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Dental PPO - UCCI

Summary Plan Description (SPD)
Effective January 1, 2014

This document describes the Chevron Dental Plan (also referred to as the Dental PPO) as of January 1, 2014, that Chevron sponsors for eligible employees. This information constitutes the summary plan description (SPD) of the Dental PPO as required by the Employee Retirement Income Security Act of 1974 (ERISA). These descriptions don't cover every provision of the plan. Many complex concepts have been simplified or omitted to present more understandable plan descriptions. If these plan descriptions are incomplete, or if there's any inconsistency between the information provided here and the official plan texts, the provisions of the official plan texts will prevail.

Chevron Corporation reserves the right to change or terminate the plan at any time and for any reason. A change also can be made to premiums and future eligibility for coverage and can apply to those who retired in the past, as well as to those who retire in the future. Once approved, plan changes are incorporated into the plan texts, SPDs and vendor administration at the effective date.

To find general benefit summaries and information about other plans that Chevron offers, visit the U.S. Benefits website at **hr2.chevron.com**.

Non-U.S.-payroll expatriates working in the United States should refer to the *Health Benefits for Expatriates in the U.S.* summary plan description available at **hr2.chevron.com** for information about the dental benefits that apply to you.

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Key Benefit Contacts

Human Resources (HR) Service Center

If you have questions regarding your plan options, eligibility and enrollment, please call the HR Service Center.

- 1-888-825-5247 (inside the U.S.)
- 610-669-8595 (outside the U.S.)

U.S. Benefits HR2 website on the Internet

You can access the HR2 website on the Internet, from home or at work. You can access summary plan descriptions, other benefit information and links to other key benefit websites, such as Benefits Connection.

- **hr2.chevron.com**

U.S. HR website on the Chevron Intranet

You can access the U.S. HR website only from the Chevron intranet. You can access HR information in addition to information about your benefits, such as summary plan descriptions and links to other key benefit websites, such as Benefits Connection and Vanguard.

- **hr.chevron.com/northamerica/us/**

United Concordia Companies, Inc. (UCCI)

- **http://www.ucci.com**
- 1-877-424-3876

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Update to the Summary Plan Description

Effective January 1, 2017

All changes described in this SMM are effective January 1, 2017 unless otherwise indicated.

This enclosed newsletter serves as an official summary of material modification (SMM) for the plans referenced herein. Please keep this information with your other plan documents for future reference. This communication provides only certain highlights about changes of benefit provisions. It is not intended to be a complete explanation. If there are any discrepancies between this communication and the legal plan documents, the legal plan documents will prevail to the extent permitted by law. There are no vested rights with respect to Chevron health care plans or any company contributions towards the cost of such health care plans. Rather, Chevron Corporation reserves all rights, for any reason and at any time, to amend, change or terminate these plans or to change or eliminate the company contribution toward the cost of such plans. Such amendments, changes, terminations or eliminations may be applicable without regard to whether someone previously terminated employment with Chevron or previously was subject to a grandfathering provision. Some benefit plans and policies described in this document may be subject to collective bargaining and, therefore, may not apply to union-represented employees.

You can access the summary plan descriptions for your benefits on the Internet at **hr2.chevron.com** or by calling the HR Service Center at 1-888-825-5247 (610-669-8595 if you're outside the U.S.), option 2.

This SMM applies to the following summary plan description:

- **January 1, 2014 Dental PPO Plan Summary Plan Description** (both the individual SPD posted online and the Your Chevron Health Benefits Summary Plan Description for U.S.-Payroll Employees compilation available in print.)

dental PPO plan

Chevron has selected **Delta Dental of California** (Delta Dental) to be the claims administrator for the Chevron Dental PPO Plan effective January 1, 2017. United Concordia (UCCI) will continue to be the claims administrator for the Dental PPO Plan for the remainder of 2016 (see *Treatment in progress* section for exceptions). This section will describe what you need to know about your Dental PPO Plan because of the change to Delta Dental, including what you'll need to know during the transition and how to access your benefits starting in January.

do I need to enroll?

If you are not currently enrolled in a Chevron dental plan and want coverage in 2017, you need to make an enrollment election during the upcoming open enrollment period, October 17 through October 28, 2016. If you are currently enrolled in the Chevron Dental PPO Plan, your coverage will automatically continue on January 1, 2017. You do not have to make an enrollment election during open enrollment, unless you want to make a change to your coverage. If you are currently enrolled in a Chevron Dental HMO Plan and you want to change your coverage to the Dental PPO Plan, you'll need to make an election during open enrollment.

eligibility rules

Who is covered, and who you can cover — the eligibility rules for active employees — are the same for the Dental PPO Plan. In addition, you can continue to add and drop eligible dependents during open enrollment or within 31-days of a qualifying life event while you're an active employee.

monthly employee premium

The monthly employee premium for the Dental PPO Plan effective January 1, 2017 is not changing.

Chevron Dental PPO Plan

2017 Monthly Employee Premium

$27.40	You only
$54.80	You + One adult
$46.70	You + Child(ren)
$74.10	You + Family

get your dental preventive care in 2017, save money on your 2018 dental PPO plan premium

We know dental exams — like many other preventive care exams — are not exactly fun. But there's a reason they are covered by your plan: they are important to good health. The Dental PPO Plan already covers at least **two** preventive dental cleanings per year; that will continue in 2017. Covered preventive dental services are 100 percent paid by your plan, with no deductible or copayment when you use a network provider.

If you are enrolled in the Chevron Dental PPO Plan, you're encouraged to take steps to protect your health and receive at least one preventive dental cleaning* between January 1 and December 31, 2017. If you do not participate in this preventive care measure in 2017, you will pay $120 more for your annual dental plan premium in 2018. It's still your choice to receive a cleaning or not, but if you choose to participate, you'll save money in 2018 and you'll be doing something good for your health.

**For participants with dentures, receive at least one oral exam in lieu of a cleaning.*

new provider network

A network is a group of independent dental care providers that have agreed with your dental plan claims administrator to charge contracted fees for services provided to plan members. With the Dental PPO, you can still see any dentist you choose, but using a network provider saves you money directly by reducing your out-of-pocket costs. They also help to lower overall claim costs for all of us. With a new claims administrator comes a new provider network. Delta Dental has a different network structure than you're used to with UCCI. Here's how they work.

Network providers

Delta Dental offers two different types of networks. Both options are considered **network** providers, so they cover the same services, have the same annual maximums, the same coinsurance or copayment levels, and covered services from these providers aren't subject to the deductible. You also don't have to worry about balance billing when you see a provider from either network option. The difference between the two comes down to the reduced fees the dentists have agreed to provide Dental PPO plan participants.

- **Delta Dental PPO℠ network**
  You'll want to find a dentist in the Delta Dental PPO℠ network to get the greatest savings on your covered dental services. That's because these dentists have agreed to the greatest reduced fees. Why does this matter? Simple math; your coinsurance will apply to a smaller fee so you pay less.
- **Delta Dental Premier® network**
  If you can't find a Delta Dental PPO℠ network dentist, a Delta Dental Premier® dentist offers the next best opportunity to save. Like the Delta Dental PPO℠ network dentists, Delta Dental Premier® dentists also have agreed to reduced fees, but the savings on these fees aren't as much as with the Delta Dental PPO℠ network dentists. So your coinsurance amount will be applied to a higher fee, but you're still saving more money than if you visited an out-of-network provider.

Out-of-network providers

With the Dental PPO, you can still see any dentist you choose, but using a network provider saves you money. When you use an out-of-network dentist, services will be subject to an annual deductible and your coinsurance amounts will be higher, so your out-of-pocket costs will be higher. In addition, out-of-network dentists may balance bill you for the difference between the plan allowance and their usual fee for services.

Find a provider

Go to **hr2.chevron.com** to research providers on the Delta Dental PPO℠ and Delta Dental Premier® networks to help you make your dental plan enrollment choices in October.

treatment in progress

Remember, the Dental PPO Plan is a preferred provider organization plan, so you can continue to use any provider you choose, network or out-of-network. If you began treatment prior to January 1, 2017, work in progress is covered as follows:

- **For active orthodontic treatment,** ask your orthodontist to submit an orthodontic treatment claim to Delta Dental. You should have your orthodontist do this regardless if they are a Delta Dental network provider or not. Delta Dental will then work with your provider regarding the care. The claim form is available on **hr2.chevron.com** or on the **Delta Dental website**. Any **standard claim form** can also be used. The claim should include:
  - All charges and fees (including the down payment or installments paid by your previous dental plan).
  - Banding date and length of active treatment.
  - Brief description of the dentition, appliance (including type) and treatment.
  - If you are covered by more than one plan, information about the other carrier.
- **For all other treatments, payment of claims for service depends on the service date:**
  - If the service date was prior to January 1, 2017, UCCI will continue to pay for claims pertaining to the service, according to the coinsurance or copayment schedules that were in effect during 2016.
  - For service dates starting on or after January 1, 2017, Delta Dental will become the claims administrator and the Delta Dental network, deductibles, and coinsurance schedules will apply.

claims for reimbursement of covered services

If you use an out-of-network provider, typically you'll need to submit a claim to be reimbursed for covered dental services. The Dental PPO Plan generally does not allow benefits to be assigned to an out-of-network provider.

Submit 2016 claims to United Concordia by June 30, 2017

Don't delay or hold your claim forms and submit them all at once at the end of each year. This practice can cause delays for getting reimbursement. It's always good practice to submit claims for reimbursement ongoing and as soon as possible after receiving services. With the transition to a new claims administrator, it's important to submit any final claims for covered 2016 dental services to UCCI as soon as possible, but your final deadline is June 30, 2017. A UCCI claim form is still available on **hr2. chevron.com**.

How to submit claims to Delta Dental

Claim forms are available on the **Delta Dental website**. Claims forms will also be available on **hr2.chevron.com**. Use the Delta Dental claim form for covered dental services from an out-of-network dentist on or after January 1, 2017. You can submit claim forms and bills by mail. Keep a copy of your completed claim form and receipts for your records. You can track the status of your claim on the Delta Dental website or the mobile app. And you can always contact Delta Dental if you have questions. (See Page 76 for contact information.)

other dental PPO plan updates

Due to the change to a new claims administrator for the Dental PPO Plan, the following administrative updates listed below will take effect January 1, 2017:

The timing of the following covered basic dental care has been changed:

- **Periodontics**
  Treatment of the gums (including scaling and root planing) and supporting tissue.
  - Periodontal surgery, not more than two within 36 months of previous treatment.
- **Crowns and inlays**
  Adjustments and recementing of crowns and inlays more than 24 months after initial installation. (Initial installation of crowns and inlays is covered under major dental care.) Recementation allowed once per 12 months. Recementation during the first six months following insertion of the crown or bridge by the same dentist is included in the cost of the initial crown or bridge when services are received by a network provider. Crown repairs are also covered under this category.

The following enhancement has been made to the Covered Basic Dental Care listing:

- Space maintainers, and required adjustments to them, for plan members under age 19.

annual deductibles, coinsurance, copayments and out-of-pocket maximums

There are no changes to the deductible, coinsurance, copayment and annual maximums for the Dental PPO Plan in 2017. You can view a summary of this information online at **hr2.chevron.com**.

new dental ID cards and enrollee ID

Good news. You don't need an ID card so one will not be mailed to you. Just tell your dental office that you're covered by Delta Dental of California and provide your:

- Name
- Date of birth
- Employer Name
- Enrollee ID number (or social security number)

If you have enrolled dependents, tell them to provide your details, not their own.

Want an ID card anyway?

On January 1, 2017, you have two ways to access your ID card online and make a print out for your use:

- **Print one from your computer.**
  - Go to the Delta Dental website and register as a new user.
  - Login to **Online Services**.
  - Click on **My ID card** and print.
- **Pull it up on your smartphone.**
  - Go to the Delta Dental website and register as a new user.
  - Login to **Online Services**.
  - Select **My ID card** from the main menu.

What's my Enrollee ID?

Your social security number can also be used to identify you, but we all want to avoid sharing that number whenever possible. Your Enrollee ID is a safer choice. It's available starting January 1, 2017, from the Delta Dental website — and you can see it on your ID card or under your **Eligibility Information** online. You can also call Delta Dental after January 1, 2017 to get the number.

delta dental website and mobile app

Delta Dental provides three ways for you to stay on top of your dental benefit: visit the website from your computer, access the mobile-optimized website on your smartphone, or download and use the free app. No matter which source you choose you'll be able to:

- Find a dentist (note that you don't have to login to search for a network dentist).
- View your electronic ID card (and grab your Enrollee ID).
- Check deductibles and maximums.
- See your benefits and eligibility.
- Check claims.

How to register

You can go to the Delta Dental website starting today to search for a network dentist and view general information about your Dental PPO Plan without registering or logging in. However, you need to wait until January 1, 2017, after your enrollment is complete and your Delta Dental coverage starts, to register and access the full site services.

- Go to **www.deltadentalins.com/chevron**
- Click on **Register Today** in the **Online Services** section.
- You'll need to provide some basic information to verify your enrollment account.
- You'll need to provide your social security number as you will not yet have your Enrollee ID. This is a one-time request only. You'll get to setup your own username and password as part of the registration process.

Do I need to find a new dentist?

You can continue to use any provider you choose, network or out-of-network, under the Dental PPO Plan. This means you aren't required to find a new dentist. If your current dentist is not in the Delta Dental PPO℠ or Delta Dental Premier® network, it's still your choice to continue to use that provider or locate a new network provider. Just be sure you understand how that choice affects your out-of-pocket costs. Go to **hr2.chevron.com** and click on **2017 Benefit Changes** to access special links that make it easier to research your dental provider options.

Dental PPO Plan

Claims Administrator	Delta Dental of California
Network Name	• Delta Dental PPO℠ • Delta Dental Premier®
Group Number	• 18368
Direct Phone Numbers	• 1-800-228-0513 (Inside the U.S.) • 415-972-8300 (Outside the U.S.) • 5 a.m. — 5 p.m. Pacific (7 a.m. — 7 p.m. Central)
Website	• **www.deltadentalins.com/chevron** • Full site available on January 1, 2017. Provider search available today.
Mobile App	• Delta Dental app

Dependent Day Care Spending Account (DCSA)

Claims Administrator	• **2016:** UnitedHealthcare • **2017:** Health Equity
Plan Group Number	• **2016:** 247893
Direct Phone Numbers	Health Equity information will be sent to 2017 DCSA participants later this year. **UnitedHealthcare** (2016 DCSA) • 1-800-654-0079
Website	Health Equity information will be sent to 2017 DCSA participants later this year. **UnitedHealthcare** (2016 DCSA) • **www.myuhc.com**

Health Care Spending Account (HCSA)

Claims Administrator	• **2016:** UnitedHealthcare • **2017:** Health Equity
Plan Group Number	• **2016:** 247893
Direct Phone Numbers	Health Equity information will be sent to 2017 HCSA participants later this year. **UnitedHealthcare** (2016 HCSA) • 1-800-654-0079
Website	Health Equity information will be sent to 2017 HCSA participants later this year. **UnitedHealthcare** (2016 HCSA) • **www.myuhc.com**

High Deductible Health Plan (HDHP)

Claims Administrator	• **Medical coverage:** Anthem Blue Cross • **Prescription drug coverage:** Express Scripts • **Basic vision coverage:** VSP
Network Name	• **Medical coverage:** National PPO • **Prescription drug coverage:** National Plus Network • **Basic vision coverage:** VSP Choice
Group Number	• **Medical coverage:** 174209 • **Prescription drug coverage:** CT1839 • **Basic vision coverage:** 30021085
Direct Phone Numbers	**Medical coverage** Anthem Blue Cross • 1-844-627-1632 **Prescription drug coverage** Express Scripts • 1-800-987-8368 **Basic vision coverage** VSP • 1-800-877-7195 (Inside the U.S.) • 1-916-851-5000 (Outside the U.S.) - press '0' for operator assistance
Website	• **Medical coverage:** **www.anthem.com/ca** • **Prescription drug coverage:** **www.express-scripts.com** • **Basic vision coverage:** **www.vsp.com/go/chevron**
Mobile App	• **Medical coverage:** Anthem Anywhere app • **Prescription drug coverage:** Express Scripts app

High Deductible Health Plan Basic (HDHP Basic)

Claims Administrator	• **Medical coverage:** Anthem Blue Cross • **Prescription drug coverage:** Express Scripts • **Basic vision coverage:** VSP
Network Name	• **Medical coverage:** National PPO • **Prescription drug coverage:** National Plus Network • **Basic vision coverage:** VSP Choice
Group Number	• **Medical coverage:** 174209 • **Prescription drug coverage:** CT1839 • **Basic vision coverage:** 30021085
Direct Phone Numbers	**Medical coverage** Anthem Blue Cross • 1-844-627-1632 **Prescription drug coverage** Express Scripts • 1-800-987-8368 **Basic vision coverage** VSP • 1-800-877-7195 (Inside the U.S.) • 1-916-851-5000 (Outside the U.S.) - press '0' for operator assistance
Website	• **Medical coverage:** **www.anthem.com/ca** • **Prescription drug coverage:** **www.express-scripts.com** • **Basic vision coverage:** **www.vsp.com/go/chevron**
Mobile App	• **Medical coverage:** Anthem Anywhere app • **Prescription drug coverage:** Express Scripts app

Hospital Indemnity Insurance

Insurer and Administrator	• **Insured by:** Aflac • **Administrator:** Mercer Voluntary Benefits
Phone Numbers	**Mercer Voluntary Benefits** Contact Mercer for information about plan coverage, how the plans work, or for payroll deduction inquiries. • Beginning October 17, 2016. • 1-800-274-4833 • 6 a.m. to 5 p.m. Pacific time (8 a.m. to 7 p.m. Central time) • Monday—Friday **HR Service Center** To enroll or change coverage, contact the Chevron HR Service Center: • 1-888-825-5247 (Inside the U.S.) • 610-669-8595 (Outside the U.S.)
Website	• **hr2.chevron.com** • Click **2017 Benefit Changes** to learn more. • Click **Benefits Connection** ongoing to review personal information or make changes.

