

General Information

(Performance Pipe Hourly Employees)



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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 301 – 302) by calling the toll-free number or accessing the appropriate Web site.



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, EAP/behavioral health, dental, health care FSA claims and RRA claims)



Time Frame for Initial Claim Determination

For urgent care claims and pre-service claims (claims that require approval of the benefit before receiving medical care), Aetna Life Insurance Company 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 (claims that are submitted for payment after receiving medical care), 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 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. This paragraph only applies to a failure that:

- Is a communication by you or your authorized representative that is received by a person or organizational unit customarily responsible for handling benefit matters, and
- Is a communication that names you, a specific medical condition or symptom, and a specific treatment, service or product for which approval is requested.

Urgent Care Claims

Urgent care claims are those which, unless the special urgent care deadlines for response to a claim are followed, either:

- Could seriously jeopardize the patient's life, health or ability to regain maximum function, or
- In the opinion of a physician with knowledge of the patient's medical condition, would subject the patient to severe pain that cannot be adequately managed without the care or treatment requested in the claim for benefits.



An individual acting on behalf of the benefit plan, applying the judgment of a prudent layperson who has an average knowledge of health and medicine, can determine whether the urgent care definition has been satisfied. However, if a physician with knowledge of the patient's medical condition determines that the claim involves urgent care, it must be considered an urgent care claim.



Concurrent Care Claims

If an ongoing course of treatment was previously approved for a specific period of time or number of treatments, and your request to extend the treatment is an urgent care claim as defined earlier, your request will be decided within 24 hours, provided your request is made at least 24 hours prior to the end of the approved treatment.

If your request for extended treatment is not made within 24 hours before the end of the approved treatment, the request will be treated as an urgent care claim and decided according to the urgent care claim time frames described earlier. If an ongoing course of treatment was previously approved for a specific period of time or number of treatments, and your request to extend treatment is a non-urgent circumstance, your request will be considered a new claim and decided according to pre-service or post-service time frames, whichever applies.



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.

If You Receive an Adverse Benefit Determination

You will be notified of any adverse benefit determination after the receipt of an initial claim. 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,
- 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.

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, you may ask for a standard review. You, or your authorized representative, have 180 days following the receipt of a notification of an adverse benefit determination within which to appeal the determination.

You have the right to:

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



- Was relied upon in making the benefit determination,
 - Was submitted, considered or generated in the course of making the benefit determination, regardless of whether such document, record or other information was relied upon in making the benefits determination,
 - Demonstrates compliance with the administrative processes and safeguards required in making the benefits determination, or
 - Constitutes a statement of policy or guidance with respect to the benefit plan concerning the denied 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.



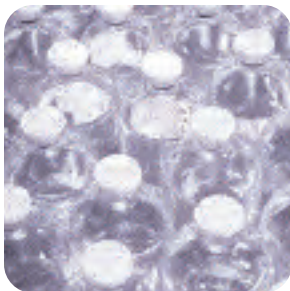


Ordinarily, a decision regarding your appeal will be reached within:

- 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.





Appeals Process for Prescription Drug Claims

There is also a specific process for appealing an adverse benefit determination of a prescription drug claim. As an alternative, or in addition, to contacting the claims administrator, as described in the preceding section, you have a right to appeal the denial of your paper claim submitted to the claims administrator or your Prior Authorization request.

Your appeal must be filed within 180 days of the date you or your authorized representative received notice of the denial. If your request is not submitted during this 180-day period, you and your authorized representative will be barred from challenging the claims administrator's denial.



Except with respect to an appeal of a claim involving urgent care, as described below, your appeal must be submitted by you or your authorized representative and must be submitted in writing to the following address:

Express Scripts, Inc.
Attn: Pharmacy Appeals
6625 West 78th Street, Mail Route BL0390
Bloomington, MN 55439

If your appeal involves an urgent care Prior Authorization request for which you have not received the requested drug or supply before submission of the appeal, either you, your authorized representative or your physician may submit your appeal verbally by calling 1-800-887-1044. Your appeal will be routed to Managing Care Managing Claims, LLC (MCMC), an independent third-party utilization management company. MCMC will be responsible for conducting your appeal within the following time frames, depending on the type of claim:

- If your appeal is filed after you received the prescription drug or supply in dispute, MCMC will notify you or your authorized representative of its decision within a reasonable period of time, but not later than 60 days following receipt of the appeal.
- If your appeal involves a non-urgent care Prior Authorization request, and your appeal is filed prior to receiving the prescription drug or supply, MCMC will notify you or your authorized representative of its decision within 30 days following receipt of the appeal.



