The information contained within this guide pertains to the eligible participants from the following companies:

INEOS Bio
INEOS Films
INEOS Nitriles
INEOS NOVA (formerly of Innovene)
INEOS Olefins & Polymers
INEOS Oligomers
INEOS Technologies

In the event any discrepancies arise between this Benefits Guide and the Summary Plan Description (aka Employee Benefits Handbook), the information in the Summary Plan Description will prevail.
# Summary of Benefits

## Healthcare Benefits

### Medical
- PPO Choice Option
- PPO/HMO Hybrid Option

*You and the Company share the cost for this coverage*

### Dental
- MetLife DPO Plan
- CIGNA DHMO Plan

*You and the Company share the cost for this coverage*

### Vision
- Coverage is voluntary

*You pay the full cost for this coverage*

## Flexible Spending Accounts

### Health Care Spending Account
Direct up to $4,800 of your before-tax pay into this account to pay for your out-of-pocket health care expenses.

*You pay the full cost for this benefit*

### Dependent Care Spending Account
Direct up to $5,000 of your before-tax pay into this account to pay for your eligible out-of-pocket childcare and elder care expenses.

*You pay the full cost for this benefit*

## Retirement Benefits

### INEOS Retirement Savings Plan
Participation is voluntary

## Welfare Benefits

### Basic Life Insurance
- Coverage equals 1 ½ times your eligible pay up to a maximum of $1 million in benefits
- Coverage is automatic

*The Company pays the full cost of coverage*

### Group Universal Life Insurance (GUL)
- Supplement your Basic Life Insurance with Group Universal Life coverage.

*You pay the full cost for this coverage*

### Basic Accidental Death & Dismemberment Insurance (AD&D)
- Coverage equals 1 ½ times your eligible pay up to a maximum of $1 million in benefits
- Coverage is automatic

*The Company pays the full cost of coverage*

### Voluntary Accidental Death & Dismemberment Insurance (VAD&D)
- Coverage options are available for yourself and eligible family members

*You pay the full cost for this coverage*

### Long Term Disability (LTD)
- 50% option - Company provided
- Optional buy-up to 60% and 65% - Employee paid

### Employee Assistance Program (EAP)
Coverage is automatic

*The Company pays the full cost of coverage*

### Mental Health
Previously, Value Options was the Mental Health carrier for INEOS. Effective January 1, 2010, BCBS will be the INEOS Mental Health Provider. Coverage is automatic.

*You and the Company share the cost for this coverage*

### Long Term Care Program (LTC)
Participation is voluntary

*You pay the full cost for this coverage*
INEOS Medical, Prescription Drug and Dental Plans

Medical Plans
The INEOS PPO medical plans, administered by Blue Cross Blue Shield (BCBS), offer the advantage of a comprehensive, nationwide network of providers. By using network providers, you and the Company share in the savings of negotiated fees with hospitals, highly qualified doctors and other healthcare providers. Our plans provide the financial security of annual out-of-pocket limits coupled with lifetime benefits per person to protect you and your family.

Choose the plan that best meets your needs! Each plan provides different levels of benefits and different costs to participants. You have two plans from which to choose:

- PPO Choice Option
- PPO/HMO Hybrid Option

Blue Cross Blue Shield customer service representatives are available from 8:30 a.m. to 6:00 p.m. CST, Monday through Friday. Call (888) 979-4516 for help in locating network providers, to receive benefit information and answers to your questions. Pre-certifications should be processed through the Blue Care Connection customer service representatives at (800) 826-8551. You can also access information and locate network providers via the internet at www.bcbsil.com.

The claims address for Blue Cross Blue Shield is:
Blue Cross Blue Shield of IL
PO Box 805107
Chicago, IL 60680-4112

Prescription Drug Plan
Blue Cross Blue Shield, a leading name in prescription drug plans nationwide, allows you to access prescription drugs, helpful information and other related services through their Pharmacy Benefits Manager, Prime Therapeutics. A separate enrollment election is not required - when you enroll in coverage under one of the BCBS PPO medical plans, you are automatically enrolled in the prescription drug plan.

Customer Service Representatives are available at (800) 423-1973, 24 hours a day, 7 days a week to answer your questions regarding your prescription drugs and/or order processing. You can access additional information via the internet at www.bcbsil.com.

Dental Plan
The INEOS dental plans combine the freedom to choose your dentist with the cost-savings advantage of network providers through two of the nation’s premier dental plan providers, MetLife and CIGNA. You have the following plans from which to choose:

- MetLife DPO Plan
- CIGNA DHMO Plan

The MetLife Plan is a PPO Plan, while the CIGNA Plan is an HMO Plan. See the Dental Plan Comparison Chart for plan design details.

Questions? You may contact the customer service representatives at the following numbers:
MetLife (800) 451-3258
CIGNA (800) 367-1037

Or visit their websites at www.metlife.com or www.cigna.com.

Waiving Coverage
If you choose not to participate in the Medical and/or Dental benefits offered, you will need to waive your coverage.
### Your Medical Plan Rates and Comparison Chart

This chart compares monthly premiums, treatments and services under the two PPO Medical Plan options.

<table>
<thead>
<tr>
<th>Monthly Premiums (Rounded to the nearest $1)</th>
<th>PPO Choice Option</th>
<th>PPO / HMO Hybrid Option</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee Only</td>
<td>$79</td>
<td>$107</td>
</tr>
<tr>
<td>Employee + Child(ren)</td>
<td>$142</td>
<td>$190</td>
</tr>
<tr>
<td>Employee + Spouse</td>
<td>$148</td>
<td>$198</td>
</tr>
<tr>
<td>Employee + Family</td>
<td>$220</td>
<td>$294</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>PPO Choice Option</th>
<th>PPO / HMO Hybrid Option</th>
</tr>
</thead>
<tbody>
<tr>
<td>In-Network</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Out-of-Network</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| General Information    |                    |                         |
| Deductible             | $250/person; $750/family | $500/person; $1,500/family | none |
| Out-of-pocket maximum  | $2,000/person; $4,000/family | $3,500/person; $7,000/family | $2,000/person; $4,000/family |
| Lifetime maximum benefit | None                  | None                    |        |

For the following treatments and services, the medical plan options pay:

### Physician Office Visits

<table>
<thead>
<tr>
<th>Treatment</th>
<th>PPO Choice Option</th>
<th>PPO / HMO Hybrid Option</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary care office visit</td>
<td>100% after $20 copayc</td>
<td>60% after deductible</td>
</tr>
<tr>
<td>Specialist office visit</td>
<td>100% after $30 copayc</td>
<td>60% after deductible</td>
</tr>
<tr>
<td>Maternity services</td>
<td>80% after deductible</td>
<td>60% after deductible</td>
</tr>
<tr>
<td>Lab and X-ray</td>
<td>80% after deductible</td>
<td>60% after deductible</td>
</tr>
</tbody>
</table>

### Preventive Care

<table>
<thead>
<tr>
<th>Treatment</th>
<th>PPO Choice Option</th>
<th>PPO / HMO Hybrid Option</th>
</tr>
</thead>
<tbody>
<tr>
<td>Routine physicals</td>
<td>100% after $10 copayc</td>
<td>60% after deductible</td>
</tr>
<tr>
<td>Annual well-woman exam</td>
<td>100% after $10 copayc</td>
<td>60% after deductible</td>
</tr>
<tr>
<td>Mammograms (routine)</td>
<td>100%, no copay, no deductible</td>
<td>60% after deductible</td>
</tr>
<tr>
<td>Prostate Specific Antigen (PSA) tests (routine)</td>
<td>100%, no copay, no deductible</td>
<td>60% after deductible</td>
</tr>
<tr>
<td>Well-child care (until the child’s 18th birthday)</td>
<td>100% after $10 copayc</td>
<td>60% after deductible</td>
</tr>
</tbody>
</table>

### Emergency Services

<table>
<thead>
<tr>
<th>Treatment</th>
<th>PPO Choice Option</th>
<th>PPO / HMO Hybrid Option</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital emergency room (applies to facility charges only) the copay is waived if admitted</td>
<td>100% after $100 copay;</td>
<td>60% after deductible</td>
</tr>
<tr>
<td>Ambulance</td>
<td>80% after deductible</td>
<td>80% after deductible</td>
</tr>
</tbody>
</table>

### Outpatient Services (services provided other than in a physician’s office)

<table>
<thead>
<tr>
<th>Treatment</th>
<th>PPO Choice Option</th>
<th>PPO / HMO Hybrid Option</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient surgery facility</td>
<td>80% after deductible</td>
<td>60% after deductible</td>
</tr>
<tr>
<td>Physician/surgeon and related professional fees</td>
<td>80% after deductible</td>
<td>60% after deductible</td>
</tr>
<tr>
<td>Lab and X-ray</td>
<td>80% after deductible</td>
<td>60% after deductible</td>
</tr>
<tr>
<td>Radiation therapy/chemotherapy</td>
<td>80% after deductible</td>
<td>60% after deductible</td>
</tr>
</tbody>
</table>

### Inpatient Hospital Services

<table>
<thead>
<tr>
<th>Treatment</th>
<th>PPO Choice Option</th>
<th>PPO / HMO Hybrid Option</th>
</tr>
</thead>
<tbody>
<tr>
<td>Room and board (semi-private room), other facility services and supplies</td>
<td>80% after deductible</td>
<td>60% after deductible</td>
</tr>
<tr>
<td>Physician hospital visits, surgery and related professional fees (including maternity and newborn care)</td>
<td>80% after deductible</td>
<td>60% after deductible</td>
</tr>
<tr>
<td>Lab, X-ray and anesthesia</td>
<td>80% after deductible</td>
<td>60% after deductible</td>
</tr>
</tbody>
</table>
In-network expenses do not apply to the out-of-network deductible or out-of-pocket maximum, and out-of-network expenses do not apply to the in-network deductible or out-of-pocket maximum.

