advice

You are eligible to access Edelman Financial Engines' online services to receive financial advice while you continue to manage your own account. You can set up a personalized investment, savings and retirement income plan and use the online forecasting tools for no additional charge.

To access online advice, log on to www.netbenefits.com and click on the Edelman Financial Engines link.

Professional Management

If you choose Edelman Financial Engines' professional management services and pay the annual fee, you will receive a personalized retirement plan that includes investment, savings and retirement income strategies. Edelman Financial Engines will manage and monitor your 401(k) account and direct Fidelity to make any necessary transactions. You will receive a quarterly retirement update and can talk with an investment advisor representative at any time.

The annual fee for professional management is 0.45% on your account balance up to $100,000, then 0.35% on the next $150,000, then 0.20% on the next $250,000, and 0.15% on your account balance over $500,000. The fee is deducted directly from your 401(k) account balance. You can cancel the service at any time with no penalty by calling 1-800-601-5957.

To enroll in professional management, call Fidelity at 1-800-601-5957 or visit www.financialengines.com/forcpchem.

PROFESSIONAL MANAGEMENT CONSIDERATIONS

You should be aware of certain features before signing up for professional management services through Edelman Financial Engines. Although you can cancel professional management at any time, you pay the fee for each day you use the service. Once you sign up for professional management, Edelman Financial Engines does not request your approval before making transactions on your account. Edelman Financial Engines may shift investment allocations, including those in Company stock, if appropriate. Note that Company stock can only be redeemed, not repurchased, so any sale of Company stock within the 401(k) Plan is irreversible.

Plan rules regarding trading restrictions, including restrictions on repurchases of certain investments, still apply when you use professional management. If you decide you want to make transactions directly with Fidelity Investments, you can cancel professional management anytime, without penalty, by calling 1-800-601-5957.

Making Investment and Contribution Rate Changes

You may change your contribution rate and/or your investment choices by calling 1-866-771-5225 or logging on to www.netbenefits.com. These resources are available virtually 24 hours a day, 7 days a week, although there will be times when they are being updated and are thus not available.

The following chart shows when your transactions take effect.

Transaction	Timing
Change investment of current account balance (there is a minimum of 1% or $250, whichever is greater)	If the request is processed by 4:00 p.m. Eastern time (the close of daily transactions on the New York Stock Exchange), the change takes effect the same business day* If the request is processed after the New York Stock Exchange closes, the change takes effect the next business day*
Change investment of future contributions	Requests are processed daily and take effect as soon as administratively possible
Change contribution rate	Requests are processed daily and take effect as soon as administratively possible
Sell Chevron, ConocoPhillips, or Phillips 66 stock	Requests are processed daily and you can specify the type of order you want — "Market," "Day Limit" or "Good 'til Canceled (GTC)," which will determine when the request is processed (see ***Selling Chevron, ConocoPhillips, and Phillips 66 Stock*** on page O-10)

* For purposes of the Plan, business day means any day that the New York Stock Exchange is open for business.

It is important to remember that 401(k) Plan accounts are not brokerage accounts. Company stock transactions are subject to certain uncontrollable market conditions that may make it difficult or, in certain rare instances, impossible to complete the transactions in one business day. In addition, Fidelity is instructed by the Company to trade Chevron, ConocoPhillips, and Phillips 66 stock with a view to minimizing the potential for significant movement in the market price during the trading day. As a result, the final settlement may take more than three business days.

Vesting

Vesting is the process of acquiring a nonforfeitable ownership right to the money in your Plan account. You are always 100% vested in your pre-tax, Roth and MSA after-tax and rollover contributions to the Plan. This means you have a nonforfeitable right to collect the amount of your contributions and rollovers, plus earnings on them, when you retire or leave the Company for any other reason.

You become 100% vested in Company matching and profit-sharing contributions, and in the earnings on them, once you accumulate three years of Vesting Service with the Company.

How You Earn Vesting Service

The following applies to earning Vesting Service:

- Your years of service are generally the period you are employed at the Company.
- You earn a year of Vesting Service each year on the anniversary of your date of hire.
- You become 100% vested in your Company contributions after completing three years of service. You become 100% vested before you complete three years of Vesting Service if one of the following events occurs while you are an active employee:
  - You reach age 65,
  - You are declared permanently and totally disabled as evidenced by (i) receipt of Social Security disability benefits, or (ii) receipt of disability payments under the Company's Long-Term Disability Plan, or (iii) certification by a physician or physicians chosen by you and acceptable to the plan administrator,
  - You die,
  - You are laid off due to lack of work,
  - You are a Ryton Member, as defined on page A-2 of the ***How to Participate*** chapter, or
  - You are a K-Resin Member, as defined on page A-2 of the ***How to Participate*** chapter.

Break in Service

If you terminate your employment with the Company and are later rehired, you may have what is called a **break in service**.

You will be considered to have a break in service if both of the following apply to you:

- You terminate your employment before you are vested in the Plan, and
- Your absence from the Company is at least five years.

If you have a break in service, you will forfeit any Vesting Service you accumulated prior to the break.

However, if you terminate your employment with the Company and return to the Company within 365 days after termination, the period after you terminated employment may be counted for purposes of Vesting Service.

Participant Accounts

For recordkeeping purposes, amounts held in the Plan are maintained in a number of separate accounts, as shown on the regular statements you will receive. For more information, see ***Account Statements*** on page O-21. The value of each of your accounts includes the value of your contributions plus any earnings on them (or minus any losses incurred). If an account is shown as frozen, it means that no new contributions can be made to the account, but these accounts are 100% vested.

Your Plan may include the following accounts:

- Pre-Tax Contribution Account — Your pre-tax contributions, subject to Plan and federal limits.
- Roth Contribution Account — Your Roth after-tax contributions, subject to Plan and federal limits.
- After-Tax Medical Savings Account — Your after-tax contributions, subject to Plan and federal limits, earmarked to help pay medical expenses after you retire (although you may use the proceeds for any purpose after retirement).
- Chevron Phillips Chemical Pre-Tax Catch-Up Account (if eligible) — Your pre-tax catch-up dollars, up to $7,500 in 2024.
- Chevron Phillips Chemical Roth Catch-Up Account (if eligible) — Your Roth catch-up dollars, up to $7,500 in 2024.
- Chevron Phillips Chemical Company Match Account — Company contributions, based on the applicable matching formula.
- Chevron Phillips Chemical Profit-Sharing Account — Company contributions, if any, based on Chevron Phillips Chemical's performance.
- Rollover Account — Any amounts rolled over from prior employer retirement plans.
- Roth In-Plan Conversion Account — Any amounts you have converted to Roth from other accounts within the Plan.
- Prior Chevron Company Match Account (frozen) — The value of Company matching contributions from your participation in a prior Chevron 401(k) plan.
- Prior ConocoPhillips Company Account (frozen) — The value of Company matching contributions from your participation in a prior ConocoPhillips 401(k) plan.
- Prior-Plan Pre-Tax Account (frozen) — The value of any prior pre-tax profit-sharing contributions, regular or supplemental deposits, Savings Plus pre-tax contributions and other pre-tax contributions from Chevron and ConocoPhillips.
- Prior-Plan After-Tax Account (frozen) — The value of any prior after-tax profit-sharing contributions, Savings Plus after-tax contributions, post-1986 regular and supplemental deposits and other after-tax contributions from Chevron and ConocoPhillips.
- Prior Chevron Company Contribution Account (frozen) — The value of special contributions, other than matching contributions, from your participation in a prior Chevron 401(k) plan.
- Qualified Nonelective Contribution Account — The value of any special contributions made by the Company to correct operational failures.

Withdrawals

The Plan was created to provide a vehicle for long-term savings, and you are generally able to maximize your benefit by leaving your money in the Plan until retirement. In addition, IRS and Plan penalties apply to the withdrawal of funds from a pre-tax account or Roth account and on taxable amounts of earnings before you reach age 59½. The Plan does, however, allow participants to make several types of withdrawals:

- Regular withdrawals,
- Hardship withdrawals,
- Terminal illness withdrawals, and
- Domestic abuse withdrawals.

A processing fee of $20 is deducted from your account when a regular withdrawal is processed for payment. All other withdrawals are not subject to the processing fee.

Withdrawals are generally considered taxable and may also be subject to penalties and withholding. It is a good idea to consult a tax advisor to learn about the impact a withdrawal has on your personal situation before requesting a withdrawal. See ***Tax Information*** on page O-24.

Regular Withdrawals Prior to Age 59½

You are allowed to make one withdrawal every 30 days, for any reason, from the vested portion of certain Plan accounts. The minimum withdrawal amount is the lesser of $250 or the total value of the vested portion of your account. You must leave any existing loan security amount in your account, and amounts withdrawn are taken proportionately from across all of your investment sources.

The order of withdrawal from your accounts is as follows:

- Rollover Account, then
- Prior-Plan After-Tax Account.

To the extent that contributions have been on deposit for at least 36 months, you may also withdraw the value of contributions and earnings in the following accounts:

- Prior-Plan Company Match Accounts, and
- Current Company Match and Profit-Sharing Accounts.

In determining if contributions to these two types of accounts have been on deposit for at least 36 months, the time during which any amounts were credited to your account(s) under a prior Chevron or ConocoPhillips plan is taken into consideration.

Regular Withdrawals After Age 59½

After you reach age 59½, you may withdraw, without penalty, from the:

- Rollover Account, and
- Prior-Plan After-Tax Account.

To the extent that contributions have been on deposit for at least 36 months, you may also withdraw the value of contributions and earnings in the following accounts:

- Prior-Plan Company Match Accounts, and
- Current Company Match and Profit-Sharing Accounts.

In determining if contributions to these two types of accounts have been on deposit for at least 36 months, the time during which any amounts were credited to your account(s) under a prior Chevron or ConocoPhillips plan is taken into consideration.

You are allowed to make one withdrawal every 30 days, for any reason. The minimum withdrawal amount is the lesser of $250 or the total value of the vested portion of your accounts. You must leave any existing loan security amount in your accounts.

When you make withdrawals after you reach age 59½, you can designate the accounts and/or investment funds from which you would like to make those withdrawals. If you do not designate a specific account and/or investment option(s), withdrawals will be made proportionately from across all of your investment funds in the following order:

- Rollover contributions,
- After-tax rollover contributions,
- Prior-plan after-tax contributions,
- Pre-tax contributions,
- Employee pre-tax catch-up contributions,
- Prior-plan pre-tax contributions,
- Prior Chevron company matching contributions,
- Prior Phillips company contributions,
- Prior Chevron company contributions,
- Chevron Phillips Chemical company matching contributions,
- Chevron Phillips Chemical profit-sharing contributions,

- Chevron Phillips Chemical pre-tax unmatched contributions.
- Qualified nonelective contributions,
- Roth basic contributions,
- Roth unmatched contributions,
- Roth catch-up contributions,
- Roth rollover contributions,
- Roth in-plan conversions,
- Roth in-plan conversions restricted I, and
- Student loan matching contributions.

Hardship Withdrawals

If you are under age 59½ and the withdrawals described previously will not satisfy your financial needs, the IRS allows withdrawals of your Pre-Tax Contribution Account, Roth Contribution Account and Prior-Plan Pre-Tax Account for reasons of financial hardship — but only when no other resources are available. Hardship withdrawals are not applicable to participants over age 59½, because they already have access to the vested portion of all their accounts.

A financial hardship is an immediate and heavy financial need that cannot reasonably be met through resources other than your 401(k) account.

Hardship withdrawals permit the withdrawal of some or all of your pre-tax contributions and earnings, but only after funds available from all after-tax and rollover contributions and other possibilities are exhausted. Hardship withdrawals are permitted only under certain specified conditions. You will be asked to certify that your hardship withdrawal is necessary for one or more of the following reasons:

- To pay unreimbursed medical expenses and other expenses necessary to secure medical care for you, your spouse, or your other eligible dependents.
- To purchase your initial primary residence (including down payment and closing costs, but not mortgage payments).
- To make payments necessary to prevent your eviction from or foreclosure on your primary residence.
- To pay tuition and related education fees (including room-and-board expenses, but excluding student activity fees and the cost of books, supplies, and uniforms) for the next 12 months of post-secondary education for you, your spouse and/or other eligible dependents.
- To pay funeral expenses for the employee's parents, spouse, children or dependents.
- To pay certain expenses to repair damage to the employee's principal residence that would qualify for the casualty deduction, such as damage from hurricanes or floods (this is for all casualty expenses, not just losses that exceed 10% of adjusted gross income).
- To satisfy any other obligation recognized by the IRS as giving rise to an immediate financial need.

A hardship withdrawal also must satisfy the following requirements:

- You must first withdraw all funds available from any existing Rollover Account and Prior-Plan After-Tax Account.
- The amount of the withdrawal is limited to the amount necessary to satisfy the specific hardship situation — including any amounts necessary to pay federal, state, and/or local income taxes and penalties reasonably anticipated to result from the distribution.

You may take a hardship withdrawal from the Plan only once every 12 months. To apply for a withdrawal, contact the Chevron Phillips Pension and Savings Service Center by calling 1-866-771-5225.

The following chart summarizes which Plan assets you are allowed to withdraw.

Source of 401(k) Assets	Amount Available for Withdrawal
Prior plan after-tax contributions, rollovers, and related investment earnings	Part or all
Pre-tax contributions	Amount needed to satisfy approved financial hardship
Company matching contributions, profit-sharing contributions and related earnings	Vested, matured amounts*

* Matured amounts are contributions that have been in these accounts for at least 36 months and are 100% vested.

Terminal Illness Withdrawals

If you have been diagnosed with a terminal illness, you are eligible to take a distribution from your account without incurring early withdrawal penalties. A physician must certify that you have an illness or physical condition reasonably expected to result in death within 84 months. To be eligible for the withdrawal, you must supply sufficient evidence of the illness in accordance with IRS guidelines.

Domestic Abuse Withdrawals

If you or another family member living in your household experience domestic abuse, you are eligible to take a penalty-free withdrawal from your account. The maximum amount you can withdraw without incurring early withdrawal penalties is the lesser of $10,000 or 50% of your vested account balance. The withdrawal must be made within one year of the domestic abuse.

CARES Act Distributions

As a result of the Coronavirus Aid, Relief, and Economic Security Act ("CARES Act") signed into law on March 27, 2020, a new type of coronavirus-related distribution is allowed, and Chevron Phillips Chemical made this distribution option available to employees from April 3, 2020 through December 27, 2020, as allowed by the CARES Act.

The CARES Act allows eligible participants to request penalty-free distributions of up to $100,000 for qualifying coronavirus-related reasons. These include adverse financial consequences due to being quarantined, furloughed, laid off or having work hours reduced; being unable to work due to a lack of childcare; or closing or reducing hours of a business owned or operated by the individual on or after January 1, 2020, and before December 31, 2020. The following list includes details on these distributions.

- Tax on the income from the distribution may be paid over a three-year period,
- Participants may repay the amount withdrawn to an eligible retirement plan within three years,
- Repayments will not be subject to the retirement plan contribution limits,
- All contribution sources were available, and
- CARES Act distributions are not subject to a 10% tax penalty when taken before age 59½ or after age 59½.

For more information on CARES Act distributions, you can contact Fidelity at the Chevron Phillips Pension and Savings Service Center at 1-866-771-5225.

Loans

The Plan offers two types of loans: general purpose loans and residential loans intended for the purchase of a principal residence. Key features of each are summarized in the following chart.

Loan Feature	General Purpose Loan	Residential Loan
Reason for loan	Any reason	For purchase of your principal residence only
Minimum loan amount	$1,000	$10,000
Maximum loan amount	Lesser of 50% of your vested accounts or $50,000, subject to restrictions	Lesser of 50% of your vested accounts or $50,000, subject to restrictions
Initiation fee	$35	$35
Required documentation	None	Copy of escrow papers or purchase contract signed by buyer and seller
Annual maintenance fee	$15 ($3.75 will be deducted on a quarterly basis)	$15 ($3.75 will be deducted on a quarterly basis)
Repayment period	6 to 60 months (five years)	6 to 360 months (30 years)
Number of loans allowed at a time	Two	One
Interest rate	Prime plus 1% as of the last business day of the quarter preceding the calendar quarter in which the loan is processed	Prime plus 1% as of the last business day of the quarter preceding the calendar quarter in which the loan is processed

Who's Eligible for 401(k) Loans

To be eligible to take out a loan, you must meet both of the following requirements:

- Have a vested 401(k) account balance of at least $2,000, and
- Be an active participant in the Plan.

Number of Loans Available — Transferred Loans

You may have a maximum of two outstanding 401(k) loans at any time. You may have one general purpose loan and one residential loan, or two general purpose loans. This two-loan maximum includes any loans transferred from a prior Chevron Corporation or ConocoPhillips plan. Once a 401(k) loan has been fully repaid, there will be a 10-day waiting period before you can initiate a new loan.

How Much You Can Borrow

For a general purpose loan, you can borrow any amount between $1,000 and $50,000 and for a residential loan, you can borrow any amount between $10,000 and $50,000, but you may not borrow more than the lesser of the following two amounts:

- 50% of your vested account balance, or
- $50,000 minus the excess of your highest outstanding loan balance during the one-year period prior to the date your loan will be processed over your actual outstanding loan balance on the date you take out the new loan.

The amount you can borrow is also limited by your ability to make repayments.

Loans are taken proportionately from all matured sources in your accounts. Contributions **mature** after they are in your accounts for a period of 36 months. After this 36-month period elapses, the value of the contributions can be used to fund loans. Your loan amount will be withdrawn from the funds in which you are invested according to a hierarchy of lowest-risk to highest-risk funds.

Interest Rates

The interest you pay on your loan is credited back to your 401(k) account along with your loan repayments.

Loan interest rates are set on the last day of the quarter preceding the loan request and are equal to the prime rate (based on a measure established by the administrator) plus 1% (rounded down to the nearest quarter percent). The rate established for each loan is fixed. It does not change for the duration of the loan.

Applying for a Loan

You can apply for a loan over the phone by calling the Chevron Phillips Pension and Savings Service Center at 1-866-771-5225 or by logging on to www.netbenefits.com. If you have questions or need assistance, you can be connected to a service representative, who will assist you in processing your loan.

Timing of Loan Transactions

The normal turnaround time for receiving a loan is summarized in the following chart.

Loan Feature	General Purpose Loan	Residential Loan
When a loan is approved	Immediately; loan approval is automatic if you qualify	Within two business days after the Chevron Phillips Pension and Savings Service Center receives the required supporting documents
When the proceeds of the loan are deducted from your 401(k) account	The same day as the request, if it's made by 4:00 p.m. Eastern time on a business day; otherwise the next business day*	The same day as approval, if approved by 4:00 p.m. Eastern time on a business day; otherwise the next business day*
When loan checks are mailed	The next business day after the funds are deducted from your account. Please allow 5 to 8 business days for receipt of your check.	The next business day after the funds are deducted from your account. Please allow 7 to 10 business days for receipt of your check.

* The New York Stock Exchange (NYSE) normally closes at 4:00 p.m. Eastern time. If the NYSE closes prior to 4:00 p.m. Eastern time, loan funding does not occur until the next business day the NYSE is open. This assumes the NYSE is open on the next business day.

Loan Fees

Two types of fees are associated with loans from the Plan:

- An initiation fee of $35 for each loan. This fee is deducted from your account when the loan is processed.
- An annual maintenance fee of $15 for each outstanding loan. This fee is deducted from your account on a quarterly basis.

Repaying Your Loan

Your loan repayments are deducted from your paychecks on an after-tax basis. The timing of the payroll deduction depends on when the loan proceeds were taken from your account. In general, the deductions will start as soon as administratively feasible after your loan is taken out. As an active employee, your loan repayments must be paid via payroll deductions. By requesting a loan, you are authorizing payroll deductions to repay the loan.

The principal and interest are invested in your 401(k) account in the same fund(s) selected in your most recent investment election for your future contributions.

Early Payoff Procedures

You may not accelerate your loan repayments, nor can you make partial repayments that exceed the amounts specified in your normal repayment schedule. However, you can repay the full outstanding balance of your loan at any time. To request an early loan payoff, call the Chevron Phillips Pension and Savings Service Center at 1-866-771-5225. A service representative will calculate the loan payoff amount for you. You must use a cashier's check or money order to pay off your loan early. If you send a personal check, it will be returned to you. Once your payoff is received by the Chevron Phillips Pension and Savings Service Center, your loan payments automatically cease.

Loan Default

If you fail to make your loan payments, you risk sending your loan into a defaulted status. The IRS mandates that a loan must be defaulted no later than the last day of the calendar quarter following the calendar quarter in which payments were discontinued. At this point the outstanding balance becomes due and payable by the end of the month in which the default occurs. If the balance is not paid, it is considered a deemed taxable distribution and is subject to ordinary income taxes plus possible early withdrawal tax penalties.

Failure to repay a loan is called a **default**. When a loan default occurs, the outstanding balance is considered a taxable distribution and is subject to ordinary income taxes plus any applicable early distribution penalties.

Under IRS regulations, a taxed loan (a loan that defaulted and was reported as a taxable distribution) is still considered an outstanding loan from your 401(k) account. The amount available for future loans is reduced by the amount of any taxed loans not repaid to your account. A taxed loan also counts toward the two loan maximum. In addition, if your account includes a taxed loan, you may not obtain another loan from the Plan unless you enter into an enforceable arrangement under which:

- Repayments are made by payroll withholding, or
- The Plan receives adequate additional security (other than your vested account balance) for the new loan.

You can repay a taxed loan on an after-tax basis, but your repayments won't reverse the taxable event already reported to the IRS. However, paying off a taxed loan will increase the amount available to you for a future 401(k) loan. Also, any earnings on the repaid loan amount accumulate tax-deferred until they are distributed to you.

Situations Affecting Loans

Certain situations could affect your ability to request a loan or make scheduled loan repayments. The following chart summarizes loan repayment procedures in certain situations.

If You...	This Will Happen...
Go on a paid leave of absence	▪ Your loan repayments continue. ▪ If the amount of your paycheck during a paid leave of absence is insufficient to make your loan repayments, see the unpaid leave of absence information below.
Go on an unpaid leave of absence or go on a paid leave of absence where there are insufficient funds in your paycheck to make your loan repayments	▪ Your loan repayments stop and are suspended for the lesser of (i) the duration of your leave of absence or (ii) one year following the beginning of your leave of absence. ▪ When you return, your loan is reamortized at its original interest rate. The end date for the reamortized loan will be the original due date for the loan, unless the original due date for the loan was less than five years. In that case, the loan term can be extended to five years from the loan origination date. ▪ If you don't return from the leave and terminate employment, you must make arrangements to continue making loan repayments by calling 1-866-771-5225 and speaking with a service representative. – If you don't make arrangements to continue to repay your loan after your termination, your loan will default and will be reported to the IRS as a taxable distribution.
Go on a military leave of absence	▪ Your loan repayments stop and are suspended for the duration of your leave. ▪ When you return from the leave, your loan is reamortized at its original interest rate. The end date of the reamortized loan is set so that you have the same amount of time remaining on your loan as you had when you went on your leave. For example, suppose when your leave began you had 36 loan repayments left to make. When you return, your reamortized loan will provide for 36 payments to pay off your loan. ▪ If you don't return from the leave and terminate employment, you must make arrangements to continue making loan repayments by calling 1-866-771-5225 and speaking with a service representative. – If you don't make arrangements to continue to repay your loan after your termination, your loan will default and will be reported to the IRS as a taxable distribution.
Change from full-time to part-time	▪ Your loan repayments continue.
Leave the Company due to termination of employment, become disabled or retire	▪ If you request a lump-sum distribution from the Plan, your unpaid loan balance is deducted from your distribution and counted for tax reporting and withholding purposes. ▪ To avoid a loan default, you may pay off your loan, either all at once, or by setting up a periodic payment plan. Call 1-866-771-5225 to speak with a service representative for details.
Divorce or have a divorce pending, or if the Company receives a notice of adverse interest (a notice that your spouse or children intend to make a claim against your account)	▪ Your loan repayment deductions continue.
Die	▪ A surviving spouse or beneficiary can repay the outstanding loan balance. ▪ If the loan balance is not paid, it will default and be reported to the IRS as a taxable distribution.

Account Statements

Your account balances are updated nightly, and current figures are available either by phone at 1-866-771-5225 or over the Internet at www.netbenefits.com. You can check the status of Mutual Fund Window investments not managed by Fidelity through a link on the NetBenefits website to the BrokerageLink® website.

A printed statement of your account will be mailed to you a few weeks after the end of each calendar quarter. The statement shows the contributions and investment results for the previous quarter, fund transfers, rollovers, loan repayments and loan balances, withdrawals during the quarter, and the value of your account — including the value of investments in the Mutual Fund Window — at the end of that quarter.

If you invest in funds from the Mutual Fund Window, you will receive a separate statement showing your balances and activities in those funds.

Quarterly statements are also available online. If you elect to receive your statements online, printed statements will not be mailed to your home.

Distributions

The full value of your vested account is available for distribution to you when one of the following occurs:

- You retire,
- You die, or
- You terminate employment.

Please note that you may also be eligible to take a distribution if you are performing military service for more than 30 days. If you take such a distribution, you would not be eligible to make contributions to the Plan for six months after you receive that distribution. Contact the Chevron Phillips Pension and Savings Service Center at 1-866-771-5225 for details.

Payment Options

You may elect to receive the value of your vested accounts in a cash lump sum or in periodic installments. If you elect to withdraw the value of your accounts or begin installment payments, you have the right to keep your Medical Savings Account (MSA) in the Plan, provided the value of your MSA is greater than $1,000.

If the value of your vested accounts (including your MSA and Rollover Account if applicable) is $1,000 or less when you leave the Company, your entire account balance is paid to you in a single lump-sum payment unless you elect a rollover.

If the Value of Your Vested Account Balance is Greater Than $1,000, You May Elect One of the Following Distribution Options	
Deferred distribution	Leave all of your 401(k) assets in the Plan and defer your distribution until a later date, but no later than age 72 (if you reach age 72 on or before December 31, 2022) or age 73 (if you reach age 72 after December 31, 2022)
Total lump-sum distribution	Receive all of your Plan assets shortly after you leave the Company
Total lump-sum distribution (excluding MSA)	Receive the value of all your accounts except your MSA, provided the value of your MSA is greater than $1,000
Partial lump-sum distribution	Receive a portion of your Plan assets as a lump sum at any time after you leave the Company; amounts are taken proportionally from across all of your investment sources
Installment payments	Receive scheduled monthly, quarterly or annual payments from your account

Total and Partial Lump-Sum Distributions

You can elect payment of a total or partial lump-sum distribution in any of the following forms:

- In cash (by check),
- As shares of Chevron, ConocoPhillips, and/or Phillips 66 common stock (this form is available only if you transferred shares of Chevron, ConocoPhillips, and/or Phillips 66 stock into your Plan and is limited to the value of your frozen Chevron, ConocoPhillips, and/or Phillips 66 stock account invested in such securities), or
- In a combination of cash and the available shares of Chevron, ConocoPhillips, and/or Phillips 66 common stock, if any.

You may also elect to have your total lump-sum distribution paid directly as a:

- Rollover to another qualified plan, or
- Rollover to an Individual Retirement Account (IRA).