- If your appeal involves an urgent care Prior Authorization request, and the appeal is filed prior to receiving the prescription drug or supply, MCMC will notify you or your authorized representative of its decision either by fax, telephone or other available similarly expeditious method within 72 hours of receipt of the appeal.

The plan administrator has designated MCMC as a fiduciary for the limited purpose of the review and determination of appeals, as described above. In such capacity relating to appeals, the plan administrator delegates to MCMC the full and discretionary authority, which shall be binding and final, to interpret, construe and administer the plan, resolve any ambiguities relating to the plan, make all factual determinations relating to the plan and determine the validity of charges submitted under the plan.

In deciding the appeal, MCMC will give no deference to the claims administrator's initial denial. You or your authorized representative have the right to submit written comments, documents, records and other information relating to your claim, all of which will be taken into account in the review, whether or not previously submitted or considered.

If you or your authorized representative wish to submit such information for consideration, please do so when submitting your appeal. You or your authorized representative have the right to receive, upon request and free of charge, access to and copies of all documents, records and other information relevant to your claim and MCMC's denial.

Please note, however, that a request for information does not constitute an appeal. To receive copies of this information, your request must be mailed to the Express Scripts appeal address listed on the previous page. You or your authorized representative may also request that any medical or vocational experts who advised MCMC or the claims administrator regarding your claim be identified. To receive this information, your request should be mailed to the Express Scripts appeal address listed on the previous page. If your claim was denied on the basis of a medical judgment (including determination of whether a particular treatment, drug or other item is experimental, investigational, medically necessary or appropriate), MCMC will consult a health care professional with appropriate training and experience.





Any health care professional who was consulted in connection with the initial denial of your claim, or his or her subordinates, will not be consulted on appeal. If the notice of a denial (in whole or in part) of any claim advises you that you need to submit additional information in order to perfect your claim, then you should make arrangements to submit all requested information if, and when, you file your appeal. Failure to promptly submit any additional information may result in the denial of your appeal.

The notice of the decision on appeal will be given in writing or, in the case of an urgent care claim, by telephone, facsimile or similar means. The decision on appeal will be final and nonreviewable, unless a court determines that the decision is arbitrary and capricious. Once you have exhausted all of your appeal rights, as described above, you have a right to bring a civil action under Section 502(a) of ERISA.

Exhaustion of Process

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.

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 External Review Organization. “External Review Organization” (ERO) means the entity with which the claims administrator has contracted to conduct external reviews for the plan.

The independent physician, appointed by the ERO, must be board certified by the appropriate American medical specialty board in a clinical specialty/area at issue to the external review. The ERO 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 ERO 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 ERO review is available to you. If available, the plan administrator shall designate an ERO to conduct the review and transmit to the entity all information necessary for the ERO 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 ERO to consider.

The ERO will notify you that it has received the external review request and indicate the date that the claims administrator received such request. The ERO 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 ERO/physician reviewer within 5 calendar days of receipt of such request by the claims administrator.

The ERO will submit the review determination to the claims administrator and you (or your authorized representative, if applicable), and specify whether the determination is upheld or reversed, and briefly specify the basis for such determination in accordance with plan documents and criteria. The determination of the ERO 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.

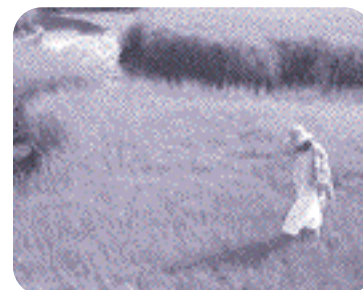
By accepting benefits under the plan, you authorize and direct any person or institution that has provided services to you to furnish the plan or the claims administrator with all information or copies of records relating to the services provided to you. The plan administrator or the claims administrator 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.



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.

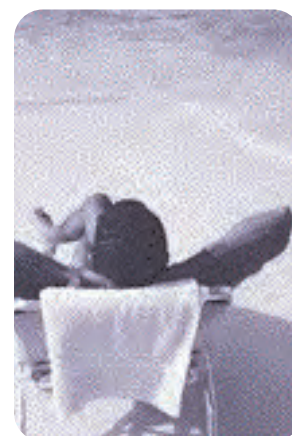


Procedures for Appealing an Adverse Benefit Determination

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 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.