Office-visit copays, emergency room copays, precertification penalties and amounts above reasonable and customary do not apply to the deductible or out-of-pocket maximum for any of the plan options, as applicable to each option. In addition, mental health and prescription drug expenses do not apply to the deductible and out-of-pocket maximum for the PPO Options.

Lab and X-ray charges performed in a doctor’s office and billed as part of the visit are covered by the office-visit copay. When these services are not performed at the time of the office visit, performed at another network facility or by a network entity other than the doctor’s office, you must first meet your deductible and then the expense is covered at 80%.

Precertification required; benefits may be reduced if precertification is not obtained.

The visit/plan year limit applies to total of both network and out-of-network visits.

### Your Prescription Drug Comparison Chart

<table>
<thead>
<tr>
<th></th>
<th>PPO Choice Option</th>
<th>PPO / HMO Hybrid Option</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Deductible</strong></td>
<td>$75/person; $225/family maximum</td>
<td>none</td>
</tr>
<tr>
<td><strong>Copay/Co-insurance</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Retail (30 day supply)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mail Service (90 day supply)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Generic</strong></td>
<td>100% after $10 copay</td>
<td>100% after $20 copay</td>
</tr>
<tr>
<td><strong>Brand name (primary)</strong></td>
<td>100% after $25 copay</td>
<td>100% after $50 copay</td>
</tr>
<tr>
<td><strong>Brand name (non-primary)</strong></td>
<td>100% after $40 copay</td>
<td>100% after $80 copay</td>
</tr>
<tr>
<td><strong>Brand name when generic is available</strong></td>
<td>100% after $10 copay plus difference in cost between the brand-name and generic prescription</td>
<td>100% after $80 copay</td>
</tr>
</tbody>
</table>
Your Dental Program Rates and Comparison Chart

The charts below compare monthly premiums, treatments and services under the two Dental Plan options.

<table>
<thead>
<tr>
<th>Monthly Premiums (Rounded to the nearest $1)</th>
<th>MetLife DPO Plan</th>
<th>CIGNA DHMO Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee Only</td>
<td>$19</td>
<td>$13</td>
</tr>
<tr>
<td>Employee + Child(ren)</td>
<td>$42</td>
<td>$28</td>
</tr>
<tr>
<td>Employee + Spouse</td>
<td>$38</td>
<td>$23</td>
</tr>
<tr>
<td>Employee + Family</td>
<td>$62</td>
<td>$41</td>
</tr>
</tbody>
</table>

General Information

- **Deductible**: $25/person; $75 family maximum
- **Plan-year maximum benefit**: $1,500/person for diagnostic and preventive services and for basic and major restoration services combined
- **Lifetime maximum benefit**: $1,500/person for orthodontia

For the following treatments and services, the dental options pay:

<table>
<thead>
<tr>
<th>Covered Services</th>
<th>MetLife DPO Plan</th>
<th>CIGNA DHMO Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diagnostic and preventive services</td>
<td>100% with no deductible*</td>
<td>100%</td>
</tr>
<tr>
<td>Basic restoration</td>
<td>85% after deductible*</td>
<td>100% after scheduled present charge**</td>
</tr>
<tr>
<td>Major restoration</td>
<td>50% after deductible*</td>
<td>100% after scheduled present charge**</td>
</tr>
<tr>
<td>Orthodontia for adults and children</td>
<td>50% with no deductible*</td>
<td>100% after scheduled present charge**</td>
</tr>
</tbody>
</table>

* Coinsurance benefit levels are subject to reasonable and customary charges.
** Provided the service is in the patient charge schedule from CIGNA.

The following is a brief description of the services covered under the above categories. Please refer to the Employee Benefits Handbook for further details.

**Diagnostic and Preventive Care:**
- Routine oral examinations
- X-rays
- Cleaning
- Topical fluoride treatments

**Basic Restoration:**
- Fillings
- Extractions
- Oral surgery
- Treatment of gums and mouth
- Root canal therapy (For DHMO, some root canals fall into Major Restoration Services)

**Major Restoration Services:**
- Crowns and caps to repair teeth
- Dentures
- Bridgework

**Orthodontia:**
- Braces
- Retainers
- Oral exams
- X-rays
The INEOS Vision Plan is offered through VSP. With VSP doctors, you’ll enjoy quality and personalized care. Besides helping you see better, routine eye exams can detect symptoms of serious conditions such as glaucoma, cataracts and diabetes. Eye exams for children may discover problems that can hinder learning and development.

VSP network doctors are in medical offices and shopping centers - close to home and work. Most offer evening and weekend hours and accept walk-ins. New patients are always welcome.

Effortless benefits
1. Choose a VSP doctor at www.vsp.com or call (800) 877-7195.
2. Make an appointment and tell the doctor you are a VSP member.
3. That’s it! No ID cards or filling out claim forms.

<table>
<thead>
<tr>
<th>Monthly Premium (Rounded to the nearest $1)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee Only</td>
</tr>
<tr>
<td>Employee + Children</td>
</tr>
<tr>
<td>Employee + Spouse</td>
</tr>
<tr>
<td>Employee + Family</td>
</tr>
</tbody>
</table>

The Vision Plan pays the following benefits:

<table>
<thead>
<tr>
<th>Signature Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Benefit – Exam/Lenses/Frame</td>
</tr>
<tr>
<td>Copayment</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>VSP Participating Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>Frame Allowance</td>
</tr>
<tr>
<td>Elective Contact Lens Allowance (Covers contact lenses and associated professional services.) Material copay does not apply.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Non-Participating Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>Examination</td>
</tr>
<tr>
<td>Single Vision Lenses</td>
</tr>
<tr>
<td>Lined Bifocal Lenses</td>
</tr>
<tr>
<td>Lined Trifocal Lenses</td>
</tr>
<tr>
<td>Frame</td>
</tr>
<tr>
<td>Elective Contact Lens Allowance (Covers contact lenses and associated professional services.) Material copay does not apply.</td>
</tr>
</tbody>
</table>

Dollar for dollar you get the best value from your VSP benefit when you visit a VSP network doctor. If you decide not to see a VSP doctor, copays still apply. You will also receive a lesser benefit and typically pay more out-of-pocket. You are required to pay the provider in full at the time of your appointment and submit a claim to VSP for partial reimbursement. If you decide to see a provider not in the network, call VSP first.

*In the event of a conflict between this information and the Company’s contract with VSP, the terms of the contract will prevail.*
Domestic Partner Coverage

What is Domestic Partner Coverage?
The Company provides employees with the opportunity to extend health, dental and vision coverage to their domestic partners. Domestic partner coverage is a taxable benefit under the IRS Regulations. The employee’s portion of the premium is deducted on a pre-tax basis and, the domestic partner coverage is deducted on an after-tax basis. In addition, the premium paid by the Company for domestic partner coverage must be taxed as imputed income.

<table>
<thead>
<tr>
<th>Monthly Premiums</th>
<th>PPO Choice Option</th>
<th>PPO / HMO Hybrid Option</th>
<th>MetLife DPO Plan</th>
<th>CIGNA DHMO Plan</th>
<th>Vision</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee Rate (pre-tax)</td>
<td>$79</td>
<td>$107</td>
<td>$19</td>
<td>$13</td>
<td>$10</td>
</tr>
<tr>
<td>Employee + DP (after-tax)</td>
<td>$70</td>
<td>$90</td>
<td>$19</td>
<td>$10</td>
<td>$5</td>
</tr>
<tr>
<td>Employee + DP Children Only</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(after-tax)</td>
<td>$64</td>
<td>$82</td>
<td>$23</td>
<td>$15</td>
<td>$6</td>
</tr>
<tr>
<td>*Includes DP &amp; Employee’s Children</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Employee + DP + Family</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(after-tax)</td>
<td>$141</td>
<td>$186</td>
<td>$43</td>
<td>$28</td>
<td>$15</td>
</tr>
</tbody>
</table>

*Domestic Partner coverage will have an employee pre-tax deduction and a domestic partner after-tax deduction

Enrollment
When enrolling a domestic partner (provided the employee has met the requirements on the Domestic Partner Affidavit), there are specific plans and tiers that must be selected not only for the domestic partner, but also the employee to ensure the appropriate employee deduction, domestic partner deduction, and imputed income are properly calculated.