Other employers' qualified defined benefit or defined contribution plans, such as 401(k), profit-sharing or money purchase pension plans, may accept rollovers from the Plan, but they are not required to do so. You should check with the plan's sponsor before electing a rollover.

Installment Payments

If you elect periodic installments, you must indicate how often you want to receive payments — that is, monthly, quarterly or annually — and the length of time over which you'd like to receive them. If you elect to have payments continue over the rest of your lifetime, the amount of each periodic payment depends on your life expectancy at the time of your request, based on IRS life expectancy tables.

Default Deferral of Benefit Distribution

Under the Plan, you have the right to the distribution of your entire benefit. However, the Plan also provides that if you do not specifically elect the distribution of your benefit, distribution is deferred until you reach age 72 (if you reach age 72 on or before December 31, 2022) or age 73 (if you reach age 72 after December 31, 2022).

Minimum Required Distributions

By law, you must start receiving minimum required distributions (MRDs) from the Plan no later than April 1 of the year **following** the calendar year in which you reach age 72 (if you reach age 72 on or before December 31, 2022) or age 73 (if you reach age 72 after December 31, 2022), unless you remain actively employed by the Company beyond age 72 or age 73, respectively. In this case you must start receiving MRDs from the Plan no later than April 1 of the year following the calendar year in which you terminate your employment. Additional required distributions must be made by December 31 of each calendar year thereafter.

If you elect to defer your first minimum required distribution (MRD) until April 1 of the year following the calendar year in which you reach age 72 (if you reach age 72 on or before December 31, 2022) or age 73 (if you reach age 72 after December 31, 2022), or the year you terminate your employment, you must receive two MRDs during that same calendar year (one for the prior year and one for the current year).

Requesting a Distribution

To request a distribution, call the Chevron Phillips Pension and Savings Service Center at 1-866-771-5225 to speak with a service representative. You must specify the method of payment and, if applicable, the amount to be rolled over to another qualified retirement plan or IRA.

Your request should specify whether you would like your distribution in cash, shares of Chevron, ConocoPhillips, and/or Phillips 66 stock (if applicable), or a combination of cash and stock. You may also specify whether you want a portion of your distribution to be withheld for state income taxes. See ***Key Transaction Dates and Deadlines*** on pages O-27 – O-28 for the timing of 401(k) plan transactions.

Distribution Due to Your Death

If Your Beneficiary Is Living

Your account balance becomes fully vested on your death and is distributed to your named beneficiary(ies). For more information, see ***Designating Your Beneficiary*** on this page. If you are married, your beneficiary is your surviving spouse unless you designate another beneficiary with Fidelity. A spousal consent form will be sent to you by Fidelity and must be signed by you and your spouse and either notarized or witnessed by a Plan representative. A PIN notice and account statement are sent to your beneficiary when your assets are transferred to a beneficiary account. Your beneficiary may elect either an immediate or a deferred distribution, subject to Internal Revenue Code rules on minimum required distributions.

If your sole beneficiary is a surviving spouse, the distribution will begin by December 31 of the calendar year following the year of your death, or by December 31 of the calendar year in which you would have reached age 72 (if you would have reached age 72 on or before December 31, 2022) or age 73 (if you would have reached age 72 after December 31, 2022), whichever is later. Such a distribution is eligible for rollover to an eligible retirement plan as defined in the Internal Revenue Code.

If your surviving spouse is not your sole beneficiary, the distribution will begin by December 31 of the calendar year following the year of your death. A non-spousal-beneficiary may roll over the distribution into an Individual Retirement Account ("IRA").

Any outstanding loans are defaulted 60 days following your death and reported to the IRS as a taxable distribution. A surviving spouse or other beneficiary is urged to contact a tax advisor to determine the tax advantages, if any, of depositing the amount of the outstanding loan balance into an IRA and thereby possibly avoiding immediate taxation.

Other Situations Affecting Your Beneficiary

The following provisions apply if you die without a named beneficiary, if your beneficiary dies before receiving the value of your account, or if you die and your beneficiary cannot be located:

- If no beneficiary designation is in effect at the time of your death, your spouse is your beneficiary. If you are unmarried, the beneficiary is deemed to be the personal representative of your estate.
- If your beneficiary is living at the time of your death but dies before receiving the benefit, the value of your account is paid to your beneficiary's estate in a lump-sum payment.
- If you die and your named beneficiary cannot be located within three years from the date your beneficiary would have received an initial distribution from the Plan, your account is canceled. If the beneficiary later contacts the Plan committee, the amount previously canceled is paid to the beneficiary upon written request.

Designating Your Beneficiary

You may designate your beneficiaries for the 401(k) Savings Plan using Fidelity's Online Beneficiaries Service. Your beneficiaries are the person or people you want to receive your 401(k) balance in the event of your death. To access Fidelity's Online Beneficiaries Service, simply log on to NetBenefits at www.netbenefits.com and click "Beneficiaries" under the "Your Profile" tab. If you do not have access to the Internet or prefer to complete your beneficiary process by paper form, please contact Fidelity at 1-866-771-5225.

If you are married, your beneficiary is your surviving spouse unless you designate another beneficiary with Fidelity. A spousal consent form will be sent to you by Fidelity and must be signed by you and your spouse and either notarized or witnessed by a Plan representative. If you are divorced and had previously named your former spouse as your beneficiary, your designation will be considered void and any successor beneficiary designations will apply, unless a Qualified Domestic Relations Order requires that benefits be paid to your former spouse.

You may change your beneficiary at any time through Fidelity's Online Beneficiaries Service, available through Fidelity NetBenefits. Simply log on to www.netbenefits.com and click "Beneficiaries" under the "Your Profile" tab.

Qualified Domestic Relations Orders

A Qualified Domestic Relations Order (QDRO) is a special order issued by the court in a divorce, child support or similar proceeding. A QDRO can require the Plan to pay part or all of your benefits to your spouse, former spouse or dependent (alternate payee) for reasons such as satisfaction of marital property rights, alimony or child support. A QDRO can require the Plan to pay the spouse's or dependent's share of the benefit at any time.

For descriptions of the Plan's procedures governing QDROs please refer to ***Qualified Domestic Relations Order (QDRO)*** on page P-24.

Administrative Holds

If Fidelity, the QDRO administrator for the Plan, receives an executed domestic relations order, an executed divorce decree or property settlement agreement that establishes an alternate payee's interest in your Plan accounts, a joinder or a written direction from the Plan sponsor, an administrative hold is placed on your account.

An administrative hold prevents you from receiving any type of payment, loan, withdrawal or distribution from the Plan until the claim is settled. However, you may make changes to your investment elections, make fund transfers and change your contribution rate if you wish. You must also continue to make payments on any outstanding loan(s).

For more information on holds and release of holds, please refer to ***Qualified Domestic Relations Order (QDRO)*** on page P-24 or the Fidelity QDRO Center website.

Tax Information

There are significant tax issues associated with your accounts under the Plan. You are encouraged to consult your personal tax advisor concerning the tax implications of your Plan, including withdrawals and distributions.

This summary of taxation is based on federal income tax laws in effect when this summary was published. It is not intended to be a complete description of all federal income tax rules that may apply. Also, you may be subject to certain state and local taxes not mentioned here. In some cases, estate and death taxes not described here may also apply.

For example, your pre-tax contributions, catch-up contributions, rollover contributions, Company contributions and all earnings are subject to ordinary income tax when they are paid out to you as a hardship withdrawal or as a distribution. You receive a *Special Tax Notice* before a withdrawal or distribution check is issued. After you receive the notice, you have up to 30 days to decide whether to elect a direct rollover and to consider the tax consequences of not electing a rollover. You cannot receive a distribution or withdrawal from your account until you receive the *Special Tax Notice* unless you waive your right to this 30-day notice. However, an election to waive the 30-day notice does not obligate the Plan to make payments within 30 days. To request a copy of this notice, call the Chevron Phillips Pension and Savings Service Center at 1-866-771-5225.

Your taxes on withdrawals and distributions vary, depending on your age, your marital status, your other income and how your withdrawal or distribution is paid. State and local taxes may also apply. You should consult a qualified tax advisor before taking any withdrawals or distributions from the Plan.

Early Withdrawal Tax Penalties

If you are under age 59½ when you receive a withdrawal — including a hardship withdrawal — or distribution, you may have to pay an additional 10% federal tax penalty, plus a state tax penalty. These penalties are waived if the money is used for tax-deductible medical expenses, or if it is paid out as the result of one of the following:

- A court order,
- Your permanent and total disability,
- Termination of employment during or after the year you reach age 55,
- Your death,
- Payment in installments over your lifetime, or
- A qualified military reservist leave of 180 days or more.

Mandatory Tax Withholding and Rollovers

If any portion of a withdrawal or distribution is eligible for rollover but instead is paid directly to you, federal law requires that 20% of the eligible rollover amount be withheld and sent to the IRS for payment of income taxes. The amount eligible for rollover is generally that portion of your account that is subject to ordinary income tax on distribution. The amount eligible for rollover does not include after-tax contributions, hardship distributions, a distribution which is one of a series of substantially equal periodic installments or a required minimum distribution.

Any withdrawals or distributions you receive from the Plan are subject to the tax laws in effect at that time. Consult your personal tax advisor if you have any questions concerning taxes on your withdrawals or distributions.

If any portion of a withdrawal or distribution is paid as shares of Chevron, ConocoPhillips, and/or Phillips 66 stock, withholding is based on your cost basis in the shares (what the Plan paid for the shares when they were allocated to your account), and the cash you receive for any remaining shares, fractional shares and/or dividends. Any ordinary income tax or tax penalties you owe on the value of the stock become due and payable in the tax year in which you receive payment.

The mandatory 20% withholding rule does not apply to any portion of your payment that is not eligible for rollover but is still taxable (such as a hardship withdrawal or a required minimum distribution). In these cases, withholding may be applied under other rules, or you may elect to not have any taxes withheld. Call the Chevron Phillips Pension and Savings Service Center at 1-866-771-5225 and speak to a service representative for information and election forms.

Taxation of After-Tax Contributions

Federal law requires that withdrawals be made from a combination of your after-tax contributions and the related earnings on those contributions. Because you have already paid taxes on your after-tax contributions, they are not taxable when they are withdrawn from the Plan. However, the related earnings you withdraw are subject to ordinary income tax, plus any early withdrawal tax penalties that apply. Different rules apply to taxation of Roth contributions. See ***Taxation of Roth Contributions*** on page O-26 for details.

10-Year Averaging

You are eligible to elect 10-year averaging one time during your lifetime if both of the following conditions are met:

- You were born before January 1, 1936, and
- You have participated in the Plan for five years or more at the time of the withdrawal.

If you roll over any portion of your payment to an IRA or another qualified plan, this special tax treatment may not be available. Consult your personal tax advisor for guidance.

Taxation of Roth Contributions

Federal law requires that withdrawals be made from a combination of your Roth contributions and the related earnings on those contributions. Because you have already paid taxes on your Roth contributions, they are not taxable when they are withdrawn from the Plan. In addition, the related earnings you withdraw are not taxable either as long as you have held the account for five (5) years or more and are at least age 59½ before you take a withdrawal.

Roth Conversions Within the Plan

You may elect to convert all or a portion of certain pre-tax and after-tax accounts to Roth accounts through the Roth in-plan conversion feature. Amounts converted will be included in gross income as if distributed in the year of conversion (except for MSA after-tax contributions and other after-tax contributions which have previously been taxed). You can also request that Fidelity automatically convert your after-tax contributions to Roth immediately after your paycheck deposits. Please contact the Chevron Phillips Pension and Savings Service Center at 1-866-771-5225 or log on to www.netbenefits.com to inquire about conversion.

Estimated Taxes

Tax withholding, especially in the case of a distribution of shares of stock, may not be sufficient to cover the full tax due on a distribution that is not rolled over to an IRA. This may require that you pay estimated taxes when you receive your distribution. Consult your personal tax advisor for guidance.

Taxation on Stock Fund Gains

If you are invested through the Plan in Chevron, ConocoPhillips, and/or Phillips 66 stock, you may be able to take a distribution of that portion of your account in stock and postpone taxation of a portion of the gains, if any (also called net unrealized appreciation or NUA), resulting from your investment in Chevron, ConocoPhillips, and/or Phillips 66 stock.

If you take a distribution in shares, you are taxed only on your cost basis or the original cost of your investment. The tax on any increase in the value of the stock above your cost basis that occurred while it was held in your account is not due until you sell or otherwise dispose of the stock.

Fidelity's NetBenefits®

Fidelity's interactive NetBenefits Planning Center provides up-to-date information on your individual Plan accounts. You can access your account information virtually 24 hours a day, 7 days a week, through the Chevron Phillips Pension and Savings Service Center automated voice response system by calling 1-866-771-5225. You'll need your Social Security number and your Fidelity PIN to access this information.

You can also access the NetBenefits Planning Center online through www.netbenefits.com. In addition to your latest account information, NetBenefits provides information and tools to help you prepare for your future. These include detailed asset allocation strategies and interactive calculators — all in one place, all accessible with the click of a mouse. Here are some of the things the Web-based NetBenefits Planning Center enables you to do:

- Get current account information and chart your contributions,
- Make investment and contribution percentage changes,
- Designate and change beneficiaries,
- Make exchanges between current investment options,
- Model a new loan,
- Compare fund performance,
- Get Plan information, and
- Request mutual fund prospectuses.

Personal Identification Number (PIN) Authorization

Your new hire enrollment package contains information on generating your PIN. The same PIN is used for the voice response and Web systems. If you lose or forget your PIN, you can request a new, temporary PIN through the Chevron Phillips Pension and Savings Service Center by calling 1-866-771-5225, or through www.netbenefits.com. You should receive your new PIN notice in approximately five business days. You cannot make changes until you receive your new, temporary PIN.

IMPORTANT NOTE

Take care to safeguard your PIN from theft or misuse. Your PIN is your electronic signature. When you use your PIN, you are electronically authorizing the use of your PIN instead of your handwritten signature to execute your transactions. You should immediately change your PIN if you suspect it has been stolen or misused by others and report this event to a service representative by calling 1-866-771-5225.

Key Transaction Dates and Deadlines

Here's a quick guide to Plan transactions and their key dates and deadlines.

Plan Transaction	How to Request	Timing
Change contribution rate	Log on to www.netbenefits.com, or call 1-866-771-5225 to speak with a rate service representative.	▪ Requests are processed daily and take effect as soon as administratively possible.
Change future investments	Log on to www.netbenefits.com, or call 1-866-771-5225 to speak with an investment service representative. The service representative can also assist you with investments in funds within the Mutual Fund Window.	▪ Requests are processed daily and take effect as soon as administratively possible.
Change investment of current balances	Log on to www.netbenefits.com, or call 1-866-771-5225 to speak with an investment service representative. The service representative can also assist you with investments in funds within the Mutual Fund Window.	▪ If the request is processed by 4:00 p.m. Eastern time, the change takes effect the same day (if the New York Stock Exchange (NYSE) is open). ▪ If the request is processed after the NYSE closes (after 4:00 p.m. Eastern time), the change takes effect the next business day.*
Apply for a general purpose loan	Log on to www.netbenefits.com, or call 1-866-771-5225 to speak with a service representative.	▪ If the loan is requested by 4:00 p.m. Eastern time, funding occurs the same day as long as the NYSE is open. ▪ If the loan is requested after the NYSE closes (after 4:00 p.m. Eastern time), funding occurs the next business day.* ▪ Payment is mailed the next business day* after the money is deducted from your account.

(continued)

Plan Transaction	How to Request	Timing
Apply for a residential loan	Log on to www.netbenefits.com, or call 1-866-771-5225 to speak with a service representative.	▪ Eligible loans are approved within two business days* after the Chevron Phillips Pension and Savings Service Center receives all required documentation. ▪ If a loan is approved by 4:00 p.m. Eastern time, funding occurs the same day (if the NYSE is open). ▪ If a loan is approved after the NYSE closes (after 4:00 p.m. Eastern time), funding occurs the next business day.* ▪ Payment is mailed the next business day* after the money is deducted from your account.
Apply for a hardship withdrawal	Call 1-866-771-5225 to speak with a service representative.	▪ Hardship withdrawals are approved within two business days* after the Chevron Phillips Pension and Savings Service Center receives all required documentation. ▪ If the withdrawal is approved by 4:00 p.m. Eastern time, funding occurs the same day (if the NYSE is open). ▪ If the withdrawal is approved after the NYSE closes (after 4:00 p.m. Eastern time), funding occurs the next business day.* ▪ Payment is mailed the next business day* after the money is deducted from your account.
Make a rollover contribution	Call 1-866-771-5225 to request a rollover form from a service representative.	▪ Rollovers are deposited and credited to participants' accounts on a daily basis.
Change your PIN	Call 1-866-771-5225 to speak with a service representative.	▪ A new PIN notice is sent within five business days of the request.

* For purposes of the Plan, ***business day*** means any day that the New York Stock Exchange (NYSE) is open for business.

Situations Affecting 401(k) Participation

Certain situations could affect your Plan participation — for example, if you become permanently and totally disabled, take a leave of absence or leave the Company. These situations are summarized in the following chart. For how these situations might affect loan repayments, see ***Situations Affecting Loans*** on page O-20.

If You…	This Will Happen…
Are rehired	▪ You may rejoin the Plan on reemployment.
Are rehired and you forfeited Company contributions when you left	▪ You have five years from your rehire date to repay, in a lump sum, the full account balance distributed to you when you left. ▪ If you repay the full account balance, any forfeited Company contributions are restored to you. ▪ You vest in the restored amount based on your total years of service before and after your rehire date.
Become permanently and totally disabled while an active employee	▪ You are 100% vested in your Company Match Account and Chevron Phillips Chemical Profit-Sharing Account. ▪ You may defer distribution up to the end of the year in which you reach age 65. Your account is distributed to you no later than the end of the year in which you reach age 65 unless you elect to defer it until the end of the year in which you turn 72 (if you reach age 72 on or before December 31, 2022) or age 73 (if you reach age 72 after December 31, 2022). ▪ As long as you maintain an account balance in the Plan, you may change your investment mix.
Change to an ineligible status (e.g., separate from service)	▪ Your contributions stop.
Die	▪ If you were an active employee, your account becomes fully vested. ▪ Your account is paid to your named beneficiary(ies). ▪ If you did not return a Beneficiary Designation Form (with spousal consent if your spouse is not listed as your beneficiary), your spouse is your beneficiary. ▪ If no beneficiary survives you, your account is paid to the personal representative of your estate. ▪ The taxable portion of the distribution payable to a surviving spouse may be eligible for rollover to an eligible retirement plan. ▪ The taxable portion of a distribution payable to a non-spouse beneficiary may be rolled over to an IRA.
Fidelity receives an executed domestic relations order, an executed divorce decree or property settlement agreement that establishes an alternate payee's interest in your plan accounts, a joinder or a written direction from the plan sponsor	▪ Your account is placed on administrative hold. ▪ You may still contribute to the Plan and direct your investments; however, loans, withdrawals and distributions will not be allowed. Loan repayments must continue. ▪ The qualification of the domestic relations order and the separation of the award from your Plan accounts to an account of the alternate payee is required to remove this administrative hold.
Are receiving Short-Term Disability benefits	▪ Your contributions may continue as long as you have sufficient earnings. ▪ Any loan repayments continue as long as you have sufficient earnings. For more information, see ***Loan Default*** on page O-19.
Are receiving Long-Term Disability benefits	▪ Your contributions stop. ▪ Your loan repayments will stop since you will be receiving your benefits from a third-party vendor. Your loan will default unless you make arrangements to send in the repayment amounts for the duration of the time in which you are receiving Long-Term Disability benefits. For more information, see ***Loan Default*** on page O-19.

(continued)

If You...	This Will Happen...
Go on an approved unpaid leave of absence including military leave	▪ Your contributions stop. ▪ Any loan repayments stop. For more information, see ***Situations Affecting Loans*** on page O-20 and ***Loan Default*** on page O-19.
Go on an approved paid leave for reasons other than disability and have sufficient earnings	▪ If you are on some other paid leave and you receive a paycheck from the Company, your contributions continue. ▪ You can voluntarily stop your contributions at any time. ▪ Any loan repayments continue. For more information, see ***Loan Default*** on page O-19.
Leave the Company for any reason including retirement	▪ Your contributions and any loan repayments stop. ▪ The vested value of your account can be distributed to you. ▪ If you are not 100% vested in your Company Match Account and Company Profit-Sharing Account, you forfeit the unvested portion at the time of distribution or after a five-year break in service. ▪ All or a portion of your distribution may be eligible for rollover to an IRA or another employer's qualified plan. Distributions prior to age 59½ may be subject to a 10% early withdrawal tax, with certain exceptions. ▪ If your vested balance is $1,000 or more, you may postpone distribution up to the end of the year in which you reach age 72 (if you reach age 72 on or before December 31, 2022) or age 73 (if you reach age 72 after December 31, 2022). ▪ If your vested balance is less than $1,000, you receive a lump-sum distribution if you did not elect to roll over your account to an IRA or to another employer's qualified retirement plan. ▪ You may request to roll over your account to an IRA or to another employer's qualified retirement plan. ▪ You may receive scheduled monthly, quarterly or annual payments from your account. ▪ You may leave the balance of your MSA in the Plan if the account balance is at least $1,000. ▪ As long as your account balance remains in the Plan, you can continue to change your investment mix.

Other Situations Affecting 401(k) Benefits

You should be aware of the following circumstances that could adversely affect your benefits:

- Federal law limits the amounts employees can save in tax-deferred plans such as the Plan. Because of these limits (which are indexed annually), some employees may not be able to contribute the full amount otherwise allowed each year. If you reach this limit, your contributions are automatically stopped until the following tax year. If you believe that any of these limits may affect you, you may want to consider changing your contribution rate. For more information, see ***Annual IRS Contribution Limits*** on page O-6.
- Investment funds can decline in value. Your account balance reflects both contributions and investment gains or losses on those contributions.
- The law requires that certain Plan provisions go into effect during any plan year in which the value of the accounts of certain key employees exceeds 60% of the value of all accounts combined. If you are affected by these provisions, you will be notified in the unlikely event that they go into effect.
- If you leave the Company before you become 100% vested, the non-vested funds in your Company Match Account and Company Profit-Sharing Account will be forfeited when:
  - The value of your account is distributed,
  - You have a five-year break in service, or
  - If you are not vested in any portion of your Company Match Account and Company Profit-Sharing Account, when you terminate service on the date your employment ends.
- If you do not provide proper notice of an address change, you may experience a delay in receiving your statements, withdrawals and distributions. To provide notice of an address change, you should update it on MySphere under "Contact Info." If you are not an active employee, you can call the CPChem Benefits Service Center at 1-833-964-3575 to update your home address.
- If there is a conflict between claimants to your account, distribution may be delayed until the conflict is resolved.
- Plan benefits may be affected if the Plan is merged, amended, suspended or discontinued. However, the value of your accounts will not be reduced as a result of any of these occurrences. For more information, see ***Other Important Information*** on this page.

Other Important Information

Plan Administration

The plan administrator shall handle general administration of the Plan and be responsible for carrying out its provisions (except for the Plan's investments). The Investment Committee shall handle general investment of the Plan's assets and be responsible for carrying out the Plan's investment provisions. Subject to the limitations of the Plan, the Company, the plan administrator and the Investment Committee shall establish rules for the administration of the Plan and the transaction of its business. The Company and the applicable delegate or committee shall have discretionary authority to interpret the Plan, to determine eligibility for participation in the Plan, and to determine benefit amounts payable under the Plan, among other matters.

Any determination by the Company's delegate as to interpretation of the Plan or any disputed question shall be conclusive and final to the extent permitted by applicable law.

Claims Procedures

If you or your surviving spouse or other beneficiary wishes to apply for benefits under the Plan, you must complete and file the proper benefit application forms, which can be obtained by calling the Chevron Phillips Pension and Savings Service Center at 1-866-771-5225 and speaking to a service representative.

If your benefit claim is denied in full or in part, you will be notified in writing within 90 days after the claim is filed. This time limit may be extended for another 90 days in special cases. In such a case, you will be notified of the reasons for the delay and told when you can expect a decision.

The written denial notice will state the specific reasons for the denial, tell you the Plan provisions on which it is based, describe any additional information or material required by the Company, explain your right to receive Plan documents, explain the procedure you need to follow to have the Company review the claim and your right to bring suit if the appeal is denied.

Appealing a Claim Denial

You may appeal a denial by following the instructions in your denial notice, or the procedures set forth on page P-14 under ***Filing Claims Under the 401(k) Plan***.

Non-Discrimination Rules

In addition to the IRS limits on contributions described previously, federal law requires that the Plan satisfy certain non-discrimination standards, which could result in the return of a portion of your contributions and forfeiture of Company contributions. You will be notified if this affects you.

Plan Merger

Your benefit will not be reduced if the Plan merges with another qualified plan.

Payment of Plan Fees

Fees charged by investment fund managers are paid by those who invest in those funds, whether they are individual investors or participants in a 401(k) plan. In addition to investment management fees, the recordkeeper imposes charges for keeping records of individual accounts, responding to telephone inquiries, mailing plan prospectuses and account statements, and performing other administrative activities. Because these services are provided by the Plan, the fees investment managers charge are used to cover their costs. The rates of return reported by each mutual fund are always shown after these fees are paid out of Plan assets.

Fees are charged to participants for the sale of Chevron, ConocoPhillips, or Phillips 66 company stock within the Plan's investment funds. If you wish to sell such stock, you can call 1-866-771-5225. You will be connected to a Fidelity service representative, who will be able to tell you the amount of the fee for your transaction.

Fees are also charged to participants for Qualified Domestic Relations Order (QDRO) reviews associated with a divorce, child support or similar proceeding. For a description of the Savings Plan's procedures governing QDROs, please refer to ***Qualified Domestic Relations Order (QDRO)*** on page P-24.

Assignment of Benefits

Benefits payable from the Plan as described in this summary are intended solely for the benefit of Plan participants entitled to payment according to Plan provisions. By law, Plan benefits are not subject to your debts or obligations, or to those of your beneficiaries, and may not be sold, transferred, assigned or encumbered in any manner.

However, certain court orders, such as a QDRO, could require that part of your account be paid to someone else — for example, your spouse, former spouse, child or other dependent.

Your ERISA Rights

As a participant in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). These include the right to receive certain Plan information and to file suit if you feel your rights have been violated.

For a full statement of your rights, see ***Your ERISA Rights*** on page P-16.

(Performance Pipe Hourly Employees)

General Information

Contents

This chapter contains general administrative information about the health and group benefit and 401(k) plans offered by Chevron Phillips Chemical Company LP (Chevron Phillips Chemical or the Company), and an explanation of your rights under the Employee Retirement Income Security Act of 1974 (ERISA).

Plan Documents

This handbook is a summary of the benefit plans for eligible employees of Chevron Phillips Chemical and does not contain all plan details. Full plan provisions and complete details of each of the plans can be found in the official plan documents, insurance contracts and trust agreements (if they apply) that govern the operation of the plans. In determining your specific benefits, the full plan provisions as they exist now or in the future will govern. All statements in this handbook are subject to the provisions and terms of those documents.

