Group Insurance Plan of Benefits for Chevron Phillips Chemical (Control #299701) Administered by Aetna Global Benefits® Effective Date: January 1, 2010

Eligibility Provision			
Employee	Regular full-time employees of Chevron Phillips Chemical participating in this plan working a minimum of 20 hours per week.		
Dependent	Wife or husband; same or opposite sex domestic partner for employees with a domestic partner on 01/01/2001; unmarried children under age 19; to age 25 if attending school.		
PPO			
		In the U.S.	
PLAN FEATURES	**OUTSIDE THE U.S.**	**Preferred Benefits (In-Network)**	**Non-Preferred Benefits (Out-of-Network)**
Individual Deductible	None	None	$200 per calendar year
Family Deductible	None	None	$400 per calendar year
Individual Payment Limit	$1,500 per calendar year	$1,500 per calendar year	$3,000 per calendar year
(Does not include deductibles, copays, benefit penalties, 50% items and Outpatient Prescription Drugs. Includes Outpatient Prescription Drugs when outside the US)			
Family Payment Limit	$4,500 per calendar year	$4,500 per calendar year	$9,000 per calendar year
(Does not include deductibles, copays, benefit penalties, 50% items and Outpatient Prescription Drugs. Includes Outpatient Prescription Drugs when outside the US)			
Lifetime Maximum	Unlimited		
Inpatient Per Confinement Deductible *(Maximum of 3 per calendar year)*	None	None	$250
Plan Payment Percentages			
Hospital Services			
Inpatient	90%	80%	60% after deductible and $250 inpatient per confinement deductible
Outpatient	90%	80%	60% after deductible
Private Room Limit	The institution's semiprivate rate		
Pre-certification Penalty	No Penalty	No Penalty	$400
Non-Emergency Use of the Emergency Room	90%	80%	60% after deductible
Emergency Room	80%	80%	60% after deductible
Urgent Care	90%	80%	60% after deductible
Physician Services			
PCP Office Visit	90%	80%	60% after deductible
Specialist Office Visit	90%	80%	60% after deductible

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PLAN FEATURES	**OUTSIDE THE U.S.**	**Preferred Benefits (In-Network)**	**Non-Preferred Benefits (Out-of-Network)**
Plan Payment Percentages			
Mental Health Services			
Mental Health Inpatient Coverage	90%	80%	60% after deductible and $250 inpatient per confinement deductible
(Unlimited days per calendar year combined with Alcoholism and Drug Abuse)			
Mental Health Outpatient Coverage	90%	80%	60% after deductible
(Unlimited visits per calendar year combined with Alcoholism and Drug Abuse)			
Alcohol/Drug Abuse Services			
Substance Abuse Inpatient Coverage	90%	80%	60% after deductible and $250 inpatient per confinement deductible
(Unlimited days per calendar year combined with Mental Health)			
Substance Abuse Outpatient Coverage	90%	80%	60% after deductible
(Unlimited visits per calendar year combined with Mental Health)			
Other Services			
Skilled Nursing Facility *(120 days per calendar year)*	90%	80%	60% after deductible and $250 inpatient per confinement deductible
Hospice Care Facility Inpatient *(30 days lifetime maximum)*	90%	80%	60% after deductible and $250 inpatient per confinement deductible
Hospice Care Facility Outpatient *(Unlimited lifetime maximum)*	90%	80%	60% after deductible
Home Health Care *(120 visits per calendar year; includes Private Duty Nursing)*	90%	80%	60% after deductible
Spinal Disorder Treatment *($1,000 per calendar year and/or Unlimited visits per calendar year)*	90%	80%	60% after deductible
Short Term Rehabilitation	90%	80%	60% after deductible
(Includes coverage for Occupational, Physical and Speech Therapies; 60 combined maximum visits per calendar year)			
Diagnostic Outpatient X-ray	90%	80%	60% after deductible
Diagnostic Outpatient Lab	90%	80%	60% after deductible
Bariatric Surgery	90%	80%	60% after deductible
Durable Medical Equipment *(includes coverage for first pair of lenses or glasses following cataract surgery)*	90%	80%	60% after deductible
Routine Hearing Exam *Includes one routine exam per calendar year.*	90%	80%	60% after deductible

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PLAN FEATURES	**OUTSIDE THE U.S.**	**Preferred Benefits (In-Network)**	**Non-Preferred Benefits (Out-of-Network)**
Hearing Aids *1 hearing aid per ear to $1,000 maximum per ear every 3 years for child to age 25*	90%	80%	60% after deductible
Global Emergency Assistance Program *($500,000 calendar year maximum)*	100%	100%	100% - not subject to deductible
Wellness Benefits			
Routine Children Physical Exams *Children age 0-18: 7 exams first year of life; 3 exams second year of life; 3 exams third year of life and 1 exam per year thereafter (includes immunizations)*	90%	80%	60% after deductible
Routine Adult Physical Exams *Adults age 18+ & -65: 1 exam/12 months Adults age 65+: 1 exam/12 months (includes immunizations)*	90%	80%	60% after deductible
Routine Gynecological Exams *Includes 1 exam and pap smear per calendar year*	90%	80%	60% after deductible
Mammograms *Includes 1 exam per calendar year*	90%	80%	60% after deductible
Prostate Specific Antigen (PSA) *Includes 1 PSA per calendar year for males 40+*	90%	80%	60% after deductible
Digital Rectal Exam (DRE) *Includes 1 DRE per calendar year for males 40+*	90%	80%	60% after deductible
Cancer Screening *Includes 1 flex sigmoid and double barium contrast every 5 years; and at age 50+ 1 colonoscopy every 5 years*	90%	80%	60% after deductible
Prescription Drug Coverage			
Generic Drugs *(365 day maximum supply)*	75%	75% (includes Mail Order Drugs)	60% after deductible
Brand Name Drugs *(365 day maximum supply)*	75%	75% (includes Mail Order Drugs)	60% after deductible
Non Brand Formulary *(365 day maximum supply)*	75%	75% (includes Mail Order Drugs)	60% after deductible
Vision Expenses			
Routine Eye Exam *(Covered under medical) Includes one routine exam per calendar year*	90%	80%	60% after deductible
Vision Care Supplies *(Schedule maximums apply every 12 months; Includes one pair of frames/lenses or contacts per 12 months)*	90% after $35 deductible	80% after $35 deductible	60% after $35 deductible

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Passive PPO Dental			
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PLAN FEATURES	OUTSIDE THE U.S.	Preferred Benefits (In-Network)	Non-Preferred Benefits (Out-of-Network)
Individual Deductible	$50 per calendar year	$50 per calendar year	$50 per calendar year
Family Deductible	$150 per calendar year	$150 per calendar year	$150 per calendar year
Type A Expense *(Diagnostic & Preventative)*	100% - not subject to deductible	100% - not subject to deductible	100% - not subject to deductible
Type B Expense *(Basic Restorative)*	80% after deductible	80% after deductible	80% after deductible
Type C Expense *(Major Restorative)*	50% after deductible	50% after deductible	50% after deductible
Calendar Year Maximum	$1,500	$1,500	$1,500
Orthodontic Treatment Coverage For Employees & Dependents	50% - not subject to deductible	50% - not subject to deductible	50% - not subject to deductible
Orthodontic Lifetime Maximum	$1,500	$1,500	$1,500

Services and Programs

Informed Health Line (24-hour nurse line)
International Employee Assistance Program
International Disease Management
International Maternity Management Program
Simple Steps To A Healthier Life®
Weight Watchers® Program
On-Line Global Health and Travel Information through HTH Worldwide *(http//www.aetnaglobalbenefits.com)*

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