The employee must make two elections for each benefit plan; one is for the employee and the other is for the domestic partner. For instance, if the employee enrolls in the PPO Choice plan for their medical option, the “USA-PPO Choice Option” should be selected for the employee election and the “USA-PPO Choice-DP” should be selected for the domestic partner election.

The employee plan is set up with a pre-tax deduction, which appears on paychecks as Medical BT; the domestic partner plan is set up with an after-tax deduction, which appears on paychecks as Dom Part Med. In addition, both the employee and domestic partner election must have the same tier selected. Please refer to your Self-Service User Guide for additional enrollment instructions.

How is the Imputed Income calculated?
The Company paid portion of the benefit cost is taxed in the form of imputed income. To properly tax the benefit, the imputed income amount is added to the paycheck as gross pay under the “Hours & Earnings” section so that taxes can be calculated and withdrawn for that specific amount. The earnings description on the paycheck is Dom Prt Incom. This same amount is deducted from the paycheck under the “Deductions” section so that it does not increase the employee’s take home pay. The deduction description is Dom Prt Incom.

<table>
<thead>
<tr>
<th>Monthly Imputed Income</th>
<th>PPO Choice Option</th>
<th>PPO / HMO Hybrid Option</th>
<th>MetLife DPO Plan</th>
<th>CIGNA DHMO Plan</th>
<th>Vision*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee + DP</td>
<td>$278</td>
<td>$362</td>
<td>$19</td>
<td>$10</td>
<td>$0</td>
</tr>
<tr>
<td>Employee + DP Children Only</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>*Includes DP &amp; Employee’s Children</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>$0</td>
</tr>
<tr>
<td>Employee + DP + Family</td>
<td>$565</td>
<td>$746</td>
<td>$43</td>
<td>$28</td>
<td>$5</td>
</tr>
</tbody>
</table>

*There is no Imputed Income for Vision benefits since you pay 100% of the premium
What is the INEOS Flexible Benefit Plan (The Flex Plan)?
The INEOS Flex Plan is an opportunity for participants to pay certain out-of-pocket medical, dental, vision and dependent care expenses with pre-tax money. In other words, pay your eligible expenses with tax-free money! The Flex Plan has two parts:

1. the Health Care Spending Account,
2. the Dependent Care Spending Account

If you choose to participate, you make an annual election for the Health Care Spending Account and/or a separate election for the Dependent Care Spending Account. The money in the two accounts cannot be co-mingled - only money in the Health Care Account can be used to pay for eligible healthcare expenses; similarly, only money in the Dependent Care Account can be used to pay for eligible dependent care expenses. You can choose to participate in either or both accounts.

Your election is then deducted from your pay on a pre-tax basis in equal installments throughout the year.

The MEDCOM Benefits Debit Card: Easy - Convenient - Smart!
When you have eligible expenses, you can pay for them with your debit card. This card operates just like any credit transaction at merchants that accept Mastercard and can be used for both Health Care and Dependent Care accounts (even if you’re enrolled in both, you can use the same card for these expenses). The money is taken directly out of your Flexible Spending Account (FSA), thereby avoiding any cash flow issues. Using your MEDCOM Benefits Debit Card also eliminates the need to submit paper claims and is provided to participants free of charge. Additional information about your debit card charges can be found via the internet at www.benefitspaymentsystem.com.

If the Merchant does not accept payment by Mastercard or if you don’t have your card with you at the time, you can pay for an eligible expense out of your own pocket and submit a paper claim for reimbursement from your FSA.

What are some of the rules regarding using the Card?
In the event of inappropriate use of a Card - the Card will be deactivated. You will have to submit paper claims; and any ineligible transaction will be reported to the IRS as taxable income.

Occasionally, you will be requested to provide proof that your debit card expense was truly an eligible expense. Failure to do so when requested will result in your debit card to be temporarily suspended. The IRS requires MEDCOM to audit all points of sale transactions made with the MEDCOM Benefits Debit Card. Periodically, MEDCOM will mail the participant a letter requesting the receipt for a specified transaction. Upon review of the requested receipt, MEDCOM will determine if the transaction is eligible under Code Section 213. If the transaction is determined to be ineligible, the participant will receive a Notice of Ineligible Transaction requesting a refund for the ineligible expense.
Health Care Spending Accounts

You can direct from $120 to $4,800 per Plan Year into the Health Care Spending Account. You will receive a Company Match contribution in the amount of 25% of your contribution up to a maximum of $200 annually.

You have until March 15th of the following year to incur eligible expenses for the plan year just completed. In other words, eligible expenses incurred up through March 15 will be considered eligible for payment from or reimbursement of your election for the prior plan year. This gives you more time in which to incur eligible expenses and thereby minimizes the possibility that you forfeit any of your pre-tax deductions.

Eligible Medical Expenses

The Internal Revenue Service defines what is considered eligible health related expenses that may be reimbursed from your Health Care Flexible Spending Account (FSA). In general, your deductibles, coinsurance, co-payments, and amounts above plan limits for medical, dental and vision expenses covered by your health insurance plan are eligible. Cosmetic procedures like tummy tucks, facelifts, and teeth whitening are NOT eligible expenses. In addition, medical services and supplies not covered or not reimbursed by your insurance may be included if they are medically necessary and are considered tax deductible by the IRS. ALWAYS CALL MEDCOM if you have any questions regarding whether an expense is eligible for your Flex Plan.

Some eligible expenses include:
- Acupuncture, Oxygen, Ambulance fees, Organ donors, Artificial limbs, Artificial teeth, Birth control pills, Eyeglasses, eye exams, contact lenses and related supplies, Dental treatment, Drug addiction rehabilitation expenses, Prescription Drugs and medicines, Certain over-the-counter expenses (if the medication meets the definition of “medical care” as defined by the IRS.)

Consult with MEDCOM on limitations and conditions or visit www.irs.gov for details.

Dependent Care Spending Accounts

Each year, you can elect Dependent Care deductions of up to $5,000 (if your tax filing status is Single or Married Filing a Joint Return), or up to $2,500 if your tax filing status is Married Filing Separate.

Eligible Dependent Care Expenses

“Eligible” dependent care expenses (child care and care for disabled parents) are expenses you incur so that you can be employed. If you are married, your spouse generally must also be employed, a full-time student, or disabled for dependent care expenses to be eligible. A complete list of eligible expenses, IRS Publication 503, “Child and Dependent Care Expenses” is available at www.irs.gov.

Expenses must be for the care of dependent child(ren) up to age 13 or for any other dependent you claim on your federal income tax return. For example, eligible expenses include care of a disabled parent, or care for a child who is older than 13 who is disabled. Just as with the Health Care Spending Account, you have until March 15th of the following year to incur eligible expenses for the plan year just completed. In other words, eligible expenses incurred up through March 15th will be considered eligible for payment or reimbursement.

The Dependent Care Account - like the Health Care Spending Account - is a great way to pay for expenses with pre-tax money, effectively reducing your cost.

Unlike the Health Care FSA, you can only use money that has been deposited into your Dependent Care Spending Account. In other words, you can only spend as much as what has been taken out of your paycheck since the start of the year.
How you can save using your flex plan
You determine your FSA amount at the first of the Plan Year and cannot change it except for family status events such as marriage, birth of a child, divorce or death.

The following example illustrates how the Flex Plan can save you money by reducing your taxable earnings.

<table>
<thead>
<tr>
<th></th>
<th>Without Flex</th>
<th>With Flex</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gross Salary</td>
<td>$36,000</td>
<td>$36,000</td>
</tr>
<tr>
<td>Tax Free Medical</td>
<td>0</td>
<td>600</td>
</tr>
<tr>
<td>Tax Free Dependent Care</td>
<td>0</td>
<td>1,200</td>
</tr>
<tr>
<td>Taxable Salary</td>
<td>$36,000</td>
<td>$34,200</td>
</tr>
<tr>
<td>Fed/FICA</td>
<td>(6,725)</td>
<td>(6,252)</td>
</tr>
<tr>
<td>Take Home Pay</td>
<td>$29,275</td>
<td>$27,948</td>
</tr>
<tr>
<td>Retail Medical and Dependent Care</td>
<td>(1,800)</td>
<td>(1,800)</td>
</tr>
<tr>
<td>Net Income</td>
<td>$27,475</td>
<td>$27,948</td>
</tr>
<tr>
<td>Savings</td>
<td>NONE</td>
<td>$473</td>
</tr>
</tbody>
</table>

Actual savings depend on individual circumstances, including earnings and tax bracket. Consult your tax advisor for a more detailed analysis of how the Flex Plan can benefit you.