You can get a copy of plan documents by calling the plan administrator at 1-833-964-3575. Copies of the official plan documents and the annual reports of plan operations are also available for review, without charge, by any plan member, spouse or beneficiary at the following location during normal business hours:

Chevron Phillips Chemical Benefits Department
10001 Six Pines Drive
The Woodlands, TX 77380

Any documents that are requested are sent within 30 days after your written request is received.

Plan Amendment or Termination

Chevron Phillips Chemical expects and intends to continue to make the benefit plans described in this summary plan description available to eligible employees on an ongoing basis. However, the Company reserves the right to modify, suspend, change or terminate any plan at any time. Benefits under these plans are at the Company's discretion and do not create a contract of employment.

No amendment of any plan shall reduce or interfere with any benefit which you have otherwise accrued or become entitled to under the plan before the adoption of the amendment. In addition, no amendment of the 401(k) Plan may impose new vesting requirements on benefits already vested, or divert any part of the plan's assets to purposes other than serving the exclusive benefit of persons entitled to benefits before all liabilities with respect to them have been satisfied.

If any plan is terminated, the termination of the plan shall not reduce or interfere with any benefit which you have otherwise accrued or become entitled to under the plan prior to its termination. In addition, if the 401(k) Plan is terminated, the rights of members in their benefits accrued as of the date of termination will be nonforfeitable to the extent then funded or protected by law. If there are excess assets, these may revert to the employer.

Claims

Each chapter of this handbook includes an explanation of the claim procedure and associated rules for that plan. You or your designated beneficiary may be required to file a written claim on the appropriate form for certain benefit plans and in accordance with any timing rules of that plan.

Claim forms are available from each of the claims administrators (for more information, see pages P-28 – P-29) by calling the toll-free number or accessing the appropriate website.

For all ERISA plans, the law allows a reasonable amount of time for the plan administrator, claims administrator or the insurance company, in the case of an insured plan, to evaluate a claim and to decide whether to pay benefits based on the information contained in the written claim.

Filing Administrative Claims Under the Plan

(Applies to eligibility and enrollment claims for all coverages)

If you have changes or questions related to an administrative matter for all coverages, you may contact the Chevron Phillips Chemical Benefits Department at CPCRABENEFITS@cpchem.com or the claims administrator. The Benefits Department or claims administrator will make an initial determination which will be communicated to you within a reasonable time frame.

If You Receive an Adverse Benefit Determination

The Benefits Department or claims administrator will provide you with a notification of any adverse benefit determination (i.e., any denial of eligibility or enrollment error), either written or oral, which will set forth:

- The specific reason(s) for the adverse benefit determination,
- Reference to the specific benefit plan provisions on which the benefit determination is based,
- A description of any additional material or information needed to process the request and an explanation of why that material or information is necessary, and

- A description of the benefit plans' appeal procedures and the time limits applicable to those procedures, including a statement of your rights to bring a legal action under section 502(a) of ERISA after an appeal of an adverse benefit determination, provided such legal action is filed no later than 12 months from the last day (including any extension) that a determination could have been timely provided by the Benefits Department or the claims administrator.

Procedures for Appealing an Adverse Benefit Determination

The plan provides for two levels of appeal of an adverse benefit determination.

First Level Appeal

If you receive an adverse benefit determination on your initial claim, and you believe that the claims administrator or the Benefits Department incorrectly denied all or part of your claim, you may ask for a standard review. You, or your authorized representative, have 180 days following the receipt of a notification of an adverse benefit determination within which to appeal the determination.

You have the right to:

- Submit written comments, documents, records and other information relating to the claim for benefits,
- Request, free of charge, reasonable access to and copies of, all documents, records and other information relevant to your claim for benefits. For this purpose, a document, record or other information is treated as relevant to your claim if it:
  - Was relied upon in making the benefit determination,
  - Was submitted, considered or generated in the course of making the benefit determination, regardless of whether such document, record or other information was relied upon in making the benefits determination,
  - Demonstrates compliance with the administrative processes and safeguards required in making the benefits determination, or
  - Constitutes a statement of policy or guidance with respect to the benefit plan concerning the denied administrative claim, and
- A review that takes into account the substance of the appeal and all comments, documents, records and other information submitted by you related to the claim, regardless of whether the information as submitted or considered in the initial benefit determination.

The decision on appeal should be made and communicated to you or your authorized representative within a reasonable time, not to exceed 60 days, unless you or your authorized representative is notified that an extension is necessary.

The Benefit Department's appeal response will contain all of the following information:

- The specific reason(s) for the determination,
- References to the specific benefit plan provisions on which the benefit determination is based,
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to your claim,
- A statement describing the procedure for filing a second level appeal, and
- Any specific rule, guidance, protocol or other similar criterion relied upon in making the benefit determination; or a statement that a copy of this information will be provided free of charge to you upon request.

Second Level Appeal

If you receive a denial of your first level appeal, you may ask for a final review from the Chevron Phillips Chemical Company LP Benefits Committee. You, or your authorized representative, have 60 days following the receipt of the first level appeal denial within which to appeal the determination.

This second level of appeal will follow the same timelines as the first level appeal. You will be notified of the final determination in a notice that contains the following:

- The specific reason(s) for the determination,
- References to the specific benefit plan provisions on which the benefit determination is based,
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to your claim, and
- Any specific rule, guidance, protocol or other similar criterion relied upon in making the benefit determination; or a statement that a copy of this information will be provided free of charge to you upon request.

Exhaustion of Process and Legal Actions

You must exhaust all of the previous appeal processes before you or your authorized representative may initiate any equitable action, suit of law, arbitration or administrative action for benefits regarding any matter within the scope of the appeals process. Any suit must be brought within one year from the last day (including extensions) that a final decision on the claim could have been provided by the claims administrator or other designated plan representative. Evidence presented in any judicial proceeding will be limited to the documentation and information presented to the Chevron Phillips Chemical Benefits Department, the claims administrator or the Benefits Committee during the claims and appeal process outlined above. Any action under the plan must be brought in the U.S. District Court for the Southern District of Texas.

Filing Health Claims Under The Plan

(Applies to Medical, Prescription Drug, EAP/Behavioral Health, Dental, Vision, Health Care FSA, Limited-Purpose FSA and RRA claims)

Types of Claims

The following are definitions of the types health claims under the plan:

- **Urgent care claim:** any pre-service claim that requires pre-authorization for benefits for care or treatment with respect to which the application of regular time periods for making health claim decisions could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function, or, in the opinion of a physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot adequately be managed without the care or treatment. **Note:** Any reduction or termination of a course of treatment will not be considered an adverse benefit determination if the reduction or termination of the treatment is the result of a benefit plan amendment or benefit plan termination.
- **Pre-service claim:** any non-urgent request for benefits with respect to which the terms of the plan require pre-authorization or condition receipt of the benefit on approval of the benefit in advance of obtaining medical care.
- **Concurrent care claim:** a claim for a health benefit in which the administrator, after having previously approved an ongoing course of treatment provided over a period of time or a specific number of treatments, subsequently reduces or terminates coverage for the treatment (other than by plan amendment or termination) or a request to extend the course of the treatment beyond what was previously approved as an urgent care claim.
- **Post-service claim:** any other claim for a benefit for a service that has been provided to you. Your claim must be in a form acceptable to the administrator and include full details of the services received, including your name, age, sex, identification number, the name and address of the provider, an itemized statement of the service rendered or furnished, the date of service, the diagnosis, the claim charge and any other information which the administrator may request in connection with the services rendered to you.

Time Frame for Initial Claim Determination

For urgent care claims and pre-service claims, the claims administrator will notify you of its benefit determination (whether adverse or not) within the following time frames:

- 72 hours after receipt of a claim initiated for urgent care (a decision can be provided to you orally, as long as a written or electronic notification is provided to you within three (3) days after the oral notification), or
- 15 calendar days after receipt of a pre-service claim.

For post-service claims, the claims administrator will notify you of an adverse benefit determination within 30 calendar days after receipt of a claim. An adverse benefit determination is any denial, reduction or termination of a benefit, or a failure to provide or make a payment, in whole or in part, for a service, supply or benefit.

For concurrent care claims, the claim must be provided sufficiently in advance to give you an opportunity to appeal and obtain a decision before the previously approved treatment is reduced or terminated. A request to extend an approved course of treatment that is an urgent care claim will receive a response within 24 hours, if the request is made at least 24 hours prior to the expiration of the previously approved period of time or number of treatments. **Note:** If such request for extension is not made at least 24 hours prior to the expiration of the previously approved period of time or number of treatments, then the claim will be handled as an urgent care claim. If a request to extend a course of treatment is not an urgent care claim, the request may be treated as a new pre-service or post-service claim, depending on the circumstances.

For urgent care claims, if you fail to provide the claims administrator with sufficient information to determine whether, or to what extent, benefits are covered or payable under the benefit plan, the claims administrator must notify you within 24 hours of receiving your claim of the specific information needed to complete the claim. You then have 48 hours to provide the information needed to process the claim. You will be notified of a determination no later than 48 hours after the earlier of:

- The claims administrator's receipt of the requested information, or
- The end of the 48-hour period given the physician to provide the additional information.

For pre- and post-service claims, a 15-calendar day extension may be allowed to make a determination, provided that the claims administrator determines that the extension is necessary due to matters beyond its control. If such an extension is necessary, the claims administrator must notify you before the end of the first 15-calendar day or 30-calendar day period of the reason(s) requiring the extension and the date it expects to provide a decision on your claim. If such an extension is necessary due to your failure to submit the information necessary to decide the claim, the notice of extension must also specifically describe the required information. You then have 45 calendar days, from the date of the notice, to provide the information needed to process your claim.

If an extension is necessary for pre- and post-service claims due to your failure to submit necessary information, the benefit plan's time frame for making a benefit determination is suspended from the date the claims administrator sends you an extension notification until the date you respond to the request for additional information.

With respect to pre-service claims, the initial 15-calendar day period ends on the date the notice requesting additional information is sent, and the extension period (i.e., 15 calendar days) within which a decision must be made by the claims administrator will begin to run from the date on which your response is received by the claims administrator (without regard to whether all of the requested information is provided), or, if earlier, the due date established by the claims administrator for furnishing the requested information (at least 45 days).

With respect to post-service claims, if the initial 30-day review period is stopped as a result of the claims administrator timely sending you an extension notice requesting additional information, then any time remaining in the initial review period will be added to the extension period in determining when the claims administrator must render a decision on your claim.

In addition, if you or your authorized representative fail to follow the benefit plan's procedures for filing a pre-service claim, you or your authorized representative must be notified of the failure and the proper procedures to be followed in filing a claim for benefits. This notification must be provided within five (5) days (24 hours in the case of a failure to file a pre-service claim involving urgent care) following the failure. Notification may be oral, unless you or your authorized representative request written notification.

If You Receive an Adverse Benefit Determination

On occasion, the claims administrator may deny all or part of your claim. There are a number of reasons why this may happen. We suggest you first review the explanation of benefits ("EOB") sections then review this Summary Plan Description to see whether you understand the reason for the determination. If all or part of your claim is denied, you will be notified of any adverse benefit determination, which will set forth:

- The specific reason(s) for the adverse benefit determination,
- Reference to the specific benefit plan provisions on which the benefit determination is based,
- A description of any additional material or information needed to process the claim and an explanation of why that material or information is necessary,
- Information sufficient to identify the claim including the date of service, health care provider, claim amount (if applicable), denial codes with their meanings and the standards used. Upon request, diagnosis/treatment codes with their meanings and the standards used are also available,
- In certain situations, a statement in non-English language(s) that written notice of claim denials and certain other benefit information may be available (upon request) in such non-English language(s),
- In certain situations, a statement in non-English language(s) that indicates how to access the language services provided by the claims administrator,
- The right to request, free of charge, reasonable access to and copies of all documents, records and other information relevant to the claim for benefits,
- An explanation of the internal review/appeals and external review processes available to you (and how to initiate an internal review or external review) and applicable time limits, information on any voluntary appeal procedures offered by the benefit plan, and a statement of your right, if any, to bring a civil action under Section 502(a) of ERISA following a final denial on internal review and the timeframe within which such action must be filed,
- Any internal rule, guideline, protocol or other similar criterion relied upon in making the adverse benefit determination, or a statement that a copy of this information will be provided free of charge to you upon request,
- If the adverse benefit determination was based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the adverse determination, applying the terms of the benefit plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request, and
- If the adverse benefit determination concerns a claim involving urgent care, a description of the expedited review process applicable to the claim. An urgent care claim decision may be provided orally, so long as a written notice is provided to you within three (3) days of the oral notification.

If the notification of an adverse benefit determination is **not** provided in accordance with the above procedure, you will be deemed to have exhausted all administrative remedies and may file suit in federal or state court.

Procedures for Appealing an Adverse Benefit Determination

The plan provides for two levels of appeal plus an option to seek External Review of an adverse benefit determination of certain medical claims only.

First Level Appeal

If you receive an adverse benefit determination on your initial claim, and you believe the claims administrator incorrectly denied all or part of your benefits, you may ask for a standard review. You, or your authorized representative, have 180 days following the receipt of a notification of an adverse benefit determination within which to appeal the determination. **Note:** In an urgent care claim situation, a health care provider may appeal on your behalf.

You have the right to:

- Submit written comments, documents, records and other information relating to the claim for benefits,
- Request, free of charge, reasonable access to, and copies of, all documents, records and other information relevant to your claim for benefits. For this purpose, a document, record or other information is treated as relevant to your claim if it:
  - Was relied upon in making the benefit determination,
  - Was submitted, considered or generated in the course of making the benefit determination, regardless of whether such document, record or other information was relied upon in making the benefits determination,

  - Demonstrates compliance with the administrative processes and safeguards required in making the benefits determination, or
  - Constitutes a statement of policy or guidance with respect to the benefit plan concerning the denied treatment option for your diagnosis, regardless of whether such statement was relied upon in making the benefit determination.
- A review that takes into account the substance of the appeal and all comments, documents, records and other information submitted by you related to the claim, regardless of whether the information was submitted or considered in the initial benefit determination,
- A review that does not defer to the initial adverse benefit determination and that is conducted neither by the individual who made the adverse determination, nor by that person's subordinate,
- A review in which the named fiduciary consults with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment, and who was neither consulted in connection with the initial adverse benefit determination, nor the subordinate of any such individual. This applies only if the appeal involves an adverse benefit determination based in whole or in part on a medical judgment (including whether a particular treatment, drug or other item is experimental),
- The qualifications of medical or vocational experts whose advice was obtained in connection with the adverse benefit determination, regardless of whether the advice was relied upon in making the decision,
- In the case of a claim for urgent care, an expedited review process in which:
  - You may submit a request in writing or by a telephone call to Member Services (see your Identification Card for Member Services telephone number) for an expedited appeal of an adverse benefit determination, and
  - All necessary information, including the benefit plan's benefit determination on review, will be transmitted between the benefit plan and you by telephone, facsimile or other available similarly prompt method.

Ordinarily, a decision regarding your appeal will be reached within:

- 36 hours after receipt of your request for review of an urgent care claim,
- 15 calendar days after receipt of your request for review of a pre-service claim, or
- 30 calendar days after receipt of your request for review of a post-service claim.

The claims administrator's notice of adverse benefit determination on a standard review will contain all of the following information:

- The specific reason(s) for the adverse benefit determination,
- References to the specific benefit plan provisions on which the benefit determination is based,
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to your claim,
- A statement describing the procedure for filing a second level appeal,
- Any specific rule, guideline, protocol or other similar criterion relied upon in making the adverse benefit determination; or a statement that a copy of this information will be provided free of charge to you upon request, and
- If the adverse benefit determination was based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the adverse determination, applying the terms of the benefit plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request.

Second Level Appeal

If you receive an adverse benefit determination on your standard review, you may ask for a final standard review. You, or your authorized representative, have 60 days following the receipt of a notification of an adverse benefit determination on your standard review within which to appeal the determination.

This second level of appeal will follow the same timelines and criteria as the first level appeal including a review in which the named fiduciary consults with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment, and who was neither consulted in connection with the initial or standard review adverse benefit determination, nor the subordinate of any such individual. This applies only if the appeal involves an adverse benefit determination based in whole or in part on a medical judgment (including whether a particular treatment, drug or other item is experimental).

You will be notified of any adverse benefit determination after the receipt of a final standard review appeal. The claims administrator's notice of an adverse benefit determination on a final standard review appeal will contain all of the following information:

- The specific reason(s) for the adverse benefit determination,
- References to the specific benefit plan provisions on which the benefit determination is based,
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to your claim,
- A statement describing any voluntary appeal procedures offered by the benefit plan and your right to obtain the information about such procedures, and a statement of your right to bring a civil action under section 502(a) of ERISA,
- Any internal rule, guideline, protocol or other similar criterion relied upon in making the adverse benefit determination; or a statement that a copy of this information will be provided free of charge to you upon request, and
- If the adverse benefit determination was based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the adverse determination, applying the terms of the benefit plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request.

Exhaustion of Process and Legal Actions

You must exhaust all the previous appeal processes before you or your authorized representative may initiate any equitable action, suit of law, arbitration or administrative action for benefits regarding any matter within the scope of the appeal process. Any suit must be brought within one year from the last day (including extensions) that a final decision on the claim could have been provided by the claims administrator or other designated plan representative. Claims against any insurer must be filed within the time limits set forth in the applicable certificate of coverage. Evidence presented in any judicial proceeding will be limited to the documentation and information presented to the claims administrator or Benefits Committee during the claims and appeal process outlined above. Any action under the plan must be brought in the U.S. District Court for the Southern District of Texas.

External Review

With respect to a medical or prescription drug claim, you or your authorized representative may file a voluntary appeal for an external review of any adverse determination of a final standard review claim provided the following are satisfied:

- All prior levels of appeal have been exhausted,
- The request for this external review is received within 123 days after you receive a final standard review adverse determination notice under the standard appeals process, and
- The appeal is based on the claim administrator's determination that the proposed or rendered service or supply is not medically necessary or is experimental or investigational.

If the claims administrator determines your eligibility for an external review after issuing you an adverse determination of a final standard review claim appeal, you will be notified in the written notice of the denial of your appeal.

The filing of a voluntary appeal for an external review will have no effect on your rights to any other benefits under the plan, and you are not required to undertake it prior to pursuing other legal remedies. If you choose not to file for a voluntary review, the plan will not assert that you have failed to exhaust your administrative remedies because of that choice.

"External Review" means a review by an independent physician as chosen by the Independent Review Organization. "Independent Review Organization" (IRO) means the entity with which the claims administrator has contracted to conduct external reviews for the plan.

The independent physician, appointed by the IRO, must be board-certified by the appropriate American medical specialty board in a clinical specialty/area at issue to the external review. The IRO will, among other things, select and credential physician reviewers; assign cases to appropriate physician reviewers; arrange for physician reviewers to conduct external reviews and issue reports on such reviews. The IRO and physician reviewers certify that they have no professional, familial, financial or research affiliation with the claims administrator, you, or the provider who recommended the service or treatment under review.

Within five business days following the date of receipt of the request, the plan administrator must provide a preliminary review as to whether the IRO review is available to you. If available, the plan administrator shall designate an IRO to conduct the review and transmit to the entity all information necessary for the IRO to conduct its review, including information the claims administrator reviewed or relied upon in making its decision on the matter, the relevant plan information, and any additional information you or your authorized representative wishes the IRO to consider.

The IRO will notify you that it has received the external review request and indicate the date that the claims administrator received such request. The IRO must provide written notice of the final external review decision within 45 days of the receipt of an external review request.

Expedited reviews are available when your treating physician certifies the clinical urgency of your situation. "Clinical Urgency" means that a delay (waiting the full 30-calendar day period) in receipt of the service at issue would jeopardize your health. Expedited reviews generally will be decided by the IRO/physician reviewer within 5 calendar days of receipt of such request by the claims administrator.

The IRO will submit the review determination to the claims administrator and you (or your authorized representative, if applicable). It will specify whether the determination is upheld or reversed, and briefly describe the basis for such determination in accordance with plan documents and criteria. The determination of the IRO shall be final and binding upon the claims administrator, you, and the plan.

Clerical Error

If a clerical error or other mistake occurs, that error does not create a right to benefits. These errors include, but are not limited to, providing misinformation on eligibility or benefit coverages or entitlements. It is your responsibility to confirm the accuracy of statements made by the plan administrator or our designees, including the claims administrator, in accordance with the terms of this and other plan documents.

Information and Records

At times the plan administrator or the claims administrator may need additional information from you. You agree to furnish all information and proofs that may reasonably be required regarding any matters pertaining to the plan. If you do not provide this information when it is requested, payment of your benefits may be delayed or denied.

By accepting benefits under the plan, you authorize and direct any person or institution that has provided services to you to furnish the plan or the claims administrator with all information or copies of records relating to the services provided to you. The plan administrator or the claims administrator has the right to request this information at any reasonable time. This applies to all covered persons, including enrolled dependents, whether or not they have signed your enrollment form. The plan administrator and the claims administrator will treat such information and records as confidential information. Any fraudulent statement or omission of fact on an enrollment form or a claim for benefits may result in cancellation or rescission of coverage and/or denial of claims for benefits.

Filing Disability Claims Under the Plan

Time Frame for Initial Claim Determination

If you receive an adverse benefit determination (i.e., any denial, reduction or termination of a benefit, or a failure to provide or make a payment), the claims administrator will notify you of the adverse determination within a reasonable period of time, but not later than 45 days after receiving the claim. This 45-day period may be extended for up to 30 days, if the claims administrator both determines the extension is necessary due to matters beyond the control of the benefit plan, and notifies you, before the initial 45-day period expires, of the reason(s) requiring the extension of time and the date by which the benefit plan expects to render a decision. If, prior to the end of the first 30-day extension period, the claims administrator again determines that, due to matters beyond the control of the benefit plan, a decision cannot be rendered within that extension period, the determination period may be extended for up to an additional 30 days. In such case, the claims administrator must notify you, before the first 30-day extension period expires, of the reason(s) requiring the extension of time and the date by which the benefit plan expects to render a decision.

All extension notices you receive regarding your disability benefits must specifically explain:

- The standards on which entitlement to a benefit is based,
- The unresolved issues that prevent a decision on the claim, and
- The additional information needed to resolve those issues. You have 45 days to provide the specified additional information.

In the event that an extension is necessary due to your failure to submit necessary information, the benefit plan's time frame for making a benefit determination is suspended from the date the claims administrator sends you the extension notification until the date you respond to the request for additional information. If the time frame is stopped as a result of the claims administrator timely sending you an extension notice requesting additional information, then any time remaining in the applicable review period (i.e., the initial 45-day period or either of the 30-day extensions) will be combined in determining when the claims administrator must render a decision on your claim.

If You Receive an Adverse Benefit Determination

The claims administrator will provide you with a notification of any adverse benefit determination, which will set forth:

- The specific reason(s) for the adverse benefit determination,
- Reference to the specific benefit plan provisions on which the benefit determination is based,
- A description of any additional material or information needed to process the claim and an explanation of why that material or information is necessary,
- A description of the benefit plan's appeal procedures and the time limits applicable to those procedures, including a statement of your right to bring a civil action under section 502(a) of ERISA after an appeal of an adverse benefit determination,
- Any internal rule, guideline, protocol or other similar criterion relied upon in making the adverse benefit determination, or a statement that a copy of this information will be provided free of charge to you upon request, and
- If the adverse benefit determination was based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the adverse determination, applying the terms of the benefit plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request.

If the notification of an adverse benefit determination is **not** provided in accordance with the above procedure, you will be deemed to have exhausted all administrative remedies and may file suit in federal or state court, provided such legal action is filed no later than 12 months from the last day (including any extension) that a determination could have been timely provided by the claims administrator.

Procedures for Appealing an Adverse Benefit Determination

You, or your authorized representative, have 180 days following the receipt of a notification of an adverse benefit determination within which to appeal the determination.

You have the right to:

- Submit written comments, documents, records and other information relating to the claim for benefits,
- Request, free of charge, reasonable access to, and copies of, all documents, records and other information relevant to your claim for benefits. For this purpose, a document, record or other information is treated as relevant to your claim if it:
  - Was relied upon in making the benefit determination,
  - Was submitted, considered or generated in the course of making the benefit determination, regardless of whether such document, record or other information was relied upon in making the benefits determination,
  - Demonstrates compliance with the administrative processes and safeguards required in making the benefits determination, or
  - Constitutes a statement of policy or guidance with respect to the benefit plan concerning the denied benefit for your diagnosis, regardless of whether such statement was relied upon in making the benefit determination.
- A review that takes into account all comments, documents, records and other information submitted by you related to the claim, regardless of whether the information was submitted or considered in the initial benefit determination,
- A review that does not defer to the initial adverse benefit determination and that is conducted neither by the individual who made the adverse determination, nor by that person's subordinate,
- If the appeal involves an adverse benefit determination based in whole or in part on a medical judgment, require the named fiduciary to consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment, and who was neither consulted in connection with the initial adverse benefit determination, nor is the subordinate of any such individual, and
- The identification of medical or vocational experts whose advice was obtained in connection with the adverse benefit determination, regardless of whether the advice was relied upon in making the decision.

The claims administrator must notify you of the benefit plan's benefit determination on review within a reasonable period of time, but not later than 45 days after receipt of your request for review by the benefit plan, unless the claims administrator determines that special circumstances require an extension of time. If an extension of time is required, a written notice of the extension must be sent to you before the end of the initial 45-day period. The notice of the extension must indicate the special circumstances and the date by which the claims administrator expects to render the determination on review.

In the event an extension is necessary due to your failure to submit necessary information, the benefit plan's time frame for making a benefit determination on review is suspended from the date the claims administrator sends you the extension notification until the date you respond to the request for additional information.

The claims administrator's notice of adverse benefit determination on appeal will contain all of the following information:

- The specific reason(s) for the adverse benefit determination,
- References to the specific benefit plan provisions on which the benefit determination is based,
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to your claim,
- A statement describing any voluntary appeal procedures offered by the benefit plan and your right to obtain the information about such procedures, and a statement of your right to bring a legal action under section 502(a) of ERISA, provided such legal action is filed no later than 12 months from the last day (including any extension) that a determination could have been timely provided by the claims administrator,
- Any internal rule, guideline, protocol or other similar criterion relied upon in making the adverse benefit determination; or a statement that a copy of this information will be provided free of charge to you upon request, and
- If the adverse benefit determination was based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the adverse determination, applying the terms of the benefit plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request.

You and your benefit plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your state insurance regulatory agency.

Clerical Error

If a clerical error or other mistake occurs, that error does not create a right to benefits. These errors include, but are not limited to, providing misinformation on eligibility or benefit coverages or entitlements. It is your responsibility to confirm the accuracy of statements made by the plan administrator or our designees, including the claims administrator, in accordance with the terms of this and other plan documents.

Information and Records

At times the plan administrator or the claims administrator may need additional information from you. You agree to furnish all information and proofs that may reasonably be required regarding any matters pertaining to the plan. If you do not provide this information when it is requested, payment of your benefits may be delayed or denied.

By accepting benefits under the plan, you authorize and direct any person or institution that has provided services to you to furnish the plan or the claims administrator with all information or copies of records relating to the services provided to you. The plan administrator or the claims administrator has the right to request this information at any reasonable time. This applies to all covered persons, including enrolled dependents, whether or not they have signed your enrollment form. The plan administrator and the claims administrator will treat such information and records as confidential information.