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 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 civil action under section 502(a) of ERISA after an appeal of an adverse benefit determination.





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 civil action under section 502(a) of ERISA.



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 appeal any claim denial 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, 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 288.





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 is not made whole). You or your dependent is 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 believes 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 does all of the following:

- Includes 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,
- Notifies 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,



- Obtains and holds all proceeds and refrains 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,
- Makes 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
- Cooperates fully with the Chevron Phillips Chemical plan in asserting the plan's rights, provides the plan with any and all reasonably required information, and executes 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 or, as an active employee, you may update your mailing address on the Employee Self Service Web site. 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. The Company has no obligation or duty to locate a plan participant, beneficiary or dependent.

No Implied Rights to Employment

The adoption and maintenance of these benefit programs do not represent an employment contract between Chevron Phillips Chemical and its employees. Nor do 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.



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. 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.

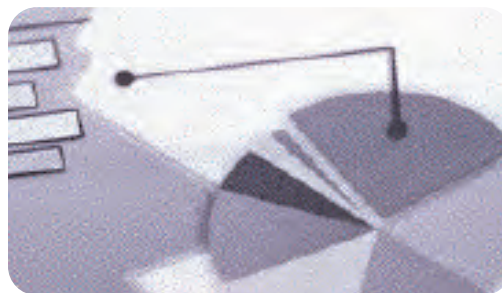


If you have any questions about this statement or about your rights under ERISA, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits 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 — 1-800-998-7542 — of the Employee Benefits Security Administration.

Health Insurance Portability and Accountability Act (HIPAA)

The federal law, HIPAA, requires group health plans such as Chevron Phillips Chemical's to protect the privacy and security of your confidential health information. The Compliance Assurance Manager monitors the Company's compliance with this law. For more information, or for a copy of the Notice of Privacy Practices, contact:

HIPAA Privacy Officer
Chevron Phillips Chemical Company LP
10001 Six Pines Drive
The Woodlands, TX 77380
Phone: 1-800-446-1422, option 3





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 ***When You're on a Leave of Absence — Family Medical Leave*** section on page 21),
- 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 on page 24.

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 8.

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 Web site ("QDRO Center"), a fully secure internet Web site, 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 Web sites 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 770001
Cincinnati, OH 45277-0018
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 301 – 302
- 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 301 – 302
- 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 9735
Providence, RI 02940

Web site: cpchembenefits.mercerhrs.com





Plan Phone Numbers and Web Sites

Note: The vendor Web sites listed below are also accessible through the Chevron Phillips Chemical Intranet/Extranet at www.benefitium.com.

Plan Name	Vendor Phone Number/Web Site
Medical and Behavioral Health Plan	1-800-269-5314 www.aetna.com
Prescription Drug Plan	1-800-243-9800 www.express-scripts.com
Employee Assistance Program	1-866-841-9377 www.aetnaEAP.com (Company ID code: MYCPCEAP)
Dental Plan	1-800-269-5314 www.aetna.com
Flexible Spending Account Program	1-888-238-6226 www.aetna.com
Retiree Reimbursement Account	1-888-238-6226 www.aetna.com
AARP Medicare Supplement Plans	1-800-392-7537 www.aarphealthcare.com (CPChem Group #845)
Basic Life Insurance Plan	1-800-446-1422, option 1 cpchembenefits.mercerhrs.com
Supplemental Life Insurance Plan	1-800-446-1422, option 1 cpchembenefits.mercerhrs.com
Basic Accidental Death and Personal Loss Plan	1-800-446-1422, option 1 cpchembenefits.mercerhrs.com
Occupational Accidental Death and Personal Loss Plan	1-800-446-1422, option 1 cpchembenefits.mercerhrs.com
Supplemental Accidental Death and Personal Loss Plan	1-800-446-1422, option 1 cpchembenefits.mercerhrs.com
Business Travel Accident Plan	1-800-446-1422, option 1 cpchembenefits.mercerhrs.com
Long-Term Disability Plan	1-800-446-1422, option 1 cpchembenefits.mercerhrs.com
401(k) Savings and Profit-Sharing Plan	1-866-771-5225 www.netbenefits.com



Plan Facts and Financing

Note: The vendor Web sites listed in this section are also accessible through the Chevron Phillips Chemical Intranet/Extranet at www.benefitium.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 Midwest Trust Company, 209 West Jackson Boulevard, Suite 700, Chicago, IL 60606.