Medical PPO Plan

Claims Administrator	• **Medical coverage:** Anthem Blue Cross • **Prescription drug coverage:** Express Scripts • **Basic vision coverage:** VSP
Network Name	• **Medical coverage:** National PPO • **Prescription drug coverage:** National Plus Network • **Basic vision coverage:** VSP Choice
Group Number	• **Medical coverage:** 174209 • **Prescription drug coverage:** CT1839 • **Basic vision coverage:** 30021085
Direct Phone Numbers	**Medical coverage** Anthem Blue Cross • 1-844-627-1632 **Prescription drug coverage** Express Scripts • 1-800-987-8368 **Basic vision coverage** VSP • 1-800-877-7195 (Inside the U.S.) • 1-916-851-5000 (Outside the U.S.) - press ‘0’ for operator assistance
Website	• **Medical coverage:** www.anthem.com/ca • **Medical provider search:** hr2.chevron.com Click 2017 Benefit Changes • **Prescription drug coverage:** www.express-scripts.com • **Basic vision coverage:** www.vsp.com/go/chevron
Mobile App	• **Medical coverage:** Anthem Anywhere app • **Prescription drug coverage:** Express Scripts app

Mental Health and Substance Abuse Plan

Claims Administrator	Beacon Health Options
Direct Phone Numbers	**Beacon Health Options** • 1-800-847-2438 (Inside the U.S.) • 714-763-2420 (Outside the U.S. call collect) **Chevron’s Employee Assistance and Worklife Services** • 1-800-860-8205 • CTN 842-3333
Website	• www.valueoptions.com

OneExchange

Direct Phone Numbers	Health benefits for post-65 eligible retirees and their post-65 eligible dependents. • 1-844-266-1392 (Inside the U.S.) • 1-801-994-9805 (Outside the U.S.) • 5 a.m. — 6 p.m. Pacific time (7 a.m. — 8 p.m. Central time)
Website	• **https://medicare.oneexchange.com/chevron**

Tobacco Coaching

Phone Number	Tobacco Cessation Specialty Coaching with WebMD • 1-888-321-1544 • 925-842-8346 from outside the U.S.
Website	• **hr2.chevron.com/wellness**

Description of the Plan

Overview

The Chevron Dental Plan (also referred to as the Dental PPO) is designed to help you pay for diagnostic, preventive, basic restorative and major dental care, up to certain benefit maximums. United Concordia Companies, Inc. (UCCI) is the claims administrator of the Dental PPO Plan.

Depending on where you live, you may be eligible for a dental health maintenance organization (DHMO) plan. If you choose a DHMO for your dental coverage, you'll want to review the Medical and Dental HMO summary plan description (SPD). The SPD gives you information about eligibility, participation and your legal rights. For information about covered services or a list of DHMO providers, contact your DHMO.

Note for U.S.-Payroll Expatriates: If you are a U.S.-payroll expatriate and an eligible employee as described under Eligibility and Participation section, you are eligible to participate in the Dental PPO Plan. Your only option for Chevron-sponsored dental coverage as a U.S.-payroll expatriate is the Dental PPO. **Please note that action may be required on your part to enroll for this coverage when you transfer to your expatriate assignment.** See the Participation section of this summary plan description for further instructions.

- The Dental PPO is a preferred provider organization made up of more than 93,300 general dentists and specialists at more than 244,900 locations who have agreed to provide dental care at discounted fees. To get a list of PPO network providers near you, call United Concordia Companies, Inc. (UCCI) at 1-877-424-3876 or visit their website at **www.ucci.com**. You can go to any dentist you choose for needed care. If you go to a dentist who participates in UCCI's Chevron Dental Network, you qualify for network coverage.
- If you see a network dentist or specialist, benefits are based on the discounted fees that UCCI's PPO dentists agree to charge; you pay coinsurance for most kinds of care, but there are no deductible requirements.
- If you choose to go to a dentist who is out-of-network, you qualify for out-of-network coverage. When you see a provider who is out-of-network, you must pay the required deductibles before plan benefits can be paid for basic and major dental care, and you're required to pay the difference between your dentist's charge and UCCI's allowance.
- Every calendar year, you and each enrolled family member can qualify for up to $2,000 in network coverage benefits or up to $1,500 in out-of-network coverage benefits.
- In addition, for orthodontic care for plan members, the plan can pay up to a lifetime maximum of $1,500 for network benefits or $1,000 for out-of-network benefits, with no deductible requirement.
- Similarly, for TMJ care for plan members, the plan can pay up to a lifetime maximum of $750 for network or out-of-network benefits.
- You can enroll in this plan when you first become an eligible employee, during open enrollment or when there's a qualifying life event. The company currently pays part of the cost of this coverage.

Note: The negotiated fee, which participating PPO dentists agree to accept, is the basis for plan reimbursement while receiving network benefits.

Important: Any network benefits you use count toward your annual maximum or lifetime maximums for out-of-network benefits. Similarly, any out-of-network benefits you use count toward your annual or lifetime maximum for network benefits. For example, if a plan member has received $1,000 in benefits under network coverage and $500 under out-of-network coverage, no further out-of-network benefits are payable for that individual, because the $1,500 annual benefit maximum has been reached. However, that individual could qualify for another $500 in benefits under network coverage — bringing total paid benefits up to the $2,000 annual network coverage benefit maximum. This same principle applies to the Lifetime Maximum for Orthodontics and TMJ-related services.

Eligibility

This section provides information about benefit plan eligibility rules for you and your dependents. If you enroll for coverage under a dental plan, you also may enroll your eligible dependents for coverage under the same plan (subject to certain restrictions if you're married to or in a domestic partnership with another Chevron employee or retiree). Eligible dependents include your spouse/domestic partner and eligible children, as all are defined below. For more information regarding enrollment procedures, see the Participation section.

Note for Expatriates: If you are a U.S.-payroll expatriate your only option for Chevron-sponsored dental coverage as a U.S.-payroll expatriate is the Dental PPO. Non-U.S.-payroll expatriates working in the United States should refer to the *Health Benefits for Expatriates in the U.S.* summary plan description for information about the dental benefits that apply to you.

Eligible Employees

Except as described below, you're generally eligible for this plan if you're considered by Chevron to be a common-law employee of Chevron Corporation or one of its subsidiaries that it has designated to participate in the Omnibus Health Care Plan and you meet *all* of the following qualifications:

- You're paid on the U.S. payroll of Chevron Corporation or a participating company.
- You're assigned to a regular work schedule (unless you're on a family leave, disability leave, short union business leave, furlough leave, military service leave or leave with pay) of at least 40 hours a week, or at least 20 hours a week if such schedule is an approved part-time work schedule under the Corporation's part-time employment guidelines.
- If you're a casual employee, you've worked (or are expected to work) a regular work schedule for more than four consecutive months.
- If you're designated by Chevron as a seasonal employee, you're not on a leave of absence.
- You're in a class of employees designated by Chevron as eligible for participation in the plan.

However, you're still not eligible if any of the following applies to you:

- You're not on the Chevron U.S. payroll, or you're compensated for services to Chevron by an entity other than Chevron — even if, at any time and for any reason, you're deemed to be a Chevron employee.
- You're a leased employee or would be a leased employee if you had provided services to Chevron for a longer period of time.
- You enter into a written agreement with Chevron that provides that you won't be eligible.
- You're not regarded by Chevron as its common-law employee and for that reason it doesn't withhold employment taxes with respect to you — even if you are later determined to have been Chevron's common-law employee.
- You're a member of a collective bargaining unit (unless eligibility to participate has been negotiated with Chevron).
- You're eligible to receive benefits from the Chevron International Healthcare Assistance Plan (IHAP).
- You're a professional intern.

You may become eligible for different benefits at different times. Participation and coverage do not always begin when eligibility begins. Chevron Corporation, in its sole discretion, determines your status as an eligible employee and whether you're eligible for the plan. Subject to the plan's administrative review procedures, Chevron Corporation's determination is conclusive and binding.

If you have questions about your eligibility for this plan, you should contact:

Chevron Human Resources Service Center
P.O. Box 199708
Dallas, TX 75219-9708
1-888-825-5247 (610-669-8595 outside the U.S.).

Eligible Spouse

If you're legally married under the law of a state or other jurisdiction where the marriage took place, you can enroll your spouse for coverage under the same dental plan you're enrolled in. However, you can't enroll your spouse for coverage if he or she is any of the following:

- Enrolled as an eligible employee.
- Enrolled as an eligible retiree.
- On active duty in the armed forces of any state, country or international authority.

If both you and your spouse are eligible employees or eligible retirees, each of you can enroll for individual coverage, or one of you can cover the other as a dependent. However, only one of you can enroll all of your children for coverage.

Before you can enroll your spouse for coverage, you may be required to provide proof that you're legally married.

Eligible Domestic Partner

To qualify for benefits available to domestic partners of Chevron employees, you must register your partner with Chevron. To do so, you and your partner must obtain and sign the *Chevron Affidavit of Domestic Partnership (F-6)* form.

This form is available through the HR Service Center at 1-888-825-5247 (610-669-8595 outside the U.S.). The original of the affidavit form must be notarized and sent to the HR Service Center. By signing the affidavit, you certify that you and your partner meet one of the following qualifications:

1. You and your partner are all of the following:

    - At least age 18 and of legal age.
    - Mentally competent to enter into contracts.
    - Jointly responsible for each other's welfare and financial obligations and have lived together for at least six months prior to signing the affidavit.
    - In an intimate, committed relationship of mutual caring that has existed for at least six months prior to the signing of the affidavit and it is expected to continue indefinitely.
    - Not related by blood.
    - Not married to anyone other than each other.

2. You live in California and meet all of the requirements of the California Family Code section 297 definition of a domestic partner, including the requirement to have registered your domestic partner with the Secretary of State's office. For more information, visit the California Domestic Partnership website at www.ss.ca.gov/business/sf/sf_dp.htm.

3. You live in another state (such as Colorado, Delaware, Illinois, Nevada, New Jersey, Oregon, Rhode Island, Vermont, Washington, and others) that recognizes civil unions or state-recognized domestic partnerships and have entered into a civil union or state-recognized domestic partnership and reside in that state.

4. You and your partner have entered into a civil union in a state that recognizes civil unions, but reside in a state where that civil union is not recognized.

5. You meet other criteria set forth in the *Chevron Affidavit of Domestic Partnership*.

Note that you must enroll your domestic partner and his or her eligible children within 31 days of the date you first meet one of the qualifications listed above. Also, the *Chevron Affidavit of Domestic Partnership (F-6)* form must be completed and notarized within the 31 days. Otherwise, you must wait until the next open enrollment. For information about imputed income and before-tax vs. after-tax contributions for domestic partners, see the Participation section.

You can enroll your registered domestic partner for dental coverage under the same dental plan you're enrolled in. However, you can't enroll your domestic partner for coverage if he or she is any of the following:

- Enrolled as an eligible employee.
- Enrolled as an eligible retiree.
- On active duty in the armed forces of any state, country or international authority.

- If both you and your domestic partner are eligible employees or eligible retirees, each of you can enroll for individual coverage, or one of you can cover the other as a dependent. However, only one of you can enroll all of your children for coverage.

Eligible Children and Other Dependents

You can enroll a dependent child for coverage if he or she is all of the following:

- Your or your spouse's/domestic partner's natural child, stepchild, legally adopted child, foster child or a child who has been placed with you or your spouse/domestic partner for adoption.
- Younger than age 26. Coverage continues until the end of the month in which your child turns age 26.

You can enroll an *other dependent* for coverage if he or she is all of the following:

- Not married.
- Younger than age 26. Coverage continues until the end of the month in which your other dependent turns age 26.
- Is a member of your household.
- Someone for whom you act as a guardian.
- Dependent on you (or on your spouse/domestic partner) for more than 50 percent of his or her financial support.

Coverage can continue after the child reaches age 26, provided he or she is enrolled in the plan and meets the plan's definition of *incapacitated child* as outlined in the Glossary. When the child reaches age 26 and periodically thereafter, Chevron Corporation will require you to provide documentation stating that the child continues to be incapacitated.

Incapacitated children over age 26 can be added to coverage only if they were disabled before age 26 and had other health care coverage immediately before being added as a dependent under a Chevron plan, You will be required to provide documentation of both conditions. Incapacitated children added after age 26 also can include a brother, sister, stepbrother or stepsister if he or she meets the definition of incapacitated child as outlined in the Glossary.

For chronic disabilities, as determined by UnitedHealthcare, you must provide documentation every two years. If the disability is not chronic, UnitedHealthcare will determine how frequently you will need to provide such documentation. For details, contact the HR Service Center at 1-888-825-5247 (610-669-8595 outside the U.S.).

Your child or other dependent isn't eligible for coverage if he or she is any one of the following:

- Covered as a dependent by another eligible employee or eligible retiree.
- Covered as an eligible employee.

Before your child can be enrolled, you may be required to provide proof of his or her eligibility.

Qualified Medical Child Support Order (QMCSO)
Pursuant to the terms of a qualified medical child support order (QMCSO), the plan also provides coverage for your child, even if you do not have legal custody of the child, the child is not dependent on you for support and regardless of any enrollment season restrictions that might otherwise exist for dependent coverage. If you are not enrolled in a dental plan, you must enroll for coverage for yourself and the child. If the plan receives a valid QMCSO and you do not enroll the dependent child, the custodial parent or state agency can enroll the affected child. Additionally, Chevron can withhold any contributions required for such coverage.

A QMCSO may be either a National Medical Support Notice issued by a state child support agency or an order or a judgment from a state court or administrative body directing Chevron to cover a child under the plan. Federal law provides that a QMCSO must meet certain form and content requirements in order to be valid. If you have any questions or if you would like to receive a copy of the written procedure for determining whether a QMCSO is valid, please contact the HR Service Center at 1-888-825-5247 (610-669-8595 outside the U.S.).

You, a custodial parent, a state agency or an alternate recipient can enroll a dependent child pursuant to the terms of a valid QMCSO. A child who is eligible for coverage pursuant to a QMCSO cannot enroll dependents for coverage under the plan.

Participation

This section provides important information about participation in the Dental PPO.

When and How You Can Enroll

As soon as you become an eligible employee, you can enroll in the Dental Plan. The chart below contains important enrollment-related information.

A Snapshot of What to Do When

The following chart highlights when and how to enroll in the Before-Tax Contribution Plan and Dental Plan.

Plan	When to Enroll	How to Enroll
Dental PPO	You can enroll yourself and your eligible dependents in a dental plan that Chevron offers: • During your first 31 days on the job, if you're eligible. • During open enrollment. • Within 31 days of a qualifying life event. **Attention U.S.-Payroll Expatriates** If you have coverage in a Chevron-sponsored dental plan just prior to starting your expatriate assignment, you will be automatically enrolled in the Dental PPO upon your transfer. If you have dental coverage that is not sponsored by Chevron – such as through your spouse's employer - just prior to starting your expatriate assignment, you will not be automatically enrolled in the Chevron Dental PPO Plan. However, you will have 31 days after your other dental coverage ends to enroll for the Dental PPO. Otherwise, you must wait until the next open enrollment period to enroll.	To enroll, contact the HR Service Center at 1-888-825-5247 (610-669-8595 outside the U.S.). Be sure to complete and turn in any forms sent to you with your confirmation statement. Before a dependent's enrollment can be processed, you may be required to provide proof of his or her eligibility (that is, a marriage license, a birth certificate or adoption papers). In addition, before you can enroll your domestic partner for Dental Plan coverage, you must file a notarized *Chevron Affidavit of Domestic Partnership (F-6)* form. To request a form, call the HR Service Center at 1-888-825-5247 (610-669-8595 outside the U.S.). If you don't enroll your eligible dependents at the same time you enroll yourself, you can enroll them during any open enrollment period or within 31 days of the date they first become eligible (for example, within 31 days of a qualifying life event).
Before-Tax Contribution Plan	If you enroll in a health plan to which Chevron contributes, you're automatically enrolled to have before-tax deductions for any medical and dental plans.	Not applicable for medical and dental, unless you elect not to enroll. If you don't want to enroll, decline before-tax participation before your health plan coverage begins by contacting the HR Service Center at 1-888-825-5247 (610-669-8595 outside the U.S.).