Filing Other Group Benefit Claims Under the Plan

(Applies to Life, AD&PL, OAD&PL, Business Travel Accident and Dependent Care FSA claims)

Time Frame for Initial Claim Determination

If you receive an adverse benefit determination (i.e., any denial, reduction or termination of a benefit, or a failure to provide or make a payment), the claims administrator will notify you of the adverse determination within a reasonable period of time, but not later than 90 days after receiving the claim. This 90-day period may be extended for up to 90 days, if the claims administrator both determines the extension is necessary due to matters beyond the control of the benefit plan, and notifies you, before the initial 90-day period expires, of the reason(s) requiring the extension of time and the date by which the benefit plan expects to render a decision.

If You Receive an Adverse Benefit Determination

The claims administrator will provide you with a notification of any adverse benefit determination, which will set forth:

- The specific reason(s) for the adverse benefit determination,
- Reference to the specific benefit plan provisions on which the benefit determination is based,
- A description of any additional material or information needed to process the claim and an explanation of why that material or information is necessary, and
- A description of the benefit plan's appeal procedures and the time limits applicable to those procedures, including a statement of your right to bring a legal action under section 502(a) of ERISA after an appeal of an adverse benefit determination, provided such legal action is filed no later than 12 months from the last day (including any extension) that a determination could have been timely provided by the claims administrator.

Procedures for Appealing an Adverse Benefit Determination

You, or your authorized representative, have 60 days following the receipt of a notification of an adverse benefit determination within which to appeal the determination.

You have the right to:

- Submit written comments, documents, records and other information relating to the claim for benefits,
- Request, free of charge, reasonable access to, and copies of, all documents, records and other information relevant to your claim for benefits. For this purpose, a document, record or other information is treated as relevant to your claim if it:
  - Was relied upon in making the benefit determination,
  - Was submitted, considered or generated in the course of making the benefit determination without regard to whether it was relied upon,
  - Demonstrates compliance with the plan's administrative processes and safeguards for ensuring consistent decision making, or
  - Constitutes a statement of policy or guidance with respect to the denied benefit for your diagnosis, without regard to whether it was relied upon in making the benefit determination.

The claims administrator must notify you of the benefit plan's benefit determination on review within a reasonable period of time, but not later than 60 days after receipt of your request for review by the benefit plan. This 60-day period may be extended for up to 60 days, if the claims administrator determines that special circumstances require an extension of time. If an extension of time is required, a written notice of the extension must be sent to you before the end of the initial 60-day period. The notice of the extension must indicate the special circumstances and the date by which the claims administrator expects to render the determination on review.

The claims administrator's notice of adverse benefit determination on appeal will contain all of the following information:

- The specific reason(s) for the adverse benefit determination,
- References to the specific benefit plan provisions on which the benefit determination is based,
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to your claim, and
- A statement describing any voluntary appeal procedures offered by the benefit plan and your right to obtain the information about such procedures, and a statement of your right to bring a legal action under section 502(a) of ERISA, provided such legal action is filed no later than 12 months from the last day (including any extension) that a determination could have been timely provided by the claims administrator.

You and your benefit plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your state insurance regulatory agency.

Clerical Error

If a clerical error or other mistake occurs, that error does not create a right to benefits. These errors include, but are not limited to, providing misinformation on eligibility or benefit coverages or entitlements. It is your responsibility to confirm the accuracy of statements made by the plan administrator or our designees, including the claims administrator, in accordance with the terms of this and other plan documents.

Information and Records

At times the plan administrator or the claims administrator may need additional information from you. You agree to furnish all information and proofs that may reasonably be required regarding any matters pertaining to the plan. If you do not provide this information when it is requested, payment of your benefits may be delayed or denied.

By accepting benefits under the plan, you authorize and direct any person or institution that has provided services to you to furnish the plan or the claims administrator with all information or copies of records relating to the services provided to you. The plan administrator or the claims administrator has the right to request this information at any reasonable time. This applies to all covered persons, including enrolled dependents, whether or not they have signed your enrollment form. The plan administrator and the claims administrator will treat such information and records as confidential.

Filing Claims Under the 401(k) Plan

Claim Review

You may appeal a denial by following the instructions in your denial notice or the procedures set forth here.

You or your authorized representative have 90 days from the time you receive the notice to submit a written request for review of the claim to the Review Panel (the Benefits Committee, unless otherwise specified).

Your written request should include a statement explaining why you think the denied claim should have been accepted, all facts in support of your request, and any other matters you think are pertinent. The Review Panel may require you to submit additional facts, documents or other material.

In preparing your request, you may ask to see documents that may affect your claim.

Result of Review

Within 60 days after you file your request for a review (or 120 days if special circumstances require an extension), the Review Panel will notify you in writing of its final decision. The written decision will specify the reasons for the decision, the plan provisions on which it is based, your right to receive access to and copies of all documents, records and other information relevant to your claim, and your right to bring suit.

Further Action

You must exhaust the appeal process, as described above, before taking other legal action regarding the claim.

If you wish to take legal action after exhausting the claims and appeals procedures, and provided legal action is filed no later than 12 months from the last day (including any extension) that a determination could have been timely provided by the claims administrator, such legal process should be served on the Office of General Counsel, Chevron Phillips Chemical Company LP, 10001 Six Pines Drive, The Woodlands, TX 77380. However, if you do not receive the notifications required by law from the Review Panel within the required time periods, you may pursue legal action without any further administrative review of your claim.

For more information, see ***Your ERISA Rights*** on page P-16.

Subrogation

This section applies whenever you or your dependent has recovered from an illness or injury for which another party (including your own insurer under an automobile or other policy) is responsible, and you are in possession of funds from that party related to your or your dependent's illness or injury for which a Chevron Phillips Chemical plan paid benefits related to that illness or injury.

If you or your dependent should receive or become eligible to receive benefits from a Chevron Phillips Chemical plan, an automatic **equitable subrogation lien** attaches to all the rights of recovery and other rights as a result of any claim that you or your dependent may have against any other party. This means that if another person or entity is liable for the injuries, you or your dependent must reimburse the Chevron Phillips Chemical plan in full from the recovery, up to the amount of the plan's payment of benefits plus reasonable costs of collection. This rule applies even if the recovery does not reimburse you or your dependent to the full extent of the loss or injury (i.e., if you or your dependent are not made whole). You or your dependent are not entitled to offset the reimbursement to any Chevron Phillips Chemical plan in the amount of attorneys' fees or for any other reason. State law doctrines and rules, such as the make whole doctrine, the common fund doctrine, the anti-assignment rule or any other state law or rule, will not prevent a Chevron Phillips Chemical plan from recovering 100% of its payment from the proceeds of the recovery.

If you or your dependent believe that another party is responsible for injuries that may also be covered by a Chevron Phillips Chemical plan, you or your dependent are obligated to cooperate with the plan and its agents to protect the Chevron Phillips Chemical plan's equitable subrogation lien and the plan is not obligated to pay benefits unless you or your dependent do all of the following:

- Include any amounts paid under the Chevron Phillips Chemical plan in any claim you or your dependent makes against any party that may be responsible for the injury or illness,
- Notify the Chevron Phillips Chemical plan of any settlement, judgment or recovery before such proceeds are disbursed to any person or entity other than you or your dependent,

- Obtain and hold all proceeds and refrain from disbursing or directing the disbursement of any settlement, judgment or other recovery to which the Chevron Phillips Chemical plan's equitable subrogation lien attaches unless and until the plan has received full restitution and reimbursement of its equitable subrogation lien,
- Make full restitution and reimbursement to the Chevron Phillips Chemical plan of any amount received from the plan that is also paid by another party. You or your dependent must make this reimbursement immediately after the receipt of the payment from the third party, and
- Cooperate fully with the Chevron Phillips Chemical plan in asserting the plan's rights, provide the plan with any and all reasonably required information, and execute any and all instruments that the plan reasonably needs for that purpose.

The costs of legal representation of the plan in matters related to subrogation are borne solely by the plan. The costs of legal representation of you or your dependent must be borne solely by you or your dependent.

Recovery of Excess Payments

Whenever payments were made in excess of the amount necessary to satisfy the provisions of a Chevron Phillips Chemical plan, the plan has the right to recover these payments from any individual (including you), insurance company or other organization to whom the excess payments were made or to withhold payment, if necessary, on future benefits until the overpayment is recovered.

If excess payments were made for services rendered to your dependent(s), the plan has the right to withhold payment of your future benefits until the overpayment is recovered.

Further, whenever payments were made on the basis of fraudulent information provided by you, the plan will exercise all available legal rights, including its right to withhold payment of future benefits, until the overpayment is recovered.

Importance of a Current Address

Because benefit-related information is mailed to you, you need to notify Chevron Phillips Chemical of a change of address. Otherwise, you may not get important information about your benefits. If you are an active employee, you can update your address via MySphere under "Contact Info." If you are not an active employee, call the CPChem Benefits Service Center at 1-833-964-3575 to update your address. If you terminate employment and are entitled to benefits under the benefit program, you must keep the Company informed of your current mailing address. If you do not, the Company may not be able to find you to give you your benefits, and your benefits may be delayed or may be lost altogether.

No Implied Rights to Employment

The adoption and maintenance of these benefit programs does not represent an employment contract between Chevron Phillips Chemical and its employees. Nor does adoption and maintenance of the plans prohibit Chevron Phillips Chemical from discharging any employee at any time, with or without cause, or interfere in any way with an employee's right to terminate at any time, in accordance with state and federal laws.

Your ERISA Rights

As a participant in the Chevron Phillips Chemical health and group benefit and 401(k) plans, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants are entitled to:

- Examine, without charge, all documents governing the plans, including insurance contracts, collective bargaining agreements and copies of all documents filed by the plans with the U.S. Department of Labor, such as detailed annual reports. These are available for your inspection at corporate headquarters and at other specified locations, such as worksites.
- Obtain copies of all plan documents and other plan information on written request to the plan administrator. The administrator may make a reasonable charge for the copies.
- Receive a summary of each plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of the summary annual report.
- Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage.
- Receive a copy of the plan's Qualified Medical Child Support Order and Qualified Domestic Relations Order procedures free of charge from the plan administrator.
- Receive a reduction or elimination of exclusionary periods of coverage for pre-existing conditions under your group health plan, if you have creditable coverage from another plan. You have to provide a certificate of creditable coverage. Without evidence of creditable coverage, you may be subject to a pre-existing condition limitation.
- File suit in a federal court if any materials requested are not received within 30 days of the request, unless the materials were not sent because of matters beyond the plan administrator's control.
- Receive a written explanation if a benefit claim is partially or wholly denied.
- Have a denied claim reviewed and reconsidered.
- File suit in federal or state court if a benefit claim is denied or ignored, provided such legal action is filed no later than 12 months from the last day (including any extension) that a determination could have been timely provided by the claims administrator.

Obligations of Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties on the people who are responsible for the operation of employee benefit plans. The people who operate your plans, called fiduciaries of the plans, have a duty to do so prudently and solely in the interest of you and other plan participants and beneficiaries. The law provides that fiduciaries that violate ERISA requirements may be removed.

Obligations of Employers

No one, including your employer, your union or any other group or person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining plan benefits for which you are eligible or from exercising your rights under ERISA.

Conditions for Legal Action

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from a Chevron Phillips Chemical plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent for reasons beyond the control of the administrator.

If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or federal court, provided such legal action is filed no later than 12 months from the last day (including any extension) that a determination could have been timely provided by the claims administrator. In addition, if you disagree with the plan's decision or lack thereof concerning the Qualified status of a Domestic Relations Order or a Medical Child Support Order, you may file suit in a federal court. If it should happen that the plan fiduciaries misuse the plan's money or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees if, for example, it finds your claim is frivolous.

If you have any questions about any of your benefit plans, you should contact the CPChem Benefits Service Center at 1-833-964-3575.

If you have any questions about this statement or about your rights under ERISA, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210. You also may obtain certain publications about your rights and responsibilities under ERISA by calling the publication hotline — 1-866-444-3272 — of the Employee Benefits Security Administration.

Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. ***Please review it carefully.***

Introduction

The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") is a federal law that, in part, requires group health plans such as the Chevron Phillips Chemical Company LP Health & Welfare Benefit Plan (the "Plan") to take reasonable steps to protect the privacy and security of your protected health information. As a group health plan, HIPAA requires that we provide you with a copy of this Notice of Privacy Practices (the "Notice"), which describes our protected health information privacy practices. We must abide by the terms of this Notice. This Notice applies only to the Plan and the component Benefit Plans, which are medical plans and which provide benefits through the Plan. It does not apply to Chevron Phillips Chemical Company LP or to any other plan or entity.

Protected Health Information

"Protected Health Information" is individually identifiable health information that is maintained or transmitted by the Plan, subject to some exceptions. Individually identifiable health information is health information:

(i) that is created or received by a health care provider, health plan, employer or health care clearinghouse, and

(ii) that is related to your past, present or future physical or mental health or condition, the provision of health care to you, or payment for the provision of health care to you, and

(iii) with respect to which there is a reasonable basis for believing that the information can be used to identify you. Protected health information does not include employment records held by Chevron Phillips Chemical Company LP in its role as an employer.

Uses and Disclosures of Your Protected Health Information Without Your Written Authorization

There are situations in which we are allowed to use and disclose your Protected Health Information without your permission (known as your "authorization"). Those situations include:

Treatment: Treatment is the provision, coordination or management of health care and related services. It also includes, but is not limited to, consultations and referrals between one or more health care providers. For example, the Plan may disclose to a surgeon the name of your primary care physician so that the surgeon may ask for your X-rays from the primary care physician.

Health Care Operations: We may use and disclose your Protected Health Information in order to administer the Plan. For example, we may use and disclose Protected Health Information for purposes of determining plan rates and evaluating plan designs.

Payment: Payment includes, but is not limited to, actions to make coverage determinations and payment (including billing, claims management, subrogation, plan reimbursement, reviews for medical necessity and appropriateness of care and utilization review and preauthorizations). For example, the Plan may tell a doctor whether you are eligible for coverage or what percentage of the bill will be paid by the Plan.

Explanation of Benefits: When we process a claim for benefits under the Plan, we will mail an explanation of benefits ("EOB") to the primary participant at the address we have on file. These EOBs contain Protected Health Information and may be for the claim(s) of the primary participant or dependent(s) of the primary participant covered under the health plan(s).

Disclosure to Plan Sponsor: We may disclose your Protected Health Information to Chevron Phillips Chemical Company LP personnel solely for purposes of administering benefits under the health plan(s). Chevron Phillips Chemical LP agrees not to use or disclose your Protected Health Information other than as permitted or required by the Plan documents and by law. Further, Chevron Phillips Chemical LP cannot use health information obtained from the Plan for any employment-related actions. However, health information collected by Chevron Phillips Chemical LP from other sources, for example, under the Family and Medical Leave Act, Americans with Disabilities Act, or workers' compensation programs is not protected under HIPAA (although this information may be protected under other federal or state laws).

Disclosure to Business Associates: We may disclose your Protected Health Information to "Business Associate(s)" who perform various services to help us administer the Plan. Before we share your Protected Health Information with other organizations, they must agree to protect your Protected Health Information. A "Business Associate" is a person or company who, on our behalf, performs or assists in the performance of a function or activity involving the use or disclosure of Protected Health Information, including, for example, claims processing or administration, data, utilization review, quality assurance, billing, benefit management, etc. A Business Associate also means a person or company who provides services for us, including, for example, legal, actuarial, accounting, consulting, administration, or financial services, and which involves the use and disclosure of Protected Health Information.

Uses and Disclosures Required by Law: We may use or disclose your Protected Health Information where required by local, state or federal law. For example, we must disclose Protected Health Information to the Secretary of Health and Human Services for investigations or determinations related to our compliance with HIPAA.

Public Health Activities: We may disclose your Protected Health Information to authorized public health officials so they may carry out their public health activities. Such activities may include, for example, preventing or controlling disease, injury or disability; reporting births or deaths; or reporting child abuse or neglect.

Victims of Abuse, Neglect, or Domestic Violence: We may disclose your Protected Health Information to a government authority that is authorized to receive reports of abuse, neglect, or domestic violence.

Health Oversight Activities: We may disclose your Protected Health Information to government agencies authorized by law to conduct audits, investigations, inspections, etc. These government agencies monitor the operation of the health care system, government benefit programs (such as Medicare and Medicaid) and compliance with government regulatory programs and civil rights laws.

Judicial and Administrative Proceedings: We may disclose your Protected Health Information if we are ordered to do so by a court that is handling a lawsuit or other dispute. We may also disclose your information in response to a subpoena, discovery request, or other lawful request by someone else involved in the dispute, but only if efforts have been made by the party seeking the information to tell you about the request or to obtain a court order protecting the information from further disclosure.

Law Enforcement: We may disclose your Protected Health Information to law enforcement officials for the following reasons:

- To comply with court orders, subpoenas, or laws that we are required to follow.
- To assist law enforcement officers with identifying or locating a suspect, fugitive, material witness, or missing person.
- To inform law enforcement officers about the victim of a crime.
- If we suspect a death resulted from criminal conduct.
- If necessary to report a crime that occurred on our premises.

Coroners, Medical Examiners and Funeral Directors: We may disclose Protected Health Information about decedents to a coroner or medical examiner. This may be necessary, for example, to determine the cause of death. We may also disclose this information to funeral directors as necessary to carry out their duties.

Cadaveric Organ, Eye and Tissue Donation: We may use or disclose your Protected Health Information to organizations that handle organ procurement or transplantation as necessary to facilitate organ, eye or tissue donation and transplantation.

Certain Limited Research Purposes: We may use or disclose Protected Health Information for certain limited research purposes provided that a waiver of authorization required by HIPAA has been approved by a privacy board.

To Avert a Serious Threat to Health or Safety: We may use or disclose your Protected Health Information when necessary to prevent a serious threat to your health or safety, or the health or safety of another person or the public.

Specialized Government Functions: We may use or disclose your Protected Health Information for specialized government functions such as disclosures deemed necessary by military authorities, correctional institutions, or authorized federal officials for the conduct of national security activities.

Workers' Compensation: We may use or disclose your Protected Health Information for workers' compensation or similar programs that provide benefits for work-related injuries or illness.

Uses and Disclosures Requiring an Opportunity to Agree or Object: In limited circumstances, we may use or disclose Protected Health Information as long as you have the opportunity to agree to, prohibit, or restrict the disclosure of Protected Health Information.

The amount of health information used, disclosed or requested will be limited and, when needed, restricted to the minimum necessary to accomplish the intended purposes, as defined under the HIPAA rules. If the Plan uses or discloses Protected Health Information for underwriting purposes, the Plan will not use or disclose Protected Health Information that is your genetic information for any such purposes.

Uses and Disclosures With Your Written Authorization

Uses and disclosure of Protected Health Information, not described in the Notice, will only be made with your written authorization, unless otherwise permitted by applicable law. Your written authorization is required for most uses and disclosures before the Plan will use or disclose psychotherapy notes (other than summary information about your mental health treatment) about you from your psychotherapist, and for uses and disclosures of Protected Health Information for marketing, and disclosures that constitute a sale of Protected Health Information.

If you provide us with a valid written authorization, you may revoke that authorization at any time, except to the extent that we have already relied on it. Your request to revoke an authorization must be made in writing and you must identify or adequately describe the authorization that is being revoked.

If you revoke your authorization, we will no longer use or disclose your Protected Health Information, unless we are otherwise permitted or required to do so by law or pursuant to another valid authorization from you. Notwithstanding the foregoing, we are unable to rescind any disclosures we have already made pursuant to your authorization. To revoke an authorization, contact the Privacy Officer.

Your Rights Regarding Your Protected Health Information

How Someone May Act on Your Behalf

Parents and guardians will generally have the right to control the privacy of Protected Health Information about minors unless the minors are permitted by law to act on their own behalf.

If, under applicable law, a parent, guardian, or other person has the authority to act on behalf of an individual who is an unemancipated minor in making decisions related to health care, we will treat that person as a personal representative with respect to certain Protected Health Information.

If, under applicable law, a person has the authority to act on behalf of an individual who is an adult or an emancipated minor in making decisions related to health care, such as an authorized legal representative, we will treat that person as a personal representative with respect to certain Protected Health Information.

Right to Request Access to Your Protected Health Information

You have the right to request access to your Protected Health Information in order to inspect and obtain a copy of such Protected Health Information. To request access to inspect or obtain a copy of your Protected Health Information, you must submit your request in writing to the Privacy Officer. We may charge a fee for the costs of copying, mailing, or other supplies we use to fulfill your request, if granted.

Sometimes Business Associates hold the Protected Health Information on behalf of the Plan. If we do not maintain the Protected Health Information that you are requesting and we know where the Protected Health Information is maintained, we will tell you where to direct your request. You may also contact the Business Associates directly.

We may deny your request to inspect or obtain a copy of your Protected Health Information under certain limited circumstances. If we deny part or all of your request, we will provide a written notice that explains our reasons for doing so, and a description of your rights to have that decision reviewed and how you can exercise those rights.

Right to Request an Amendment to Your Records

If you believe that the Protected Health Information we have about you is incorrect or incomplete, you may ask us to amend the Protected Health Information. You have the right to request an amendment for as long as the Protected Health Information is kept in a "Designated Record Set" maintained by us. A "Designated Record Set" is a group of records maintained by or for the Plan that is:

(i) the medical records and billing records about individuals maintained by or for a covered health care provider,

(ii) the enrollment, payment, claims adjudication, and case or medical management record systems maintained by or for the Plan, or

(iii) used, in whole or in part, by or for the Plan to make decisions about individuals.

To request an amendment to your Protected Health Information, you must submit your request in writing to the Privacy Officer.

We may deny your request to amend your Protected Health Information under certain circumstances (for example, because the information was not created by us, unless you can provide us with a reasonable basis to believe that the originator of the Protected Health Information is no longer available to act on your requested amendment). If we deny part or all of your request, we will provide a written notice that explains our reasons for doing so, and a description of your rights to have that decision reviewed and how you can exercise those rights.

Right to Receive an Accounting of Disclosures

You have a right to request an accounting of disclosures about how we have shared your Protected Health Information with others. However, the accounting of disclosures will not include any of the following:

- Disclosures made before April 14, 2003,
- Disclosures related to treatment, payment, or health care operations,
- Disclosures we made to you,
- Disclosures you authorized,
- Disclosures made to federal officials for national security and intelligence activities,
- Disclosures about inmates or detainees to correctional institutions or law enforcement officials,
- Disclosures made more than six years ago (the amount of time we are required to maintain records under HIPAA), or
- Disclosures that were made as part of a limited data set.

We may temporarily suspend your right to receive an accounting of disclosures under certain circumstances, such as when we are requested to do so by a health oversight agency or law enforcement official.

To request this accounting of disclosures, you must submit your request in writing to the Privacy Officer. Your request must state a time period for the disclosures you want us to include. You have a right to one free accounting of disclosures in any 12-month period. However, we may charge you for the cost of providing any additional accounting of disclosures in that same 12-month period. We will notify you of any cost involved so that you may choose to withdraw or modify your request before any costs are incurred.

You have a right to and will receive a notification from the Plan, or a Business Associate of the Plan, if the Plan becomes aware that there has been a loss or disclosure of your unsecured Protected Health Information, in a manner that could compromise the privacy of your health information consistent with HIPAA's standards.

Right to Request Additional Privacy Protections

You have the right to request that we further restrict the way we use and disclose your Protected Health Information for treatment, payment or health care operations. You may also request that we limit how we disclose Protected Health Information about you to someone who is involved in your care or the payment for your care.

NOTE: We are not required to agree to your request for a restriction in all circumstances, and in some cases the restriction you request may not be permitted by law. We are required to agree to your request for a restriction involving Protected Health Information used for Plan payment or health care operations, if you pay the provider in full for the services. Depending on the circumstances, either the Plan or you may have the right to revoke the restriction.

To request restrictions, you must submit your request in writing to the Privacy Officer. Your request must include all of the following information:

(i) what Protected Health Information you want to limit,

(ii) whether you want to limit how we use the Protected Health Information, how we share it with others, or both, and

(iii) to whom you want the limits to apply.

Right to Request Confidential Communications

You have the right to request that we communicate with you about your medical matters in a more confidential way. For example, you may ask that we contact you at home instead of at work. To request more confidential communications, you must submit your request in writing to the Privacy Officer. You must specify in your request how or where you wish to be contacted, however, please note that we are not required to accommodate your request.

How to Obtain a Copy of This Notice

If this Notice has been provided electronically, you also have the right to a paper copy of this Notice. You may request a paper copy at any time by contacting the Privacy Officer or by sending an email to cpcrabenefits@cpchem.com.

How to File a Complaint

If you believe your privacy rights have been violated, you may file a complaint with us or with the Secretary of Health and Human Services. To file a complaint with us, contact the Privacy Officer.

Retaliation and Waiver

We will not intimidate, threaten, coerce, discriminate against, or take other retaliatory action against you (or any other individual) for the exercise of any right established under HIPAA, including filing a complaint with us or with the Secretary of Health and Human Services; testifying, assisting or participating in an investigation, compliance review, proceeding or hearing under HIPAA; or opposing any act or practice made unlawful by HIPAA, provided that you (or the individual) have a good faith belief that the practice opposed is unlawful and the manner of the opposition is reasonable and does not involve a disclosure of Protected Health Information in violation of HIPAA.

We will not require you to waive your privacy rights under HIPAA as a condition of treatment, payment, enrollment in a group health plan(s), or eligibility for benefits.

Changes to This Notice

We reserve the right to change our Privacy Policies and Procedures and this Notice at any time. We reserve the right to make the revised or changed Notice effective for Protected Health Information we already have about you as well as any Protected Health Information we receive in the future. If we change our Privacy Policies and Procedures, we will send you a revised copy of this Notice so that you will have a current summary of our practices.

How to Contact the Privacy Officer

The Privacy Officer is Dolores Lenfest. She may be contacted at 832-813-4994; by e-mail at lenfed@cpchem.com; or in writing at the Office of Compliance Assurance, 10001 Six Pines Drive, The Woodlands, TX 77380.

Additional Information

If you have any questions about this Notice or would like further information, contact the Privacy Officer.

Family and Medical Leave Act of 1993 (FMLA)

You may continue your coverage and coverage for your dependents during a leave of absence in accordance with the Family and Medical Leave Act of 1993 (FMLA). If you continue coverage during such leave:

- Any required employer contributions must continue to be paid by your employer,
- Any required employee contributions must continue to be paid by you to your employer (according to one of the alternatives described in the ***Paying for Coverage During Your Leave*** section on page A-16),
- Any change in benefits that occurs during the period of continuation applies on the effective date of the change,
- Any actively-at-work or hospital confinement requirement is waived, and
- The continuation during a family and medical leave runs concurrent with a continuation during any other leave of absence except COBRA, which is described in the ***How to Continue Coverage*** section beginning on page A-17.

If you do not continue your coverage and your dependents' coverage during such leave:

- You and your dependents are covered without Statement of Health (SOH) on the date you return to work from the leave. For this to happen, you must return to work immediately after the family and medical leave ends,
- Any eligibility waiting period that is not completed is not credited during your leave, and
- Any condition that manifests itself during the leave is not considered a pre-existing condition if you return to work immediately after such leave ends, but not later than three months after your coverage ends.