Official Plan Name	Plan Type	Funding	Claim Assistance and Administration
Chevron Phillips Chemical Company LP Medical Plan	Group medical benefit plan	Self-funded by employee and Company contributions	Aetna P.O. Box 14586 Lexington, KY 40512-4586 1-800-269-5314 www.aetna.com
Chevron Phillips Chemical Company LP Prescription Drug Plan	Group prescription drug benefit plan	Self-funded by employee and Company contributions	Express Scripts BL-0470 P.O. Box 390873 Bloomington, MN 55439-0873 1-800-243-9800 www.express-scripts.com
Chevron Phillips Chemical Company LP Employee Assistance Program	Group counseling benefit plan	Fully insured Company contributions	Aetna 1-866-841-9377 Aetna, Inc. EAP Unit 1000 Middle Street Middletown, CT 06457 www.aetnaEAP.com (Company code: MYCPCEAP)
Chevron Phillips Chemical Company LP Dental Plan	Group dental benefit plan	Self-funded by employee and Company contributions	Aetna P.O. Box 14091 Lexington, KY 40512 1-800-269-5314 www.aetna.com
Chevron Phillips Chemical Company LP Flexible Spending Account Program	IRS Section 125 reimbursement account	Funded by employee contributions	Aetna P.O. Box 4000 Richmond, KY 40476-4000 1-888-238-6226 www.aetna.com
Chevron Phillips Chemical Company LP Retiree Medical Reimbursement Account Plan	Retiree medical benefits	Funded by Company contributions	Aetna P.O. Box 4000 Richmond, KY 40476-4000 1-888-238-6226 www.aetna.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	Claim Assistance and Administration
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 cpchembenefits.mercerhrs.com
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 cpchembenefits.mercerhrs.com
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 cpchembenefits.mercerhrs.com
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 cpchembenefits.mercerhrs.com
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 cpchembenefits.mercerhrs.com
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 cpchembenefits.mercerhrs.com
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 cpchembenefits.mercerhrs.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 Aetna 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, Aetna 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 Aetna contact number on the back of your ID card.

If your Aetna 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 Aetna 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 Aetna 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 Aetna 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 Inpatient Surgery under the medical options of the Chevron Phillips Chemical Medical Plan. For the deductible and co-insurance, if any, applicable to Inpatient Surgery, see the Schedule of Benefits in the 2011 Chevron Phillips Chemical *Employee Benefits Handbook*.

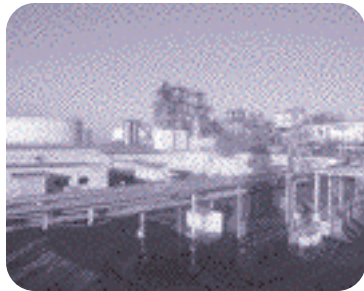
If you would like more information on WHCRA benefits call the Chevron Phillips Benefits Service Center at 1-800-446-1422 (option 1).

IMPORTANT NOTICE ABOUT YOUR PRESCRIPTION DRUG COVERAGE AND MEDICARE

(for employees eligible for Medicare — over-65 employees and certain disabled employees)

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Chevron Phillips Chemical Company and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.





1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. Chevron Phillips Chemical Company has determined that the prescription drug coverage offered by the Chevron Phillips Chemical Company Medical Plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is considered Creditable Coverage.

Because your existing coverage is, on average, at least as good as standard Medicare prescription drug coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

You can join a Medicare drug plan when you first become eligible for Medicare and each year from November 15th through December 31st. This may mean that you have to wait to join a Medicare drug plan and that you pay a higher premium (a penalty) if you join later. You may pay that higher premium (a penalty) for as long as you have Medicare prescription drug coverage. However, if you lose creditable prescription drug coverage, through no fault of your own, you will be eligible for a sixty (60) day Special Enrollment Period (SEP) because you lost creditable coverage to join a Part D plan.

In addition, if you lose or decide to leave employer/union-sponsored coverage; you will be eligible to join a Part D plan at that time using an Employer Group Special Enrollment Period.

You should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area.

If you decide to join a Medicare drug plan, your Chevron Phillips Chemical Company coverage will be affected. See below for more information about what happens to your current coverage if you join a Medicare drug plan.



If you do decide to join a Medicare drug plan and drop your Chevron Phillips Chemical Company prescription drug coverage, be aware that you and your dependents may not be able to get this coverage back, except during the annual benefits enrollment period.