Before-Tax vs. After-Tax Contributions

If you enroll to have before-tax deductions taken for this plan, you will be automatically enrolled in the Before-Tax Contribution Plan. Most employees benefit by making health plan contributions on a before-tax basis. However, when you make before-tax contributions, you limit your ability to make enrollment changes in your health plans during the year. Also, if you make contributions on a before-tax basis for dental coverage, you are required to make contributions on a before-tax basis for medical coverage and vice versa. When you make after-tax contributions, you have more flexibility to make changes during the year, such as dropping coverage for yourself or an eligible dependent.

When you make before-tax contributions, federal law allows you to make enrollment changes during the year only if the change is allowed under plan rules and one of the following applies:

- The change doesn't affect the total amount of your monthly before-tax contributions.
- The change is a result of a qualifying life event. (In this case, any change you make must be consistent with the qualifying life event.)

Making before-tax contributions may lower your Social Security benefits slightly if you earn less than the Social Security wage base (which is $117,000 in 2014 and may change each year). However, the advantages of current tax savings may outweigh the possible reduction in your Social Security benefits at retirement. If you earn more than the Social Security wage base, you won't save any Social Security tax by making before-tax contributions, and your future Social Security benefits won't be reduced.

Congress may change the laws that govern before-tax contribution programs. (Chevron will notify you if you're affected by any changes in the laws.)

Imputed Income and Before-Tax vs.
After-Tax Contributions for Domestic Partners

Before you enroll your domestic partner in Chevron benefits, remember that the federal government does not recognize domestic partnerships. Thus, with a very limited exception described below, the fair market value of the benefits provided for your domestic partner and his or her eligible children (unless they also are your natural or adopted children) is considered by the federal government to be "imputed income" that is taxable income to you. The imputed income amount will be added to each of your paychecks, and Chevron will deduct applicable taxes (federal, state, Social Security, etc.) each pay period. Whether there is imputed state income depends upon the state. There currently will not be imputed income for state purposes if you qualify under the criteria noted below. Because the federal government does not recognize domestic partnerships, you also cannot pay for the benefits of your domestic partner or his or her children (unless such child is also your natural or adopted child) on a before-tax basis. This does not, however, affect your ability to pay for your benefits on a before-tax basis. As a result, you may see two deductions on your paycheck stub — one for before-tax contributions for your coverage and one for after-tax contributions for coverage for your domestic partner's and his or her eligible children (who also are not your natural or adopted children).

The one exception to imputed federal income to you is if your domestic partner and/or his or her children (unless they are your natural or adopted children – in which case, they are treated just as any other children of an employee) qualify as your dependent as defined in Internal Revenue Code section 152 and you are able to claim them as a dependent on your federal income tax return.

If one of the following applies to you then you may not be subject to imputed income for state tax purposes:

- You live in California and meet all of the requirements of the California Family Code section 297 definition of a domestic partner, including the requirement to have registered your domestic partner with the Secretary of State's office. For more information, visit the California Domestic Partnership website at **www.ss.ca.gov/business/sf/sf_dp.htm**. If you reside in California, you will be exempt from imputed income if you report that your domestic partner meets the state's requirement of a tax dependent and you report that you have registered your domestic partner or with the Secretary of State.
- You live in another state such as Oregon or the District of Columbia, that recognizes domestic partnerships and you meet that state's requirements to cover your domestic partner on a before-tax basis. Check with your tax advisor about the tax treatment of coverage.

Before you enroll your domestic partner in Chevron benefits, request and complete the "domestic partner" package that includes important forms and personalized information about benefits enrollment, taxes and beneficiaries. Contact the HR Service Center at 1-888-825-5247 (610-669-8595 outside the U.S.) to speak with a Customer Service Representative.

Making Changes

You can make changes to some of your benefit elections at any time. Other changes can be made only during open enrollment (which is typically held during a two-week period each fall) or when there's a qualifying life event during the year. If you want to change or cancel coverage, contact the HR Service Center at 1-888-825-5247 (610-669-8595 outside the U.S.).

The following chart includes a brief explanation of the changes you can make under coverage related to the Dental Plan and the Before-Tax Contribution Plan.

Plan	Types of Changes
Dental PPO	• During open enrollment, you can switch to another dental plan if one is available in your area. • You can switch to another dental plan if you're in the Concordia Plus dental HMO, the CIGNA Dental Care HMO or Hawaii Dental Service and you move out of their service area. • You can't otherwise change your plan elections unless there's a qualifying life event. • If you pay for your coverage on an after-tax basis; however, you can cancel your coverage or drop dependents from coverage at any time.
Before-Tax Contribution Plan	• You can change the tax status of your health plan contributions (before-tax to after-tax or vice versa) during any open enrollment. Changes take effect the following January 1. You can't otherwise change your plan elections unless there's a qualifying life event.

Midyear Changes

If you pay for your dental coverage on a before-tax basis, because of the plan's tax advantages, the Internal Revenue Service restricts your ability to make changes to your benefits after initial enrollment. In general, once you enroll for (or decline) coverage, your benefit elections stay in effect for the entire plan year. However, under certain circumstances, you can enroll for or change certain coverages during the year (for example, if you experience a qualifying life event that affects your, your spouse's/domestic partner's, or your dependent's eligibility for plan benefits).

Qualifying Life Events
You can change certain benefit elections during the plan year if you experience a qualifying life event that results in a loss or gain of eligibility under the plan for yourself, your spouse/domestic partner or your dependent children. Changes can be made to your medical and dental coverage as long as the changes are consistent with, and correspond to, the qualifying life event.

A qualifying life event is any of the following circumstances that may affect coverage:

- You get divorced or legally separated, you have your marriage annulled or your domestic partnership ends.
- Your spouse/domestic partner or dependent child dies.
- Your dependent child becomes ineligible or eligible for coverage (for example, he or she reaches the plan's eligibility age limit).
- You get married or acquire a domestic partner.
- You have a baby, adopt a child or have a child placed with you for adoption.
- You, your spouse/domestic partner or your dependent child experiences a change in employment status that affects eligibility for coverage (for example, a change from part-time to full-time or vice versa, or commencement of or return from an unpaid leave of absence).
- You, your spouse/domestic partner or your dependent child experiences a significant change in cost of coverage. This does not apply to the Health Care Spending Account (HCSA) Plan.
- Your, your spouse's/domestic partner's or your dependent child's home address changes (outside the network service area). This does not apply to the Health Care Spending Account (HCSA) Plan.
- You, your spouse/domestic partner or your dependent child qualifies for or loses Medicare or Medicaid coverage.
- The plan receives a qualified medical child support order (QMCSO) or other court order, judgment or decree requiring you to enroll a dependent in the plan.
- You commence or return from a leave of absence under the Family and Medical Leave Act of 1993 (FMLA).
- You qualify for a special enrollment during the year under the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

If you experience a qualifying life event and need to change your coverage during the plan year, notify the HR Service Center within 31 days of the event that necessitates the change. If you don't, you can't make a coverage change until the next open enrollment, unless you have another qualifying life event.

Special Enrollment Rights Under HIPAA

Special enrollment rights apply due to a loss of other coverage or a need to enroll because of a new dependent's eligibility.

If you are eligible for special enrollment rights under HIPAA, you may enroll in any health plan option offered under the Omnibus Health Care Plan for which you are eligible or, if you're already enrolled in a health plan option, you may change health plan options if another option is available.

Special Enrollment Due to Loss of Other Coverage

You and your eligible dependents may enroll for dental coverage (subject to certain conditions) if you waived your initial coverage at the time it was first offered under this plan because you (or your spouse/domestic partner or dependent) were covered under another plan or insurance policy. You may enroll, provided your or your dependents' other coverage was either of the following and you meet the conditions described below:

- COBRA continuation coverage that has since ended.
- Coverage (if not COBRA continuation coverage) that has since terminated due to a loss of eligibility, a loss of employer contributions or for the other reasons described below.

  Loss of eligibility includes a loss of coverage due to any of the following:
  - Legal separation.
  - Divorce.
  - Death.
  - Ceasing to be a dependent as defined by the terms of a plan.
  - Termination of employment.
  - Reduction in the number of hours of employment.

  It doesn't include loss of coverage due to failure to timely pay required contributions or premiums, or loss of coverage for cause (for example, you commit fraud or make an intentional misrepresentation of a material fact).

Special enrollment rights also are available if you or your dependents lose other coverage due to either of the following:

- A plan no longer offers any benefits to the class of similarly situated individuals to which you or any of your dependents belong.
- You or one of your dependents who has coverage through an HMO/DHMO no longer resides, lives or works in the HMO/DHMO service area.
- You or one of your dependents incurs a claim that would meet or exceed a lifetime limit on all benefits under the terms of a plan.

You and your dependents must meet certain other requirements as well:

- **Required length of special enrollment:** You and your dependents must request special enrollment in writing no later than 31 days from the day the other coverage was lost.

- **Effective date of coverage:** If you enroll within the 31-day period, coverage takes effect the first day of the month after the other coverage ended.

Special Enrollment Due to New Dependent Eligibility
You and your eligible dependents may enroll in the plan (subject to certain conditions) if you acquire a dependent through marriage or formation of a new domestic partnership, birth, adoption or placement for adoption. You and your dependents must request special enrollment in writing no later than 31 days from the date of marriage, the date all of the requirements set forth in the *Chevron Affidavit of Domestic Partnership* are first met, birth, adoption or placement for adoption. The conditions that apply are as follows:

- **Nonenrolled employee:** If you're eligible but haven't yet enrolled, you can enroll upon your marriage, upon acquiring a new domestic partner, or upon the birth, adoption or placement for adoption of your child.

- **Nonenrolled spouse/domestic partner:** If you're already enrolled, you can enroll your spouse/domestic partner at the time of your marriage or acquiring a new domestic partner. You also can enroll your spouse/domestic partner if you acquire a child through birth, adoption or placement for adoption.

- **New dependents of an enrolled employee:** If you're already enrolled, you can enroll a child who becomes your eligible dependent as a result of your marriage or acquiring a new domestic partner, birth, adoption or placement for adoption.

- **New dependents of a nonenrolled employee:** If you're eligible but not enrolled, you can enroll an individual (spouse/domestic partner or child) who becomes your dependent as a result of your marriage or acquiring a new domestic partner, birth, adoption or placement for adoption. However, you (the nonenrolled employee) must also be eligible to enroll and actually enroll at the same time.

- **Effective date of coverage:**

  - **Upon marriage:** On the first day of the month coinciding with or following the date of marriage.
  - **Upon formation of a domestic partnership:** On the first day of the month coinciding with or following the date all of the requirements of the *Chevron Affidavit of Domestic Partnership* are first met.
  - **Upon birth:** On the date of the dependent's birth.
  - **Upon adoption or placement for adoption:** On the date of such adoption or placement for adoption.
  - **When adding a child (other than your own newborn or adopted child):** On the first day of the month coinciding with or following the date the child first becomes your dependent.

Special Enrollment Due to the Children's Health Insurance Program (CHIP)
The Children's Health Insurance Program (CHIP) Reauthorization Act of 2009 extends and expands the State Children's Health Insurance Program (SCHIP). The Act establishes special enrollment rights for employees and their dependents that are eligible for, but not enrolled in coverage under an employer-provided group health plan (such as the Chevron health plans). You and your dependents are eligible to enroll for Chevron health coverage as long as you apply within 60 days of the date that *either* of the following occurs:

- Medicaid or CHIP coverage is terminated due to loss of eligibility.
- You become eligible for a Medicaid or CHIP premium assistance subsidy. This means that Medicaid or CHIP will subsidize, or pay for, a portion of the Chevron health plan premium cost if you enroll.

If your request for coverage is made within the 60 day period, coverage takes effect:

- The first day of the month after the Medicaid or CHIP coverage ended, or
- The first day of the month following the date you first become eligible for the premium assistance subsidy.

More information, including a listing of states that currently have premium assistance programs, is available in the Other Plan Information section, Free or Low-Cost Health Coverage to Children and Families section of this summary plan description.

When Participation Begins

The following chart shows when participation begins under the following plans, provided you or your dependents are eligible.

Plan	Participation Begins:
Dental PPO Employee Coverage	• On your hire date, if you enroll in a dental plan within 31 days of your hire date. • On the day you first become eligible, if you enroll in a dental plan within 31 days of the date you first become eligible. • The day you acquire a dependent child, if you enroll within 31 days of the birth or the earlier of the date of adoption or placement for adoption. • On the first day of the month coinciding with or following the date of your marriage, if you enroll within 31 days of your marriage. • On the first day of the month coinciding with or following the date all of the requirements listed on the Chevron Affidavit of Domestic Partnership are first met, if you enroll within 31 days of first meeting the requirements listed on the Chevron *Affidavit of Domestic Partnership (F-6)* form. • The following January 1, if you enroll in a dental plan during the open enrollment period.
Dependent Coverage	• On the same day your coverage begins, if you enroll yourself and your dependents at the same time. • On the date of birth, if you enroll a newborn child within 31 days of the date he or she is born. • On the date of adoption or on the date the child is placed with you for adoption (if earlier), if you enroll the child within 31 days. • On the first day of the month coinciding with or following the date he or she becomes eligible, if you enroll a new spouse/domestic partner, child or stepchild (other than a newborn or newly adopted child) within 31 days. • The following January 1, if you enroll in a dental plan during the open enrollment period.
Before-Tax Contribution Plan	• Generally, at the same time as your participation in any one of the health plans. • The following January 1, if you enroll in the plan during the open enrollment period.

When Participation Ends

Your benefit plan participation will end if any of the following applies:

- You're no longer an eligible employee.
- You stop making required contributions.
- Chevron Corporation terminates the plan.

Generally, dependent coverage will end when you're no longer an eligible employee. Your dependents' participation also will end if they're no longer eligible (for example, you become divorced or a child reaches age 26.

If you commit fraud or make an intentional misrepresentation of a material fact about your participation in the health care plans, the plan has the right to terminate coverage permanently for you and all of your eligible dependents. Also, the plan may seek financial damages caused by the misrepresentations and may pursue legal action against you. Material misrepresentation includes, but is not limited to, adding a dependent who is ineligible (for instance, adding a spouse when you aren't married or adding a child who doesn't meet the plan qualifications of an eligible dependent).

A Snapshot of When Coverage Ends

The following chart shows additional rules regarding when coverage ends under each plan.

Plan	Participation Ends When:
Dental PPO	• You or your dependent is no longer eligible. Coverage ends on the last day of the month. • You cancel coverage or stop making required contributions. Coverage for you and your dependents ends on the last day of the month for which contributions were received. Coverage for you and your dependents also ends after 31 days of the following types of leave: • Personal Leave Without Pay. • Leave for Educational Reasons. • Long Union Business Leave (unless you elect to pay 100% of the cost of continued coverage).

Plan	Participation Ends When:
Before-Tax Contribution Plan	• As a result of a qualifying life event, you stop participating in all of the health plans to which Chevron requires you to contribute. • You elect to make contributions on an after-tax basis (participation ends on the following December 31). • You transfer to a company that doesn't participate in the dental plans. • You no longer receive a paycheck from Chevron and, as a result, you're unable to make before-tax contributions. • You're no longer eligible to participate because of a plan change, a change in your employment status or other reasons. • The plan is terminated or your employer stops participating in the plan.

What Happens if You Die

If you die, your enrolled dependents are eligible for either continuation coverage or retiree and survivor coverage. For more information, see the Continuation Coverage and COBRA Coverage section.

How Much You Pay for Coverage

You and Chevron currently share the cost of dental coverage. Your cost for coverage depends on the number of dependents you cover. The cost of coverage is communicated each year during open enrollment. For the most up-to-date costs for each plan, you can visit the Benefits Connection website at **hr2.chevron.com** or contact the HR Service Center at 1-888-825-5247 (610-669-8595 outside the U.S).

Your contributions are withheld from your paycheck on a before-tax basis unless you choose to make your contributions on an after-tax basis. When you enroll for coverage, you decide if you want your contributions withheld before or after taxes are deducted from your pay. You can change your election during the open enrollment period.