Qualified Medical Child Support Order (QMCSO)

A QMCSO is a type of court order, usually issued as a part of a settlement agreement or divorce decree, that provides for child support or health care coverage for the child of a plan participant. Your plan honors QMCSOs if they:

- Create, or recognize the existence of, the child's right:
  - To receive benefits for which the participant is eligible under the plan, or
  - To assign those rights.
- Clearly specify the name and last known mailing address of the participant and the name and mailing address of each child covered by the court order,
- Provide a reasonable description of the type of coverage to be provided by the plan to each child or the manner in which the type of coverage is to be determined, and
- Specify each plan to which the court order applies and the period to which it applies.

The court order may not require a plan to provide any type or form of benefit, or any option, not otherwise provided under the plan.

The term **alternate recipient** means any child of a participant who is recognized under a Medical Child Support Order as having a right to enrollment under a group health plan.

When a plan administrator receives a Medical Child Support Order, the following steps must be taken:

- Notify both the participant and each alternate recipient of the receipt of the order,
- Furnish an explanation of the plan's procedures for determining whether the court order is a QMCSO,
- Determine if the court order is qualified, and
- Notify the participant and each alternate recipient of the determination.

On receipt of the Medical Child Support Order, the plan administrator will determine whether it qualifies as a QMCSO. If it does not qualify as a QMCSO, the plan administrator will specify the modifications required.

Qualified Domestic Relations Order (QDRO)

Benefits accrued by participants under the Chevron Phillips Chemical LP 401(k) Savings and Profit-Sharing Plan ("Savings Plan") can be considered divisible property by a court in a divorce, child support or similar proceeding.

In order for a participant's spouse, former spouse or dependent ("Alternate Payee") to receive a portion (or all) of a participant's benefits in the Savings Plan for the satisfaction of marital property rights, alimony or child support, a Domestic Relations Order ("DRO" or "Order") must first be issued by the court. For an Order to be effective it must meet certain requirements under the Internal Revenue Code and ERISA (i.e., it must be "Qualified").

QDRO Preparation

Before any payments can be made pursuant to a QDRO, the plan administrator must have a QDRO that gives sufficient instruction on how to divide and pay the benefit. Not all court orders are QDROs. The QDRO must specify the names, addresses and Social Security numbers of the divorcing parties, the exact name of the benefit plan, and a formula or method for dividing benefits. If a divorce decree contains these essential elements, it may be accepted as a QDRO.

Fidelity Investments provides all QDRO administration for the Chevron Phillips Chemical 401(k) Savings Plan. As part of Fidelity's QDRO administration services, participants, Alternate Payees or their attorneys can use the Fidelity QDRO Center website ("QDRO Center"), a fully secure internet website, to create an Order online which can then be submitted to a court of competent jurisdiction for execution and thereafter forwarded to Fidelity for qualification review. For security and privacy reasons, this online application does not interface with any other online Fidelity benefits websites and applications. Therefore, there is no access to any participant account or benefits information via the QDRO Center.

The QDRO Center features informative Frequently Asked Questions (FAQ's), a glossary of QDRO-related terms, plan QDRO Guidelines and Procedures ("QDRO Guidelines") and helpful text for more complex issues. Fidelity will work with the parties to answer general QDRO-related questions. It is important, however, that all parties should consult with appropriate legal counsel for details relative to the substance of any QDRO.

Simple Steps to Prepare and Submit a Web-Generated Order:

- Visit the QDRO Center at http://qdro.fidelity.com,
- Register as a user and log in,
- Choose the applicable plan name and fill out the Order,
- Review the Order, print and file with the court, and
- Forward a court-executed and certified copy of the Order to Fidelity at:

  Fidelity Employer Services Company LLC
  QDRO Administration Group
  P.O. Box 770003
  Cincinnati, OH 45277-0066
  ATTN: Chevron Phillips Chemical Company LP

An Order Review Fee will be assessed on the participant and/or Alternate Payee for Savings Plan Orders submitted for qualification review. This fee will be charged to the applicable Savings Plan Account(s) of the participant and/or the Alternate Payee in accordance with the QDRO Guidelines. The Order Review Fees are currently:

- **$300** for the review of Orders generated via the QDRO Center **with no material modifications**,
- **$1,200** for the review of Orders **not** generated via the QDRO Center, and
- **$1,200** for the review of Orders generated via the QDRO Center **but then materially altered**.

QDRO Payments

Any payment awarded under a QDRO is calculated according to directives in the QDRO. A record is established in the name and Social Security number of the spouse or former spouse. If the spouse or former spouse is also an employee of the Company and already has a 401(k) account balance, a separate account is established for purposes of complying with the QDRO. Assets are then transferred from the participant's account to the spouse's or former spouse's account.

The participant is notified in writing of the amount and effective date of the 401(k) asset transfer. The spouse or former spouse receives a personal identification number (PIN) to access his or her 401(k) account, along with applicable tax information and instructions on how to request a distribution.

The spouse's or former spouse's account must be credited with the full amount of the benefit as soon as administratively possible once his or her account is established, unless the QDRO provides otherwise. A QDRO distribution to a spouse or former spouse is eligible for a partial or complete rollover to an Individual Retirement Account (IRA) or another qualified plan.

Taxes on QDRO Payments

QDRO payments are subject to taxation in a similar manner as distributions to plan participants. Thus, if a spouse receives a distribution pursuant to a QDRO, portions of it will be taxed as ordinary income. The spouse or former spouse is urged to consult a financial planner or tax advisor before receiving a QDRO distribution.

Plan Information

The following information is provided for the Chevron Phillips Chemical health and group benefit plans:

- Employer/plan sponsor: Chevron Phillips Chemical Company LP, 10001 Six Pines Drive, The Woodlands, TX 77380
- Plan administrator: Chevron Phillips Chemical Company LP Benefits Committee, 10001 Six Pines Drive, The Woodlands, TX 77380; phone: 1-833-964-3575
- Claims administrators: See pages P-28 – P-29
- Agent for service of legal process: Office of General Counsel, Chevron Phillips Chemical Company LP, 10001 Six Pines Drive, The Woodlands, TX 77380. Legal process may also be served on plan trustees and/or the plan administrator.
- Employer ID number: 73-1587712
- Plan numbers: See pages P-28 – P-29
- Plan year ends: December 31

The following information is provided for the Chevron Phillips Chemical Company LP 401(k) Savings and Profit-Sharing Plan:

- Employer/plan sponsor: Chevron Phillips Chemical Company LP, 10001 Six Pines Drive, The Woodlands, TX 77380
- Plan administrator: Chevron Phillips Chemical Company LP Benefits Committee, 10001 Six Pines Drive, The Woodlands, TX 77380; phone: 1-833-964-3575
- Recordkeeper: Fidelity Investments Institutional Services Company, Inc., 82 Devonshire St., Boston, MA 02109; phone: 1-866-771-5225
- Employer ID number: 73-1587712
- Plan number: 001
- Plan year ends: December 31
- Source of funding: Employee and employer contributions
- Plan trustee: Fidelity Management Trust, Inc., 82 Devonshire St., Boston, MA 02109; phone: 1-866-771-5225
- Agent for service of legal process: Office of General Counsel, Chevron Phillips Chemical Company LP, 10001 Six Pines Drive, The Woodlands, TX 77380. Legal process may also be served on the plan trustee or plan administrator.

Benefit Administrators and Claims Payers

Chevron Phillips Chemical has contracts with benefit administrators and claim payers. These providers are independent contractors, and Chevron Phillips Chemical is not responsible for any acts or omissions of any of these organizations, their providers or independent contractors, including the quality of goods and services provided through any health care provider or program.

Benefits Service Center (Enrollment and Benefits Questions)

Phone: 1-833-964-3575

Fax: 1-833-933-2879

Mail: DEPT 14613
P.O. Box 64050
The Woodlands, TX 77387-4050

Website: digital.alight.com/cpchem

Benefits Service Center (Dependent Verification)

Phone: 1-800-725-5810

Fax: 1-877-965-9555

Mail: Dependent Verification Center
P.O. Box 1401
Lincolnshire, IL 60069-1401

Website: digital.alight.com/cpchem

Plan Phone Numbers and Websites

Note: The vendor websites listed below are also accessible through the Chevron Phillips Chemical Intranet/Extranet at www.mycpchembenefits.com.

Plan Name	Vendor Phone Number/Website
Medical Plan	1-800-240-6430 www.bcbstx.com
Prescription Drug Plan	1-855-305-3028 www.caremark.com
Behavioral Health	1-800-528-7264 www.bcbstx.com
MDLIVE	1-888-680-8646 www.mdlive.com/bcbstx
Employee Assistance Program (EAP)	1-866-799-2691 healthadvocate.com/cpchem
Critical Illness Plan	1-800-438-6388 digital.alight.com/cpchem
Dental Plan	1-800-269-5314 www.aetna.com
Vision PLUS Plan	1-800-877-7195 www.vsp.com
Flexible Spending Accounts	1-888-678-8242 www.inspirafinancial.com
Health Savings Account (HSA)	1-866-771-5225 www.netbenefits.com
Retiree Reimbursement Account (RRA)	1-888-678-8242 www.inspirafinancial.com
AARP Medicare Supplement Plans	1-800-392-7537 www.aarphealthcare.com (CPChem Group #845)
Basic and Supplemental Life Insurance Plans	1-833-964-3575 digital.alight.com/cpchem
Basic and Supplemental Accidental Death and Personal Loss (AD&PL) Plans	1-833-964-3575 digital.alight.com/cpchem
Occupational Accidental Death and Personal Loss (OAD&PL) Plan	1-833-964-3575 digital.alight.com/cpchem
Business Travel Accident Plan	1-833-964-3575 digital.alight.com/cpchem
Long-Term Disability (LTD) Plan	1-833-964-3575 digital.alight.com/cpchem
Group Legal Plan	1-800-821-6400 info.legalplans.com (Access code: GETLAW)
401(k) Savings and Profit-Sharing Plan	1-866-771-5225 www.netbenefits.com
Edelman Financial Engines Investment Advice	1-800-601-5957 www.financialengines.com/forcpchem

Plan Facts and Financing

Note: The vendor websites listed in this section are also accessible through the Chevron Phillips Chemical Intranet/Extranet at www.mycpchembenefits.com.

The benefit plans listed below are funded by direct payments by the Company and/or employee contributions. These payments are made to and held by the Chevron Phillips Chemical Company LP Health and Welfare Benefit Plan Trust, plan 501; the plan trustee is Bank of New York Mellon Trust Company, N.A., 700 South Flower Street, Suite 200, Los Angeles, CA 90017.

Official Plan Name	Plan Type	Funding	Claims Assistance and Administration
Chevron Phillips Chemical Company LP Medical Plan	Group medical benefit plan	Self-funded by employee and Company contributions	Blue Cross and Blue Shield of Texas Appeals Coordinator P.O. Box 660044 Dallas, TX 75266-0044 1-800-240-6430 www.bcbstx.com
Chevron Phillips Chemical Company LP Prescription Drug Plan	Group prescription drug benefit plan	Self-funded by employee and Company contributions	CVS Caremark Appeals Department P.O. Box 52084 Phoenix, AZ 85072-2084 1-855-305-3028 www.caremark.com
Chevron Phillips Chemical Company LP Employee Assistance Program	Group counseling benefit plan	Fully insured and funded by Company contributions	Health Advocate 3043 Walton Road Plymouth Meeting, PA 19462 1-866-799-2691 healthadvocate.com/cpchem
Chevron Phillips Chemical Company LP Dental Plan	Group dental benefit plan	Self-funded by employee and Company contributions	Aetna P.O. Box 14094 Lexington, KY 40512-4094 1-800-269-5314 www.aetna.com
Chevron Phillips Chemical Company LP Vision Plan	Group vision benefit plan	Funded by employee contributions	VSP 3333 Quality Drive Rancho Cordova, CA 95670 1-800-877-7195 www.vsp.com
Chevron Phillips Chemical Company LP Health Care Flexible Spending Account and Limited-Purpose Flexible Spending Account Programs	IRS Section 125 reimbursement account	Funded by employee contributions	Inspira Financial P.O. Box 2495 Omaha, NE 68103 1-888-678-8242 www.inspirafinancial.com
Chevron Phillips Chemical Company LP Retiree Medical Reimbursement Account Plan	Retiree medical benefits	Funded by Company contributions	Inspira Financial P.O. Box 2495 Omaha, NE 68103 1-888-678-8242 www.inspirafinancial.com

The following benefit plans — plan 502 — are funded by Company and/or employee contributions and administered as noted.

Official Plan Name	Plan Type	Funding	Claims Assistance and Administration
Chevron Phillips Chemical Company LP Critical Illness Plan	Group critical illness benefit plan	Funded by employee contributions	MetLife P.O. Box 6120 Scranton, PA 18505-9972 1-833-964-3575 digital.alight.com/cpchem
Chevron Phillips Chemical Company LP Basic Life Insurance Plan	Group life benefit plan	Fully funded by Company contributions	MetLife Group Life Claims P.O. Box 6100 Scranton, PA 18505 1-833-964-3575 digital.alight.com/cpchem
Chevron Phillips Chemical Company LP Supplemental Life Insurance Plan	Group life benefit plan	Fully funded by employee contributions	MetLife Group Life Claims P.O. Box 6100 Scranton, PA 18505 1-833-964-3575 digital.alight.com/cpchem
Chevron Phillips Chemical Company LP Basic Accidental Death and Personal Loss Plan	Group benefit plan	Fully funded by Company contributions	MetLife Group Life Claims P.O. Box 6100 Scranton, PA 18505 1-833-964-3575 digital.alight.com/cpchem
Chevron Phillips Chemical Company LP Occupational Accidental Death and Personal Loss Plan	Group benefit plan	Fully funded by Company contributions	MetLife Group Life Claims P.O. Box 6100 Scranton, PA 18505 1-833-964-3575 digital.alight.com/cpchem
Chevron Phillips Chemical Company LP Supplemental Accidental Death and Personal Loss Plan	Group benefit plan	Fully funded by employee contributions	MetLife Group Life Claims P.O. Box 6100 Scranton, PA 18505 1-833-964-3575 digital.alight.com/cpchem
Chevron Phillips Chemical Company LP Business Travel Accident Plan	Group benefit plan	Fully funded by Company contributions	MetLife Group Life Claims P.O. Box 6100 Scranton, PA 18505 1-833-964-3575 digital.alight.com/cpchem
Chevron Phillips Chemical Company LP Long-Term Disability Plan	Group benefit plan	Fully funded by Company contributions	MetLife Disability Unit P.O. Box 14590 Lexington, KY 40511 1-833-964-3575 digital.alight.com/cpchem
Chevron Phillips Chemical Company LP Group Legal Plan	Group benefit plan	Fully funded by employee contributions	MetLife Legal Plans 1111 Superior Ave. Cleveland, OH 44114 1-800-821-6400 info.legalplans.com (Access code: GETLAW)

The following non-ERISA benefit plans are funded by Company and/or employee contributions and administered as noted.

Official Plan Name	Plan Type	Funding	Claims Assistance and Administration
Chevron Phillips Chemical Company LP Health Savings Account	Individual Health Savings Account	Funded by Company and employee contributions	Fidelity Investments 82 Devonshire Street Boston, MA 02109 1-866-771-5225 www.netbenefits.com
Chevron Phillips Chemical Company LP Flexible Benefits Plan	IRS Section 125 premium conversion program and dependent care reimbursement	Funded by employee contributions	Inspira Financial P.O. Box 2495 Omaha, NE 68103 1-888-678-8242 www.inspirafinancial.com

Rates for Imputed Income

According to federal tax law, up to the first $50,000 of Company-provided life insurance is available tax-free. But, once the face amount of your life insurance coverage grows larger than $50,000, the Internal Revenue Service (IRS) says that the value of the Company-provided insurance is taxable to you. The value of coverage over $50,000 is commonly called imputed income and is added to your taxable pay.

The IRS table used for calculating imputed income is provided below for reference.

IRS Imputed Income Table	
Age	**Monthly Cost per $1,000**
Under 25 years	$0.05
25 to 29 years	$0.06
30 to 34 years	$0.08
35 to 39 years	$0.09
40 to 44 years	$0.10
45 to 49 years	$0.15
50 to 54 years	$0.23
55 to 59 years	$0.43
60 to 64 years	$0.66
65 to 69 years	$1.27
70 years or above	$2.06
Note: Your age at the **end** of the year applies to the calculation of your imputed income for the whole year.	

Legal Notices

Important Health Care Reform Notices

Choice of Provider

If your BlueCross BlueShield plan generally requires or allows the designation of a primary care provider, you have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. If the plan or health insurance coverage designated a primary care provider automatically, then until you make this designation, BlueCross BlueShield designates one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact your employer, or if you are a current member, your BlueCross BlueShield contact number on the back of your ID card.

If your BlueCross BlueShield plan allows for the designation of a primary care provider for a child, you may designate a pediatrician as the primary care provider.

If your BlueCross BlueShield plan provides coverage for obstetric or gynecological care and requires the designation of a primary care provider then you do not need prior authorization from BlueCross BlueShield or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care

professionals who specialize in obstetrics or gynecology, contact your employer or, if you are a current member, your BlueCross BlueShield contact number on the back of your ID card.

Women's Health and Cancer Rights Act of 1998

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 ("WHCRA"). For participants and beneficiaries receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed,
- Surgery and reconstruction of the other breast to produce a symmetrical appearance,
- Prostheses, and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and co-insurance applicable to other medical and surgical benefits provided under the medical options of the Chevron Phillips Chemical Medical Plan.

If you would like more information on WHCRA benefits, call the CPChem Benefits Service Center at 1-833-964-3575.

Notice of Creditable Coverage

(for employees eligible for Medicare — over-65 employees and certain disabled employees)

Please read this notice carefully. It has information about prescription drug coverage available under Chevron Phillips Chemical's medical plans and prescription drug coverage available for people with Medicare. It also tells you where to find more information to help you make decisions about your prescription drug coverage.

You may have heard about Medicare's prescription drug coverage (called Part D), and wondered how it would affect you. Prescription drug coverage is available to everyone with Medicare through Medicare prescription drug plans. All Medicare prescription drug plans provide at least a standard level of coverage set by Medicare. Some plans also offer more coverage for a higher monthly premium.

Individuals can enroll in a Medicare prescription drug plan when they first become eligible, and each year from October 15 through December 7. Individuals leaving employer/union coverage may be eligible for a Medicare Special Enrollment Period.

If you are covered by a Chevron Phillips Chemical medical plan, you'll be interested to know that the prescription drug coverage under our plans is, on average, at least as good as standard Medicare prescription drug coverage for 2024. This is called creditable coverage. Coverage under these plans will help you avoid a late Part D enrollment penalty if you are or become eligible for Medicare and later decide to enroll in a Medicare prescription drug plan.

If you decide to enroll in a Medicare prescription drug plan and you are an active employee or family member of an active employee, you may also continue your employer coverage. In this case, the Chevron Phillips Chemical medical plan will continue to pay primary or secondary as it had before you enrolled in a Medicare prescription drug plan. If you waive or drop Chevron Phillips Chemical coverage, Medicare will be your only payer. You can re-enroll in the Chevron Phillip Chemical plan only during the annual benefits enrollment period or if you have a Special Enrollment event for the Chevron Phillips Chemical plan.

You should know that if you waive or leave coverage with Chevron Phillips Chemical and you go 63 days or longer without creditable prescription drug coverage (once your applicable Medicare enrollment period ends), your monthly Part D premium will go up at least 1% per month for every month that you did not have creditable coverage. For example, if you go 19 months without coverage, your Medicare prescription drug plan premium will always be at least 19% higher than what most other people pay. You'll have to pay this higher premium as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to enroll in Part D.

If you are no longer an active employee and you and/or your spouse are over age 65, Chevron Phillips Chemical no longer provides medical plan coverage including prescription drug coverage and you should enroll in Medicare and a Medicare prescription drug plan.

For more information about this notice or your current prescription drug coverage...

Contact the CPChem Benefits Service Center at 1-833-964-3575. **Note:** You'll get this notice each year. You may receive this notice at other times in the future — such as before the next period you can enroll in Medicare prescription drug coverage, if Chevron Phillips Chemical's coverage changes, or upon your request.

For more information about your options under Medicare prescription drug coverage…

More detailed information about Medicare plans that offer prescription drug coverage is in the *Medicare & You* handbook. Medicare participants will get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare prescription drug plans. Here's how to get more information about Medicare prescription drug plans:

- Visit www.medicare.gov for personalized help.
- Call your State Health Insurance Assistance Program (see a copy of the *Medicare & You* handbook for the telephone number).
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

For people with limited income and resources, extra help paying for a Medicare prescription drug plan is available. Information about this extra help is available from the Social Security Administration (SSA). For more information about this extra help, visit SSA online at www.socialsecurity.gov or call 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this creditable coverage notice. If you enroll in a Medicare prescription drug plan after your applicable Medicare enrollment period ends, you may need to provide a copy of this notice when you join a Part D plan to show that you are not required to pay a higher Part D premium amount.

For more information about this notice or your prescription drug coverage, contact:

Chevron Phillips Chemical Company
Health Plan Administrator
10001 Six Pines Drive
The Woodlands, TX 77380

Phone: 832-813-4100

Newborns' and Mothers' Health Protection Act

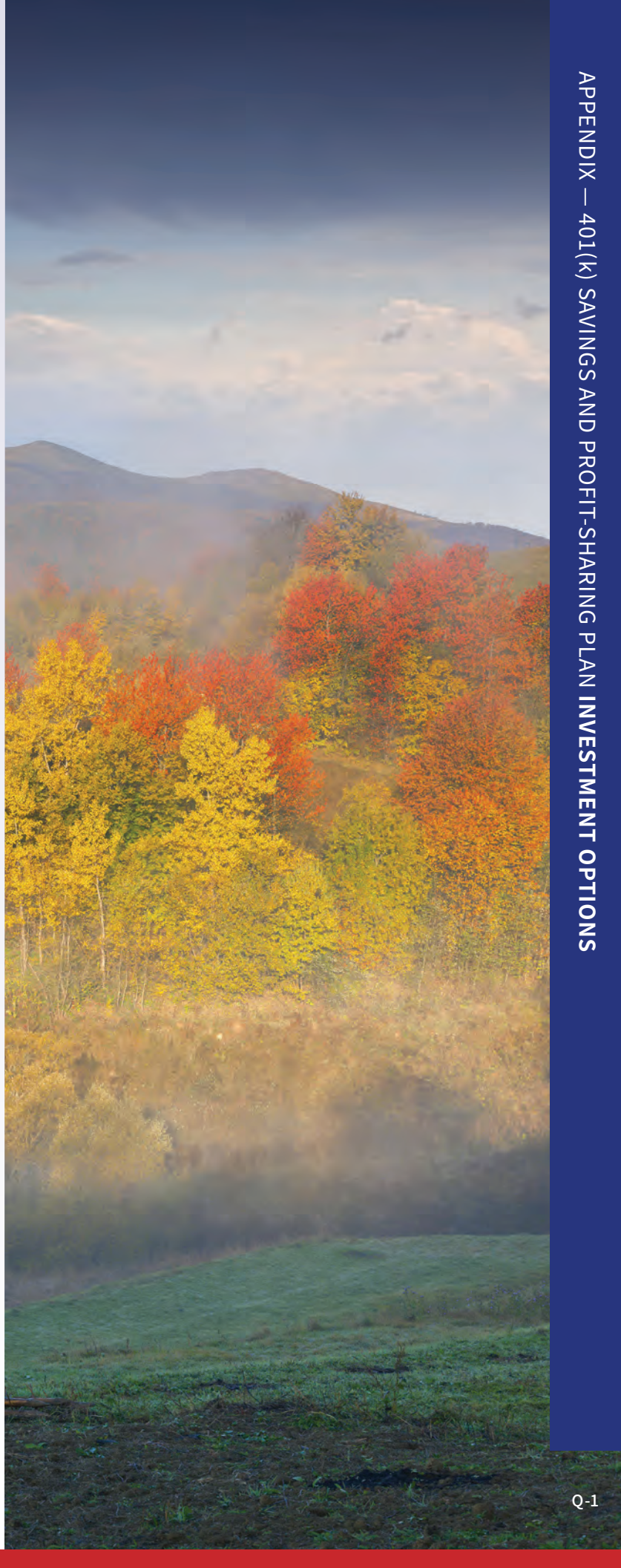
Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours, as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

If you would like more information about maternity benefits, please contact your plan administrator.

(Performance Pipe Hourly Employees)

Appendix — 401(k) Savings and Profit-Sharing Plan Investment Options (Effective as of March 31, 2024)

Contents



Spectrum of Plan Investment Options

Target Date Funds

Investment options to the **left** have potentially more inflation risk and less investment risk

Investment options to the **right** have potentially less inflation risk and more investment risk

Lifecycle Funds

LifePath® Index Retirement Non-Lendable Fund M
LifePath® Index 2025 Non-Lendable Fund M
LifePath® Index 2030 Non-Lendable Fund M
LifePath® Index 2035 Non-Lendable Fund M
LifePath® Index 2040 Non-Lendable Fund M
LifePath® Index 2045 Non-Lendable Fund M
LifePath® Index 2050 Non-Lendable Fund M
LifePath® Index 2055 Non-Lendable Fund M
LifePath® Index 2060 Non-Lendable Fund M
LifePath® Index 2065 Non-Lendable Fund M

Target date investments are represented on a separate spectrum because they are generally designed for investors expecting to retire around the year indicated in each investment's name. The investments are managed to gradually become more conservative over time. The investment risks of each target date investment change over time as its asset allocation changes. They are subject to the volatility of the financial markets, including equity and fixed income investments in the U.S. and abroad and may be subject to risks associated with investing in high yield, small cap and foreign securities. Principal invested is not guaranteed at any time, including at or after their target dates.

Category Funds

Investment options to the **left** have potentially more inflation risk and less investment risk

Investment options to the **right** have potentially less inflation risk and more investment risk

Conservative → **Aggressive**

Money Market	Stable Value	Bond	Domestic Equities			International/ Global	Specialty	Company Stock
Government Vanguard Federal Money Market Fund Investor Shares	Galliard Stable Return Fund C	**Diversified** Dodge & Cox Income Fund Class I Vanguard Total Bond Market Index Fund Institutional Plus Shares **Inflation-Protected** Vanguard Short-Term Inflation-Protected Securities Index Fund Institutional Shares	**Large Value** Spartan® Large Cap Value Index Pool Class D	**Large Blend** Spartan® 500 Index Pool Class D **Mid Blend** Spartan® Extended Market Index Pool Class D	**Large Growth** Fidelity® Contrafund® Commingled Pool Class A **Mid Growth** Snyder Capital Small/Mid Cap Value Collective Investment Fund – R2 William Blair Small Mid Cap Growth CIT – Class III	**Diversified** Spartan® Global ex U.S. Index Pool Class D Invesco International Growth Trust – Class I	Vanguard Real Estate Index Fund Institutional Shares	Chevron Corporation Stock Fund* ConocoPhillips Stock Fund* Phillips 66 Stock Fund*

This spectrum, with the exception of the Domestic Equity category, is based on Fidelity's analysis of the characteristics of the general investment categories of the investment options and not on the actual security holdings, which can change frequently. Investment options in the Domestic Equity category are based on the options' Morningstar categories as of 12/31/2023. Morningstar categories are based on a fund's style as measured by its underlying portfolio holdings over the past three years and may change at any time. These style calculations do not represent the investment options' objectives and do not predict the investment options' future styles. Investment options are listed in alphabetical order within each investment category. Risk associated with the investment options can vary significantly within each particular investment category, and the relative risk of categories may change under certain economic conditions. For a more complete discussion of risk associated with the mutual fund options, please read the prospectuses before making your investment decisions. The spectrum does not represent actual or implied performance.