You should also know that if you drop or lose your coverage with Chevron Phillips Chemical Company and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without prescription drug coverage that's at least as good as Medicare's prescription drug coverage, your monthly premium may go up by at least 1% of the base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without coverage, your premium may consistently be at least 19% higher than the base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following November to join.

If you are no longer an active employee and you and/or your spouse are over age 65, Chevron Phillips Chemical Company 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 will also get it before the next period you can join a Medicare drug plan, and if this coverage through Chevron Phillips Chemical Company changes. You may also request a copy.

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. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.





For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov,
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the “Medicare & You” handbook for their telephone number) for personalized help,
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the Web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and whether or not you are required to pay a higher premium (a penalty).

Date: October 2010

Name of
Entity/Sender: Chevron Phillips Chemical Company LP

Contact: Chevron Phillips Chemical Company
Health Plan Administrator
10001 Six Pines Drive
The Woodlands, TX 77380

Phone Number: 832-813-4100



PATIENT PROTECTION

The Chevron Phillips Chemical LP 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 eligible dependents. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact Aetna at 1-800-269-5314.



LOOKING FOR SOMETHING? TIPS FOR FINDING INFORMATION ... FAST!

There is a wealth of important information included in this summary, but who has time to look for it? Believe it or not, you can find what you need without having to search through pages and pages of information. By taking advantage of the summary's "search" function and "bookmarks," you can find the information you need in a matter of seconds.

LOOKING FOR GENERAL, BIG PICTURE INFORMATION?

Just scroll down the table of contents — or "bookmarks" — shown at the left. Click on the applicable bookmark, and you will be taken to that section of the document.

WANT SPECIFICS?

Use the summary's "search" function. To access this function:

- Select "Search" under the "Edit" menu.
- Type the word, words, or part of a word for which you want to search. If you want, you can refine the search by selecting one or more of the following options:
 - "Whole words only" to find only occurrences of the complete word you enter in the text box. For example, if you search for the word "doctor," the words "doctors" and "doctor's" will not be selected during the search.
 - "Case-Sensitive" to find only occurrences of the words that are in the case that you typed. For example, if you search for the word "doctor," the search would find "doctor," but wouldn't find "Doctor."
 - **Note:** For searching this summary, you do not need to select "Search in Bookmarks" or "Search in Comments."
- Click on "In the current PDF document" to show that you just want to search this summary. (Searching multiple PDF documents works well for PDFs that are copied onto your hard drive, but not for searching online PDFs such as our benefit summaries.)
- Click on "Search."
- All occurrences of the text for which you are searching will be shown in the results box. Scroll through the list and click on the applicable highlighted text to be taken to that text in the document.

You can also use the "Find" feature in the toolbar, but you won't be able to refine your search like you can with the "Search" function.

Click on "New search" if you want to perform another search.

(continued)



REAL-WORLD EXAMPLES ...

The following examples show you how to make the best use of the PDF search function.

■ **To find out if you can enroll your domestic partner under your plan coverage:**

- Access the search function, and search for “domestic.” The search results will be displayed in the results box. Click on the link to be taken to the exact information you need.
- Time spent searching? **5 seconds!**

■ **You are getting married, and you want to see if you can enroll your new spouse in your coverage:**

- You can save time by searching for “married,” “marriage” and “marry” all at the same time. To do so, access the search function, and search for “marr” (the first four letters of all three search terms). Every instance of “**m**arried,” “**m**arriage” and “**m**arry” in the summary will be displayed in the results box. Click on the links to see the plan provisions that apply. **Hint:** If you typed in “marr” and no instances were found, make sure the “Whole words only” box was not checked.
- Alternatively, you could have clicked on “When You Can Change Coverage” in the “bookmarks” shown at the left of the summary to be taken to that section of the summary. By scrolling through that section, you would have found the information you need in order to enroll your new spouse.
- Time spent searching? **20 seconds!**

■ **You need to take a military leave of absence and want to know how your benefits will be affected:**

- Access the search function, and search for “military.” The search results will be displayed in the results box. Click on the link to be taken to the “Military Leave” section of the summary.
Hint: Do not narrow your search too much. If you had entered a very specific term, such as “military leave of absence,” the search function would not have helped you because those exact words are not used in this summary. It is better to start with a more generic search term, such as “military,” and then narrow your search later if necessary.
- While you are reading the “Military Leave” section information, you see references to the “Uniformed Services Employment and Reemployment Rights Act (USERRA).” If you perform a follow-up search for “USERRA,” you will learn more about military leaves and your Company benefits.
- Time spent searching? **20 seconds!**