Analyze Your Costs Carefully
Whether it’s the Health Care Account or the Dependent Care Account, you must plan carefully to take maximum advantage of the Flex Plans and minimize the possibility of forfeiting any of the money you deposit in your account(s). Calculate your deductions based on what you know you usually spend each year for medical, dental, vision and/or day care expenses.

Federal regulations require that you forfeit any money deposited into your Flex Plan account if you don’t incur eligible expenses within the allowable time frame.
INEOS Retirement Savings Plan

The INEOS Retirement Savings Plan is a 401(k) plan that lets you save up to 75% of your eligible pay you elect, up to legal limits, toward your retirement. You can elect to contribute on a before-tax or after-tax basis, or a combination of both. Plus, the Company matches your before-tax contributions, in accordance with the match schedule for your Company. Please see the Employee Benefits Handbook for details on your matching contributions.

All contributions and investment gains or losses are credited to your plan account. You choose how your savings are invested from a wide variety of investment options. You – not the Company - assume all the investment risk. That means your account will benefit from any investment gains and experience any investment losses as well. You have a variety of different investment options from which to choose, including a Self-Directed Brokerage account.

You have access to your account through the Plan’s loan provisions, and, under certain conditions, may withdraw a portion of your account while still working with the Company.

The Plan is intended to be a “qualified retirement plan” under Section 401(a) of the Internal Revenue Code and to meet the requirements of Code Section 401(k).

The Plan is administered by The Principal Financial Group. Additional information can be obtained by calling The Principal at (800) 547-7754 or via the internet at www.principal.com.

Please refer to the Employee Benefits Handbook for eligibility requirements and other plan details.

INEOS Welfare Benefits

INEOS Basic Life Insurance Plan

Your Company pays for life insurance in the amount of 1 ½ times your base compensation up to a maximum of $1 million. Coverage is automatic and is fully paid by the Company. Upon attainment of age 65 your benefit may decrease.

If your Basic Life insurance amount is over $50,000, you will have to pay “imputed income”, which is income tax on the cost of the coverage for any amount over $50,000. The amount of tax is based on IRS tax tables and will be reported on your W-2 form each year.

INEOS Group Universal Life Insurance Plan (GUL)

In addition to your Company provided Basic Life Insurance, you have the opportunity to elect additional life insurance coverage for yourself, your spouse and your eligible children. These options give you flexibility as you plan for your family’s future financial needs. The program is administered by CIGNA effective January, 1, 2010

The GUL Program provides life insurance coverage at group rates and gives you the chance to build cash value through the program’s Cash Accumulation Fund.

Effective January 1, 2010, the GUL rates will be:

<table>
<thead>
<tr>
<th>Age</th>
<th>Smoker</th>
<th>Non-Smoker</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;25</td>
<td>$0.046</td>
<td>$0.039</td>
</tr>
<tr>
<td>25 - 29</td>
<td>$0.053</td>
<td>$0.045</td>
</tr>
<tr>
<td>30 - 34</td>
<td>$0.058</td>
<td>$0.049</td>
</tr>
<tr>
<td>35 - 39</td>
<td>$0.063</td>
<td>$0.054</td>
</tr>
<tr>
<td>40 - 44</td>
<td>$0.100</td>
<td>$0.088</td>
</tr>
<tr>
<td>45 - 49</td>
<td>$0.150</td>
<td>$0.136</td>
</tr>
<tr>
<td>50 - 54</td>
<td>$0.230</td>
<td>$0.212</td>
</tr>
<tr>
<td>55 - 59</td>
<td>$0.430</td>
<td>$0.365</td>
</tr>
<tr>
<td>60 - 64</td>
<td>$0.660</td>
<td>$0.590</td>
</tr>
<tr>
<td>65 - 69</td>
<td>$1.152</td>
<td>$0.943</td>
</tr>
</tbody>
</table>
INEOS Basic Accidental Death & Dismemberment (AD&D) Plan

Your Company provided AD&D plan pays a benefit if you die or are dismembered as the result of an accident. In the event of death, this benefit is payable in addition to any life insurance benefit. Coverage is equal to 1 ½ times your annual base pay, up to a maximum of $1 million in coverage. Enrollment in this coverage is automatic.

INEOS Voluntary Accidental Death & Dismemberment (VAD&D)

Voluntary AD&D insurance coverage is available for you and your family at group rates. You can obtain coverage up to 6 times your annual base pay to a maximum of $1 million, if you suffer a loss due to an accident. Your dependents must be covered as a percentage of your own coverage; therefore, you must be enrolled in the Plan in order to purchase coverage for your dependents.

Voluntary AD&D is calculated at $0.020 per $1,000 of coverage for single coverage and $0.034 per $1,000 of coverage for family coverage.

This coverage also applies while traveling for business or pleasure. The Occupational Accidental Death Insurance (OAD) plan has been replaced by adding this provision to the Voluntary AD&D plan.

How to Enroll

Since INEOS is converting our GUL and Voluntary AD&D policies to CIGNA, a “Special Enrollment Period” will be offered during the 1st quarter of 2010 for new enrolments and changes to existing coverage. Changes to GUL and Voluntary AD&D cannot be made during the Open Enrollment process. All current GUL certificates and additional AD&D coverage will be converted to CIGNA effective 1/1/2010.

Enrollment will occur online through CIGNA’s Trusted Advisor website. You may be asked to complete a health questionnaire on-line or provide further evidence of insurability to approve your requested coverage.

INEOS Long Term Disability Plan (LTD)

The INEOS Long Term Disability Plan provides continuation of 50% of your monthly eligible compensation, if you are disabled beyond 26 weeks (6 months). This plan offers you the opportunity to increase your coverage up to 65% of your monthly eligible compensation, in the event of a disability. You pay for the additional coverage in full.

Coverage Options

The Company provides basic LTD coverage and offers two levels of optional, employee-paid LTD coverage:

<table>
<thead>
<tr>
<th>Coverage Level</th>
<th>Benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Basic coverage (company-paid)</td>
<td>Up to 50% of your eligible pay</td>
</tr>
<tr>
<td>60% coverage (optional coverage amount is employee-paid)</td>
<td>An additional 10% of your eligible pay, for a total LTD benefit of up to 60% of your eligible pay</td>
</tr>
<tr>
<td>65% coverage (optional coverage amount is employee-paid)</td>
<td>An additional 15% of your eligible pay, for a total LTD benefit of up to 65% of your eligible pay</td>
</tr>
</tbody>
</table>

The maximum monthly pay considered is:

- basic coverage - $40,000
- 60% coverage - $33,333
- 65% coverage - $30,769

The minimum LTD benefit is $100 per month. The maximum is $20,000 per month minus any offsetting benefits. You pay for this additional coverage in full. The costs below are per $100 of monthly eligible earnings:

<table>
<thead>
<tr>
<th>Age Bracket</th>
<th>60% Buy-Up</th>
<th>65% Buy-Up</th>
</tr>
</thead>
<tbody>
<tr>
<td>18 - 39</td>
<td>$0.074</td>
<td>$0.100</td>
</tr>
<tr>
<td>40 - 44</td>
<td>$0.118</td>
<td>$0.161</td>
</tr>
<tr>
<td>45 - 49</td>
<td>$0.161</td>
<td>$0.224</td>
</tr>
<tr>
<td>50 - 54</td>
<td>$0.187</td>
<td>$0.298</td>
</tr>
<tr>
<td>55 - 59</td>
<td>$0.211</td>
<td>$0.261</td>
</tr>
<tr>
<td>60 - 64</td>
<td>$0.187</td>
<td>$0.261</td>
</tr>
<tr>
<td>65 - 69</td>
<td>$0.174</td>
<td>$0.248</td>
</tr>
<tr>
<td>70+</td>
<td>$0.161</td>
<td>$0.224</td>
</tr>
</tbody>
</table>

How To Enroll

If you need additional information or wish to file a claim, you may contact CIGNA at (800) 538-3543.
**INEOS Employee Assistance Plan (EAP)**

All employees have access to the Company provided Employee Assistance Plan through CIGNA Behavioral Health. CIGNA’s Behavioral Health Program provides access to in-person behavioral health assistance, telephonic counseling and online tools.

The program offers covered employees and their families:

- Professional counseling from licensed behavioral health providers:
  
  *Access to telephonic counseling 24 hours a day, seven days a week and up to 8, free in-person sessions from CIGNA’s Masters and Ph.D.-level licensed behavioral health clinicians*

- Life event referrals and research:
  
  *Research and up to three qualified referrals within 12 business hours for services*

- Health Rewards discount program:
  
  *Up to 60% discounts on health and wellness products and services*

- Personal Stress Navigator:
  
  *An interactive tool that helps you and your family evaluate stress sources and symptoms in order to make effective behavioral changes*

To discover the full array of benefits that CIGNA’s Behavioral Health Program has to offer, visit their website at [www.cigna-behavioral.com/cgi](http://www.cigna-behavioral.com/cgi) or call (800) 538-3543.