Chevron Corporation, in its sole discretion, determines the amount that plan members contribute for coverage. In doing this, Chevron Corporation takes into account several factors, including the expected cost of claims and expenses and the amount it has agreed to pay toward coverage. If the payment of claims and expenses exceeds contributions from plan members and Chevron, Chevron Corporation will make up the difference. However, this deficit would then be considered when Chevron Corporation determines future contribution rates for plan members.

How the Plan Works

The plan provides two levels of coverage for dental care:

- **Network coverage:** Applies when you receive dental care from a provider who participates in the plan's preferred provider organization (PPO), the Chevron Dental Network. To get a list of Chevron Dental Network PPO providers near you, call UCCI at 1-877-424-3876 or visit their website at **www.ucci.com**. You don't have to pay a deductible when you receive care from a network provider, and you don't have to file claim forms. You'll pay your dentist the required coinsurance, if any.

- **Out-of-network coverage:** Applies when you choose to receive care from a dentist who doesn't participate in United Concordia's Chevron Dental Network. If you use an out-of-network provider, you must satisfy a deductible for certain types of care, and you have to file claim forms to receive reimbursement for covered expenses.

You and your enrolled dependents decide whether to go to a network dentist — or an out-of-network dentist — each time you need dental care. This decision determines whether the care you receive qualifies for network coverage or out-of-network coverage. Your out-of-pocket expenses generally will be lower when you receive services from a network provider than for the same services received from an out-of-network provider.

There are benefit maximums under both network and out-of-network coverage.

Note: If you or your enrolled dependents reach a benefit maximum when using network providers, then the participating provider can charge his or her normal fee for future services. In this case, the provider is not bound by the negotiated fee schedule.

Deductibles

If you choose to go to an out-of-network provider, you must pay required deductibles before plan benefits can be paid for basic and major dental care. You're also required to pay any difference between your dentist's charge and the plan's reimbursement, which is based on the dental allowance charges.

No deductible is required for preventive and diagnostic care, orthodontic care, or non-surgical TMJ services.

Annual Deductible for Basic and Major Dental Care	Network Coverage	Out-of-Network Coverage
You Only	$0	$100
You and One Adult	$0	$200
You and Child(ren)	$0	$200
You and Family	$0	$300

Each covered individual has a maximum deductible equal to the *You Only* deductible amount. For the *You and One Adult*, *You and Child(ren)* and *You and Family* coverage category levels, there is an overall maximum deductible amount for all covered participants that corresponds to the coverage category elected. No more than the You Only deductible amount can be applied toward the family deductible for any one person to satisfy the You and Child(ren) or You and Family deductible.

For example, if you choose the You and Family coverage category, your annual deductible is met when the family's accumulation of deductible costs reaches $300, with no more than $100 applied for each family member. Your family could meet the $300 maximum limit with charges of $100 for one member, $100 for a second member, $50 for a third member and $50 for a fourth member.

Benefit Maximums

Every calendar year, you and each enrolled family member can qualify for up to $2,000 in network coverage benefits or up to $1,500 in out-of-network coverage benefits.

In addition, for orthodontic care for plan members, the plan can pay up to a lifetime maximum of $1,500 in network benefits and $1,000 in out-of-network benefits, with no deductible requirement. These benefits are not counted when determining if the plan's annual maximums have been reached.

Nonsurgical treatment of temporomandibular joint dysfunction (TMJ) has a lifetime benefit maximum of $750 for each plan member. These benefits aren't counted when determining if the plan's deductibles or annual maximums have been reached.

Important: Any network benefits you use count toward your annual maximum or lifetime maximums for out-of-network benefits. Similarly, any out-of-network benefits you use count toward your annual or lifetime maximum for network benefits. For example, if a plan member has received $1,000 in benefits under network coverage and $500 under out-of-network coverage, no further out-of-network benefits are payable for that individual, because the $1,500 annual benefit maximum has been reached. However, that individual could qualify for another $500 in benefits under network coverage — bringing total paid benefits up to the $2,000 annual network coverage benefit maximum. This same principle applies to the Lifetime Maximum for Orthodontics and TMJ related services.

Note: If you or your enrolled dependents reach a benefit maximum when using network providers, then the participating provider can charge his or her normal fee for future services. In this case, the provider is not bound by the negotiated fee schedule.

What the Plan Pays

Network coverage and out-of-network coverage help pay for the following kinds of care:

- Diagnostic and preventive care.
- Basic dental care.
- Major dental care, including implants.
- TMJ Services (non-surgical).
- Orthodontic care.

You have to satisfy the plan's deductible requirements before the plan pays out-of-network benefits for some kinds of care.

Diagnostic and Preventive Care

To encourage you and your dependents to take good care of your teeth, the plan can pay 100 percent of covered charges for routine diagnostic and preventive care, such as checkups and cleanings.

- **Network coverage:** Pays 100 percent of the negotiated fees with no deductible.
- **Out-of-network coverage:** Pays 100 percent of UCCI's allowance with no deductible. (You pay the difference between your dentist's fees and UCCI's allowance.)

These benefits are subject to the plan's annual benefit maximums.

The following services and supplies are covered for each enrolled member of your family:

- Two oral examinations per calendar year.
- Cleaning and scaling of teeth (called prophylaxis) performed by a dentist or dental hygienist twice per calendar year (an additional dental cleaning will be covered for pregnant women).
- Periodontal cleanings twice per calendar year following active periodontal therapy, in addition to cleaning and scaling of teeth (prophylaxis).
- Bitewing x-rays twice per calendar year.
- Full-mouth or panoramic x-rays once every 36 months.
- One sealant treatment of the permanent posterior teeth every 36 months for each covered child under age 14.
- Two fluoride treatments per calendar year for each plan member under age 19.
- Space maintainers, and required adjustments to them, for plan members under age 19 (if medically necessary due to premature loss or extraction of teeth, and necessary to prevent adjacent or opposing teeth from moving).
- Emergency treatment to relieve dental pain, including charges for X-rays (other kinds of care provided on the same day will be paid according to the plan's basic, major and orthodontic care coverages).

Basic Dental Care

- **Network coverage:** Pays 90 percent of the negotiated fees with no deductible.
- **Out-of-network coverage:** Pays 80 percent of UCCI's allowance after you pay the deductible. (You pay the difference between your dentist's fees and UCCI's allowance.)

Covered basic dental care includes the following:

- **Fillings:** Amalgam, silicate, acrylic, synthetic, porcelain and composite fillings (anterior teeth only) to repair teeth that are broken or decayed. Coverage for composite fillings in posterior teeth is limited to the covered amount for amalgam fillings. Gold fillings are covered under major dental care. Replacement of restorative services only when they are not, and cannot be made serviceable, including:
  - Basic restorations – not within twelve (12) months of previous placement.
- **Oral surgery:** Tooth extractions, treatment of a fractured or dislocated jaw, cutting procedures (including removal of stitches and postoperative examinations), and the medically necessary anesthesia when performed by a dentist or an oral surgeon in his or her office, including when prescribed as part of an orthodontic treatment plan.

Note: When oral surgery is performed in a facility other than the oral surgeon's office, the oral surgeon's fees will be covered, but the facility and anesthesia charges will be excluded. Coordinate with your medical plan for facility and anesthesia coverage.

- **Periodontics:** Treatment of the gums (including scaling and root planing) and supporting tissue.
  - Scaling and root planning, not within 24 months of previous treatment.
  - Periodiodontal surgery, not within 24 months of previous treatment.
- **Endodontics:** Root canal therapy and other treatments related to dental pulp as follows:
  - Root canal re-treatment – one per tooth per lifetime.;
  - Pulpal therapy – one per eligible tooth per lifetime. Eligible teeth limited to primary anterior teeth under age six and primary posterior molars under age twelve;
- **Antibiotic injections:** Injectable antibiotics only.
- **Crowns and inlays:** Adjustments and recementing of crowns and inlays more than twelve months after initial installation. (Initial installation of crowns and inlays is covered under major dental care.) Recementation allowed once per twelve months. Recementation during the first 12 months following insertion of the crown or bridge by the same dentist is included in the cost of the initial crown or bridge when services are received by a network provider. Crown repairs are also covered under this category.
- **Bridgework and dentures:** Repairs, adjustments and recementing of bridgework or dentures, relining or rebasing of dentures and charges for adding teeth to existing dentures, if needed to replace teeth while covered under the plan. Adjustments, relining or rebasing done within six months after initial installation aren't covered under the basic dental care. (Initial installation of bridgework and dentures and the first six months of their maintenance are covered under major dental care.)

- **Second opinions:** Covered if provided by an independent consulting dentist.
- **Lab tests and reports:** The plan covers lab tests and reports necessary for diagnosis, such as microscopic exams and tests of cysts from oral surgery.

Major Dental Care

- **Network coverage:** Pays 50 percent of the negotiated fees with no deductible.
- **Out-of-network coverage:** Pays 50 percent of UCCI's allowance after you pay the deductible (except TMJ, see below). You pay the difference between your dentist's fees and UCCI's allowance.

Covered major dental care includes the following:

- **Prosthodontics:** Initial installation of bridgework and full or partial dentures is covered under this part of the plan. Benefits payable for both a temporary and permanent appliance are limited to covered charges for the permanent appliance. (Charges for extractions and other preparatory work, as well as repair, adjustment, recementing, relining, rebasing and adding teeth to existing dentures more than
six months after their initial installation are covered under basic dental care.)
- **Cast Restorations:** Initial installation of crowns and inlays is covered under this part of the plan. Gold inlays, gold onlays and gold fillings and gold and porcelain crowns are covered only when the tooth can't be restored with fillings using the materials covered under basic dental care. If the other materials can be used, benefits for the gold restoration will be limited to the amount that would be paid for the alternate materials.
- **Dental implants:** Dental implants are covered only if they're used to replace natural teeth lost while the patient is covered under the plan. Before you receive services, you must contact UCCI for approval of the services.
- **Nonsurgical treatment of temporomandibular joint dysfunction (TMJ), including Occlusal guards:** The out-of-network coverage pays 50 percent of UCCI's allowance, but there is *no deductible* required for this coverage. Nonsurgical treatment of TMJ has a lifetime benefit maximum of $750 per covered member of your household. These benefits aren't counted when determining if the plan's annual benefit maximums have been reached.

  Treatment for TMJ includes examinations and the installation and adjustment of removable appliances designed to correct the condition. Charges for surgery to correct TMJ aren't covered under this plan, but may be covered under your medical plan.

Orthodontic Care

You don't have to pay a deductible before orthodontia benefits can be paid. You pay the difference between your dentist's fees and UCCI's allowance. Any network orthodontia benefits you use count toward your maximum out-of-network orthodontia benefits. Similarly, any out-of-network orthodontia benefits you use count toward your maximum network orthodontia benefits. For example, if a plan member has received $500 in benefits for orthodontic care under network coverage and $500 under out-of-network coverage, no further out-of-network orthodontia benefits are payable for that individual, because the $1,000 lifetime benefit maximum has been reached. However, that individual could qualify for another $500 in orthodontic care benefits under the plan's network coverage — bringing total paid benefits up to the $1,500 lifetime network coverage benefit maximum.

If installation of appliances occurs before coverage is in effect, orthodontic services will be covered on a prorated basis once coverage begins under the plan.

- **Network coverage:** Pays 50 percent of the negotiated fees for braces and other teeth-straightening services and appliances, including second opinions. There is a lifetime benefit maximum of $1,500 per plan member.

- **Out-of-network coverage:** Pays 50 percent of UCCI's allowance for braces and other teeth-straightening services and appliances, including second opinions. There is a lifetime benefit maximum of $1,000 per plan member.

Benefits paid for orthodontic care don't count toward the plan's annual individual benefit maximums.

If you go to an out-of-network dentist for care, you should ask the dentist to prepare a request for predetermination of benefits and send it to UCCI, the plan's claims administrator, before orthodontic treatments are started. That way, you and your orthodontist will find out in advance how much the plan's out-of-network coverage will pay for the treatment and what you'll be required to pay.

The plan's orthodontia benefits for network coverage are paid in equal installments. Payments begin when the first orthodontic appliance is inserted. The last payment is made approximately two years after payments begin or, if sooner, when the treatment is completed, or will cease when that individual's coverage in the plan ends.

Note: Charges for tooth extractions and space maintainers prescribed as part of an orthodontic treatment plan are covered under basic dental care.

Smile for Health Program

For people with certain health conditions, having gum disease (periodontal disease) is fairly common. Inflammatory agents from the mouth can affect other areas of the body which are already under stress from chronic illness. If you or a covered dependent have a covered health condition, you can get additional benefits through the Smile for Health Program that makes gum disease treatment more affordable. This program is available at no cost to you. The additional benefits are:

Service	Smile for Health Program Coverage
Periodontal Maintenance	One additional per year, all at 100% coverage
Scaling and root planing	100% coverage*
Periodontal surgery	100% coverage*

* Standard frequency limitations apply

The medical conditions eligible for the Smile for Health Program are:

- Diabetes
- Heart (coronary artery) disease
- Lupus
- Oral Cancer
- Organ Transplants
- Pregnancy
- Rheumatoid arthritis
- Stroke (cerebrovascular) disease

You'll need to register for Smile for Health before you can get benefits. You can register at any time by calling UCCI or going to **www.unitedconcordia.com** and creating an account or signing in to **My Dental Benefits**. Once signed in, click the **My Oral Health** box on the right to add a condition or to view your reported condition. If you have questions about what conditions are covered and how the program works, call United Concordia's Customer Service Team at 1-877-424-3876.

If Your Care Costs More Than $300

If the dental care you need is expected to cost more than $300, before you receive care you can find out how much you will pay and how much the plan will pay.

Just ask your dentist to request a predetermination of benefits by submitting a pre-treatment estimate request online or by mail, using the UCCI claim form. Your dentist should describe the treatment he or she recommends and send it to UCCI, the plan's claims administrator. You can get a copy of the predetermination of benefits claim form from UCCI's customer service group at 1-877-424-3876. Or, you can request the form from the HR Service Center at 1-888-825-5247 (610-669-8595 outside the U.S.).

UCCI will send you a letter explaining how much the plan's coverage will pay for the proposed care. In some cases, the letter also will include suggestions for alternative treatments that are less expensive than those your dentist recommends.

It's important for you and your dentist to get this information before treatment begins because the benefits paid will be based on covered charges for the least expensive service or supply considered professionally adequate treatment, as determined by UCCI, the plan's claims administrator.

Note that requesting a predetermination is not a requirement or considered a submission of a claim. Also, a predetermination of benefits is not binding.

Expenses That Aren't Covered

In certain situations, your Dental PPO benefits — or your eligibility for them — may be limited. For example, the plan doesn't pay for the following:

- Charges for treatment or services that aren't prescribed as medically necessary by a dentist or a doctor (although not all treatment or services prescribed by a dentist are considered covered charges).
- If alternate services or supplies are available for your treatment, charges you incur that exceed the least expensive service or supply considered professionally adequate treatment, as determined by UCCI, the plan's claims administrator.
- Hospital room and board, and any associated hospitalization costs such as facility use fees.
- Charges for services rendered while the patient isn't covered by the plan. (However, coverage is provided for charges for dentures, bridgework, crowns and inlays that are initiated/ordered while the patient is covered under the plan and that are delivered within 90 days after coverage ends, and coverage is provided for charges for root canal therapy if the tooth is opened while the patient is covered and treatment is completed within 90 days after coverage ends.)
- Charges you're not required to pay or charges that wouldn't be made if there were no coverage under this plan.
- Charges for treatment, supplies or services provided by an immediate relative of the covered individual or someone who normally lives with the covered individual.
- Charges for which a claim for benefits isn't filed within six months (by June 30) following the calendar year in which the service was provided.
- Dentures, bridgework, crowns and inlays ordered before the patient becomes covered under the plan.
- Extra sets or replacement of lost or stolen dentures, retainers or other appliances.
- Treatment or services provided by a government facility, doctor or dentist, or payable under a government plan or program, except as required by law.
- Dental implants or related services or devices which were not approved by UCCI before services were received.
- Experimental or investigative procedures, drugs or devices not generally recognized as being safe and effective, as determined by UCCI.

- Treatment of an injury or any dental condition that results from the patient's active participation in any of the following:
  - An insurrection or riot.
  - A crime, unlawful act or attempted crime.
  - War or any act of war (declared or undeclared) or international armed conflict or conflict involving armed forces of any international authority.

- Treatment of an injury or other loss that results from service in the armed forces of any government or international authority.

- Treatments provided by someone other than a dentist or doctor, except for treatment provided by a qualified technician or licensed hygienist under the supervision of a dentist or doctor.

- Cosmetic services or supplies, such as for teeth whitening.

- Porcelain facings on crowns or bridgework on back teeth.

- Training in or supplies used for dietary counseling, oral hygiene, plaque control and tobacco counseling.

- Prescription drugs, and non-prescription drugs, vitamins or dietary supplements.

- Charges for nitrous oxide over age 12.