* The Chevron Corporation Stock Fund, the ConocoPhillips Stock Fund, and the Phillips 66 Stock Fund are frozen to new contributions and exchanges-in. These investment options are neither mutual funds nor diversified or managed investment options.

Fund Descriptions

The following are descriptions that are intended to provide an overview of your investment options available under the plan. For more detailed information, please read the prospectus (with respect to mutual funds) or fact sheets/similar documentation (with respect to collective trust funds).

Fund Name	Description
Chevron Corporation Stock Fund	**Ticker:** N/A **What It Is:** A fund that allows you to own shares of stock of Chevron Corporation (CVX). Your ownership is measured in shares of the fund. This is neither a mutual fund nor a diversified or managed investment option. **Goal:** Seeks to increase the value of your investments over the long term by investing in CVX common stock. **What it invests in:** The value of your investment will vary depending on the performance of CVX and the overall stock market. Investing in a nondiversified single stock fund involves more risk than investing in a diversified fund. Share price and return will vary. **Short-term Redemption Fee Note:** None **Who may want to invest:** Someone who wants to own an individual stock and share in its gains or losses. Someone whose investment portfolio can withstand the higher risk of investment in a single stock. **Footnotes:** Chevron Phillips Chemical Company LP provided the description for this fund.
ConocoPhillips Stock Fund	**Ticker:** N/A **What It Is:** A fund that allows you to own shares of stock of ConocoPhillips (COP). Your ownership is measured in shares of the fund. This is neither a mutual fund nor a diversified or managed investment option. **Goal:** Seeks to increase the value of your investments over the long term by investing in COP common stock. **What it invests in:** The value of your investment will vary depending on the performance of COP and the overall stock market. Investing in a nondiversified single stock fund involves more risk than investing in a diversified fund. Share price and return will vary. **Short-term Redemption Fee Note:** None **Who may want to invest:** Someone who wants to own an individual stock and share in its gains or losses. Someone whose investment portfolio can withstand the higher risk of investment in a single stock. **Footnotes:** Chevron Phillips Chemical Company LP provided the description for this fund.

(continued)

Fund Name	Description
Dodge & Cox Income Fund Class I	**Ticker:** DODIX **Objective:** The investment seeks a high and stable rate of current income, consistent with long-term preservation of capital; a secondary objective is capital appreciation. **Strategy:** The fund invests in a diversified portfolio of bonds and other debt securities. The fund will invest at least 80% of its total assets in (1) investment-grade debt securities and (2) cash equivalents. "Investment grade" means securities rated Baa3 or higher by Moody's Investors Service, or BBB- or higher by Standard & Poor's Ratings Group or Fitch Ratings, or equivalently rated by any nationally recognized statistical rating organization, or, if unrated, deemed to be of similar quality by Dodge & Cox. **Risk:** In general the bond market is volatile, and fixed income securities carry interest rate risk. (As interest rates rise, bond prices usually fall, and vice versa. This effect is usually more pronounced for longer-term securities.) Fixed income securities also carry inflation risk and credit and default risks for both issuers and counterparties. Unlike individual bonds, most bond funds do not have a maturity date, so avoiding losses caused by price volatility by holding them until maturity is not possible. The fund may invest in lower-quality debt securities that involve greater risk of default or price changes due to potential changes in the credit quality of the issuer. Foreign securities are subject to interest-rate, currency-exchange-rate, economic, and political risks, all of which may be magnified in emerging markets. Additional risk information for this product may be found in the prospectus or other product materials, if available. **Short-term redemption fee:** None **Who may want to invest:** Someone who is seeking potential returns primarily in the form of interest income rather than through an increase in share price; Someone who is seeking to diversify an equity portfolio with a more conservative investment option. **Footnotes:** This description is only intended to provide a brief overview of the mutual fund. Read the fund's prospectus for more detailed information about the fund.
Fidelity® Contrafund® Commingled Pool Class A	**Ticker:** N/A **Objective:** The portfolio's investment objective is to seek to provide capital appreciation over a market cycle relative to the S&P 500 Index, through the active management of equities with a focus on companies having strong long-term growth prospects. **Strategy:** The portfolio's investment philosophy is to capitalize on the strength of Fidelity's internal research by selecting those stocks whose value the manager believes is not fully recognized by the public. The portfolio may invest in domestic and foreign issuers in either "growth" or "value" stocks or both. **Risk:** The value of the fund's domestic and foreign investments will vary from day to day in response to many factors. Stock values may fluctuate in response to the activities of individual companies, and general market and economic conditions, and the value of an individual security or particular type of security can be more volatile than, or can perform differently from, the market as a whole. Investments in foreign securities involve greater risk than U.S. investments, including increased political and economic risk, as well as exposure to currency fluctuations. You may have a gain or loss when you sell your units. **Short-term redemption fee:** None **Who may want to invest:** Someone who is seeking the potential for long-term share-price appreciation; Someone who is willing to accept the generally greater price volatility associated with growth-oriented stocks. **Footnotes:** The Fidelity® Contrafund® Commingled Pool Class A is a collective investment trust maintained under the Fidelity Group Trust for Employee Benefit Plans, and is managed by Fidelity Management Trust Company (FMTC). It is not insured by the FDIC. This description is only intended to provide a brief overview of this investment option, which is available only to eligible retirement plans and is not offered to the general public. S&P 500 Index is a market capitalization-weighted index of 500 common stocks chosen for market size, liquidity, and industry group representation to represent U.S. equity performance. This investment option is not a mutual fund.

(continued)

Fund Name	Description
Galliard Stable Return Fund C	**Ticker:** N/A **Objective:** The Fund seeks safety of principal and consistency of returns while attempting to maintain minimal volatility. The Fund is designed for investors seeking more income than money market funds without the price fluctuation of stock or bond funds. **Strategy:** The Fund's underlying fixed income strategy is managed in a conservative style that utilizes a disciplined value investing process to build a high quality portfolio with broad diversification and an emphasis on risk management. The core investment philosophy is to build a portfolio of realizable yield through bottom-up, fundamental research, utilizing a team-based approach to portfolio management. Galliard's fixed income portfolios emphasize high quality spread sectors, diversification across sectors and issuers to reduce risk, neutral duration positioning, and a laddered portfolio structure for ample natural liquidity. The majority of the Fund's assets will be invested in fixed income portfolios that are wrapped by stable value contracts which allow Fund participants to transact at book value. The Fund will hold cash in order to maintain sufficient liquidity, and may also invest in traditional GICs. The Fund utilizes high credit quality stable value contract issuers, with an emphasis on diversification. **Risk:** The Contracts and securities purchased for the fund are backed solely by the financial resources of the issuers of such Contracts and securities. An investment in the fund is not insured or guaranteed by the manager(s), the plan sponsor, the trustee, the FDIC, or any other government agency. The Contracts purchased by the fund permit the fund to account for the fixed income securities at book value (principal plus interest accrued to date). Through the use of book value accounting, there is no immediate recognition of investment gains and losses on the fund's securities. Instead, gains and losses are recognized over time by periodically adjusting the interest rate credited to the fund under the Contracts. However, while the fund seeks to preserve your principal investment, it is possible to lose money by investing in this fund. The Contracts provide for the payment of certain withdrawals and exchanges at book value during the terms of the Contracts. In order to maintain the Contract issuers' promise to pay such withdrawals and exchanges at book value, the Contracts subject the fund and its participants to certain restrictions. For example, withdrawals prompted by certain events (e.g., layoffs, early retirement windows, spin-offs, sale of a division, facility closings, plan terminations, partial plan terminations, changes in laws or regulations) may be paid at the market value of the fund's securities, which may be less than your book value balance. Additional risk information for this product may be found in the prospectus or other product materials, if available. Certain investment options offered by your plan (e.g., money market funds, short term bond funds, certain asset allocation/lifecycle funds and brokerage window) may be deemed by the Contract issuers to "compete" with this fund. The terms of the Contracts prohibit you from making a direct exchange from this fund to such competing funds. Instead, you must first exchange to a non-competing fund for 90 days. While these requirements may seem restrictive, they are imposed by the Contract issuers as a condition for the issuer's promise to pay certain withdrawals and exchanges at book value. **Short-term redemption fee:** None **Who may want to invest:** Someone who seeks a slightly higher yield over the long term than is offered by money market funds, but who is willing to accept slightly more investment risk; Someone who is interested in balancing an aggressive portfolio with an investment that seeks to provide stability of price. **Footnotes:** The investment option is a stable value fund. It is managed by SEI Trust Company. This description is only intended to provide a brief overview of the fund. This investment option is not a mutual fund. The analysis on these pages may be based, in part, on adjusted historical returns for periods prior to the class's actual inception of 06/01/2006. The returns are provided by Morningstar and reflect the historical performance of the oldest, eligible share class of the Pool with reported expenses and an inception date of 04/30/2003, adjusted to reflect the fees and expenses of this share class (when this share class's fees and expenses are higher.) The adjusted historical returns are not actual returns. Calculation methodologies utilized by Morningstar may differ from those applied by other entities, including the Pool itself. Please refer to a Pool's offering materials for information regarding its' fees and expenses.

(continued)

Fund Name	Description
Invesco International Growth Trust – Class I	**Ticker:** N/A **Objective:** The Fund seeks long-term growth of capital by investing in a diversified portfolio of international companies with sustainable above-average earnings growth, efficient capital allocation, and attractive prices. **Strategy:** The Fund invests primarily in equity securities and depositary receipts of foreign issuers. The principal types of equity securities in which the Fund invests are common and preferred stock. The Fund invests, under normal circumstances, in securities of issuers located in at least three different countries outside of the U.S. The Fund invests primarily in securities of issuers that are considered by the Fund's portfolio managers to have potential for earnings or revenue growth. The Fund invests primarily in the securities of large-capitalization issues; however, the Fund may invest a significant amount of its net assets in the securities of mid-capitalization issuers. The portfolio managers employ a disciplined investment strategy that emphasizes fundamental research to identify quality growth companies and is supported by quantitative analysis, portfolio construction and risk management techniques. Investments for the portfolio are selected bottom-up on a security-by-security basis. The focus is on the strengths of individual issuers, rather than sector or country trends. The portfolio managers' strategy primarily focuses on identifying issuers that they believe have sustainable above-average earnings growth, efficient capital allocation, and attractive prices. The Fund's portfolio managers may consider selling a security for several reasons, including when (1) its price changes such that they believe it has become too expensive, (2) the original investment thesis for the company is no longer valid, or (3) a more compelling investment opportunity is identified. In anticipation of or in response to market, economic, political, or other conditions, the Fund's portfolio managers may temporarily use a different investment strategy for defensive purposes. If the Fund's portfolio managers do so, different factors could affect the Fund's performance and the Fund may not achieve its investment objective. **Risk:** Foreign securities are subject to interest-rate, currency-exchange-rate, economic, and political risks, all of which may be magnified in emerging markets. Growth stocks can perform differently from the market as a whole and can be more volatile than other types of stocks. Stock markets are volatile and can decline significantly in response to adverse issuer, political, regulatory, market, economic or other developments. Additional risk information for this product may be found in the prospectus or other product materials, if available. **Short-term redemption fee:** None **Who may want to invest:** Someone who is seeking to complement a portfolio of domestic investments with international investments, which can behave differently; Someone who is willing to accept the higher degree of risk associated with investing overseas. **Footnotes:** The investment option is a collective investment trust. It is managed by Invesco Trust Company. This description is only intended to provide a brief overview of the fund. This investment option is not a mutual fund.

(continued)

Fund Name	Description
LifePath® Index 2025 Non-Lendable Fund M	**Ticker:** N/A **Objective:** The Fund seeks to provide for retirement outcomes consistent with investor preferences throughout the savings and draw down phase based on quantitatively measured risk that investors, on average, may be willing to accept. **Strategy:** The Fund is a collective investment trust maintained and managed by BlackRock Institutional Trust Company, N.A. ("BTC"). The Fund shall be invested and reinvested in securities and other assets with the objective of providing for retirement outcomes consistent with investor preferences throughout the savings and drawdown phase based on quantitatively measured risk that investors, on average, may be willing to accept. In pursuit of that objective, the Fund will be broadly diversified across global asset classes, with asset allocations becoming more conservative over time if the Fund has a year in its name. The Fund's investments may include: equity securities; depositary receipts; debt securities and other fixed income obligations (including those issued or guaranteed by the U.S. government, its agencies or instrumentalities, and those issued by corporations or other entities); mortgage-backed securities; other asset-backed securities; commodities; and/or cash equivalents. The Fund may invest in securities and other obligations of U.S. issuers or non-U.S. issuers, and those issuers may be of any market capitalization. The Fund's fixed income investments may be investment-grade or non-investment grade, and may include securities and other obligations of any maturity. In addition to, or in lieu of, investing in the assets listed above, the Fund may engage in structured transactions in these asset classes, as well as over-the-counter forward contracts, swaps and options. When deemed appropriate by BTC, the Fund may invest in futures contracts, for the purpose of acting as a temporary substitute for investment in securities and/or to gain exposure to commodities. The difference between the normal and current securities holdings for the Fund varies over time and is based on the factors analyzed by the asset allocation model used by BTC to manage the Fund. The normal asset allocations will gradually change over the investment horizon of the Fund to become more heavily oriented toward debt and debt-like securities. As time passes, the Fund is managed more conservatively — prior to retirement — in terms of its allocation to equity securities and markets, on the premise that individuals investing for retirement desire to reduce investment risk in their retirement accounts as their retirement date approaches. The trajectory along which asset allocations are adjusted over time to gradually become more conservative is called the "glidepath." The glidepath illustrates the target allocation among asset classes as the Fund approaches its target date. The target asset allocation of the Fund at its retirement date is expected to be 40% in underlying index funds that invest primarily in equity and equity-like securities and 60% in underlying index funds that invest primarily in fixed income and fixed income-like securities. BTC employs a proprietary investment model that analyzes securities market data, including risk, correlation and expected return statistics, to recommend the portfolio allocation among the asset classes. Rather than choosing specific securities within each asset class, BTC selects among indices representing segments of the global equity and debt markets and invests in securities that comprise the chosen index. The Fund generally invests in a chosen index through a series of collective investment trusts maintained and managed by BTC, each such fund representing one of the indices (each, an "Underlying Fund"). In the event of a conflict between this summary description of the Fund's investment objective and principal investment strategies and the Trust Document under which the Fund was established, the Trust Document will govern. For more information related to the Fund, please see the Fund's Trust Document, Profile and most recent audited financial statements. The Fund will not engage in securities lending.

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Fund Name	Description
LifePath® Index 2025 Non-Lendable Fund M *(continued)*	**Risk:** The target date funds are designed for investors expecting to retire around the year indicated in each fund's name. The funds are managed to gradually become more conservative over time as they approach their target date. The investment risk of each target date fund changes over time as its asset allocation changes. They are subject to the volatility of the financial markets, including that of equity and fixed income investments in the U.S. and abroad, and may be subject to risks associated with investing in high-yield, small-cap, and foreign securities. Principal invested is not guaranteed at any time, including at or after their target dates. Additional risk information for this product may be found in the prospectus or other product materials, if available. **Short-term redemption fee:** None **Who may want to invest:** Someone who is seeking an investment option that gradually becomes more conservative over time and who is willing to accept the volatility of the markets; Someone who is seeking a diversified mix of stocks, bonds, and short-term investments in one investment option or who does not feel comfortable making asset allocation choices over time. **Footnotes:** The investment option is a collective investment trust. It is managed by BlackRock. This description is only intended to provide a brief overview of the fund. This investment option is not a mutual fund. The analysis on these pages may be based, in part, on adjusted historical returns for periods prior to the class's actual inception of 09/09/2016. The returns are provided by Morningstar and reflect the historical performance of the oldest, eligible share class of the Pool with reported expenses and an inception date of 01/23/2009, adjusted to reflect the fees and expenses of this share class (when this share class's fees and expenses are higher.) The adjusted historical returns are not actual returns. Calculation methodologies utilized by Morningstar may differ from those applied by other entities, including the Pool itself. Please refer to a Pool's offering materials for information regarding its' fees and expenses.

(continued)

Fund Name	Description
LifePath® Index 2030 Non-Lendable Fund M	**Ticker:** N/A **Objective:** The Fund seeks to provide for retirement outcomes consistent with investor preferences throughout the savings and draw down phase based on quantitatively measured risk that investors, on average, may be willing to accept. **Strategy:** The Fund is a collective investment trust maintained and managed by BlackRock Institutional Trust Company, N.A. ("BTC"). The Fund shall be invested and reinvested in securities and other assets with the objective of providing for retirement outcomes consistent with investor preferences throughout the savings and drawdown phase based on quantitatively measured risk that investors, on average, may be willing to accept. In pursuit of that objective, the Fund will be broadly diversified across global asset classes, with asset allocations becoming more conservative over time if the Fund has a year in its name. The Fund's investments may include: equity securities; depositary receipts; debt securities and other fixed income obligations (including those issued or guaranteed by the U.S. government, its agencies or instrumentalities, and those issued by corporations or other entities); mortgage-backed securities; other asset-backed securities; commodities; and/or cash equivalents. The Fund may invest in securities and other obligations of U.S. issuers or non-U.S. issuers, and those issuers may be of any market capitalization. The Fund's fixed income investments may be investment-grade or non-investment grade, and may include securities and other obligations of any maturity. In addition to, or in lieu of, investing in the assets listed above, the Fund may engage in structured transactions in these asset classes, as well as over-the-counter forward contracts, swaps and options. When deemed appropriate by BTC, the Fund may invest in futures contracts, for the purpose of acting as a temporary substitute for investment in securities and/or to gain exposure to commodities. The difference between the normal and current securities holdings for the Fund varies over time and is based on the factors analyzed by the asset allocation model used by BTC to manage the Fund. The normal asset allocations will gradually change over the investment horizon of the Fund to become more heavily oriented toward debt and debt-like securities. As time passes, the Fund is managed more conservatively — prior to retirement — in terms of its allocation to equity securities and markets, on the premise that individuals investing for retirement desire to reduce investment risk in their retirement accounts as their retirement date approaches. The trajectory along which asset allocations are adjusted over time to gradually become more conservative is called the "glidepath." The glidepath illustrates the target allocation among asset classes as the Fund approaches its target date. The target asset allocation of the Fund at its retirement date is expected to be 40% in underlying index funds that invest primarily in equity and equity-like securities and 60% in underlying index funds that invest primarily in fixed income and fixed income-like securities. BTC employs a proprietary investment model that analyzes securities market data, including risk, correlation and expected return statistics, to recommend the portfolio allocation among the asset classes. Rather than choosing specific securities within each asset class, BTC selects among indices representing segments of the global equity and debt markets and invests in securities that comprise the chosen index. The Fund generally invests in a chosen index through a series of collective investment trusts maintained and managed by BTC, each such fund representing one of the indices (each, an "Underlying Fund"). In the event of a conflict between this summary description of the Fund's investment objective and principal investment strategies and the Trust Document under which the Fund was established, the Trust Document will govern. For more information related to the Fund, please see the Fund's Trust Document, Profile and most recent audited financial statements. The Fund will not engage in securities lending.

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Fund Name	Description
LifePath® Index 2030 Non-Lendable Fund M ***(continued)***	**Risk:** The target date funds are designed for investors expecting to retire around the year indicated in each fund's name. The funds are managed to gradually become more conservative over time as they approach their target date. The investment risk of each target date fund changes over time as its asset allocation changes. They are subject to the volatility of the financial markets, including that of equity and fixed income investments in the U.S. and abroad, and may be subject to risks associated with investing in high-yield, small-cap, and foreign securities. Principal invested is not guaranteed at any time, including at or after their target dates. Additional risk information for this product may be found in the prospectus or other product materials, if available. **Short-term redemption fee:** None **Who may want to invest:** Someone who is seeking an investment option that gradually becomes more conservative over time and who is willing to accept the volatility of the markets; Someone who is seeking a diversified mix of stocks, bonds, and short-term investments in one investment option or who does not feel comfortable making asset allocation choices over time. **Footnotes:** The investment option is a collective investment trust. It is managed by BlackRock. This description is only intended to provide a brief overview of the fund. This investment option is not a mutual fund. The analysis on these pages may be based, in part, on adjusted historical returns for periods prior to the class's actual inception of 09/09/2016. The returns are provided by Morningstar and reflect the historical performance of the oldest, eligible share class of the Pool with reported expenses and an inception date of 01/23/2009, adjusted to reflect the fees and expenses of this share class (when this share class's fees and expenses are higher.) The adjusted historical returns are not actual returns. Calculation methodologies utilized by Morningstar may differ from those applied by other entities, including the Pool itself. Please refer to a Pool's offering materials for information regarding its' fees and expenses.

(continued)

Fund Name	Description
LifePath® Index 2035 Non-Lendable Fund M	**Ticker:** N/A **Objective:** The Fund seeks to provide for retirement outcomes consistent with investor preferences throughout the savings and draw down phase based on quantitatively measured risk that investors, on average, may be willing to accept. **Strategy:** The Fund is a collective investment trust maintained and managed by BlackRock Institutional Trust Company, N.A. ("BTC"). The Fund shall be invested and reinvested in securities and other assets with the objective of providing for retirement outcomes consistent with investor preferences throughout the savings and drawdown phase based on quantitatively measured risk that investors, on average, may be willing to accept. In pursuit of that objective, the Fund will be broadly diversified across global asset classes, with asset allocations becoming more conservative over time if the Fund has a year in its name. The Fund's investments may include: equity securities; depositary receipts; debt securities and other fixed income obligations (including those issued or guaranteed by the U.S. government, its agencies or instrumentalities, and those issued by corporations or other entities); mortgage-backed securities; other asset-backed securities; commodities; and/or cash equivalents. The Fund may invest in securities and other obligations of U.S. issuers or non-U.S. issuers, and those issuers may be of any market capitalization. The Fund's fixed income investments may be investment-grade or non-investment grade, and may include securities and other obligations of any maturity. In addition to, or in lieu of, investing in the assets listed above, the Fund may engage in structured transactions in these asset classes, as well as over-the-counter forward contracts, swaps and options. When deemed appropriate by BTC, the Fund may invest in futures contracts, for the purpose of acting as a temporary substitute for investment in securities and/or to gain exposure to commodities. The difference between the normal and current securities holdings for the Fund varies over time and is based on the factors analyzed by the asset allocation model used by BTC to manage the Fund. The normal asset allocations will gradually change over the investment horizon of the Fund to become more heavily oriented toward debt and debt-like securities. As time passes, the Fund is managed more conservatively — prior to retirement — in terms of its allocation to equity securities and markets, on the premise that individuals investing for retirement desire to reduce investment risk in their retirement accounts as their retirement date approaches. The trajectory along which asset allocations are adjusted over time to gradually become more conservative is called the "glidepath." The glidepath illustrates the target allocation among asset classes as the Fund approaches its target date. The target asset allocation of the Fund at its retirement date is expected to be 40% in underlying index funds that invest primarily in equity and equity-like securities and 60% in underlying index funds that invest primarily in fixed income and fixed income-like securities. BTC employs a proprietary investment model that analyzes securities market data, including risk, correlation and expected return statistics, to recommend the portfolio allocation among the asset classes. Rather than choosing specific securities within each asset class, BTC selects among indices representing segments of the global equity and debt markets and invests in securities that comprise the chosen index. The Fund generally invests in a chosen index through a series of collective investment trusts maintained and managed by BTC, each such fund representing one of the indices (each, an "Underlying Fund"). In the event of a conflict between this summary description of the Fund's investment objective and principal investment strategies and the Trust Document under which the Fund was established, the Trust Document will govern. For more information related to the Fund, please see the Fund's Trust Document, Profile and most recent audited financial statements. The Fund will not engage in securities lending.

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Fund Name	Description
LifePath® Index 2035 Non-Lendable Fund M *(continued)*	**Risk:** The target date funds are designed for investors expecting to retire around the year indicated in each fund's name. The funds are managed to gradually become more conservative over time as they approach their target date. The investment risk of each target date fund changes over time as its asset allocation changes. They are subject to the volatility of the financial markets, including that of equity and fixed income investments in the U.S. and abroad, and may be subject to risks associated with investing in high-yield, small-cap, and foreign securities. Principal invested is not guaranteed at any time, including at or after their target dates. Additional risk information for this product may be found in the prospectus or other product materials, if available. **Short-term redemption fee:** None **Who may want to invest:** Someone who is seeking an investment option that gradually becomes more conservative over time and who is willing to accept the volatility of the markets; Someone who is seeking a diversified mix of stocks, bonds, and short-term investments in one investment option or who does not feel comfortable making asset allocation choices over time. **Footnotes:** The investment option is a collective investment trust. It is managed by BlackRock. This description is only intended to provide a brief overview of the fund. This investment option is not a mutual fund. The analysis on these pages may be based, in part, on adjusted historical returns for periods prior to the class's actual inception of 09/09/2016. The returns are provided by Morningstar and reflect the historical performance of the oldest, eligible share class of the Pool with reported expenses and an inception date of 01/23/2009, adjusted to reflect the fees and expenses of this share class (when this share class's fees and expenses are higher.) The adjusted historical returns are not actual returns. Calculation methodologies utilized by Morningstar may differ from those applied by other entities, including the Pool itself. Please refer to a Pool's offering materials for information regarding its' fees and expenses.