**INEOS Mental Health Program**

The Mental Health Program, previously administered by Value Options, will be administered by BCBS effective January 1, 2010. You can access a mental health provider or facility by calling BCBS at (800) 423-1973 or by searching for a provider on [www.bcbsil.com](http://www.bcbsil.com). Please see the Medical Plan comparison chart for more detailed information.

**INEOS Long Term Care Program (LTC)**

The Long Term Care Insurance Program provides reimbursement of covered charges for the care a person needs at home, in a nursing home or at an adult day care facility for an extended period of time. The program is administered by Long Term Care Financial Partners and underwritten by MetLife.

The program is unique in that it allows you to create a policy specifically designed to meet your needs. You will work one-on-one with a Long Term Care Financial Partners (LTCFP) representative in creating the policy that you choose. Once the policy is established and approved, your payroll department will be notified of the appropriate payroll deduction.

**How to Enroll**

To obtain more information on creating the policy that best works for you, you may call Long Term Care Financial Partners to discuss further. LTCFP can be reached at (866) 471-4072 or via the internet at [www.ineos-ltc.com](http://www.ineos-ltc.com). Keep in mind that often times an in-house meeting is desired to review the policy before you actually sign it. Once you sign the policy, LTCFP will submit it for approval and automatically send notification to INEOS to begin payroll deductions. Before signing, be sure the policy is exactly how you want it and the amount of your deductions is clear.
Questions regarding your benefit plans may arise when traveling outside of the country, either for personal travel or business. Where do I go for treatment in the case of an emergency? How are my claims processed? Do I have to pay for services out of pocket? This guide will help answer these questions.

**Medical - Blue Cross Blue Shield (BCBS)**

While traveling out of the country, you have access to the BCBS World Wide network of physicians and hospitals. Providers and hospitals that participate in this network can be found by accessing the website link below.


If you do not have access to a computer while traveling, you can call the Customer Service number on the back of your BCBS insurance card to help locate an in-network provider.

There are a few different ways your claims can be processed.

- **If you go to a BCBS network physician/hospital outside the United States, the provider will generally file the claim with BCBS on your behalf. You will most likely owe a co-payment just as you would when in the U.S.**

- **It is possible that the provider will ask for a full payment for services rendered and expect reimbursement by BCBS. If this should occur, submit the receipt or itemized statement to the address on the back of the BCBS insurance card. It is preferable to have the receipt or statement in English and in US currency. If that is not possible, BCBS has the capability to translate the claim upon receipt.**

- **Claims will be paid based on the INEOS plan details, the same deductible, co-pays, and co-insurance will apply based on the in-network or out-of-network status of the provider.**

**Dental PPO - MetLife**

When traveling outside of the United States, all dental services received will be paid at the out of network benefit level. MetLife does not have an International network of providers. Payment will be requested at the time of the service from the provider.

To receive reimbursement for your payment, you will have to file a claim with MetLife. Be sure to send a copy of an itemized receipt along with the claim form. It is preferred to have the receipt in English and in US currency; however, if it is not, MetLife can translate it for payment.

**Dental HMO - CIGNA**

Under the Dental HMO plan with CIGNA, only emergency dental services will be paid while traveling outside of the country. If this should occur, you will need to pay for the service out of your pocket and submit a claim for reimbursement. Please retain your receipt and an itemized statement to submit with the claim form for processing.

**Vision - Vision Service Plan (VSP)**

While traveling outside of the United States, vision services will need to be paid out of pocket at the point of sale. VSP does not have an International network of providers. VSP will reimburse you based on the out of network benefit levels provided that a reimbursement form is completed with an itemized statement.

**FSA - MedCom**

The MedCom Flexible Spending Account Debit Card (administered by MBI) cannot be used at the point of sale when traveling outside of the country. If you incur eligible health care expenses while traveling, a claim form must be completed with a receipt for reimbursement.

Please note: if you order prescription drugs from another country, for example, Canada, you will not be reimbursed for those expenses if you did not order and consume them while traveling to Canada.
COBRA Continuation Coverage

When you leave the Company you and your eligible dependents may temporarily continue your current coverage under the Health, Dental, Vision and FSA plans as prescribed under COBRA. COBRA is the Consolidated Omnibus Budget Reconciliation Act of 1985 (Public Law 99-272, Title X). If COBRA applies, you may be able to temporarily continue coverage under the plan beyond the point at which coverage would otherwise end because of a life event known as a “qualifying event”.

What are My COBRA Rights if I am a Covered Employee?
If you are a covered employee, you will become a qualified beneficiary if you lose coverage under the plan because either one of the following qualifying events happens:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

COBRA coverage will continue for up to a total of 18 months from the date of your termination of employment or reduction in hours, assuming you pay your premiums on time. If, apart from COBRA, your employer continues to provide coverage to you after your termination of employment or reduction in hours (regardless of whether such extended coverage is permitted under the terms of the plan), the extended coverage you receive will ordinarily reduce the time period over which you may buy COBRA benefits.

If you are on a leave of absence covered by the Family and Medical Leave Act of 1993 (FMLA), and you do not return to work, you will be given the opportunity to elect COBRA coverage. The period of your COBRA coverage will begin when you fail to return to work following the expiration of your FMLA leave or you inform your employer that you do not intend to return to work, whichever occurs first.

What are My COBRA Rights if I am a Covered Spouse?
If you are covered under the plan as a spouse of a covered employee, you will become a qualified beneficiary if you would otherwise lose coverage under the plan as a result of any of the following events:

- Your spouse dies;
- Your spouse’s hours of employment are reduced;
- Your spouse’s employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes enrolled in Medicare; or
- You become divorced from your spouse.

If your spouse cancels your coverage in anticipation of divorce and a divorce later occurs, your divorce may be a qualifying event even though you actually lost coverage under the plan earlier. If you timely notify the plan administrator of your divorce and can establish that your spouse canceled your coverage in anticipation of divorce, COBRA coverage may be available to you beginning on the date of your divorce (but not the period between the date your coverage ended and the date of the divorce).

What are My COBRA Rights if I am a Dependent Child?
If you are covered under the plan as a dependent child of a covered employee, you will become a qualified beneficiary if you would otherwise lose coverage under the plan as a result of any of the following events:

- The parent-employee dies;
- The parent-employee’s hours of employment are reduced;
- The parent-employee’s employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes enrolled in Medicare;
- Your parents become divorced; or
- You lose dependent child status under the plan.
If you are a child of the covered employee or former employee and you are receiving benefits under the plan pursuant to a qualified medical child support order, you are entitled to the same rights under COBRA as a dependent child of the covered employee.

**How Long will COBRA Last if I am a Covered Spouse or Dependent Child?**

If you are a covered spouse or dependent child, the period of COBRA coverage will generally last up to a total of 18 months in the case of a termination of employment or reduction in hours and up to a total of 36 months in the case of other qualifying events, provided that premiums are paid on time.

If, however, the covered employee became enrolled in Medicare before the end of his or her employment or reduction in hours, COBRA coverage for the covered spouse and dependent children will continue for up to 36 months from the date of Medicare enrollment or 18 months from the date of termination of employment or reduction in hours, whichever period ends last.

**Do I have to Give Notice of any Qualifying Events?**

Yes. You will be offered COBRA Coverage only after the plan administrator (through your HR Representative) has been notified that a qualifying event has occurred. When the qualifying event is a divorce or a child losing dependent status under the plan, you must timely notify the plan administrator of the qualifying event. You must provide this notice within 60 days of the event or within 60 days of the date on which coverage would be lost because of the event, whichever is later. If you do not follow these notice procedures or if you do not give the plan administrator notice of your divorce or a child losing dependent status under the plan within the 60 day notice period, you will not be permitted to buy COBRA Coverage as a result of divorce or a child losing dependent status.

When the qualifying event is the end of employment, death of the employee, commencement of a proceeding in bankruptcy with respect to the employer, if the plan provides retiree health coverage, or the employee becoming enrolled in Medicare, the employer must notify the plan administrator (through HR) of the qualifying event.

**Can COBRA Coverage be extended if I have a Second Qualifying Event?**

Yes. In certain circumstances spouses and children can take advantage of a special second qualifying event extension.

For spouses and children receiving COBRA coverage, the 18-month period may be extended to 36 months if another qualifying event occurs during the 18-month period, if you give the plan administrator timely notice of the second qualifying event. The 36-month period will run from the date of the termination of employment or reduction in hours.

This extension is available to the spouse and children receiving COBRA coverage if the covered employee or former employee dies, becomes enrolled in Medicare, or gets divorced, or if the child stops being eligible under the plan as a dependent child, but only if the event would have caused the spouse or child to lose coverage under the plan had the first qualifying event not occurred.