- Procedures, restorations or appliances to increase vertical dimension or to restore occlusion, except as covered under treatment for TMJ.

- Root canal therapy if the tooth has been opened and drained prior to the effective date of coverage under the Dental PPO.

- Crowns and restorations for any tooth not broken down by decay or traumatic injury.

- Orthodontic care, services or appliances received before the patient became covered under the Dental PPO except as noted under covered charges.

- Services and supplies for injuries sustained while engaged in any occupation for remuneration or profit or in connection with a disease or injury for which workers' compensation or similar benefits are payable, or in connection with a disease or injury for which benefits are payable under state or federal disability laws.

- Charges for partial procedures performed by a dentist, unless the partial procedure is a result of or due to additional services performed at the same visit, as determined by and at the sole discretion of the Dental Claims Administrator.

- Charges for dental consultations, unless accompanied by a limited oral evaluation diagnostic code and limited to one per dentist per patient per 12-month period.

- Charges for congenital mouth malformations or skeletal imbalances (such as treatment related to cleft lip or cleft palate, disharmony of facial bone or required as the result of orthognathic surgery including orthodontic treatment.

- Treatment for of malignancies or neoplasms, including biopsies.

- Services or appliances, crowns and fillings, for the purpose of restoring tooth structure lost from wear, including attrition, erosion or abrasion, or any other method of wear.

- Elective procedures (such as prophylactic extraction of third molars).

- Preventive restorations.

- Periodontal splinting of teeth by any method.

- Replacement or repair of lost, stolen or damaged prosthetic or orthodontic appliances.

- Facial photographs.

- Genetic tests for susceptibility to oral disease and caries susceptibility tests.

- Viral cultures.

- Any procedure that is not a standard dental procedure or part of an enhanced benefit not currently covered under the Dental PPO.

Major services are limited as follows:

- Charges for a gold filling or crown are limited to the cost of a silver, porcelain or other filling, unless the tooth can't be restored with those materials.

- Charges for personalized restorations or characterizations of prosthetic appliances aren't covered.

- Charges for both a temporary and permanent prosthesis are limited to the charges for the permanent one. (To be covered, the prosthetic device must be necessary due to the loss of natural teeth or an unserviceable existing device.)

- Charges to replace gold fillings, crowns, bridgework or dentures less than five years old aren't covered.

If you or your dependent is injured by someone else's action or failure to act, or expenses are reimbursable under no-fault automobile insurance, benefits are provided under the plan only if you or your dependent agrees to reimburse the plan for all charges paid by the plan once damages are recovered from that person.

Dental PPO Claims

This section describes how to file a claim for Dental PPO benefits and the claim review and appeals process that is followed whenever you submit a claim for benefits. You should be aware that UCCI has the right to request repayment if they overpay a claim for any reason. If your dispute concerns eligibility to participate in the plan, you must follow the procedures described in the How to File a Claim for Eligibility section of this summary plan description.

How to File a Dental Claim

If you go to a network dentist when you need dental care, you don't have to file a claim form to get plan benefits. The plan pays your dentist directly. You pay any required coinsurance directly to your dentist.

If you go to an out-of-network dentist for care, you have to file a claim form to receive reimbursement of covered expenses. You should file your dental claims as soon as you incur covered charges, even if you haven't satisfied out-of-network coverage deductible requirements. Claim forms are available from the HR Service Center at 1-888-825-5247 (610-669-8595 outside the U.S.). You also can obtain forms from the Benefits Connection website at **hr2.chevron.com** or UCCI's website at **www.ucci.com.**

When you fill out the claim form, use your full name and include your member ID number. Attach all the bills and receipts you received for the services and supplies provided, ask your dentist to sign the completed claim form and mail it to:

United Concordia Companies, Inc.
Dental Claims Department
P.O. Box 69421
Harrisburg, PA 17106-9421

If you have questions about a submitted claim, wait at least three weeks after you send in the claim form and then call UCCI at 1-877-424-3876 between 8 a.m. and 5 p.m. Pacific time, Monday through Friday.

You must file a claim for payment of plan benefits no later than six months (by June 30) following the calendar year in which the service was provided. If you don't file a proper claim with UCCI within this time frame, benefits for that service will be denied.

The claims administrator will not reimburse third parties who have purchased or have been assigned benefits by dentists or other providers.

If your claim is denied, or if UCCI needs more information before it can approve your claim, you'll be notified in writing. When a claim is denied, you can appeal the denial.

Initial Claim Review and Decision

When you file a claim, the claims administrator (UCCI or its delegate) reviews the claim and makes a decision to either approve or deny the claim (in whole or in part). You will receive a written notice of the claim decision within the time limits described in the chart that follows. Those time limits are based on whether you submit a proper claim, including all necessary information.

Generally, all claims for the Dental PPO will be **postservice claims**. A postservice claim is any claim that does not require approval before you receive services, and that is filed for payment of benefits after care has been received.

Time Limits for Processing Claims

The claims administrator must follow certain time limits when processing claims for plan benefits:

- **Plan notice of improper or incomplete claim:** If you filed the claim improperly, or if additional information is needed to process the claim, you will receive a notice describing how to properly file the claim or describing the additional information needed.

- **Your deadline to complete the claim:** If you receive a notice from the plan that your claim is incomplete, you then have a deadline to complete the claim.

- **Plan notice of initial claim decision:** Once the plan receives a proper claim, the plan has a deadline to notify you of its decision.

Time Limits For Processing Claims This chart describes the time limits for processing claims.	
Time Limits	**Postservice Dental Claims**
Your deadline to provide additional information required by the plan to decide your claim	**45 days** after receiving notice that additional information is required.
Plan notice of initial claim decision	1. **Not later than 30 days** after receiving the initial claim, unless an extension, up to 15 days, is necessary due to matters beyond the control of the plan. The maximum time period is 45 days total. You will be notified within the initial 30 days if an extension is needed. 2. **Not later than 30 days** after receiving the initial claim, unless you need to provide additional information. You will be notified during the initial 30-day period, and will have 45 days to provide the additional information requested. A decision will be made within 15 days after receiving your additional information or after the expiration of your 45-day deadline to complete the claim, whichever is earlier.

Notice and Payment of Claims
The claims administrator will make a benefit determination on behalf of the plan and according to the plan's provisions. You'll receive a notice within the time limits described in the chart above in this section, Time Limits for Processing Claims (see the Plan Notice of Initial Claim Decision).

If your claim is approved, benefits will be paid to you unless the provider notifies the claims administrator that your signature is on file, assigning benefits directly to that provider. The claims administrator will not reimburse third parties who have purchased or have been assigned benefits by doctors or other providers.

If your claim is denied, there is an additional procedure for appealing a denied decision.

You should also be aware that the claims administrators have the right to request repayment if they overpay a claim for any reason.

If Your Claim Is Denied

If your claim is denied (in whole or in part), you will receive a written notice that includes the following:

- The reason(s) for the denial.
- The specific plan provision(s) upon which the denial was based.
- A description of any additional material or information that's needed to complete the claim and an explanation of why such material or information is needed.
- An explanation of the plan's appeals procedures and the time limits that apply to them (including a statement of your right to file a civil lawsuit under Section 502(a) of ERISA following an adverse determination after completion of all levels of appeal required by the plan).

Sometimes a claim is denied based on an internal rule, guideline, protocol or other similar item. If this happens, the notice will include a copy of the rule, guideline, protocol or item that was relied on to deny the claim. Alternatively, the notice will include a statement that an internal rule, guideline, protocol or similar item was relied on to deny your claim, and you can request a copy of it (the rule, guideline, protocol or other similar item) free of charge.

If your claim for benefits is denied based on medical necessity or experimental treatment or a similar exclusion or limit, the notice must include an explanation of the scientific or clinical judgment for the determination. It also must apply the terms of the plan to your medical circumstances. Alternatively, the notice will include a statement that such explanation will be provided to you free of charge upon request.

Before you officially appeal a denial of a claim, you can call the claims administrator (see the Summary Chart under Administrative Information section) to see if a resolution is possible. For example, the claims administrator may need more information to process your claim. However, if no further information is needed or if you aren't satisfied with the explanation of why the claim was denied, you can request, in writing, to have the claim reviewed.

The claims administrator processes payments for claims, answers questions and reviews appeals according to the plan's provisions.

Time Limits for Processing Dental PPO Appeals This chart describes the time limits for processing appeals.	
Time Limits	**Postservice Dental Claims**
Your deadline to file a first appeal	**180 days** after receiving the claim denial notice.
Plan notice of first appeal decision	**Not later than 30 days** after receiving an appeal, if the plan allows two levels of appeal.
Your deadline to file a second appeal	**90 days** after receiving the first appeal denial notice.
Plan notice of second appeal decision	**Not later than 30 days** after receiving a second appeal.

How to File an Appeal

This section describes how to file an appeal and the time limits that apply to the different types of medical appeals.

First Appeal

After receiving the notice of denial, you or your authorized representative (this can be your provider, your beneficiary, your legal representative or another appropriately authorized individual) may ask for an appeal, which is a full and fair review of the initial claim decision, by writing to the claims administrator. You must make this request for an appeal in writing within the time limits noted in the chart above.

During the time limit for requesting an appeal, upon request and free of charge, you or your authorized representative will be given reasonable access to, and copies of, all documents, records and other information (other than legally or medically privileged documents) relevant to your claim for benefits.

Your appeal should include *all* of the following:

- Patient's name and the identification number from the ID card.
- Date(s) of dental service(s).
- Provider's name.
- Explanation of why you believe the claim should be paid.

You also can submit to the claims administrator any written comments, documents, records and other information relating to your claim for benefits.

Where to Send Your Appeal

The Dental Plan offers two levels of appeals. Send your appeals to:

United Concordia Companies, Inc.
Dental Customer Service Department
P.O. Box 69420
Harrisburg, PA 17106-9420

The claims administrator is the named fiduciary that serves as the final review committee and, in its sole discretion, has the authority to interpret plan provisions as well as facts and other information related to claims and appeals.

Time Limits and Procedures for Processing Your First Appeal

Upon receipt of your first appeal, the claims administrator will review the claim again and will make a decision based on all comments, documents, records and other information you've submitted, without regard to whether such information was submitted or considered in the initial benefit determination. This review will be completed within the time limits shown in the chart above, Time Limits for Processing Dental PPO Appeals.

As part of the appeals procedure, these steps are followed:

- The review on appeal will not afford deference to the initial denial, and it will be conducted by a fiduciary who is neither the individual who initially denied the claim that is the subject of the appeal, nor the subordinate of such individual.

- If your claim is denied based in whole or in part on a medical judgment — including determinations with regard to whether a particular treatment, drug or other item is experimental, investigational or not medically necessary or appropriate — the fiduciary reviewing the appeal will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment.

- The health care professional consulted by the fiduciary reviewing the appeal will be neither an individual who was consulted in connection with the denial of the claim that is the subject of the appeal, nor the subordinate of such individual.

- Upon your request, the claims administrator will identify any medical or vocational experts whose advice was obtained on behalf of the plan in connection with the denial, without regard to whether the advice was relied upon in making the benefit determination.

Notice of Decision on First Appeal
If, on the first appeal, the claims administrator determines that your explanation and additional information support the payment of your claim, the claims administrator will process your claim. Benefits are paid to you unless the provider notifies the claims administrator that your signature is on file, assigning benefits directly to that provider.

If your first appeal is denied (in whole or in part), you will receive a written notice. The notice will state the reasons for the denial, including references to specific plan provisions upon which the denial was based and a statement of your right to file a civil lawsuit under Section 502(a) of ERISA following an adverse determination after completion of all levels of appeal required by the plan.

The notice will state that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information (other than legally or medically privileged documents) relevant to your claim for benefits.

If your first appeal is denied based on an internal rule, guideline, protocol or other similar item, the notice will include a copy of the rule, guideline, protocol or item that was relied on to deny the claim. Alternatively, the notice will include a statement that an internal rule, guideline, protocol or similar item was relied on to deny your claim, and you can request a copy of it (the rule, guideline, protocol or other similar item) free of charge.

If your first appeal is denied based on medical necessity or experimental treatment or a similar exclusion or limit, the notice must include an explanation of the scientific or clinical judgment for the determination. It also must apply the terms of the plan to your medical circumstances. Alternatively, the notice will include a statement that such explanation will be provided to you free of charge upon request.

If, on the first appeal, the claims administrator upholds the denial of your claim and the claims administrator allows two levels of appeal, you may file a second appeal within 90 days after receiving the notice of denial of your first appeal.

Second Appeal

The Dental Plan allows two levels of appeal. After receiving the notice of denial of your first appeal, you or your authorized representative (this can be your provider, your beneficiary, your legal representative or another appropriately authorized individual) may ask for a second appeal. You must make this request for a second appeal in writing within the time limits noted in the chart above, *Time Limits for Processing Dental PPO Appeals*. The second appeal should also include any additional information that wasn't previously submitted with your first appeal, as well as an explanation supporting your position.

Time Limits and Procedures for Processing Your Second Appeal

Upon receipt of your second appeal, the claims administrator reviews the claim again and makes a decision based on all comments, documents, records and other information you've submitted, without regard to whether such information was submitted or considered in the initial benefit determination.

This second appeal will be completed within the time limits shown in the chart above, *Time Limits for Processing Dental PPO Appeals*.

The second appeal will follow the same procedural steps as described for the first appeal.

Notice of Decision on Second Appeal

If, on second appeal, the claims administrator's doctor or specialist determines that your explanation and additional information support the payment of your claim, the claims administrator will process your claim. Benefits are paid to you unless the provider notifies the claims administrator that your signature is on file, assigning benefits directly to that provider.

If your second appeal is denied (in whole or in part), you will receive a written notice. The notice will state the reasons for the denial, including references to specific plan provisions upon which the denial was based and a statement of your right to file a civil lawsuit under Section 502(a) of ERISA.

The notice will state that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information (other than legally or medically privileged documents) relevant to your claim for benefits.

If your second appeal is denied based on an internal rule, guideline, protocol or other similar item, the notice will include a copy of the rule, guideline, protocol or item that was relied on to deny the claim. Alternatively, the notice will include a statement that an internal rule, guideline, protocol or similar item was relied on to deny your claim, and you can request a copy of it (the rule, guideline, protocol or other similar item) free of charge.

If your second appeal is denied based on medical necessity or experimental treatment or a similar exclusion or limit, the notice must include an explanation of the scientific or clinical judgment for the determination. It also must apply the terms of the plan to your medical circumstances. Alternatively, the notice will include a statement that such explanation will be provided to you free of charge upon request.

The claims administrator is the named fiduciary that serves as the final review committee and, in its sole discretion, has the authority to interpret plan provisions, as well as facts and other information related to claims and appeals.

Administrative Power and Responsibilities

Chevron Corporation has the discretionary authority to control and manage the administration and operation of the Omnibus Health Care Plan (the *Plan*). Chevron Corporation shall have the full, exclusive and discretionary authority to prescribe such forms; make such rules, regulations, interpretations and computations; construe the terms of the Plan; determine all issues relating to coverage and eligibility for benefits; and take such other action to administer the Plan as it may deem appropriate in its sole discretion. Chevron Corporation's rules, regulations, interpretations, computations and actions shall be final and binding on all persons. Such discretionary authority can also be exercised by a delegate.

How to File a Claim for Eligibility

This section describes how to dispute decisions regarding your eligibility to participate in Chevron's health plans or for credit for health and welfare eligibility service.

If you have a question regarding your eligibility to participate in the Omnibus Health Care Plan or if you believe you are entitled to credit for health and welfare eligibility service, contact the HR Service Center at 1-888-825-5247, option 2, (610-669-8595 outside the U.S.). If you are not satisfied with the outcome, you can file a claim by following the procedures described below.

If you have been denied participation or if you believe you are entitled to credit for health and welfare eligibility service in the Omnibus Health Care Plan, you can file a written claim with the plan administrator. Include the grounds on which your claim is based and any documents, records, written comments or other information you feel will support the claim. Address your written correspondence to:

Chevron Corporation
Omnibus Health Care Plan Administrator
Chevron Human Resources Service Center
P.O. Box 199708
Dallas, TX 75219-9708

If you file a claim for participation or for credit for health and welfare eligibility service in the Omnibus Health Care Plan, the plan administrator will send you a decision on the claim within 90 days after the claim is received. However, if there are special circumstances that require additional time, the plan administrator will advise you that additional time is needed and then will send you a decision within 180 days after the claim is received.

If the claim for participation or for credit for health and welfare eligibility service in the Omnibus Health Care Plan is denied (in whole or in part), the plan administrator will send you a written explanation that includes:

- Specific reasons for the denial, as well as the specific Omnibus Health Care Plan provisions or Chevron policy on which the denial is based.
- A description of any additional information that could help you complete the claim, and reasons why the information is needed.
- Information about how you can appeal the denial of the claim.
- A statement explaining your right to file a civil lawsuit under section 502(a) of ERISA if your appeal is denied.