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Fund Name	Description
LifePath® Index 2040 Non-Lendable Fund M	**Ticker:** N/A **Objective:** The Fund seeks to provide for retirement outcomes consistent with investor preferences throughout the savings and draw down phase based on quantitatively measured risk that investors, on average, may be willing to accept. **Strategy:** The Fund is a collective investment trust maintained and managed by BlackRock Institutional Trust Company, N.A. ("BTC"). The Fund shall be invested and reinvested in securities and other assets with the objective of providing for retirement outcomes consistent with investor preferences throughout the savings and drawdown phase based on quantitatively measured risk that investors, on average, may be willing to accept. In pursuit of that objective, the Fund will be broadly diversified across global asset classes, with asset allocations becoming more conservative over time if the Fund has a year in its name. The Fund's investments may include: equity securities; depositary receipts; debt securities and other fixed income obligations (including those issued or guaranteed by the U.S. government, its agencies or instrumentalities, and those issued by corporations or other entities); mortgage-backed securities; other asset-backed securities; commodities; and/or cash equivalents. The Fund may invest in securities and other obligations of U.S. issuers or non-U.S. issuers, and those issuers may be of any market capitalization. The Fund's fixed income investments may be investment-grade or non-investment grade, and may include securities and other obligations of any maturity. In addition to, or in lieu of, investing in the assets listed above, the Fund may engage in structured transactions in these asset classes, as well as over-the-counter forward contracts, swaps and options. When deemed appropriate by BTC, the Fund may invest in futures contracts, for the purpose of acting as a temporary substitute for investment in securities and/or to gain exposure to commodities. The difference between the normal and current securities holdings for the Fund varies over time and is based on the factors analyzed by the asset allocation model used by BTC to manage the Fund. The normal asset allocations will gradually change over the investment horizon of the Fund to become more heavily oriented toward debt and debt-like securities. As time passes, the Fund is managed more conservatively — prior to retirement — in terms of its allocation to equity securities and markets, on the premise that individuals investing for retirement desire to reduce investment risk in their retirement accounts as their retirement date approaches. The trajectory along which asset allocations are adjusted over time to gradually become more conservative is called the "glidepath." The glidepath illustrates the target allocation among asset classes as the Fund approaches its target date. The target asset allocation of the Fund at its retirement date is expected to be 40% in underlying index funds that invest primarily in equity and equity-like securities and 60% in underlying index funds that invest primarily in fixed income and fixed income-like securities. BTC employs a proprietary investment model that analyzes securities market data, including risk, correlation and expected return statistics, to recommend the portfolio allocation among the asset classes. Rather than choosing specific securities within each asset class, BTC selects among indices representing segments of the global equity and debt markets and invests in securities that comprise the chosen index. The Fund generally invests in a chosen index through a series of collective investment trusts maintained and managed by BTC, each such fund representing one of the indices (each, an "Underlying Fund"). In the event of a conflict between this summary description of the Fund's investment objective and principal investment strategies and the Trust Document under which the Fund was established, the Trust Document will govern. For more information related to the Fund, please see the Fund's Trust Document, Profile and most recent audited financial statements. The Fund will not engage in securities lending.

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Fund Name	Description
LifePath® Index 2040 Non-Lendable Fund M ***(continued)***	**Risk:** The target date funds are designed for investors expecting to retire around the year indicated in each fund's name. The funds are managed to gradually become more conservative over time as they approach their target date. The investment risk of each target date fund changes over time as its asset allocation changes. They are subject to the volatility of the financial markets, including that of equity and fixed income investments in the U.S. and abroad, and may be subject to risks associated with investing in high-yield, small-cap, and foreign securities. Principal invested is not guaranteed at any time, including at or after their target dates. Additional risk information for this product may be found in the prospectus or other product materials, if available. **Short-term redemption fee:** None **Who may want to invest:** Someone who is seeking an investment option that gradually becomes more conservative over time and who is willing to accept the volatility of the markets; Someone who is seeking a diversified mix of stocks, bonds, and short-term investments in one investment option or who does not feel comfortable making asset allocation choices over time. **Footnotes:** The investment option is a collective investment trust. It is managed by BlackRock. This description is only intended to provide a brief overview of the fund. This investment option is not a mutual fund. The analysis on these pages may be based, in part, on adjusted historical returns for periods prior to the class's actual inception of 09/09/2016. The returns are provided by Morningstar and reflect the historical performance of the oldest, eligible share class of the Pool with reported expenses and an inception date of 01/23/2009, adjusted to reflect the fees and expenses of this share class (when this share class's fees and expenses are higher.) The adjusted historical returns are not actual returns. Calculation methodologies utilized by Morningstar may differ from those applied by other entities, including the Pool itself. Please refer to a Pool's offering materials for information regarding its' fees and expenses.

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Fund Name	Description
LifePath® Index 2045 Non-Lendable Fund M	**Ticker:** N/A **Objective:** The Fund seeks to provide for retirement outcomes consistent with investor preferences throughout the savings and draw down phase based on quantitatively measured risk that investors, on average, may be willing to accept. **Strategy:** The Fund is a collective investment trust maintained and managed by BlackRock Institutional Trust Company, N.A. ("BTC"). The Fund shall be invested and reinvested in securities and other assets with the objective of providing for retirement outcomes consistent with investor preferences throughout the savings and drawdown phase based on quantitatively measured risk that investors, on average, may be willing to accept. In pursuit of that objective, the Fund will be broadly diversified across global asset classes, with asset allocations becoming more conservative over time if the Fund has a year in its name. The Fund's investments may include: equity securities; depositary receipts; debt securities and other fixed income obligations (including those issued or guaranteed by the U.S. government, its agencies or instrumentalities, and those issued by corporations or other entities); mortgage-backed securities; other asset-backed securities; commodities; and/or cash equivalents. The Fund may invest in securities and other obligations of U.S. issuers or non-U.S. issuers, and those issuers may be of any market capitalization. The Fund's fixed income investments may be investment-grade or non-investment grade, and may include securities and other obligations of any maturity. In addition to, or in lieu of, investing in the assets listed above, the Fund may engage in structured transactions in these asset classes, as well as over-the-counter forward contracts, swaps and options. When deemed appropriate by BTC, the Fund may invest in futures contracts, for the purpose of acting as a temporary substitute for investment in securities and/or to gain exposure to commodities. The difference between the normal and current securities holdings for the Fund varies over time and is based on the factors analyzed by the asset allocation model used by BTC to manage the Fund. The normal asset allocations will gradually change over the investment horizon of the Fund to become more heavily oriented toward debt and debt-like securities. As time passes, the Fund is managed more conservatively — prior to retirement — in terms of its allocation to equity securities and markets, on the premise that individuals investing for retirement desire to reduce investment risk in their retirement accounts as their retirement date approaches. The trajectory along which asset allocations are adjusted over time to gradually become more conservative is called the "glidepath." The glidepath illustrates the target allocation among asset classes as the Fund approaches its target date. The target asset allocation of the Fund at its retirement date is expected to be 40% in underlying index funds that invest primarily in equity and equity-like securities and 60% in underlying index funds that invest primarily in fixed income and fixed income-like securities. BTC employs a proprietary investment model that analyzes securities market data, including risk, correlation and expected return statistics, to recommend the portfolio allocation among the asset classes. Rather than choosing specific securities within each asset class, BTC selects among indices representing segments of the global equity and debt markets and invests in securities that comprise the chosen index. The Fund generally invests in a chosen index through a series of collective investment trusts maintained and managed by BTC, each such fund representing one of the indices (each, an "Underlying Fund"). In the event of a conflict between this summary description of the Fund's investment objective and principal investment strategies and the Trust Document under which the Fund was established, the Trust Document will govern. For more information related to the Fund, please see the Fund's Trust Document, Profile and most recent audited financial statements. The Fund will not engage in securities lending.

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Fund Name	Description
LifePath® Index 2045 Non-Lendable Fund M *(continued)*	**Risk:** The target date funds are designed for investors expecting to retire around the year indicated in each fund's name. The funds are managed to gradually become more conservative over time as they approach their target date. The investment risk of each target date fund changes over time as its asset allocation changes. They are subject to the volatility of the financial markets, including that of equity and fixed income investments in the U.S. and abroad, and may be subject to risks associated with investing in high-yield, small-cap, and foreign securities. Principal invested is not guaranteed at any time, including at or after their target dates. Additional risk information for this product may be found in the prospectus or other product materials, if available. **Short-term redemption fee:** None **Who may want to invest:** Someone who is seeking an investment option that gradually becomes more conservative over time and who is willing to accept the volatility of the markets; Someone who is seeking a diversified mix of stocks, bonds, and short-term investments in one investment option or who does not feel comfortable making asset allocation choices over time. **Footnotes:** The investment option is a collective investment trust. It is managed by BlackRock. This description is only intended to provide a brief overview of the fund. This investment option is not a mutual fund. The analysis on these pages may be based, in part, on adjusted historical returns for periods prior to the class's actual inception of 09/09/2016. The returns are provided by Morningstar and reflect the historical performance of the oldest, eligible share class of the Pool with reported expenses and an inception date of 01/23/2009, adjusted to reflect the fees and expenses of this share class (when this share class's fees and expenses are higher.) The adjusted historical returns are not actual returns. Calculation methodologies utilized by Morningstar may differ from those applied by other entities, including the Pool itself. Please refer to a Pool's offering materials for information regarding its' fees and expenses.

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Fund Name	Description
LifePath® Index 2050 Non-Lendable Fund M	**Ticker:** N/A **Objective:** The Fund seeks to provide for retirement outcomes consistent with investor preferences throughout the savings and draw down phase based on quantitatively measured risk that investors, on average, may be willing to accept. **Strategy:** The Fund is a collective investment trust maintained and managed by BlackRock Institutional Trust Company, N.A. ("BTC"). The Fund shall be invested and reinvested in securities and other assets with the objective of providing for retirement outcomes consistent with investor preferences throughout the savings and drawdown phase based on quantitatively measured risk that investors, on average, may be willing to accept. In pursuit of that objective, the Fund will be broadly diversified across global asset classes, with asset allocations becoming more conservative over time if the Fund has a year in its name. The Fund's investments may include: equity securities; depositary receipts; debt securities and other fixed income obligations (including those issued or guaranteed by the U.S. government, its agencies or instrumentalities, and those issued by corporations or other entities); mortgage-backed securities; other asset-backed securities; commodities; and/or cash equivalents. The Fund may invest in securities and other obligations of U.S. issuers or non-U.S. issuers, and those issuers may be of any market capitalization. The Fund's fixed income investments may be investment-grade or non-investment grade, and may include securities and other obligations of any maturity. In addition to, or in lieu of, investing in the assets listed above, the Fund may engage in structured transactions in these asset classes, as well as over-the-counter forward contracts, swaps and options. When deemed appropriate by BTC, the Fund may invest in futures contracts, for the purpose of acting as a temporary substitute for investment in securities and/or to gain exposure to commodities. The difference between the normal and current securities holdings for the Fund varies over time and is based on the factors analyzed by the asset allocation model used by BTC to manage the Fund. The normal asset allocations will gradually change over the investment horizon of the Fund to become more heavily oriented toward debt and debt-like securities. As time passes, the Fund is managed more conservatively — prior to retirement — in terms of its allocation to equity securities and markets, on the premise that individuals investing for retirement desire to reduce investment risk in their retirement accounts as their retirement date approaches. The trajectory along which asset allocations are adjusted over time to gradually become more conservative is called the "glidepath." The glidepath illustrates the target allocation among asset classes as the Fund approaches its target date. The target asset allocation of the Fund at its retirement date is expected to be 40% in underlying index funds that invest primarily in equity and equity-like securities and 60% in underlying index funds that invest primarily in fixed income and fixed income-like securities. BTC employs a proprietary investment model that analyzes securities market data, including risk, correlation and expected return statistics, to recommend the portfolio allocation among the asset classes. Rather than choosing specific securities within each asset class, BTC selects among indices representing segments of the global equity and debt markets and invests in securities that comprise the chosen index. The Fund generally invests in a chosen index through a series of collective investment trusts maintained and managed by BTC, each such fund representing one of the indices (each, an "Underlying Fund"). In the event of a conflict between this summary description of the Fund's investment objective and principal investment strategies and the Trust Document under which the Fund was established, the Trust Document will govern. For more information related to the Fund, please see the Fund's Trust Document, Profile and most recent audited financial statements. The Fund will not engage in securities lending.

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Fund Name	Description
LifePath® Index 2050 Non-Lendable Fund M ***(continued)***	**Risk:** The target date funds are designed for investors expecting to retire around the year indicated in each fund's name. The funds are managed to gradually become more conservative over time as they approach their target date. The investment risk of each target date fund changes over time as its asset allocation changes. They are subject to the volatility of the financial markets, including that of equity and fixed income investments in the U.S. and abroad, and may be subject to risks associated with investing in high-yield, small-cap, and foreign securities. Principal invested is not guaranteed at any time, including at or after their target dates. Additional risk information for this product may be found in the prospectus or other product materials, if available. **Short-term redemption fee:** None **Who may want to invest:** Someone who is seeking an investment option that gradually becomes more conservative over time and who is willing to accept the volatility of the markets; Someone who is seeking a diversified mix of stocks, bonds, and short-term investments in one investment option or who does not feel comfortable making asset allocation choices over time. **Footnotes:** The investment option is a collective investment trust. It is managed by BlackRock. This description is only intended to provide a brief overview of the fund. This investment option is not a mutual fund. The analysis on these pages may be based, in part, on adjusted historical returns for periods prior to the class's actual inception of 09/09/2016. The returns are provided by Morningstar and reflect the historical performance of the oldest, eligible share class of the Pool with reported expenses and an inception date of 01/23/2009, adjusted to reflect the fees and expenses of this share class (when this share class's fees and expenses are higher.) The adjusted historical returns are not actual returns. Calculation methodologies utilized by Morningstar may differ from those applied by other entities, including the Pool itself. Please refer to a Pool's offering materials for information regarding its' fees and expenses.

(continued)

Fund Name	Description
LifePath® Index 2055 Non-Lendable Fund M	**Ticker:** N/A **Objective:** The Fund seeks to provide for retirement outcomes consistent with investor preferences throughout the savings and draw down phase based on quantitatively measured risk that investors, on average, may be willing to accept. **Strategy:** The Fund is a collective investment trust maintained and managed by BlackRock Institutional Trust Company, N.A. ("BTC"). The Fund shall be invested and reinvested in securities and other assets with the objective of providing for retirement outcomes consistent with investor preferences throughout the savings and drawdown phase based on quantitatively measured risk that investors, on average, may be willing to accept. In pursuit of that objective, the Fund will be broadly diversified across global asset classes, with asset allocations becoming more conservative over time if the Fund has a year in its name. The Fund's investments may include: equity securities; depositary receipts; debt securities and other fixed income obligations (including those issued or guaranteed by the U.S. government, its agencies or instrumentalities, and those issued by corporations or other entities); mortgage-backed securities; other asset-backed securities; commodities; and/or cash equivalents. The Fund may invest in securities and other obligations of U.S. issuers or non-U.S. issuers, and those issuers may be of any market capitalization. The Fund's fixed income investments may be investment-grade or non-investment grade, and may include securities and other obligations of any maturity. In addition to, or in lieu of, investing in the assets listed above, the Fund may engage in structured transactions in these asset classes, as well as over-the-counter forward contracts, swaps and options. When deemed appropriate by BTC, the Fund may invest in futures contracts, for the purpose of acting as a temporary substitute for investment in securities and/or to gain exposure to commodities. The difference between the normal and current securities holdings for the Fund varies over time and is based on the factors analyzed by the asset allocation model used by BTC to manage the Fund. The normal asset allocations will gradually change over the investment horizon of the Fund to become more heavily oriented toward debt and debt-like securities. As time passes, the Fund is managed more conservatively — prior to retirement — in terms of its allocation to equity securities and markets, on the premise that individuals investing for retirement desire to reduce investment risk in their retirement accounts as their retirement date approaches. The trajectory along which asset allocations are adjusted over time to gradually become more conservative is called the "glidepath." The glidepath illustrates the target allocation among asset classes as the Fund approaches its target date. The target asset allocation of the Fund at its retirement date is expected to be 40% in underlying index funds that invest primarily in equity and equity-like securities and 60% in underlying index funds that invest primarily in fixed income and fixed income-like securities. BTC employs a proprietary investment model that analyzes securities market data, including risk, correlation and expected return statistics, to recommend the portfolio allocation among the asset classes. Rather than choosing specific securities within each asset class, BTC selects among indices representing segments of the global equity and debt markets and invests in securities that comprise the chosen index. The Fund generally invests in a chosen index through a series of collective investment trusts maintained and managed by BTC, each such fund representing one of the indices (each, an "Underlying Fund"). In the event of a conflict between this summary description of the Fund's investment objective and principal investment strategies and the Trust Document under which the Fund was established, the Trust Document will govern. For more information related to the Fund, please see the Fund's Trust Document, Profile and most recent audited financial statements. The Fund will not engage in securities lending.

(continued)

Fund Name	Description
LifePath® Index 2055 Non-Lendable Fund M ***(continued)***	**Risk:** The target date funds are designed for investors expecting to retire around the year indicated in each fund's name. The funds are managed to gradually become more conservative over time as they approach their target date. The investment risk of each target date fund changes over time as its asset allocation changes. They are subject to the volatility of the financial markets, including that of equity and fixed income investments in the U.S. and abroad, and may be subject to risks associated with investing in high-yield, small-cap, and foreign securities. Principal invested is not guaranteed at any time, including at or after their target dates. Additional risk information for this product may be found in the prospectus or other product materials, if available. **Short-term redemption fee:** None **Who may want to invest:** Someone who is seeking an investment option that gradually becomes more conservative over time and who is willing to accept the volatility of the markets; Someone who is seeking a diversified mix of stocks, bonds, and short-term investments in one investment option or who does not feel comfortable making asset allocation choices over time. **Footnotes:** The investment option is a collective investment trust. It is managed by BlackRock. This description is only intended to provide a brief overview of the fund. This investment option is not a mutual fund. The analysis on these pages may be based, in part, on adjusted historical returns for periods prior to the class's actual inception of 09/09/2016. The returns are provided by Morningstar and reflect the historical performance of the oldest, eligible share class of the Pool with reported expenses and an inception date of 01/29/2010, adjusted to reflect the fees and expenses of this share class (when this share class's fees and expenses are higher.) The adjusted historical returns are not actual returns. Calculation methodologies utilized by Morningstar may differ from those applied by other entities, including the Pool itself. Please refer to a Pool's offering materials for information regarding its' fees and expenses.

(continued)

Fund Name	Description
LifePath® Index 2060 Non-Lendable Fund M	**Ticker:** N/A **Objective:** The Fund seeks to provide for retirement outcomes consistent with investor preferences throughout the savings and draw down phase based on quantitatively measured risk that investors, on average, may be willing to accept. **Strategy:** The Fund is a collective investment trust maintained and managed by BlackRock Institutional Trust Company, N.A. ("BTC"). The Fund shall be invested and reinvested in securities and other assets with the objective of providing for retirement outcomes consistent with investor preferences throughout the savings and drawdown phase based on quantitatively measured risk that investors, on average, may be willing to accept. In pursuit of that objective, the Fund will be broadly diversified across global asset classes, with asset allocations becoming more conservative over time if the Fund has a year in its name. The Fund's investments may include: equity securities; depositary receipts; debt securities and other fixed income obligations (including those issued or guaranteed by the U.S. government, its agencies or instrumentalities, and those issued by corporations or other entities); mortgage-backed securities; other asset-backed securities; commodities; and/or cash equivalents. The Fund may invest in securities and other obligations of U.S. issuers or non-U.S. issuers, and those issuers may be of any market capitalization. The Fund's fixed income investments may be investment-grade or non-investment grade, and may include securities and other obligations of any maturity. In addition to, or in lieu of, investing in the assets listed above, the Fund may engage in structured transactions in these asset classes, as well as over-the-counter forward contracts, swaps and options. When deemed appropriate by BTC, the Fund may invest in futures contracts, for the purpose of acting as a temporary substitute for investment in securities and/or to gain exposure to commodities. The difference between the normal and current securities holdings for the Fund varies over time and is based on the factors analyzed by the asset allocation model used by BTC to manage the Fund. The normal asset allocations will gradually change over the investment horizon of the Fund to become more heavily oriented toward debt and debt-like securities. As time passes, the Fund is managed more conservatively — prior to retirement — in terms of its allocation to equity securities and markets, on the premise that individuals investing for retirement desire to reduce investment risk in their retirement accounts as their retirement date approaches. The trajectory along which asset allocations are adjusted over time to gradually become more conservative is called the "glidepath." The glidepath illustrates the target allocation among asset classes as the Fund approaches its target date. The target asset allocation of the Fund at its retirement date is expected to be 40% in underlying index funds that invest primarily in equity and equity-like securities and 60% in underlying index funds that invest primarily in fixed income and fixed income-like securities. BTC employs a proprietary investment model that analyzes securities market data, including risk, correlation and expected return statistics, to recommend the portfolio allocation among the asset classes. Rather than choosing specific securities within each asset class, BTC selects among indices representing segments of the global equity and debt markets and invests in securities that comprise the chosen index. The Fund generally invests in a chosen index through a series of collective investment trusts maintained and managed by BTC, each such fund representing one of the indices (each, an "Underlying Fund"). In the event of a conflict between this summary description of the Fund's investment objective and principal investment strategies and the Trust Document under which the Fund was established, the Trust Document will govern. For more information related to the Fund, please see the Fund's Trust Document, Profile and most recent audited financial statements. The Fund will not engage in securities lending.

(continued)

Fund Name	Description
LifePath® Index 2060 Non-Lendable Fund M *(continued)*	**Risk:** The target date funds are designed for investors expecting to retire around the year indicated in each fund's name. The funds are managed to gradually become more conservative over time as they approach their target date. The investment risk of each target date fund changes over time as its asset allocation changes. They are subject to the volatility of the financial markets, including that of equity and fixed income investments in the U.S. and abroad, and may be subject to risks associated with investing in high-yield, small-cap, and foreign securities. Principal invested is not guaranteed at any time, including at or after their target dates. Additional risk information for this product may be found in the prospectus or other product materials, if available. **Short-term redemption fee:** None **Who may want to invest:** Someone who is seeking an investment option that gradually becomes more conservative over time and who is willing to accept the volatility of the markets; Someone who is seeking a diversified mix of stocks, bonds, and short-term investments in one investment option or who does not feel comfortable making asset allocation choices over time. **Footnotes:** The investment option is a collective investment trust. It is managed by BlackRock. This description is only intended to provide a brief overview of the fund. This investment option is not a mutual fund. The analysis on these pages may be based, in part, on adjusted historical returns for periods prior to the class's actual inception of 09/09/2016. The returns are provided by Morningstar and reflect the historical performance of the oldest, eligible share class of the Pool with reported expenses and an inception date of 12/31/2014, adjusted to reflect the fees and expenses of this share class (when this share class's fees and expenses are higher.) The adjusted historical returns are not actual returns. Calculation methodologies utilized by Morningstar may differ from those applied by other entities, including the Pool itself. Please refer to a Pool's offering materials for information regarding its' fees and expenses.

(continued)

Fund Name	Description
LifePath® Index 2065 Non-Lendable Fund M	**Ticker:** N/A **Objective:** The Fund seeks to provide for retirement outcomes consistent with investor preferences throughout the savings and draw down phase based on quantitatively measured risk that investors, on average, may be willing to accept. **Strategy:** The Fund is a collective investment trust maintained and managed by BlackRock Institutional Trust Company, N.A. ("BTC"). The Fund shall be invested and reinvested in securities and other assets with the objective of providing for retirement outcomes consistent with investor preferences throughout the savings and drawdown phase based on quantitatively measured risk that investors, on average, may be willing to accept. In pursuit of that objective, the Fund will be broadly diversified across global asset classes, with asset allocations becoming more conservative over time if the Fund has a year in its name. The Fund's investments may include: equity securities; depositary receipts; debt securities and other fixed income obligations (including those issued or guaranteed by the U.S. government, its agencies or instrumentalities, and those issued by corporations or other entities); mortgage-backed securities; other asset-backed securities; commodities; and/or cash equivalents. The Fund may invest in securities and other obligations of U.S. issuers or non-U.S. issuers, and those issuers may be of any market capitalization. The Fund's fixed income investments may be investment-grade or non-investment grade, and may include securities and other obligations of any maturity. In addition to, or in lieu of, investing in the assets listed above, the Fund may engage in structured transactions in these asset classes, as well as over-the-counter forward contracts, swaps and options. When deemed appropriate by BTC, the Fund may invest in futures contracts, for the purpose of acting as a temporary substitute for investment in securities and/or to gain exposure to commodities. The difference between the normal and current securities holdings for the Fund varies over time and is based on the factors analyzed by the asset allocation model used by BTC to manage the Fund. The normal asset allocations will gradually change over the investment horizon of the Fund to become more heavily oriented toward debt and debt-like securities. As time passes, the Fund is managed more conservatively — prior to retirement — in terms of its allocation to equity securities and markets, on the premise that individuals investing for retirement desire to reduce investment risk in their retirement accounts as their retirement date approaches. The trajectory along which asset allocations are adjusted over time to gradually become more conservative is called the "glidepath." The glidepath illustrates the target allocation among asset classes as the Fund approaches its target date. The target asset allocation of the Fund at its retirement date is expected to be 40% in underlying index funds that invest primarily in equity and equity-like securities and 60% in underlying index funds that invest primarily in fixed income and fixed income-like securities. BTC employs a proprietary investment model that analyzes securities market data, including risk, correlation and expected return statistics, to recommend the portfolio allocation among the asset classes. Rather than choosing specific securities within each asset class, BTC selects among indices representing segments of the global equity and debt markets and invests in securities that comprise the chosen index. The Fund generally invests in a chosen index through a series of collective investment trusts maintained and managed by BTC, each such fund representing one of the indices (each, an "Underlying Fund"). In the event of a conflict between this summary description of the Fund's investment objective and principal investment strategies and the Trust Document under which the Fund was established, the Trust Document will govern. For more information related to the Fund, please see the Fund's Trust Document, Profile and most recent audited financial statements. The Fund will not engage in securities lending.

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Fund Name	Description
LifePath® Index 2065 Non-Lendable Fund M *(continued)*	**Risk:** The target date funds are designed for investors expecting to retire around the year indicated in each fund's name. The funds are managed to gradually become more conservative over time as they approach their target date. The investment risk of each target date fund changes over time as its asset allocation changes. They are subject to the volatility of the financial markets, including that of equity and fixed income investments in the U.S. and abroad, and may be subject to risks associated with investing in high-yield, small-cap, and foreign securities. Principal invested is not guaranteed at any time, including at or after their target dates. Additional risk information for this product may be found in the prospectus or other product materials, if available. **Short-term redemption fee:** None **Who may want to invest:** Someone who is seeking an investment option that gradually becomes more conservative over time and who is willing to accept the volatility of the markets; Someone who is seeking a diversified mix of stocks, bonds, and short-term investments in one investment option or who does not feel comfortable making asset allocation choices over time. **Footnotes:** The investment option is a collective investment trust. It is managed by BlackRock. This description is only intended to provide a brief overview of the fund. This investment option is not a mutual fund. The analysis on these pages may be based, in part, on adjusted historical returns for periods prior to the class's actual inception of 09/09/2016. The returns are provided by Morningstar and reflect the historical performance of the oldest, eligible share class of the Pool with reported expenses and an inception date of 12/31/2014, adjusted to reflect the fees and expenses of this share class (when this share class's fees and expenses are higher.) The adjusted historical returns are not actual returns. Calculation methodologies utilized by Morningstar may differ from those applied by other entities, including the Pool itself. Please refer to a Pool's offering materials for information regarding its' fees and expenses.