**Do I have to Give Notice of Second Qualifying Events?**

Yes. For this 18-month extension to apply, you must give the plan administrator timely notice of the second qualifying event with 60 days after the event occurs or within 60 days after the date on which coverage would be lost because of the event, whichever is later.

**Are There Election Rules That Apply To COBRA?**

Yes. After the plan administrator receives timely notice that a qualifying event has occurred, the plan administrator is responsible for (i) notifying you that you have the option to buy COBRA, and (ii) sending you an application to buy COBRA Coverage. You have 60 days within which to elect to buy COBRA Coverage. The 60 day period begins to run from the later of (i) the date you would lose coverage under the plan, or (ii) the date on which the employer notifies you that you have the option to buy COBRA Coverage. Each qualified beneficiary has an independent right to elect COBRA Coverage.
You may elect COBRA Coverage on behalf of your spouse, and parents may elect COBRA coverage on behalf of their children.

**Can My COBRA Coverage Terminate Early?**

Yes. Your COBRA Coverage will terminate early if any of the following events occurs:

- the employer no longer provides group health coverage to any of its employees;
- You do not pay the premium for your continuation coverage on time;
- After electing COBRA Coverage, you become covered under another group health plan that does not contain any exclusion or limitation on any pre-existing condition you may have or you have sufficient creditable coverage to preclude application of the new plan’s pre-existing condition exclusion period to you;
- After electing COBRA coverage, you become enrolled in Medicare; or,
- You are covered under the additional 11-month disability extension and there has been a final determination that the disable person is no longer disabled for Social Security Purposes.

In addition, COBRA coverage can be terminated if otherwise permitted under the terms of the plan.

**Can COBRA Benefits Change?**

Yes, your COBRA benefits can change when benefits under the group health plan change. By law, COBRA benefits are required to be the same as those made available to similarly situated active employees. If the employer changes the group coverage, coverage will also change for you.

**How to enroll**

When you leave the employ of the Company and your last day worked has been processed by HR, you will automatically receive a COBRA enrollment package from Ceridian Cobra Serve, the Company’s COBRA administrator. You will have 60 days within which to complete the enrollment form and return it to Ceridian for processing, as specified in the enrollment package.

Please keep in mind that when you leave the Company, your coverage is terminated. If you elect COBRA, your coverage will be reinstated as of the date of your severance, termination or retirement once your completed COBRA enrollment form has been received, and accompanied by a check for your outstanding COBRA premium(s). After 60 days to elect, you have 45 days to pay your initial premium.

**COBRA Costs**

COBRA costs are 102% of the total cost of the coverage. If you cross over the plan year, your COBRA costs will change in accordance with the costs for the new plan year.

**How to pay for COBRA**

Ceridian Cobra Serve will send you a bill each month for the amount owed based on the coverage(s) you elected. If you fail to send your payment to Ceridian within 30 days of your due date, your coverage will be cancelled automatically.
HIPAA CERTIFICATES OF CREDITABLE COVERAGE

The Plan is required by Federal law (known as the “HIPAA Privacy Rules”) to maintain the privacy of participants’ PHI (Protected Health Information) and to provide participants with notice of its legal duties and privacy practices regarding PHI. HIPAA stands for the Health Insurance Portability and Accountability Act of 1996. For purposes of the HIPAA Privacy Rules, “Protected Health Information” or “PHI” generally means health information relating to you - including your past, present or future health, or payment for your health care - that is created or received by the Plan (including by the Plan’s claims administrators and service providers). For purposes of the HIPAA Privacy Rules, the claims administrators and service providers used by the Plan are referred to as “claims administrators” of the Plan. Claims administrators are contractually obligated to the Plan to take the same care with your PHI that the HIPAA Privacy Rules impose upon the Plan.

At any time up to 24 months after the date on which your coverage ceases under the plan, you may request a copy of a certificate of creditable coverage. In order to request this certificate, you must call or write Blue Cross Blue Shield of Illinois Customer Service.

This Notice summarizes how the Plan may use and disclose your PHI for:

- Your treatment,
- Payment of your claims,
- Health care operations of the Plan, and,
- Other uses and disclosures of such information allowed by law.

In addition, it describes your ability to access and control the use and disclosure of your PHI. The Plan must abide by the terms of this Notice of Privacy Practices, which may be amended from time to time.

Use or Disclosure of your PHI for Plan Administration
This section describes how the Plan uses and discloses PHI. Not every possible use or disclosure is listed, but all of the ways your information may be disclosed for Plan administration fall into three categories: (i) treatment, (ii) payment, and (iii) health care operations.

Treatment
Your PHI may be used or disclosed to carry out medical treatment or services by health care providers. For example, in carrying out treatment functions, the Plan’s prescription drug claims administrator could use or disclose your PHI to protect you from receiving inappropriate medications or share information about prior prescriptions if a newly prescribed drug could cause problems for you.

Payment
Your PHI may be used or disclosed to determine your eligibility for Plan benefits, to coordinate coverage between this Plan and another plan, and to facilitate payment for services you receive. For example, your information may be shared with a claims administrator that the Plan has hired to review use of certain services or medications, or with a claims administrator hired to review use of certain services or medications, or with a claims administrator hired to help the Plan ensure that it is properly reimbursed if a third party is responsible for medical costs the Plan would otherwise pay.

Health Care Operations
Your PHI may be used for various administrative purposes that are called “health care operations” of the Plan. For example, your information might be included as part of an audit designed to ensure that the Plan’s claims administrator is performing its job as well as it should for the Plan.
Disclosures for Treatment, Payment and Health Care Operations
The Plan often relies on claims administrators to handle important administrative tasks on behalf of the Plan. When these tasks involve the use or disclosure of PHI, the Plan is permitted to share your information with these claims administrators. Whenever an arrangement between the Plan and a claims administrator involves the use or disclosure of your PHI, that claims administrator will be required to keep your information confidential.

The Plan also may share your PHI with the Plan sponsor. For instance, the Plan may disclose whether you are participating in, enrolled in, or disenrolled from the Plan. Generally, the Plan sponsor may use the information to carry out its Plan administrative functions. The Plan sponsor has agreed to prevent unauthorized use or disclosure of the information and to limit the employees who have access to such information. In no event, may the Plan sponsor use the PHI it receives from the Plan for benefit programs that do not provide health benefits, to make any employment-related decisions, or for any other purpose - other than as permitted or required by applicable law, or permitted by the Plan.

Additional Uses and Disclosures Allowed by Law
The HIPAA Privacy Rules also allow covered health care entities, such as the Plan, to use and disclose PHI without obtaining written authorization in the following circumstances:

- As authorized by and to the extent necessary to comply with Worker’s Compensation or similar laws;
- For judicial and administrative proceedings, such as lawsuits or other disputes in response to a court order or subpoena; and
- For public health activities, such as preventing or controlling disease and reporting reactions to medications.2

No Other Uses or Disclosures Without Your Authorization
Other than the uses and disclosures described in this Notice, the Plan may not disclose your PHI or make any other use of it without your written authorization. You may revoke any such authorization in writing except to the extent that the Plan has already taken action in reliance on your authorization.

Your Rights Regarding Your PHI
Your rights regarding PHI are summarized below. You may exercise these rights only by making a request directly to the applicable claims administrator maintaining the PHI. In order to determine how to pursue your rights, first contact the applicable claims administrator. Note that you will not be able to access any rights provided under the HIPAA Privacy Rules unless you follow the specific directions of the applicable claims administrator - which may include completing and returning to the applicable claims administrator a specific form made available by the claims administrator for accessing such rights. Also note, that you may not make a blanket request for all PHI maintained by the Plan to the Plan or to any claims administrator; instead, you will need to make your request in writing to the applicable claims administrator maintaining the information by following the claims administrator’s procedures. For example, if you wish to access your health PHI maintained by Blue Cross Blue Shield, you will need to contact Blue Cross Blue Shield directly. A request for health PHI submitted to the Company or any other claims administrator will not be addressed.

You May Access Your PHI Maintained by the Plan
You have a right to inspect and copy your PHI as long as it is maintained by the Plan or on behalf of the Plan, as described in this Notice. Generally, your information will be provided to you in a form regularly maintained by the claims administrator. If you want copies of your PHI, a charge for copying and postage may be required. You have a right to choose to get a summary instead of a copy of the whole record.
The applicable claims administrator will respond to your request within 30 days after its receipt if the information is maintained or accessible on-site or 60 days after receipt if the information is not maintained or accessible on-site. If additional time is needed, you will be notified in writing to explain the delay and to give you the date by which your response will be sent. Even if you are provided with notice of a delay, in no event will the applicable claims administrator act on your request later than 60 days after its receipt if the information is available on-site or 90 days after receipt if the information is not available on-site. You will receive written notification of the claims administrator’s decision.

