(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 1-800-446-1422, option 3. 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-26 – P-27) 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 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:

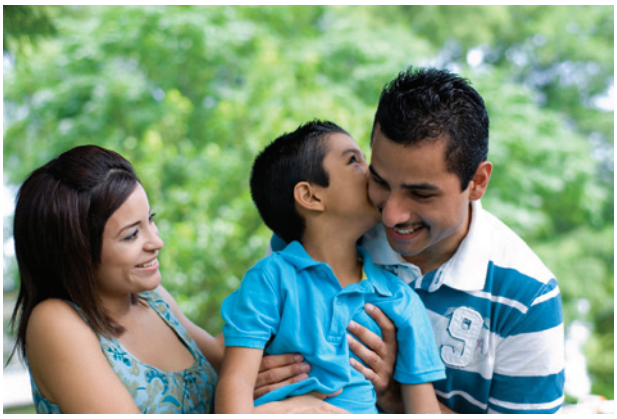
- Submit written comments, documents, records and other information relating to the claim for benefits,
- Request, free of charge, reasonable access to, and copies of, all documents, records and other information relevant to your claim for benefits. For this purpose, a document, record or other information 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-14.

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 the Chevron Phillips Employee Service Center at 1-800-446-1422, option 3 of a change of address or, as an active employee, you may update your mailing address on the Employee Self Service website. Otherwise, you may not get important information about your benefits. 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 Chevron Phillips Benefits Service Center at 1-800-446-1422, option 1.

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 logging onto our website at http://ncompass.cpchem.net.

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 David Heinsohn. He may be contacted at 832-813-4853; by e-mail at heinsdb@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. For example, the child must meet the plan's definition of an eligible dependent as defined under ***Dependents*** on page A-3.

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: 1-800-446-1422, option 3
- Claims administrators: See pages P-26 – P-27
- 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-26 – P-27
- 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: 1-800-446-1422, option 3
- 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

Phone: 1-800-446-1422 (option 1) or (832) 813-1422 (option 1)

Fax: (832) 590-7480

Mail: Chevron Phillips Benefits Service Center
P.O. Box 10361
Des Moines, IA 50306

Website: www.mercerbenefitscentral.com/cpchembenefits

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)	1-800-424-4519 www.MagellanAscend.com
Critical Illness Plan	1-800-446-1422, option 1 www.mercerbenefitscentral.com/cpchembenefits
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.payflex.com
Health Savings Account (HSA)	1-866-771-5225 www.netbenefits.com
Retiree Reimbursement Account (RRA)	1-888-678-8242 www.payflex.com
AARP Medicare Supplement Plans	1-800-392-7537 www.aarphealthcare.com (CPChem Group #845)
Basic and Supplemental Life Insurance Plans	1-800-446-1422, option 1 www.mercerbenefitscentral.com/cpchembenefits
Basic and Supplemental Accidental Death and Personal Loss (AD&PL) Plans	1-800-446-1422, option 1 www.mercerbenefitscentral.com/cpchembenefits
Occupational Accidental Death and Personal Loss (OAD&PL) Plan	1-800-446-1422, option 1 www.mercerbenefitscentral.com/cpchembenefits
Business Travel Accident Plan	1-800-446-1422, option 1 www.mercerbenefitscentral.com/cpchembenefits
Long-Term Disability (LTD) Plan	1-800-446-1422, option 1 www.mercerbenefitscentral.com/cpchembenefits
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	1-877-401-5762 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	Magellan Healthcare Magellan Midwest Office 14100 Magellan Plaza Maryland Heights, MO 63043 1-800-424-4519 www.MagellanAscend.com
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	PayFlex Systems USA, Inc. P.O. Box 4000 Richmond, KY 40476-4000 1-888-678-8242 www.payflex.com
Chevron Phillips Chemical Company LP Retiree Medical Reimbursement Account Plan	Retiree medical benefits	Funded by Company contributions	PayFlex Systems USA, Inc. P.O. Box 4000 Richmond, KY 40476-4000 1-888-678-8242 www.payflex.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 1-800-446-1422, option 1 www.mercerbenefitscentral.com/cpchembenefits
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 1-800-446-1422, option 1 www.mercerbenefitscentral.com/cpchembenefits
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 1-800-446-1422, option 1 www.mercerbenefitscentral.com/cpchembenefits
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 1-800-446-1422, option 1 www.mercerbenefitscentral.com/cpchembenefits
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 1-800-446-1422, option 1 www.mercerbenefitscentral.com/cpchembenefits
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 1-800-446-1422, option 1 www.mercerbenefitscentral.com/cpchembenefits
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 1-800-446-1422, option 1 www.mercerbenefitscentral.com/cpchembenefits
Chevron Phillips Chemical Company LP Long-Term Disability Plan	Group benefit plan	Fully funded by employee contributions	MetLife Disability Unit P.O. Box 14590 Lexington, KY 40511 1-800-446-1422, option 1 www.mercerbenefitscentral.com/cpchembenefits
Chevron Phillips Chemical Company LP Group Legal Plan	Group benefit plan	Fully funded by employee contributions	Hyatt 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	PayFlex Systems USA, Inc. P.O. Box 4000 Richmond, KY 40476-4000 1-888-678-8242 www.payflex.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 Chevron Phillips Benefits Service Center at 1-800-446-1422 (option 1).

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 2020. 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 Chevron Phillips Benefits Service Center at 1-800-446-1422, option 1. **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.