Appeal Procedures for Denied Claims

Regarding Eligibility to Participate or Credit for Health and Welfare Eligibility Service

If your claim for participation or for credit for health and welfare eligibility service in the Omnibus Health Care Plan is denied, in whole or in part, and you want to appeal the denial, you must file an appeal within 90 days after you receive written notice of the denial of your claim.

The appeal must be in writing, must describe all of the grounds on which it is based, and should include any documents, records, written comments or other information you feel will support the appeal. Before submitting the appeal, you can review and receive, at no charge, copies of Omnibus Health Care Plan documents, records and other information relevant to your claim for participation or for credit for health and welfare eligibility service in the Omnibus Health Care Plan.

The Review Panel will provide you with a written response to the appeal and will either reverse the earlier decision and permit participation or provide credit for health and welfare eligibility service in the Omnibus Health Care Plan, or it will deny the appeal. If the appeal is denied, the written response will contain:

- The specific reasons for the denial and the specific Omnibus Health Care Plan provisions or Chevron policy on which the denial is based.
- Information explaining your right to review and receive, at no charge, copies of Omnibus Health Care Plan documents, records and other information relevant to your claim for participation or for credit for health and welfare eligibility service in the Omnibus Health Care Plan.
- A statement explaining your right to file a civil lawsuit under section 502(a) of ERISA.

The Review Panel doesn't have the authority to change Omnibus Health Care Plan provisions or Chevron policy or to grant exceptions to the Omnibus Health Care Plan rules or Chevron policy.

For appeals regarding participation or credit for health and welfare eligibility service in the Omnibus Health Care Plan, address your written correspondence to:

Review Panel
Omnibus Health Care Plan
P.O. Box 6075
San Ramon, CA 94583-0775

The Review Panel may require you to submit (at your expense) additional information, documents or other material that it believes is necessary for the review.

You will be notified of the final determination of the appeal within 60 days after the date it's received, unless there are special circumstances that require additional time. You will be advised if more time is needed, and you'll then receive the final determination within 120 days after the appeal is received. If you do not receive a written decision within 60 or 120 days (whichever applies), you can take legal action.

If You're Covered by More Than One Plan

Coordination of benefits is a feature used to determine how much the Dental PPO will pay when you or one of your dependents is covered by more than one group insurance plan. This feature is designed to prevent overpayment of benefits.

How It Works

Under the coordination of benefits rules, one plan pays benefits first (the *primary payer*) and one plan pays second (the *secondary payer*). (See below and the following page for explanations of primary payer and secondary payer.)

The primary payer pays the benefits provided by its plan features. The secondary payer then pays any excess amounts required to bring the total benefits paid up to the levels payable under its plan.

If the Dental PPO is the secondary payer, plan benefits cannot be more than the negotiated fees or UCCI's allowance, but not to exceed your responsibility under the primary plan.

Different coordination of benefits rules apply under different circumstances.

Coordination of benefits doesn't apply to medical or dental HMOs available to Chevron employees or to individual (nongroup) dental care insurance policies.

If You or a Dependent Is Covered by More Than One Plan

A plan other than your Dental PPO will be the primary payer if any of the following conditions applies to the other plan:

- It doesn't have a coordination of benefits rule.
- It covers the individual as an eligible employee or retiree (while the Dental PPO covers the individual as a dependent).
- It covers the individual as an eligible employee (while the Dental PPO covers the individual as an eligible retiree).
- It has covered the individual longer than the Dental PPO (if the other conditions in this list don't apply).

When you or a dependent is covered under both the Dental PPO and a Medical PPO Plan, the Dental Plan will be the primary payer for services or supplies that are covered under both plans.

Coordinating Your Children's Coverage With Your Spouse's/Domestic Partner's Plan

If you're covered by the Dental PPO and your spouse/domestic partner is covered by another group plan (and the other group plan has a coordination of benefits rule), special rules apply to dependent children covered under both plans:

- In the case of domestic partnerships, the dental plan of the natural parent will be the primary payer.
- In the case of a married couple, the dental plan of the parent whose birthday falls earlier in the calendar year will be the primary payer.
- If both parents have the same birthday, the plan that covered a parent longer is the primary payer.
- If the other plan does not have a birthday rule, the plan of the male is the primary payer.
- If the other plan does not have a birthday rule but instead has a rule based on the gender of the parent, and if as a result the plans do not agree on the order of benefits, the rule in the other plan will determine the order of benefits.

Your Children's Coverage if You're Divorced or Separated

When parents are separated or divorced, or are living apart due to termination of a domestic partnership, and children are covered under more than one health care plan and there is no court order to the contrary, the following rules apply:

- The plan of the parent with custody of (or court-ordered financial responsibility for) the child is the primary payer.
- The plan of the spouse of the parent or domestic partner of the parent with custody of the child is the secondary payer.
- The plan of the parent or domestic partner without custody (or court-ordered financial responsibility) pays last.

Other Plan Information

- Administrative Information
- Your ERISA Rights
- Other Legislation That Can Affect Your Benefits
- Third Party Responsibility

Administrative Information

This section provides important legal and administrative information you may need regarding the benefits described in this book that are governed by the Employee Retirement Income Security Act of 1974 (ERISA).

Employer Identification Number (EIN)

The employer identification number is 94-0890210.

Plan Sponsor and Plan Administrator

Chevron Corporation is the plan sponsor and plan administrator and can be reached at the following address:

Chevron Corporation
P.O. Box 6075
San Ramon, CA 94583-0767

1-888-825-5247 (610-669-8595 outside the U.S.).

Chevron Corporation Dental Plan (also referred to as the Dental PPO) This plan is part of the Omnibus Health Care Plan.
Plan number: 560 **Claims Administrator:** United Concordia Companies, Inc. ǀ Dental Claims Department P.O. Box 69420 ǀ Harrisburg, PA 17106 ǀ **www.ucci.com** **Type of Administration:** Contract Administration **Type of Plan:** Dental Benefit

Chevron Corporation Omnibus Health Care Plan
Plan number: 560 **Type of Administration:** Contract Administration **Type of Plan:** Health Plan

Before-Tax Contribution Plan
Plan number: 721 **Type of Administration:** Company Administered **Type of Plan:** Health Contribution (Cafeteria Plan)

Agent for Service of Legal Process

Any legal process related to the plans should be served on:

Service of Process
Chevron Corporation
6001 Bollinger Canyon Road
Building T (T-3371)
San Ramon, CA 94583

You can also serve process on a plan by serving the plan administrator.

For information about the procedure for a QMCSO, please contact the HR Service Center at 1-888-825-5247 (610-669-8595 outside the U.S.).

Plan Amendments and Changes

Chevron Corporation reserves the right to change or terminate a plan at any time and for any reason. A change also can be made to premiums and future eligibility for coverage and can apply to those who retired in the past, as well as to those who retire in the future. Once approved, plan changes are incorporated into the plan texts, SPDs and vendor administration at the effective date.

Participating Companies

A complete list of the participating companies (designated by Chevron Corporation) whose employees are covered by each of Chevron's benefit plans can be obtained by writing to the plan administrator.

Collective Bargaining Agreements

If a union represents you, you're eligible for the health care plans, provided both of the following apply:

- Your collective bargaining agreement allows for your participation.
- You meet the plans' eligibility requirements.

Generally, Chevron's collective bargaining agreements don't mention specific plans or benefits. They merely provide that Chevron will extend to its employees who are members of the collective bargaining unit, the employee benefit programs that it generally makes available.

In some cases, however, a collective bargaining agreement contains more restrictive rules regarding participation or benefits than the rules described here. In such cases, the provisions of the collective bargaining agreement will prevail. For example, represented employees in a particular location might be able to enroll only in particular HMOs sponsored by the union.

A copy of any relevant collective bargaining agreement can be obtained by participants upon written request to their union representative.

All documents for this plan are available for examination by participants who follow the procedures outlined under Your ERISA Rights.

Incorrect Computation of Benefits

If you believe that the amount of the benefit you receive from the plan is incorrect, you should notify the appropriate claim administrator in writing. If it's found that you or a beneficiary wasn't paid benefits you or your beneficiary was entitled to, the plan will pay the unpaid benefits.

Similarly, if the calculation of your or your beneficiary's benefit results in an overpayment, you or your beneficiary will be required to repay the amount of the overpayment to the plan. The claim administrator may make reasonable arrangements with you for repayment, such as reducing future benefits under the plan from which you received the overpayment.

Recovery of Overpayments

An "overpayment" is any payment made to you and/or your covered dependent (or elsewhere for the benefit of you and/or your covered dependent) in excess of the amount properly payable under the health plans. Upon any overpayment, the health plans shall have a first right of reimbursement and restitution with an equitable lien by contract in such amount. Furthermore, the holder of such overpayment shall hold it as the health plans' constructive trustee.

If you and/or your covered dependent has cause to reasonably believe that an overpayment may have been made, you and/or your covered dependent must promptly notify the claims administrator of the relevant facts. If the claims administrator determines that an overpayment was made to you (or any other person), it will notify you in writing and you shall promptly pay (or cause another person to pay) the amount of such overpayment to the claims administrator.

If the claims administrator has made a written demand for the repayment of an overpayment and you (or another person) have not repaid (or caused to be repaid) the overpayment within 30 days following the date on which the demand was mailed, then any amounts subsequently payable as benefits under the health plans with respect to you and/or your covered dependent may be reduced by the amount of the outstanding overpayment, or the claims administrator may recover such overpayment by any other appropriate method that the applicable claims administrator (or the Corporation) shall determine.

Plan Year

The plan year for the health plans begins on January 1 and ends on December 31 of each year.

No Right to Employment

Nothing in your benefit plans gives you a right to remain in employment or affects Chevron's right to terminate your employment at any time and for any reason (which right is hereby reserved).

Future of the Plans

Chevron Corporation has the right to change or terminate a plan, including this Plan, at any time and for any reason. A change also may be made to premiums and future eligibility for coverage, and may apply to those who retired in the past, as well as those who retire in the future. Dental claims incurred before the effective date of a plan change or termination won't be affected. Claims incurred after a plan is terminated won't be covered.

If a self-funded plan can't pay all of the incurred claims and plan expenses as of the date the plan is changed or terminated, Chevron Corporation will make sufficient contributions to the self-funded plan to make up the difference. If all claims and expenses are paid and Chevron Corporation's book reserve established for the purpose of making contributions toward the cost of employees' health care coverage retains a balance, Chevron Corporation will determine what to do with the excess amount in view of the purposes of the plans.

Administrative Power and Responsibilities

Chevron Corporation has the discretionary authority to control and manage the administration and operation of the Omnibus Health Care Plan (the "Plan"). Chevron Corporation shall have the full, exclusive and discretionary authority to prescribe such forms; make such rules, regulations, interpretations and computations; construe the terms of the Plan; determine all issues relating to coverage and eligibility for benefits; and take such other action to administer the Plan as it may deem appropriate in its sole discretion. Chevron Corporation's rules, regulations, interpretations, computations and actions shall be final and binding on all persons. Such discretionary authority can also be exercised by a delegate.

Your ERISA Rights

The Employee Retirement Income Security Act of 1974 (ERISA) protects your benefit rights as an employee. It doesn't require Chevron Corporation to provide a benefit plan; however, it does provide you with certain legal protections under the ERISA plans that Chevron Corporation does provide. This section summarizes these rights. In addition, you should be aware that Chevron Corporation reserves the right to change or terminate the plans at any time. Chevron Corporation will make every effort to communicate any changes to you in a timely manner.

As a participant in the Plan you're entitled to certain rights and protections under ERISA.

Receive Information About Your Plan and Benefits

You have the right to:

- Examine (without charge) at the plan administrator's office and at other specified locations, such as work sites, all Plan documents. These may include insurance contracts, collective bargaining agreements, official Plan texts, trust agreements and copies of all documents, such as the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration (EBSA).

- Obtain (by writing to the plan administrator) copies of all documents governing the operation of the Plan, including insurance contracts, collective bargaining agreements, copies of the latest Form 5500 annual report, and an updated SPD. The plan administrator can make a reasonable charge for the copies.

- Receive a summary of the Plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

You have a right to continue health care coverage for yourself, your spouse or your 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. For information regarding your continuation coverage rights, review Continuation Coverage and COBRA Coverage section and the documents governing the plan.

If You Have a Pre-existing Condition

If you have creditable coverage from another plan, any exclusionary periods of coverage for pre-existing conditions under your group health plan may be reduced or eliminated. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when any of the following occurs:

- You lose coverage under the plan.

- You become entitled to elect continuation coverage.

- Your continuation coverage ceases.

You may request the certificate before losing coverage or up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage. To request a certificate of creditable coverage, contact the HR Service Center at 1-888-825-5247 (610-669-8595 outside the U.S.). Your personal identification number (PIN) will be required when making this request. Additionally, you can mail your request to the following address:

Chevron Corporation
Human Resources Service Center
P.O. Box 199708
Dallas, TX 75219-9708

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon certain people who are responsible for the operation of Chevron Corporation's plans. These people are called "fiduciaries" and have a duty to exercise fiduciary functions prudently and in the interest of you and other plan participants and beneficiaries.

No one, including your employer, your union or any other person, can fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your ERISA rights.

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain (without charge) copies of documents related to the decision, and to appeal any denial — all within certain time schedules.

Under ERISA, there are steps you can take to enforce your ERISA rights. For instance:

- If you request a copy of the plan documents or the plan's latest annual report and do not receive them within 30 days, you can file suit in a federal court. In such a case, the court can 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 because of reasons beyond the control of the plan administrator.

- If you disagree with the plan's decision or lack of response to your request concerning the qualified status of a domestic relations order or medical child support order, you can file suit in a federal court.

- If you have a claim for benefits that is denied or ignored, in whole or in part, you can file suit in a state or federal court (see the Filing a Lawsuit section below).

- If it should happen that plan fiduciaries misuse the plan's money, or if you're discriminated against for asserting your ERISA rights, you can seek assistance from the U.S. Department of Labor or you can file suit in a federal court.

If you file suit, the court decides who should pay court costs and legal fees. If you're successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees — for example, if it finds your claim is frivolous.

Assistance With Your Questions

If you have any questions about the plan, you should contact the claims administrator and/or plan administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Employee Benefits Security Administration (EBSA), 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 can obtain certain publications about your rights and responsibilities under ERISA by:

- Calling the Employee Benefits Security Administration publications hotline at 1-866-444-3272.
- Logging on to the Internet at www.dol.gov/ebsa/publications/main.html.

Filing a Lawsuit

You can file a lawsuit to recover a benefit under a plan provided the action is commenced within the lesser of the applicable statute of limitations period or four years after the occurrence of the loss for which a claim is made. You can file a lawsuit to recover a benefit under a plan, provided *all* of the following have been completed:

- You initiate a claim as required by the plan.
- You receive a written denial of the claim.
- You file a timely written request for a review of the denied claim with the plan administrator or the claims administrator (or you receive written notification that the claim has been denied on appeal).
- If the plan provides for two levels of appeal, you file a timely written request for a second review of the denied claim with the plan administrator or the claims administrator (or you receive written notification that the claim has been denied on second appeal).
- If the plan provides for external review, you file a timely request for an external review of the denied claim with the plan administrator or the claims administrator.
- You receive written notification that the claim has been denied on final review.

If you want to take legal action after you exhaust the plan's claims and appeals procedures, you can serve legal process on:

Service of Process
Chevron Corporation
6001 Bollinger Canyon Road
Building T (T-3371)
San Ramon, CA 94583

You also can serve process on a plan by serving the plan administrator. If you have a dispute with a health maintenance organization (HMO) or dental health maintenance organization (DHMO) regarding benefits or claims, then any legal action should be directed to the agent for service of legal process appointed by the HMO or DHMO. The plan administrator is the appropriate party to sue for all Chevron Corporation benefit plans.

Other Legislation That Can Affect Your Benefits

Over the years, several federal laws have been passed that can affect your benefits under certain circumstances.

Health Insurance Portability and Accountability Act of 1996 (HIPAA)

HIPAA was designed to make health care coverage easier to obtain for people who switch jobs or are between jobs. Companies are required to provide plan members with specific information about HIPAA when their medical coverage ends.