Grant of Request for Amendment
If your request for amendment of your PHI is granted, the applicable claims administrator will make the appropriate amendment by identifying the records that are affected by the amendment and appending (or otherwise linking) the amendment to the original record. The claims administrator will notify you that the amendment has been made and request your permission to notify others of the amendment. These other individuals may include those you have identified to receive the amendment, as well as, individuals the claims administrator knows have the original PHI and may have relied, or could foreseeably rely, on that information to your detriment.

Denial of Request for Amendment
Your request for amendment may be denied if:

- The applicable claims administrator did not create the information;
- The information is not part of the records maintained by or on behalf of the Plan;
- The information would not be available for your inspection (for one of the reasons described above); or
- The claims administrator determines that the information is accurate and complete without the amendment.

If your request for changes to your PHI is denied, you will be notified in writing with the reason for the denial. You will be informed of your right to submit a written statement disagreeing with the denial that is a reasonable length. A rebuttal statement to your statement of disagreement may be prepared by or on behalf of the Plan. You will be provided a copy of any such rebuttal statement.

Your statement of disagreement and any corresponding rebuttal statement will be included with any subsequent disclosures of applicable information. If you do not file a statement of disagreement, the Plan must submit your request for amendment (or a summary of such request) with any disclosure of the applicable information.

Denial of Request for Access
The applicable claims administrator may deny your request for access to your PHI only under certain limited circumstances. In the event of a denial, the claims administrator will provide access to any part of the requested material that would not cause these problems.

Requesting Review of Access Denial
In most situations, you are entitled to request review of an access denial. In these instances, a health care professional that the applicable claims administrator has chosen may review your PHI. This person will not have been involved in the original decision to deny your request.

Amendment of your PHI
You may have your PHI amended, as described in this Notice, for as long as it is maintained by the Plan or on behalf of the Plan.

In your request for amendment, you must provide a reason to support the requested amendment.

The applicable claims administrator will respond to your request within 60 days after its receipt. If additional time is needed, you will be notified in writing to explain the delay and to give you the date by which your response will be sent. In any event, the claims administrator will act on your request within 90 days after its receipt.
Accountings of Disclosure of Your PHI
If the Plan discloses your PHI to anyone besides you for reasons that you have not authorized, you will be able to receive information about such disclosures, as described in this Notice. This information is called an “accounting”.

A few minor exceptions do apply. By law, no accountings are required for disclosures described earlier in the “Additional Uses and Disclosures Allowed by Law” section of this Notice or for disclosures to persons involved in your care, for national security or intelligence purposes, for disclosures to correctional institutions or law enforcement officials, or for disclosures that are part of a limited data set that contains no more information than: (i) your age or date of admission, discharge or death and (ii) your city, state, county, precinct or Zip code.

Requesting an Accounting
You must make your request for an accounting of disclosures of your PHI to the applicable claims administrator in accordance with its express procedures for making such a request. Your request must specify a time period, which may not be longer than six years. (Remember, though, that information is available only for disclosures made after April 13, 2003, or later if permitted under the HIPAA Privacy Rules.) The applicable claims administrator will respond to your request within 60 days after its receipt. If additional time is needed, you will be notified in writing to explain the delay and to give you the date by which your response will be sent. In any event, the claims administrator will act on your request within 90 days after its receipt.

For each disclosure, you will receive:

- the date of the disclosure;
- the name of the receiving entity and address, if known;
- a brief description of the PHI disclosed; and,
- a brief statement of the purpose of the disclosure or a written copy of the request for the information, if any.

Accounting Fee
In any given 12-month period, you may receive one accounting of the disclosures of your PHI at no charge. Any additional request for an accounting during that period will be subject to a reasonable fee to cover the Plan’s costs in preparing the accounting.

You May Request Restrictions and Confidential Communications
You may request the applicable claims administrator to impose restrictions on certain uses and disclosures of your PHI to carry out treatment, payment or health care operations functions as described in this Notice. You may also request the claims administrator to provide you with confidential communication of PHI. It is important to note that the applicable claims administrator is not required to agree to the requested restriction. If the claims administrator does agree to honor your request, it will not use or disclose your information in the way you specified unless it is needed to provide emergency treatment. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Complaints
If you believe the Plan has violated your privacy rights, you may file a complaint with the Plan or with the Secretary of Health and Human Services. Complaints to the Plan should be filed in writing with:

INEOS HIPAA Privacy Compliance Monitor
Director of Benefits
Marina View Building, Suite 400
2600 South Shore Boulevard
League City, TX  77573

You will not be penalized in any way for filing such a complaint.
Additional Information
For further information regarding the issues covered by this Notice of Privacy Practices, please contact:

INEOS HIPAA Privacy Compliance Monitor
Director of Benefits
Marina View Building, Suite 400
2600 South Shore Boulevard
League City, TX  77573

- Access to PHI by the Plan sponsor will be limited to the officer(s) and/or employee(s) appointed by the Company to serve as Plan Administrator for purposes of maintaining health information privacy and those employees who either are assigned to perform specific Plan administrative functions that involve the use or disclosure of PHI or supervise the employees who have access to PHI. The access of those individuals who work with PHI will be restricted except to the extent reasonably necessary for them to perform the Plan administrative functions assigned or delegated to them. The Plan sponsor will maintain a disciplinary policy and enforce it against any employee with access to PHI who fails to comply with the Plan’s privacy policy and procedures.

- The Plan sponsor will report to the Plan Administrator (or its designee) any improper use or disclosure of PHI of which it becomes aware. When the Plan sponsor no longer needs particular PHI, it will destroy the information or, if destruction is not feasible, maintain the protected information as required by the privacy rules and limit further uses and disclosures to the purposes that make the destruction unfeasible. Any agent or subcontractor to whom the Plan sponsor provides PHI received from the Plan must agree to the same restrictions and conditions that apply to the Plan sponsor.

- Several other uses and disclosures are allowed by law but are unlikely to affect the Plan, including: to government agencies for victims of abuse, neglect or domestic violence; for health oversight activities (audits, investigations, inspections, licensure, etc.); for law enforcement purposes (responding to a court order or subpoena, identifying a suspect or a missing person, providing information about a crime victim or criminal conduct, etc.); to coroners and medical examiners for identification or to determine a cause of death of a deceased person or as otherwise authorized by law; to funeral directors as necessary to carry out their duties; to an organ procurement organization or entity for organ, eye or tissue donation purposes; for certain research purposes, or to avert a serious threat to health or safety of a person or the public; and under specialized government functions that warrant the use and disclosure of PHI (these government functions may include military and veterans’ activities, national security and intelligence activities, and protective services for the President and others). Information may also be disclosed to correction institutions and other law enforcement officials with lawful custody of an inmate or other person.

- Your request may be denied if: a licensed health care professional determines that your request is reasonably likely to endanger your or anyone else’s life or physical safety; the information you request refers to another person and a licensed health care professional determines that the access requested is reasonably likely to cause substantial harm to that person; or the request is made by your personal representative and a licensed health care professional determines that providing access to your representative is reasonably likely to cause substantial harm to you or to another person.

- In the following limited cases, your request for access to your PHI may be denied without giving you an opportunity to request review of that decision: the information you seek to access is excepted from the right to access as described above; the information you seek was created or obtained in the course of ongoing research; you are an inmate at a correctional institution and obtaining a copy of the information would risk the
health, safety, security, custody or rehabilitation of you or of other inmates (the claims administrator will not provide your information if it would threaten the safety of any officer, employee or other person at the correctional institution who is responsible for transporting you); the information you seek to access is contained in records protected by the Federal Privacy Act and the denial satisfies the requirements of that law; or the information you seek to access is obtained from someone other than a health care provider under a promise of confidentiality and your access request would be reasonably likely to reveal the source of the information.
OTHER DISCLOSURES

Women’s Health & Cancer Rights Act
Do you know that your medical plan, as required by the Women’s Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services, including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedemas? Call your medical provider for more information.

Section 125 enrollment
Enrollment under the provisions of Internal Revenue Code Section 125 applies to the following benefit plans; medical, dental, vision, health care spending account, dependent care spending account, and supplemental healthcare coverage.

Because many of your benefits under the INEOS Welfare Benefit Plan qualify for pre-tax status, the IRA requests that you be provided the opportunity to elect these benefits on an annual basis and that your elections remain in effect from January 1 through December 31. During the year, you cannot stop, start, increase or decrease your level of coverage for these benefits unless you experience a change in status during the year, such as:

- Marriage
- Divorce or legal separation
- Birth, adoption or placement for adoption of a child
- Death of a spouse or child
- Change in your spouse’s or dependent’s employment status
- Loss of spouse’s benefit coverage
- Dependent child is no longer eligible

The IRS also requires that any change in benefits be consistent with your change in status. For example, if you marry during the year, you can add your spouse to your medical and dental plan coverage.