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Fund Name	Description
LifePath® Index Retirement Non-Lendable Fund M	**Ticker:** N/A **Objective:** The Fund seeks to provide for retirement outcomes consistent with investor preferences throughout the savings and draw down phase based on quantitatively measured risk that investors, on average, may be willing to accept. **Strategy:** The Fund is a collective investment trust maintained and managed by BlackRock Institutional Trust Company, N.A. ("BTC"). The Fund shall be invested and reinvested in securities and other assets with the objective of providing for retirement outcomes consistent with investor preferences throughout the savings and drawdown phase based on quantitatively measured risk that investors, on average, may be willing to accept. In pursuit of that objective, the Fund will be broadly diversified across global asset classes, with asset allocations becoming more conservative over time if the Fund has a year in its name. The Fund's investments may include: equity securities; depositary receipts; debt securities and other fixed income obligations (including those issued or guaranteed by the U.S. government, its agencies or instrumentalities, and those issued by corporations or other entities); mortgage-backed securities; other asset-backed securities; commodities; and/or cash equivalents. The Fund may invest in securities and other obligations of U.S. issuers or non-U.S. issuers, and those issuers may be of any market capitalization. The Fund's fixed income investments may be investment-grade or non-investment grade, and may include securities and other obligations of any maturity. In addition to, or in lieu of, investing in the assets listed above, the Fund may engage in structured transactions in these asset classes, as well as over-the-counter forward contracts, swaps and options. When deemed appropriate by BTC, the Fund may invest in futures contracts, for the purpose of acting as a temporary substitute for investment in securities and/or to gain exposure to commodities. The difference between the normal and current securities holdings for the Fund varies over time and is based on the factors analyzed by the asset allocation model used by BTC to manage the Fund. The normal asset allocations will gradually change over the investment horizon of the Fund to become more heavily oriented toward debt and debt-like securities. As time passes, the Fund is managed more conservatively — prior to retirement — in terms of its allocation to equity securities and markets, on the premise that individuals investing for retirement desire to reduce investment risk in their retirement accounts as their retirement date approaches. The trajectory along which asset allocations are adjusted over time to gradually become more conservative is called the "glidepath." The glidepath illustrates the target allocation among asset classes as the Fund approaches its target date. The target asset allocation of the Fund at its retirement date is expected to be 40% in underlying index funds that invest primarily in equity and equity-like securities and 60% in underlying index funds that invest primarily in fixed income and fixed income-like securities. BTC employs a proprietary investment model that analyzes securities market data, including risk, correlation and expected return statistics, to recommend the portfolio allocation among the asset classes. Rather than choosing specific securities within each asset class, BTC selects among indices representing segments of the global equity and debt markets and invests in securities that comprise the chosen index. The Fund generally invests in a chosen index through a series of collective investment trusts maintained and managed by BTC, each such fund representing one of the indices (each, an "Underlying Fund"). In the event of a conflict between this summary description of the Fund's investment objective and principal investment strategies and the Trust Document under which the Fund was established, the Trust Document will govern. For more information related to the Fund, please see the Fund's Trust Document, Profile and most recent audited financial statements. The Fund will not engage in securities lending.

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Fund Name	Description
LifePath® Index Retirement Non-Lendable Fund M ***(continued)***	**Risk:** The fund is subject to the volatility of the financial markets, including that of equity and fixed income investments. Fixed income investments carry issuer default and credit risk, inflation risk, and interest rate risk. (As interest rates rise, bond prices usually fall, and vice versa. This effect is usually more pronounced for longer-term securities.) Principal invested is not guaranteed at any time, including at or after retirement. Additional risk information for this product may be found in the prospectus or other product materials, if available. **Short-term redemption fee:** None **Who may want to invest:** Someone who is seeking an investment option intended for people in retirement and who is willing to accept the volatility of diversified investments in the market. Someone who is seeking a diversified mix of stocks, bonds, and short-term investments in one investment option and looking primarily for the potential for income and, secondarily, for share-price appreciation. **Footnotes:** The investment option is a collective investment trust. It is managed by BlackRock. This description is only intended to provide a brief overview of the fund. This investment option is not a mutual fund. The inception date of this Pool was 09/09/2016. The earliest share class of this Pool had an inception date of 01/23/2009. Performance between the inception date of the earliest share class and the inception date of this Pool was calculated by subtracting this Pool's management fee and the Pool's net administrative expenses for that period from the Pool's gross performance.
Phillips 66 Stock Fund	**Ticker:** N/A **What It Is:** A fund that allows you to own shares of stock of Phillips 66 (PSX). Your ownership is measured in shares of the fund. This is neither a mutual fund nor a diversified or managed investment option. **Goal:** Seeks to increase the value of your investments over the long term by investing in PSX common stock. **What it invests in:** The value of your investment will vary depending on the performance of PSX and the overall stock market. Investing in a nondiversified single stock fund involves more risk than investing in a diversified fund. Share price and return will vary. **Short-term Redemption Fee Note:** None **Who may want to invest:** Someone who wants to own an individual stock and share in its gains or losses. Someone whose investment portfolio can withstand the higher risk of investment in a single stock. **Footnotes:** Chevron Phillips Chemical Company LP provided the description for this fund.

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Fund Name	Description
Snyder Capital Small/Mid Cap Value Collective Investment Fund – R2	**Ticker:** N/A **Objective:** The Fund seeks capital appreciation. **Strategy:** The Fund invests in high quality companies that can appreciate 35-50% over a 3 year time horizon and whose expected appreciation potential is greater than their potential downside. The Funds investable equity universe generally consists of U.S. companies listed on U.S. exchanges that meet at least one of the two following criteria: a member of the Russell 2500™ Index, or has a market cap within the range of the Russell 2500™ Index when it was last. reconstituted. **Risk:** Growth stocks can perform differently from the market as a whole and can be more volatile than other types of stocks. The securities of smaller, less well-known companies can be more volatile than those of larger companies. Stock markets are volatile and can decline significantly in response to adverse issuer, political, regulatory, market, economic or other developments. These risks may be magnified in foreign markets. Additional risk information for this product may be found in the prospectus or other product materials, if available. **Short-term redemption fee:** None **Who may want to invest:** Someone who is seeking the potential for long-term share-price appreciation; Someone who is willing to accept the generally greater price volatility associated both with growth-oriented stocks and with smaller companies. **Footnotes:** The investment option is a collective investment trust. It is managed by Hand Benefits & Trust, a BPAS Co. This description is only intended to provide a brief overview of the fund. The Russell 2500™ Index is an unmanaged market capitalization-weighted index measuring the performance of the 2,500 smallest companies in the Russell 3000 Index. This investment option is not a mutual fund. The analysis on these pages may be based, in part, on adjusted historical returns for periods prior to the class's actual inception of 12/31/2019. The returns are provided by Morningstar and reflect the historical performance of the oldest, eligible share class of the Pool with reported expenses and an inception date of 09/01/2016, adjusted to reflect the fees and expenses of this share class (when this share class's fees and expenses are higher.) The adjusted historical returns are not actual returns. Calculation methodologies utilized by Morningstar may differ from those applied by other entities, including the Pool itself. Please refer to a Pool's offering materials for information regarding its' fees and expenses.

(continued)

Fund Name	Description
Spartan® 500 Index Pool Class D	**Ticker:** N/A **Objective:** The portfolio seeks to replicate the performance and overall characteristics, before fees and expenses, of the S&P 500® Index in a risk-managed and cost-effective way. **Strategy:** The portfolio generally invests at least 80% of its assets in securities of companies that comprise the Index. **Risk:** Stock markets, especially foreign markets, are volatile and can decline significantly in response to adverse issuer, political, regulatory, market, or economic developments. **Short-term redemption fee:** None **Who may want to invest:** Someone who is seeking the potential for long-term share-price appreciation. Someone who is seeking both growth- and value-style investments and who is willing to accept the volatility associated with investing in the stock market. **Footnotes:** This investment option is a Separate Fund ("Fund") established under a Declaration of Separate Funds ("DOSF") pursuant to the Declaration of Trust of the Spartan Group Trust for Employee Benefit Plans ("Trust"). It is managed by Geode Capital Management Trust Company, LLC, as trustee ("Geode"). Neither the Fund nor Geode is registered with the Securities and Exchange Commission and the Fund is not FDIC-insured. The Fund is only available to Qualified Investors as detailed in the Trust. This description is only intended to provide a brief overview of the Fund. Please review the Trust and DOSF for more complete details. The portfolio may not always hold all of the same securities as the Index and may use statistical sampling techniques to attempt to replicate the returns of the Index. Statistical sampling techniques attempt to match the investment characteristics of the Index and the portfolio by taking into account such factors as market capitalization, industry exposures, dividend yield, P/E ratio, P/B ratio, and earnings growth. Information presented herein is for discussion and illustrative purposes only and is not a recommendation nor an offer or solicitation to buy or sell any securities. Past performance is no guarantee of future results. References to any index do not imply that the portfolio will achieve returns, volatility, or other results similar to the index. The composition of the index may not reflect the manner in which the portfolio is constructed in relation to expected or achieved returns, portfolio guidelines, restrictions, sectors, correlations, concentrations, volatility or tracking error targets, all of which are subject to change over time. S&P 500® Index is a market capitalization-weighted index of 500 common stocks chosen for market size, liquidity, and industry group representation to represent U.S. equity performance. This investment option is not a mutual fund. The inception date of this Pool was 10/13/2017. The earliest share class of this Pool had an inception date of 06/30/2017. Performance between the inception date of the earliest share class and the inception date of this Pool was calculated by subtracting this Pool's management fee and the Pool's net administrative expenses for that period from the Pool's gross performance.

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Fund Name	Description
Spartan® Extended Market Index Pool Class D	**Ticker:** N/A **Objective:** The portfolio seeks to replicate the performance and overall characteristics, before fees and expenses, of the Dow Jones U.S. Completion Total Stock Market Index℠ in a risk-managed and cost-effective way. **Strategy:** The Portfolio generally invests at least 80% of its assets in securities of companies that comprise the Index. **Risk:** Stock markets, especially foreign markets, are volatile and can decline significantly in response to adverse issuer, political, regulatory, market, or economic developments. Investments in smaller companies may involve greater risks than those in larger, more well-known companies. **Short-term redemption fee:** None **Who may want to invest:** Someone who is seeking the potential for long-term share-price appreciation and, secondarily, dividend income. Someone who is seeking both growth- and value-style investments and who is willing to accept the generally greater volatility of investments in smaller companies. **Footnotes:** This investment option is a Separate Fund ("Fund") established under a Declaration of Separate Funds ("DOSF") pursuant to the Declaration of Trust of the Spartan Group Trust for Employee Benefit Plans ("Trust"). It is managed by Geode Capital Management Trust Company, LLC, as trustee ("Geode"). Neither the Fund nor Geode is registered with the Securities and Exchange Commission and the Fund is not FDIC-insured. The Fund is only available to Qualified Investors as detailed in the Trust. This description is only intended to provide a brief overview of the Fund. Please review the Trust and DOSF for more complete details. The Portfolio may not always hold all of the same securities as the Index and may use statistical sampling techniques to attempt to replicate the returns of the Index. Statistical sampling techniques attempt to match the investment characteristics of the Index and the Portfolio by taking into account such factors as market capitalization, industry exposures, dividend yield, P/E ratio, P/B ratio, and earnings growth. Information presented herein is for discussion and illustrative purposes only and is not a recommendation nor an offer or solicitation to buy or sell any securities. Past performance is no guarantee of future results. References to any index do not imply that the portfolio will achieve returns, volatility, or other results similar to the index. The composition of the index may not reflect the manner in which the portfolio is constructed in relation to expected or achieved returns, portfolio guidelines, restrictions, sectors, correlations, concentrations, volatility or tracking error targets, all of which are subject to change over time. The Dow Jones U.S. Completion Total Stock Market Index is an unmanaged index that represents all U.S. equity issues with readily available prices, excluding components of the S&P 500. This investment option is not a mutual fund. The inception date of this Pool was 10/01/2021. The earliest share class of this Pool had an inception date of 08/03/2018. Performance between the inception date of the earliest share class and the inception date of this Pool was calculated by subtracting this Pool's management fee and the Pool's net administrative expenses for that period from the Pool's gross performance.

(continued)

Fund Name	Description
Spartan® Global ex US Index Pool Class D	**Ticker:** N/A **Objective:** The portfolio seeks to replicate the performance and overall characteristics, before fees and expenses, of the MSCI ACWI ex USA Index in a risk-managed and cost-effective way. **Strategy:** The portfolio will generally employ a fund-of-fund process by investing in units of the Spartan Developed International Index Pool and the Spartan Emerging Market Index Pool (together "Underlying Collective Investment Pools") established under the Declaration of Trust of the Spartan Group Trust for Employee Benefit Plans ("Trust") managed by Geode Capital Management Trust Company, LLC as trustee ("Geode"). Geode sets the target asset allocation mix for the portfolio in the Underlying Collective Investment Pools. **Risk:** Stock markets, especially foreign markets, are volatile and can decline significantly in response to adverse issuer, political, regulatory, market, or economic developments. Foreign securities are subject to interest rate, currency exchange rate, economic, and political risks, all of which are magnified in emerging markets. **Short-term redemption fee:** None **Who may want to invest:** Someone who is seeking to complement a portfolio of domestic investments with international investments, which can behave differently. Someone who is willing to accept the higher degree of risk associated with investing overseas. **Footnotes:** This investment option is a Separate Fund ("Fund") established under a Declaration of Separate Funds ("DOSF") pursuant to the Declaration of Trust of the Spartan Group Trust for Employee Benefit Plans ("Trust"). It is managed by Geode Capital Management Trust Company, LLC, as trustee ("Geode"). Neither the Fund nor Geode is registered with the Securities and Exchange Commission and the Fund is not FDIC-insured. The Fund is only available to Qualified Investors as detailed in the Trust. This description is only intended to provide a brief overview of the Fund. Please review the Trust and DOSF for more complete details. The portfolio, including the Underlying Collective Investment Pools on a look through basis, may not always hold all of the same securities as the Index and may use statistical sampling techniques to attempt to replicate the returns of the Index. Statistical sampling techniques attempt to match the investment characteristics of the Index and the portfolio (including the Underlying Collective Investment Pools) by taking into account such factors as market capitalization, industry exposures, dividend yield, P/E ratio, P/B ratio, and earnings growth. Information presented herein is for discussion and illustrative purposes only and is not a recommendation nor an offer or solicitation to buy or sell any securities. Past performance is no guarantee of future results. References to any index do not imply that the portfolio will achieve returns, volatility, or other results similar to the index. The composition of the index may not reflect the manner in which the portfolio is constructed in relation to expected or achieved returns, portfolio guidelines, restrictions, sectors, correlations, concentrations, volatility or tracking error targets, all of which are subject to change over time. MSCI ACWI ex USA Index is a market capitalization-weighted index of stocks traded in global developed and emerging markets, excluding the United States. This investment option is not a mutual fund. The inception date of this share class was 12/05/2023. The earliest share class of this Pool had an inception date of 08/11/2017. Performance between the inception date of this share class and the inception date of this Pool was calculated by subtracting this Pool's management fee and the Pool's net administrative expenses for that period from the Pool's gross performance.

(continued)

Fund Name	Description
Spartan® Large Cap Value Index Pool Class D	**Ticker:** N/A **Objective:** The portfolio seeks to replicate the performance and overall characteristics, before fees and expenses, of the Russell 1000 Value Index in a risk-managed and cost-effective way. **Strategy:** The portfolio generally invests at least 80% of its assets in securities of companies that comprise the Index. **Risk:** Stock markets, especially foreign markets, are volatile and can decline significantly in response to adverse issuer, political, regulatory, market, or economic developments. Value stocks can perform differently than other types of stocks and can continue to be undervalued by the market for long periods of time. **Short-term redemption fee:** None **Who may want to invest:** Someone who is seeking the potential for long-term share-price appreciation. Someone who is comfortable with the volatility of large-cap stocks and value-style investments. **Footnotes:** This investment option is a Separate Fund ("Fund") established under a Declaration of Separate Funds ("DOSF") pursuant to the Declaration of Trust of the Spartan Group Trust for Employee Benefit Plans ("Trust"). It is managed by Geode Capital Management Trust Company, LLC, as trustee ("Geode"). Neither the Fund nor Geode is registered with the Securities and Exchange Commission and the Fund is not FDIC-insured. The Fund is only available to Qualified Investors as detailed in the Trust. This description is only intended to provide a brief overview of the Fund. Please review the Trust and DOSF for more complete details. The portfolio may not always hold all of the same securities as the Index and may use statistical sampling techniques to attempt to replicate the returns of the Index. Statistical sampling techniques attempt to match the investment characteristics of the Index and the portfolio by taking into account such factors as market capitalization, industry exposures, dividend yield, P/E ratio, P/B ratio, and earnings growth. Information presented herein is for discussion and illustrative purposes only and is not a recommendation nor an offer or solicitation to buy or sell any securities. Past performance is no guarantee of future results. References to any index do not imply that the portfolio will achieve returns, volatility, or other results similar to the index. The composition of the index may not reflect the manner in which the portfolio is constructed in relation to expected or achieved returns, portfolio guidelines, restrictions, sectors, correlations, concentrations, volatility or tracking error targets, all of which are subject to change over time. Russell 1000 Value Index is a market capitalization-weighted index designed to measure the performance of the large-cap value segment of the U.S. equity market. This investment option is not a mutual fund.

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Fund Name	Description
Vanguard Federal Money Market Fund Investor Shares	**Ticker:** VMFXX **Objective:** The investment seeks to provide current income while maintaining liquidity and a stable share price of $1. **Strategy:** The fund invests primarily in high-quality, short-term money market instruments. Under normal circumstances, at least 80% of the fund's assets are invested in securities issued by the U.S. government and its agencies and instrumentalities. It maintains a dollar-weighted average maturity of 60 days or less and a dollar-weighted average life of 120 days or less. The fund generally invests 100% of its assets in government securities and therefore will satisfy the 99.5% requirement for designation as a government money market fund. **Risk:** You could lose money by investing in a money market fund. Although the fund seeks to preserve the value of your investment at $1.00 per share, it cannot guarantee it will do so. An investment in the fund is not insured or guaranteed by the Federal Deposit Insurance Corporation or any other government agency. The fund's sponsor has no legal obligation to provide financial support to money market funds and you should not expect that the sponsor will provide financial support to the fund at any time. Additional risk information for this product may be found in the prospectus or other product materials, if available. **Short-term Redemption Fee Note:** None **Who may want to invest:** Someone who has a low tolerance for investment risk and who wishes to keep the value of his or her investment relatively stable. Someone who is seeking to complement his or her bond and stock fund holdings in order to reach a particular asset allocation. **Footnotes:** This description is only intended to provide a brief overview of the fund. Read the fund's prospectus for more detailed information about the fund. Weighted average maturity (WAM) is the weighted average of all the maturities of the securities held in a fund. WAM for money market funds can be used as a measure of sensitivity to interest rate changes. Generally, the longer the maturity, the greater the sensitivity. WAM for money market funds is based on the dollar-weighted average length of time until principal payments must be paid, taking into account any call options exercised by the issuer and any permissible maturity shortening devices, such as demand features and interest rate resets. For bond funds, WAM can be used as a measure of sensitivity to the markets. Generally, the longer the maturity, the greater the sensitivity. The WAM calculation for bond funds excludes interest rate resets and only takes into account issuer call options if it is probable that the issuer of the instrument will take advantage of such options. For money market funds, weighted average life (WAL) is the weighted average of the life of the securities held in a fund or portfolio, and can be used as a measure of sensitivity to changes in liquidity and/or credit risk. Generally, the higher the value, the greater the sensitivity. WAL is based on the dollar-weighted average length of time until principal payments must be paid, taking into account any call options exercised by the issuer and any permissible maturity shortening features other than interest rate resets. For money market funds, the difference between weighted average maturity (WAM) and WAL is that WAM takes into account interest rate resets and WAL does not. WAL for money market funds is not the same as WAL of a mortgage- or asset-backed security.

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Fund Name	Description
Vanguard Real Estate Index Fund Institutional Shares	**Ticker:** VGSNX **Objective:** The investment seeks to provide a high level of income and moderate long-term capital appreciation by tracking the performance of the MSCI US Investable Market Real Estate 25/50 Index that measures the performance of publicly traded equity REITs and other real estate-related investments. **Strategy:** The advisor attempts to track the index by investing all, or substantially all, of its assets — either directly or indirectly through a wholly owned subsidiary, which is itself a registered investment company — in the stocks that make up the index, holding each stock in approximately the same proportion as its weighting in the index. The fund is non-diversified. **Risk:** Real Estate is a cyclical industry that is sensitive to interest rates, economic conditions (both nationally and locally), property tax rates, and other factors. Changes in real estate values or economic downturns can have a significant negative effect on issuers in the real estate industry. Stock markets are volatile and can decline significantly in response to adverse issuer, political, regulatory, market, economic or other developments. These risks may be magnified in foreign markets. Sector funds can be more volatile because of their narrow concentration in a specific industry. In general the bond market is volatile, and fixed income securities carry interest rate risk. (As interest rates rise, bond prices usually fall, and vice versa. This effect is usually more pronounced for longer-term securities.) Fixed income securities also carry inflation risk and credit and default risks for both issuers and counterparties. Unlike individual bonds, most bond funds do not have a maturity date, so avoiding losses caused by price volatility by holding them until maturity is not possible. Additional risk information for this product may be found in the prospectus or other product materials, if available. **Short-term redemption fee:** None **Who may want to invest:** Someone who is willing to accept the potentially lower diversification and higher risks associated with investing in a particular industry or sector; Someone who is seeking to complement his or her core holdings with investments concentrated in a particular sector or industry. **Footnotes:** This description is only intended to provide a brief overview of the mutual fund. Read the fund's prospectus for more detailed information about the fund. MSCI US Investable Market Real Estate 25/50 Transition Index measures the performance of publicly traded equity REITs and other real estate-related investments. The analysis on these pages may be based, in part, on adjusted historical returns for periods prior to the class's actual inception of 12/02/2003. These calculated returns reflect the historical performance of the oldest share class of the fund, with an inception date of 05/13/1996, adjusted to reflect the fees and expenses of this share class (when this share class's fees and expenses are higher.) Please refer to a fund's prospectus for information regarding fees and expenses. These adjusted historical returns are not actual returns. Calculation methodologies utilized by Morningstar may differ from those applied by other entities, including the fund itself.

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Fund Name	Description
Vanguard Short-Term Inflation-Protected Securities Index Fund Institutional Shares	**Ticker:** VTSPX **Objective:** The investment seeks to track the performance of a Bloomberg U.S. 0-5 Year Treasury Inflation-Protected Securities Index that measures the investment return of inflation-protected public obligations of the U.S. Treasury with remaining maturities of less than 5 years. **Strategy:** The index is a market-capitalization-weighted index that includes all inflation-protected public obligations issued by the U.S. Treasury with remaining maturities of less than 5 years. **Risk:** The interest payments of TIPS are variable, they generally rise with inflation and fall with deflation. In general the bond market is volatile, and fixed income securities carry interest rate risk. (As interest rates rise, bond prices usually fall, and vice versa. This effect is usually more pronounced for longer-term securities.) Fixed income securities also carry inflation risk and credit and default risks for both issuers and counterparties. Unlike individual bonds, most bond funds do not have a maturity date, so avoiding losses caused by price volatility by holding them until maturity is not possible. Additional risk information for this product may be found in the prospectus or other product materials, if available. **Short-term redemption fee:** None **Who may want to invest:** Someone who is seeking potential returns primarily in the form of interest income and who can tolerate more frequent changes in the size of income distributions than those usually found with more conservative bond funds; Someone who is seeking to supplement his or her core fixed-income holdings with a bond investment that is tied to changes in inflation. **Footnotes:** This description is only intended to provide a brief overview of the mutual fund. Read the fund's prospectus for more detailed information about the fund. Bloomberg U.S. 0-5 Year TIPS Index is an unmanaged market index comprised of U.S. Treasury Inflation Protected securities having a maturity of less than five years.

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Fund Name	Description
Vanguard Total Bond Market Index Fund Institutional Plus Shares	**Ticker:** VBMPX **Objective:** The investment seeks to track the performance of the Bloomberg U.S. Aggregate Float Adjusted Index. **Strategy:** This index measures the performance of a wide spectrum of public, investment-grade, taxable, fixed income securities in the United States — including government, corporate, and international dollar-denominated bonds, as well as mortgage-backed and asset-backed securities — all with maturities of more than 1 year. All of the fund's investments will be selected through the sampling process, and at least 80% of its assets will be invested in bonds held in the index. **Risk:** In general the bond market is volatile, and fixed income securities carry interest rate risk. (As interest rates rise, bond prices usually fall, and vice versa. This effect is usually more pronounced for longer-term securities.) Fixed income securities also carry inflation risk and credit and default risks for both issuers and counterparties. Unlike individual bonds, most bond funds do not have a maturity date, so avoiding losses caused by price volatility by holding them until maturity is not possible. Additional risk information for this product may be found in the prospectus or other product materials, if available. **Short-term redemption fee:** None **Who may want to invest:** Someone who is seeking potential returns primarily in the form of interest income rather than through an increase in share price; Someone who is seeking to diversify an equity portfolio with a more conservative investment option. **Footnotes:** This description is only intended to provide a brief overview of the mutual fund. Read the fund's prospectus for more detailed information about the fund. The Bloomberg U.S. Aggregate Float Adjusted Index measures the total universe of public, investment-grade, taxable, fixed income securities in the United States — including government, corporate, and international dollar-denominated bonds, as well as mortgage-backed and asset-backed securities — all with maturities of more than 1 year. The analysis on these pages may be based, in part, on adjusted historical returns for periods prior to the class's actual inception of 02/05/2010. These calculated returns reflect the historical performance of the oldest share class of the fund, with an inception date of 12/11/1986, adjusted to reflect the fees and expenses of this share class (when this share class's fees and expenses are higher.) Please refer to a fund's prospectus for information regarding fees and expenses. These adjusted historical returns are not actual returns. Calculation methodologies utilized by Morningstar may differ from those applied by other entities, including the fund itself.

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Fund Name	Description
William Blair Small Mid Cap Growth CIT – Class III	**Ticker:** N/A **Objective:** The Fund seeks to outperform the Russell 2500® Growth Index over a full market cycle. **Strategy:** The Fund invests is a diversified portfolio of small and medium-sized growth companies. **Risk:** Growth stocks can perform differently from the market as a whole and can be more volatile than other types of stocks. The securities of smaller, less well-known companies can be more volatile than those of larger companies. Stock markets are volatile and can decline significantly in response to adverse issuer, political, regulatory, market, economic or other developments. These risks may be magnified in foreign markets. Additional risk information for this product may be found in the prospectus or other product materials, if available. **Short-term redemption fee:** None **Who may want to invest:** Someone who is seeking the potential for long-term share-price appreciation; Someone who is willing to accept the generally greater price volatility associated both with growth-oriented stocks and with smaller companies. **Footnotes:** The investment option is a collective investment trust. It is managed by Global Trust Company. This description is only intended to provide a brief overview of the fund. Russell 2500 Growth Index is a market capitalization-weighted index designed to measure the performance of the small to mid-cap growth segment of the U.S. equity market. It includes those Russell 2500 Index companies with higher price-to-book ratios and higher forecasted growth rates. This investment option is not a mutual fund. The analysis on these pages may be based, in part, on adjusted historical returns for periods prior to the class's actual inception of 08/29/2017. The returns are provided by Morningstar and reflect the historical performance of the oldest, eligible share class of the Pool with reported expenses and an inception date of 05/01/2012, adjusted to reflect the fees and expenses of this share class (when this share class's fees and expenses are higher.) The adjusted historical returns are not actual returns. Calculation methodologies utilized by Morningstar may differ from those applied by other entities, including the Pool itself. Please refer to a Pool's offering materials for information regarding its' fees and expenses.