When you lose coverage under a Chevron medical plan, you automatically will be sent a certificate of creditable coverage. You may need to provide this certificate of creditable coverage to a new medical plan in which you enroll to reduce or eliminate the time period for which any pre-existing condition exclusions otherwise may apply. If you do not receive a certificate of creditable coverage within 10 days of the date your Chevron medical plan coverage terminates, you may request a certificate of creditable coverage by calling Chevron's HR Service Center at 1-888-825-5247 (610-669-8595 outside the U.S.). Your personal identification number (PIN) will be required when making this request. Additionally, you can mail your request to the following address:

Chevron Corporation
Human Resources Service Center
P.O. Box 199708
Dallas, TX 75219-9708

Free or Low-Cost Health Coverage to Children and Families

Offered by Medicaid and the Children's Health Insurance Program (CHIP)

If you are eligible for health coverage (medical, dental, vision) from Chevron or another employer, but you're unable to afford the monthly premiums, some states have premium assistance programs that can help pay for coverage. These states use funds from their Medicaid or CHIP programs to help people who are eligible for employer-sponsored health coverage, but need assistance with paying their health premiums.

- **If you or your dependents are already enrolled in Medicaid or CHIP** and you live in a participating state, contact your state's Medicaid or CHIP office to find out if premium assistance is available.

- **If you or your dependents are not currently enrolled in Medicaid or CHIP**, but you think you or your dependent(s) might be eligible for either of these programs, contact your state's Medicaid or CHIP office. You can also call 1-877-KIDS NOW (1-877-543-7669) or visit **www.insurekidsnow.gov** to learn how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, then Chevron is required to allow you and your dependents to enroll in a company-offered plan. To qualify for this special enrollment opportunity, you must be eligible for Chevron coverage, but not already enrolled. **In addition, you must contact the Human Resources (HR) Service Center and request Chevron health coverage within 60 days of being determined eligible for Medicaid or CHIP premium assistance**. If you enroll timely, Medicaid or CHIP will subsidize, or pay for, a portion of the Chevron health plan premium cost.

If you have any questions

Please call the HR Service Center at 1-888-825-5247 (610-669-8595 outside the U.S.) to speak with a Customer Service Representative. Customer Service Representatives are available from 6 a.m. to 5 p.m., Pacific time (8 a.m. to 7 p.m., Central time), Monday through Friday, except on holidays.

If you live in one of the following States, you may be eligible for assistance paying your employer health plan premiums. The following list of States is current as of July 31, 2013. You should contact your State for further information on eligibility.

ALABAMA – Medicaid	**COLORADO** – Medicaid
Website: http://www.medicaid.alabama.gov Phone: 1-855-692-5447	Medicaid Website: http://www.colorado.gov/ Medicaid Phone (In state): 1-800-866-3513 Medicaid Phone (Out of state): 1-800-221-3943
ALASKA – Medicaid	
Website: http://health.hss.state.ak.us/dpa/programs/medicaid/ Phone (Outside of Anchorage): 1-888-318-8890 Phone (Anchorage): 907-269-6529	
ARIZONA – CHIP	**FLORIDA** – Medicaid
Website: http://www.azahcccs.gov/applicants Phone (Outside of Maricopa County): 1-877-764-5437 Phone (Maricopa County): 602-417-5437	Website: https://www.flmedicaidtplrecovery.com/ Phone: 1-877-357-3268
	GEORGIA – Medicaid
	Website: http://dch.georgia.gov/ Click on Programs, then Medicaid, then Health Insurance Premium Payment (HIPP) Phone: 1-800-869-1150
IDAHO – Medicaid and CHIP	**MONTANA** – Medicaid
Medicaid Website: www.accesstohealthinsurance.idaho.gov Medicaid Phone: 1-800-926-2588 CHIP Website: www.medicaid.idaho.gov CHIP Phone: 1-800-926-2588	Website: http://medicaidprovider.hhs.mt.gov/clientpages/clientindex.shtml Phone: 1-800-694-3084
INDIANA – Medicaid	**NEBRASKA** – Medicaid
Website: http://www.in.gov/fssa Phone: 1-800-889-9949	Website: www.ACCESSNebraska.ne.gov Phone: 1-800-383-4278
IOWA – Medicaid	**NEVADA** – Medicaid
Website: www.dhs.state.ia.us/hipp/ Phone: 1-888-346-9562	Medicaid Website: http://dwss.nv.gov/ Medicaid Phone: 1-800-992-0900
KANSAS – Medicaid	
Website: http://www.kdheks.gov/hcf/ Phone: 1-800-792-4884	
KENTUCKY – Medicaid	**NEW HAMPSHIRE** – Medicaid
Website: http://chfs.ky.gov/dms/default.htm Phone: 1-800-635-2570	Website: http://www.dhhs.nh.gov/oii/documents/hippapp.pdf Phone: 603-271-5218

LOUISIANA – Medicaid	**NEW JERSEY** – Medicaid and CHIP
Website: http://www.lahipp.dhh.louisiana.gov Phone: 1-888-695-2447	Medicaid Website: http://www.state.nj.us/humanservices/ dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
MAINE – Medicaid	
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-977-6740 TTY 1-800-977-6741	
MASSACHUSETTS – Medicaid and CHIP	**NEW YORK –** Medicaid
Website: http://www.mass.gov/MassHealth Phone: 1-800-462-1120	Website: http://www.nyhealth.gov/health_care/medicaid/ Phone: 1-800-541-2831
MINNESOTA – Medicaid	**NORTH CAROLINA** – Medicaid
Website: http://www.dhs.state.mn.us/ Click on Health Care, then Medical Assistance Phone: 1-800-657-3629	Website: http://www.ncdhhs.gov/dma Phone: 919-855-4100
MISSOURI – Medicaid	**NORTH DAKOTA** – Medicaid
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-800-755-2604
OKLAHOMA – Medicaid and CHIP	**UTAH** – Medicaid and CHIP
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://health.utah.gov/upp Phone: 1-866-435-7414
OREGON – Medicaid and CHIP	**VERMONT**– Medicaid
Website: http://www.oregonhealthykids.gov http://www.hijossaludablesoregon.gov Phone: 1-800-699-9075	Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
PENNSYLVANIA – Medicaid	**VIRGINIA** – Medicaid and CHIP
Website: http://www.dpw.state.pa.us/hipp Phone: 1-800-692-7462	Medicaid Website: http://www.dmas.virginia.gov/rcp-HIPP.htm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.famis.org/ CHIP Phone: 1-866-873-2647

RHODE ISLAND – Medicaid	**WASHINGTON** – Medicaid
Website: www.ohhs.ri.gov Phone: 401-462-5300	Website: http://hrsa.dshs.wa.gov/premiumpymt/Apply.shtm Phone: 1-800-562-3022 ext. 15473
SOUTH CAROLINA – Medicaid	**WEST VIRGINIA** – Medicaid
Website: http://www.scdhhs.gov Phone: 1-888-549-0820	Website: www.dhhr.wv.gov/bms/ Phone: 1-877-598-5820, HMS Third Party Liability
SOUTH DAKOTA - Medicaid	**WISCONSIN** – Medicaid
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: http://www.badgercareplus.org/pubs/p-10095.htm Phone: 1-800-362-3002
TEXAS – Medicaid	**WYOMING** – Medicaid
Website: https://www.gethipptexas.com/ Phone: 1-800-440-0493	Website: http://health.wyo.gov/healthcarefin/equalitycare Phone: 307-777-7531

To see if any more States have added a premium assistance program since July 31, 2013, or for more information on special enrollment rights, you can contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

OMB Control Number 1210-0137 (expires 10/31/2016)

Third Party Responsibility

Payment of Certain Benefits Subject to Full Right to Subrogation and Reimbursement

If you and/or your covered dependent receives benefits under any of the health plans related to injuries, illnesses or conditions resulting from the act or omission of any third person, or related to any matter reimbursable under a contract of no-fault automobile insurance, you agree that the health plans retain full rights of subrogation, reimbursement and restitution for the payment of such benefits. This means that if you and/or your covered dependent recovers payment from any third party (including another insurance provider) as a result of the event that caused a benefit to be paid under any of the health plans, you and/or your covered dependent will be required to repay the expenses incurred by that health plan.

If, as a result of someone else's actions or omissions, you seek care which requires payment under the health plans, you should inform the applicable claims administrator of this as soon as possible. It is your responsibility, as a condition of participation in the health plans, that you inform the health plans of someone else's liability for your injuries, illnesses or conditions.

First Right of Recovery

As a condition of receiving benefits under the health plans, you and/or your covered dependent grants specific and first rights of subrogation, reimbursement and restitution to the health plans. This means that you agree to repay the health plans first, before paying any other creditors or otherwise disposing of any settlement that you receive related to the event that caused benefits to be paid under the health plans. The right of the health plans to recover is not diminished by how such recovery may be itemized, structured, allocated, denominated or characterized (for example, whether your recovery is characterized as for lost wages or damages, rather than for medical expenses).

These rights extend to any property (including money) that is directly or indirectly related to the health plans' benefits that were paid. These rights are not affected by the type of property or the source or amount of the recovery, including, but not limited to, any recovery from the payment or compromise of a claim (including an insurance claim), a judgment or settlement of a lawsuit, resolution through any alternative dispute resolution process (including arbitration), or any insurance (including insurance on you and/or your covered dependent, no-fault coverage, and uninsured and/or underinsured motorist coverage).

Furthermore, the health plans' rights to reimbursement, restitution, to an equitable lien by contract, and as beneficiary of a constructive trust shall in no way be affected, reduced, compromised, or eliminated by any state law, common law, or equitable doctrines limiting its rights, including, but not limited to, the make-whole doctrine, common fund doctrine, comparative fault rule, contributory negligence rule, unjust enrichment doctrine, or any similar doctrine or rule established by common law or by statute, or any other defense which may act to reduce the amount the health plans' may be entitled to recover.

Granting of an Equitable Lien by Contract

At the time the health plans pay benefits, you and/or your covered dependent grants to the health plans (as a condition of such payment) an equitable lien by contract in any property described above. This means that you grant the health plans a first right to any property (including money) that you recover as a result of the event that caused the benefits to be paid. This right to an equitable lien by contract exists without regard to the identity of the property's source or holder at any particular time, or whether at any particular time the property exists, is segregated, or you and/or your covered dependent has any rights to it.

Creation of Constructive Trust
You and/or your covered dependent agrees that until such equitable lien by contract is completely satisfied (that is, the health plans are reimbursed in full), the holder of any such property (whether you and/or your covered dependent, you and/or your covered dependent's attorney, an account or trust set up for you and/or your covered dependent's benefit, an insurer, or any other holder) shall hold such property as the Omnibus Health Care Plan's constructive trustee. The constructive trustee agrees to immediately pay over such property to or on behalf of the health plans, pursuant to their direction, to the extent necessary to satisfy the equitable lien by contract.

Your Responsibilities
As a condition of receiving benefits under the health plans, you and/or your covered dependent agrees:

- not to assign any rights or causes of action you may have against others (including under insurance policies) without the express written consent of the health plans;
- to take possession of any property subject to the health plans' equitable lien by contract in your own name, place it in a segregated account within your control (at least in the amount of the equitable lien by contract), and not to alienate it or otherwise take any action so that it is not in your possession prior to the satisfaction of such equitable lien by contract;
- that if such property is not in your possession (other than in possession by or on behalf of the health plans), to immediately take whatever steps possible to regain possession or have possession transferred to or on behalf of the health plans pursuant to their direction;
- to cooperate with the health plans and take any action that may be necessary to protect the health plans' right to recovery.

Your Notice Obligations
You and/or your covered dependent agrees to timely notify the health plans of:

- the possibility that benefits paid by the health plans may be the responsibility of a third party;
- the submission of any claim or demand letter, the filing of any legal action, the request for any alternative dispute resolution process, or the commencement date of any trial or alternative dispute resolution process, regarding or related to any property that may be subject to the health plans' rights (1) of subrogation, reimbursement and restitution, (2) to an equitable lien by contract, and (3) as beneficiary of a constructive trust;
- any agreement that any property that may be subject to the health plans' rights (1) of subrogation, reimbursement and restitution, (2) to an equitable lien by contract, and (3) as beneficiary of a constructive trust will be paid to or on behalf of you and/or your covered dependent (whether pursuant to resolution of a claim, legal action, alternative dispute resolution proceeding, or otherwise).

Timely notice is notice that provides the health plans with sufficient time to protect their own rights to subrogation, reimbursement and restitution; to an equitable lien by contract; and as beneficiary of a constructive trust. Notice of the commencement date of any trial or alternative dispute resolution process must be given at least 30 days in advance.

No Duty to Independently Sue or Intervene

Although the health plans' subrogation rights include the right to file an independent legal action or alternative dispute resolution proceeding against such third party (or to intervene in one brought by or on behalf of you and/or your covered dependent), the health plans have no obligation to do so.

Recovery of Overpayments

An "overpayment" is any payment made to you and/or your covered dependent (or elsewhere for the benefit of you and/or your covered dependent) in excess of the amount properly payable under the health plans. Upon any overpayment, the health plans shall have a first right of reimbursement and restitution with an equitable lien by contract in such amount.

Furthermore, the holder of such overpayment shall hold it as the health plans' constructive trustee.

If you and/or your covered dependent has cause to reasonably believe that an overpayment may have been made, you and/or your covered dependent must promptly notify the applicable claims administrator of the relevant facts. If the applicable claims administrator determines that an overpayment was made to you (or any other person), it will notify you in writing and you shall promptly pay (or cause another person to pay) the amount of such overpayment to the applicable claims administrator.

If the applicable claims administrator has made a written demand for the repayment of an overpayment and you (or another person) have not repaid (or caused to be repaid) the overpayment within 30 days following the date on which the demand was mailed, then any amounts subsequently payable as benefits under the health plans with respect to you and/or your covered dependent may be reduced by the amount of the outstanding overpayment, or the applicable claims administrator may recover such overpayment by any other appropriate method that the applicable claims administrator (or the Corporation) shall determine.

Continuation Coverage and COBRA Coverage

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) is a federal law that entitles you and your eligible dependents to continue health plan coverage for a period of time after it would otherwise end. Read this section for:

- Important information about your right to continuation coverage.
- An explanation of when continuation coverage may become available.
- A description of what you need to do to protect your right to receive continuation coverage.

Introduction

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) is a federal law that entitles you and your eligible dependents to continue health plan coverage for a period of time after it would otherwise end. This continuation coverage becomes available when a qualifying event occurs. If you or your dependents decline this coverage when first eligible for it, you waive the right to enroll at a later date, except that you or your dependents may enroll at any time during the initial period of eligibility, even if you have previously declined coverage. This section:

- Contains important information about your right to continuation coverage.
- Explains when continuation coverage may become available.
- Describes what you need to do to protect your right to receive continuation coverage.

Pursuant to Chevron policy, your domestic partner and any of your domestic partner's dependent children who are covered by a Chevron health plan on the day before a qualifying event occurs are also eligible for continuation coverage that is similar to COBRA.

What Is Continuation Coverage?

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) requires most employers sponsoring group health plans to offer employees and their families the opportunity for a temporary extension of health coverage (called COBRA continuation coverage) at group rates when there is a "qualifying event" where coverage would otherwise end. (Specific qualifying events are listed later in this section.) After a qualifying event, continuation coverage must be offered to each "qualified beneficiary."

You, your spouse and your dependent children could become qualified beneficiaries if coverage under a Chevron health plan is lost because of the qualifying event. Qualified beneficiaries also include any children born to you or adopted or placed for adoption with you during the continuation coverage period. Pursuant to Chevron policy, domestic partners and domestic partner dependent children who are covered under a Chevron health plan on the day before a qualifying event are also permitted to elect continuation coverage that is similar to COBRA.

You do not have to show that you are insurable to choose continuation coverage. However, you will have to pay the total premium for your continuation coverage, plus a 2 percent administration fee.

Conversion Coverage

If you are enrolled in an insured plan or HMO, and you elect continuation coverage, you may have an option to convert your health coverage to an individual policy at the termination of your continuation coverage. Contact your insurer or HMO for additional information about any conversion rights you may have. There are no conversion rights for dental coverage, mental health and substance abuse coverage, the Healthy Heart Program, Health Decision Support, or Executive Physical Program.

Who's Eligible for Continuation Coverage

Under COBRA and pursuant to Chevron policy, you, your spouse, your domestic partner and your eligible dependent children are eligible to enroll for continuation coverage under a Chevron health plan if they are enrolled in the plan on the day before a qualifying event occurs.

If you acquire a new dependent through birth, adoption or placement for adoption while you are receiving continuation coverage, that new dependent will also be considered a qualified beneficiary as long as he or she is timely enrolled in a Chevron health plan. If you otherwise acquire a new eligible dependent after your continuation coverage begins, you can enroll him or her for continuation coverage but the new dependent will not be considered a qualified beneficiary. If your former spouse/domestic partner or dependent child acquires a new eligible dependent after continuation coverage begins, he or she can enroll the new dependent for continuation coverage but the newly enrolled dependent will not be considered a qualified beneficiary.