If you have a change in status and wish to change your benefit elections, you must process a family status change in Ceridian Self-Service within 31 days of the change.

Special Enrollment Requirements
Certain special enrollment requirements apply to the medical plan, dental plan and health care spending account benefits under the INEOS Welfare Benefit Plans.

If you decline initial enrollment in these benefits for yourself or your dependents (including your spouse) because of other similar coverage, you may in the future be able to enroll yourself or your dependents in these benefits, provided that you request enrollment within 31 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents in these benefits, provided that you request enrollment within 31 days after the event.
INEOS RETIREE BENEFITS

Effective 1/1/2008, newly hired employees will not be eligible for Retiree Medical benefits.

Retirement Medical Eligibility
Effective 1/1/2008, plan eligibility requirements changed to age 55 with 10 years of service at the time of retirement. If an employee had attained age 50 with 10 years vesting service as of 12/31/2007, these individuals will be grandfathered under the old eligibility requirements.

If you were age 50 with 10 years of service at the time of the transition from BP on December 16, 2005, you will be eligible for retiree medical coverage from BP and not the INEOS Plan. Please contact the BP Benefits Center for more information.

Benefits Coverage
Retirees will have the same benefit options and coverage as active employees up until age 65.

Company subsidized post-65 retiree medical coverage will be offered to those employees that are age 50 with 10 years of service as of 1/1/2013 (provided the Plan’s eligibility requirements are met at the time of retirement). This grandfathered group will continue to be eligible to participate on a post-65 basis in the same plans and at the same benefit levels as active employees. The Company will continue to share in the cost of providing this coverage to the grandfathered group.

To ensure that all retirees have access to post-65 supplemental coverage, the Company will be sponsoring a new group plan. The plan will be designed as a supplement to Medicare, paying secondary, and will be made available at reduced group rates. Retirees will be responsible for the entire cost of this benefit.

Paying For Your Benefit Program
In general, under the Plan, the Employer will pay a portion of the premiums for your selected coverage and you will be responsible for the remainder of the cost of such premiums. Your cost of coverage under this Plan will depend upon:

1. the type of coverage that you select;
2. the number of your dependents that you elect to cover;
3. the date that you retire from the Employer;
4. your status under the INEOS Pension Plan when you retire;
5. the amount of the Employer’s maximum premium contribution, as determined by the Employer from time to time.

You will be notified of the cost of each option prior to the enrollment period for the Plan year.

For Employees who retired before 01/01/2008:
If you retired prior to 1/1/2008 and enrolled into retiree medical benefit plan, you will be grandfathered under the old cost structure. Please refer to the Employee Benefits Handbook for details.

For Employees who retire on or after 01/01/2008:
If an employee retires with a Full Pension Benefit, as defined under the Retiree Medical Plan, the retiree will pay the same rates as active employees. The definition of a Full Pension Benefit is:

- Age 62 or Older With At Least 20 Years of Service, or
- Age 65 With At Least 10 Years of Service

If an employee retires with a reduced pension benefit, or before reaching a Full Pension Benefit as defined above, the retiree will pay a multiple of the current active employee premium.
The multipliers are based on the age and service of the employee at the time of retirement, as reflected below:

<table>
<thead>
<tr>
<th>Years Until Full Pension</th>
<th>Multiplier</th>
</tr>
</thead>
<tbody>
<tr>
<td>Greater than 0 But Less Than</td>
<td>1.2</td>
</tr>
<tr>
<td>1</td>
<td>1.4</td>
</tr>
<tr>
<td>2</td>
<td>1.6</td>
</tr>
<tr>
<td>3</td>
<td>1.8</td>
</tr>
<tr>
<td>4</td>
<td>2.0</td>
</tr>
<tr>
<td>5</td>
<td>2.2</td>
</tr>
<tr>
<td>6</td>
<td>2.4</td>
</tr>
<tr>
<td>7</td>
<td>2.6</td>
</tr>
<tr>
<td>8</td>
<td>2.8</td>
</tr>
<tr>
<td>9</td>
<td>3.0</td>
</tr>
<tr>
<td>10</td>
<td>3.0</td>
</tr>
</tbody>
</table>

For example, if an employee retires at the age of 57 with 16 years of Service, this person is 5 years away from meeting the earliest retirement age for full pension, or age 62. This person is also 4 years away from meeting the retirement service requirement of 20 years. Taking the greater of the two numbers based on age and service, this determines the multiplier to be used. This person’s rate multiplier is 5 and thus will pay 2.2 times the active employees rates.

Once a retiree attains age 65, and if eligible for subsidized post-65 coverage, the retiree rate will be reduced to 1/3 of the pre-65 cost.

The maximum company contribution is limited under this new rate structure. In addition, a lifetime maximum benefit applies to all retirees:

<table>
<thead>
<tr>
<th>Coverage</th>
<th>Pre-65</th>
<th>Post-65 (subsidized)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Company Maximum Contribution</td>
<td>$6,000 per person per year</td>
<td>$2,000 per person per year</td>
</tr>
<tr>
<td>Lifetime Maximum Benefit*</td>
<td>$2 million per person</td>
<td>$2 million per person</td>
</tr>
</tbody>
</table>

*The lifetime maximum benefit includes medical benefits received while actively employed and in retirement.

The above table does not apply to post-65 unsubsidized coverage.

Keep in mind that an employee’s retirement date will be the day AFTER his/her last day worked with the Company. So, if a person works on 12/31/2007, their retirement date will be 1/1/2008. This retirement date falls under the NEW cost structure.

**How to Enroll**

At the time of your retirement, you will receive a retirement package from the Plan Administrator with your enrollment options and retiree medical costs. This package will contain an enrollment for you to complete and return to the Benefits Department.

**How to Pay for Your Retiree Benefits**

Once the Benefits Department has received your enrollment form, you will begin receiving bills directly from Ceridian, the Company’s Benefits Billing provider. You will receive a monthly bill and will be required to send your payment directly to Ceridian for processing. All you have to do is follow the instructions on your bill for remittance. If you have any questions regarding your bill or this process, you may contact Ceridian at (800) 877-7994.
<table>
<thead>
<tr>
<th>For more information about:</th>
<th>Provider:</th>
<th>Contact Information:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical</td>
<td>Blue Cross Blue Shield</td>
<td>(888) 979-4516 or <a href="http://www.bcbsil.com">www.bcbsil.com</a></td>
</tr>
<tr>
<td>Medical Pre-certification</td>
<td>Blue Care Connection</td>
<td>(800) 826-8551 or <a href="http://www.bcbsil.com">www.bcbsil.com</a></td>
</tr>
<tr>
<td>Pharmacy</td>
<td>Blue Cross Blue Shield</td>
<td>(800) 423-1973 or <a href="http://www.bcbsil.com">www.bcbsil.com</a></td>
</tr>
<tr>
<td>Dental PPO</td>
<td>MetLife Dental</td>
<td>(800) 451-3258 or <a href="http://www.metlife.com">www.metlife.com</a></td>
</tr>
<tr>
<td>Dental DHMO</td>
<td>CIGNA Dental</td>
<td>(800) 367-1037 or <a href="http://www.cigna.com">www.cigna.com</a></td>
</tr>
<tr>
<td>Vision</td>
<td>VSP</td>
<td>(800) 877-7195 or <a href="http://www.vsp.com">www.vsp.com</a></td>
</tr>
<tr>
<td>Flexible Spending Accounts</td>
<td>MEDCOM MEDCOM Debit Card</td>
<td>(800) 523-7542 or via email at <a href="http://www.benefitspaymentsystem.com">www.benefitspaymentsystem.com</a></td>
</tr>
<tr>
<td>Employee Assistance Program</td>
<td>CIGNA Behavioral Health</td>
<td>(800) 538-3543 or <a href="http://www.cignabehavioral.com/cgi">www.cignabehavioral.com/cgi</a></td>
</tr>
<tr>
<td>Long Term Disability</td>
<td>CIGNA</td>
<td>(800) 362-4462</td>
</tr>
<tr>
<td>Long Term Care</td>
<td>Long Term Care Financial Partners</td>
<td>(866) 471-4072 or <a href="http://www.ineos-ltc.com">www.ineos-ltc.com</a></td>
</tr>
<tr>
<td>COBRA</td>
<td>Ceridian Cobra Serve</td>
<td>(800) 877-7994 or <a href="http://www.ceridian-benefits.com">www.ceridian-benefits.com</a></td>
</tr>
<tr>
<td>Retiree Benefits Billing</td>
<td>Ceridian Benefits Billing</td>
<td>(800) 877-7994 or <a href="http://www.ceridian-benefits.com">www.ceridian-benefits.com</a></td>
</tr>
<tr>
<td>401(k) Plan</td>
<td>Principal Financial Group</td>
<td>(800) 547-7754 or <a href="http://www.principal.com">www.principal.com</a></td>
</tr>
</tbody>
</table>