Your spouse and dependent children may also be eligible for continuation coverage if it's determined that you canceled their regular health plan coverage to prevent them from qualifying for continuation coverage (in anticipation of your divorce, for example). In this situation, your spouse and dependent children must notify Chevron within 60 days if you're divorced or if an enrolled child no longer satisfies the eligibility requirements for regular health plan coverage. Please see the section titled Eligible Children and Other Dependents for details on eligibility. Your domestic partner and dependent children must notify Chevron within 31 days if your domestic partnership ends. If your spouse/domestic partner and dependent children do not notify Chevron within the above time limits, they will become permanently ineligible for future continuation coverage as a result of that qualifying event.

Qualifying Events

You become a qualified beneficiary and can enroll in continuation coverage if your Chevron health plan coverage ends because of one of the following qualifying events:

- Your Chevron employment ends for any reason other than termination for gross misconduct.
- You're on a Personal Leave Without Pay, Leave for Educational Reasons or Long Union Business Leave that's scheduled to last more than 31 days.
- Your work hours are reduced and you're no longer eligible for Chevron health care benefits.

Note that a termination of employment following a reduction of hours will not be considered a qualifying event if you became ineligible for Chevron health care coverage as a result of a reduction in hours.

Your enrolled spouse/domestic partner and dependent children have the right to elect continuation coverage if their Chevron health plan coverage ends because of one of the following events:

- Your Chevron employment ends for any reason other than termination for gross misconduct.
- You're on a Personal Leave Without Pay, Leave for Educational Reasons or Long Union Business Leave that's scheduled to last more than 31 days.
- Your work hours are reduced and you're no longer eligible for Chevron health care benefits.
- You die.
- Your spouse/domestic partner or enrolled child or other dependent no longer meets the Chevron health plans' eligibility requirements.
- You and your spouse get a divorce.
- You are the spouse of a member and your group health coverage is reduced or eliminated in anticipation of a divorce and a divorce later occurs.
- You and your domestic partner end your domestic partnership.

Special Rule for Bankruptcy of the Employer

Pursuant to COBRA, sometimes, filing a proceeding in bankruptcy under Title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy were to be filed with respect to Chevron, and that bankruptcy resulted in the loss of coverage of any retired employee covered under a Chevron health plan, the retired employee would become a qualified beneficiary with respect to the bankruptcy. The retired employee's spouse/domestic partner, surviving spouse/domestic partner, and dependent children would also become qualified beneficiaries if such bankruptcy results in the loss of their coverage under a Chevron health plan.

How to Enroll

Chevron Must Give Notice of Some Events

Chevron has the responsibility to notify ADP Benefit Services, which handles Chevron's continuation coverage administration, when any of the following occurs:

- Your Chevron employment ends for any reason other than termination for gross misconduct.
- You're on a Personal Leave Without Pay, Leave for Educational Reasons or Long Union Business Leave that's scheduled to last more than 31 days.
- Your work hours are reduced and you're no longer eligible for Chevron health care benefits.
- You die while actively employed.

You Must Give Notice of Some Events

You must notify Chevron within 60 days after the first of the month coinciding with or following your divorce, or if an enrolled child no longer satisfies the eligibility requirements for regular health plan coverage. Please see the section titled Eligible Children and Other Dependents for details on eligibility. You must notify Chevron within 31 days after the first of the month coinciding with or following the termination of your domestic partnership or any final determination by the Social Security Administration that a qualified beneficiary is disabled or is no longer disabled. If you don't notify Chevron within the above time limits, your dependents won't be eligible for continuation coverage.

You must also notify Chevron within 31 days if, after electing continuation coverage, you become covered by another group health plan or enroll in Medicare Part A, Part B or both.

The following information should be included in the notice:

- The name of the individual experiencing the qualifying event (the qualified beneficiary).
- The name and Social Security number of the employee or former employee.
- The type of qualifying event.
- The date of the qualifying event.
- The address of the qualified beneficiary.
- A copy of the *Notice of Award* letter from the Social Security Administration, if applicable.

Chevron may also require you to provide documentation of a qualifying event, such as a final divorce decree, before continuation coverage is offered.

You should provide your notice to the Chevron HR Service Center at 1-888-825-5247 (610-669-8595 outside the U.S.). Your personal identification number (PIN) will be required when reporting the event by telephone. Additionally, you can mail your notice to the following address:

Chevron Corporation
Human Resources Service Center
P.O. Box 199708
Dallas, TX 75219-9708

If you or a family member does not provide this notice to Chevron's HR Service Center within the time limit specified above, you and your dependents will lose eligibility for continuation coverage with respect to that qualifying event.

Also, if while you are receiving continuation coverage you acquire a new dependent as a result of birth, adoption or placement for adoption, you must enroll your new dependent with the HR Service Center within 31 days of acquiring the new dependent. If you fail to do so, your new dependent will not be considered a qualified beneficiary for purposes of continuation coverage and may not be covered under a Chevron health plan until a subsequent open enrollment period, if applicable.

Electing Continuation Coverage

When ADP Benefit Services is notified by the HR Service Center that one of these events has occurred, ADP Benefit Services will in turn notify you that you have the right to elect continuation coverage. Under the law, you have 60 days from the date you would lose Chevron health plan coverage because of one of these events, or the date your continuation coverage election notice is sent to you, whichever is later, to inform ADP Benefit Services that you want continuation coverage.

Each qualified beneficiary has an independent right to elect continuation coverage. Covered employees can elect continuation coverage on behalf of their spouses/domestic partners, and parents can elect continuation coverage on behalf of their dependent children.

You or your eligible dependents must complete and return the continuation coverage election form within 60 days after Chevron health plan coverage would otherwise end or, if later, within 60 days after the date your continuation coverage election notice is sent to you. If you do not choose continuation coverage during the election period, your Chevron health plan coverage will end the last day of the month in which your employment ends.

If you or your dependent elects continuation coverage within this 60-day period, upon timely receipt of the full amount of the first required premium payment for continuation coverage, your or your dependent's Chevron health plan coverage will be reinstated retroactive to the date Chevron health plan coverage ended.

Keep the Plan Informed of Address Changes

In order to protect your family's rights, you should keep Chevron informed of any changes in the addresses of family members by contacting the HR Service Center at 1-888-825-5247 (610-669-8595 outside the U.S.). You should also keep a copy, for your records, of any notices you send to the HR Service Center.

How Much Continuation Coverage Costs

In most cases, you or your dependents pay 100 percent, plus a 2 percent administrative fee, of the cost of health plan coverage that's continued. The cost of coverage will vary based on the plans you're enrolled in and how many family members are enrolled. (If you're eligible for continuation coverage because you're on a Long Union Business Leave that's scheduled to last more than 31 days, you're not required to pay the 2 percent administrative fee.) If you or your dependents are eligible for the 11-month disability extension and the disabled qualified beneficiary elects continuation coverage, you or your dependents will pay 150 percent of the cost of health plan coverage that's continued for months 19 through 29.

You or your dependents must pay Chevron for this coverage as long as it's in effect. Your first payment for continuation coverage is due within 45 days after the date of your election. (This is the date the continuation coverage election form is postmarked, if mailed.) If you do not make your first premium payment for continued coverage within 45 days, you will lose all continuation coverage rights under the plan.

After that, payments are due on the first day of each month. For example, payment for January coverage is due on January 1. Coverage will be canceled and can't be reinstated if a payment is 30 days overdue. It is the qualified beneficiary's responsibility to make timely payments, even if he or she does not receive a payment coupon.

Regular monthly COBRA payments should be mailed to:

ADP Benefit Services – COBRA
P.O. Box 7247-0367
Philadelphia, PA 19170-0367

Or via overnight to:

ADP Benefit Services – COBRA Lockbox 0367
c/o Citibank Lockbox Operations
1615 Brett Road
New Castle, DE 19720-2425

When Continuation Coverage Starts

Your regular health plan coverage will end on the last day of the month in which a qualifying event occurs. If you or your dependents enroll for continuation coverage within 60 days after regular coverage ends (or, if later, within 60 days after the date the continuation coverage election notice is sent to you) upon timely receipt of the full amount of the required first payment for continuation coverage, your or your dependent's Chevron health plan coverage will be reinstated retroactive to the date Chevron health plan coverage ended. If you fail to meet these deadlines, you or your dependents will waive the right to enroll for continuation coverage.

How Long Continuation Coverage Lasts

You, your spouse, your domestic partner and your covered dependents may qualify for up to 18 months of health care continuation coverage if you qualify due to one of the following qualifying events:

- Your Chevron employment ends for any reason other than termination for gross misconduct.
- You're on a Personal Leave Without Pay, Leave for Educational Reasons or Long Union Business Leave that's scheduled to last more than 31 days.
- Your work hours are reduced and you're no longer eligible for Chevron health care benefits.

Your covered spouse, your domestic partner and your covered dependents may qualify for up to 36 months of health care continuation coverage if they qualify due to one of the following qualifying events:

- You die.
- An enrolled child or other dependent no longer meets the Chevron health plans' eligibility requirements.
- You and your spouse get a divorce.
- You and your domestic partner end your domestic partnership.

Your survivor and his or her covered dependents may qualify for up to 36 months of health care continuation coverage when:

- Your survivor's Chevron retiree and survivor coverage ends because your survivor adds a new spouse or another dependent to health coverage.

Continuation coverage generally lasts for up to a total of 18 months when the qualifying event is the end of employment or reduction of the employee's hours of employment. This 18-month period of continuation coverage can be extended in two ways: disability extension or second qualifying event extension.

Disability extension of 18-month period of continuation coverage
The 18-month period may be extended for you and your covered family members if the Social Security Administration determines that you or another family member who is a qualified beneficiary is disabled at any time during the first 60 days of continuation coverage. If all of the following requirements are met, coverage for all family members who are qualified beneficiaries as a result of the same qualifying event can be extended for up to an additional 11 months (for a total of 29 months):

- Your continuation coverage qualifying event was an employee's termination of employment (for any reason other than gross misconduct) or a reduction in hours so that the employee (and you) was no longer eligible for Chevron health care benefits.

- The disability started at some time before the 60th day of continuation coverage and lasts at least until the end of the 18-month period of continuation coverage.

- A copy of the Notice of Award from the Social Security Administration is provided to the HR Service Center within 60 days of receipt of the notice and before the end of the initial 18 months of continuation coverage.

- If the disabled qualified beneficiary elects continuation coverage, you must pay an increased premium of 150 percent of the monthly cost of health plan coverage that's continued, beginning with the 19th month of continuation coverage.

Second qualifying event extension of 18-month period of continuation coverage
If another qualifying event occurs during the first 18 months of continuation coverage, your spouse/domestic partner and dependent children can receive up to an additional 18 months of continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is timely provided to the HR Service Center as described in You Must Give Notice of Some Events under How to Enroll in this Continuation Coverage and COBRA Coverage section.

This extension may be available to your spouse/domestic partner and any dependent children receiving continuation coverage if you die, get divorced or terminate your domestic partner relationship or if your dependent child is no longer eligible under the terms of a Chevron health plan as a dependent child. A second event will be considered a qualifying event only if the second event would have caused your spouse/domestic partner or dependent child to lose coverage under the health plan had the first qualifying event not occurred.

Extension Due to Medicare Eligibility
When the qualifying event is the end of employment (for reasons other than gross misconduct) or reduction of the employee's hours of employment, and the employee became entitled to Medicare (Part A, Part B or both) benefits within 18 months prior to the qualifying event, continuation coverage for qualified beneficiaries (other than the employee) can last until 36 months after the date of Medicare entitlement. In order to qualify for this extension, you must provide the HR Service Center with a copy of your Medicare card showing the date of Medicare entitlement.

In no event will continuation coverage last beyond 36 months from the date of the event that originally made a qualified beneficiary eligible to elect continuation coverage.

When Continuation Coverage Ends

Continuation coverage may be terminated before the maximum period if one of the following occurs:

- The premium for your continuation coverage is not paid on time.
- If after electing continuation coverage, you become covered by another group health plan, unless the plan contains any exclusions or limitations with respect to any pre-existing condition you or your covered dependents may have.
- If after electing continuation coverage, you first become eligible for and enroll in Medicare Part A, Part B or both.
- You extend coverage for up to 29 months due to a qualified beneficiary's disability and there has been a final determination by the Social Security Administration that the qualified beneficiary is no longer disabled. In this case, continuation coverage will end on the first of the month that begins more than 30 days after the final determination by the Social Security Administration that the qualified beneficiary is no longer disabled. This will be the case only if the qualified beneficiary has been covered by continuation coverage for at least 18 months.
- Chevron no longer provides group health coverage to any of its eligible employees or eligible retirees.

Continuation coverage also may be terminated early for any reason the Chevron health plans would terminate coverage of a participant or beneficiary not receiving continuation coverage (for example, you commit fraud or make an intentional misrepresentation of a material fact).

Continuation Coverage vs. Retiree and Survivor Coverage

If you qualify as an eligible retiree at the time of your termination of employment with Chevron, you will have the option to elect either one of the following for you and your covered dependents:

- Retiree and survivor coverage.
- Continuation coverage.

The costs for retiree and survivor coverage and continuation coverage may differ. You should carefully review the information provided to you by Chevron at the time you terminate employment with Chevron.

Although you have the option to elect either retiree and survivor coverage, or continuation coverage, generally, if you don't enroll in retiree and survivor coverage when you first become eligible, then you can only elect retiree and survivor coverage during an open enrollment period. However, there are a few exceptions as follows:

- This provision does not apply if you were a former employee who was eligible for both subsidized COBRA and retiree medical coverage and initially elected subsidized COBRA coverage. In this case you can immediately enroll in retiree medical coverage after your subsidized COBRA coverage ends, provided you do so within 31 days of the subsidized COBRA coverage ending.

- This provision does not apply if you and your dependents are covered by another Group Plan upon your death. In this case, your survivors are able to elect coverage under the retiree and survivor plan, provided they do so within 31 days of your death.

Elections you make during an open enrollment period will become effective at the beginning of the next calendar year, unless you have a qualifying life event (for example, you get married or divorced) that is subject to midyear special enrollment rights.

Continuation Coverage Considerations

If you don't elect continuation coverage …

If you qualify as an eligible retiree and *don't* elect continuation coverage, you and your eligible dependents that were enrolled in a Chevron health plan on the day before the qualifying event will be automatically enrolled in retiree and survivor coverage with Chevron. Retiree and survivor coverage will be effective retroactively to the first day of the month following your termination of employment. You may still elect continuation coverage during the 60-day election period. If you elect continuation coverage after you have been automatically enrolled in retiree and survivor coverage, your retiree and survivor coverage will be retroactively canceled.

If you elect continuation coverage …

If you qualify as an eligible retiree at the time of your termination of employment with Chevron and you elect continuation coverage, you may enroll in retiree and survivor coverage at a later time, but only during an open enrollment period. However, there are a few exceptions that apply – please see above.

Special exceptions if you are eligible for subsidized COBRA …
If you are eligible for both retiree medical coverage and subsidized COBRA, and you initially elect subsidized COBRA coverage, some of the provisions above do not apply to you:

- You can immediately enroll in retiree and survivor coverage after your subsidized COBRA coverage has ended, as long as you do so within 31 days of the subsidized coverage ending. You do not have to wait for an open enrollment period.
- If you die while enrolled in subsidized COBRA, your survivors can immediately enroll in retiree and survivor coverage after subsidized COBRA coverage has ended, as long as they do so within 31 days of the subsidized coverage ending.
- If you die while enrolled in another employer's group health plan, your survivors can immediately enroll in retiree and survivor coverage after your death, as long as they do so within 31 days of your death.

Retiree and Survivor Coverage Considerations

If you die, your enrolled dependents are eligible for either continuation coverage (described under Continuation Coverage and COBRA Coverage in this section) or survivor coverage under Chevron's health plans. Chevron currently pays a portion of the cost for survivor coverage. However, if your enrolled dependent(s) elect continuation coverage, they must pay the entire cost plus a 2 percent administrative fee.

Your enrolled dependents may elect survivor coverage within 31 days of your death. Upon timely receipt of any required premiums, an election of survivor coverage will be effective retroactive to the day after the day that the survivor's (and his or her covered dependent(s), if applicable) coverage under Chevron's health plans terminates. In the event that such survivor subsequently elects continuation coverage within the election period, such survivor's (and his or her eligible dependent(s), if applicable) survivor coverage shall be canceled retroactive to the day it commenced.

Survivor coverage for your spouse/domestic partner can continue until he or she dies, cancels survivor coverage or does not make timely premium payments. Survivor coverage can continue if a surviving spouse/domestic partner remarries or enters into a new domestic partner relationship, but the new spouse/domestic partner or any other dependents cannot be added to any Chevron health plan. If your spouse wishes to add his or her new spouse or other dependent to the plan, survivor coverage ends, and up to 36 months of continuation coverage becomes available.

Survivor coverage for your enrolled children can continue until the child reaches age 26 (unless incapacitated), or is no longer eligible according to the eligibility provisions for the health plans for reasons other than your death. Please see the Eligible Children and Other Dependents section for details on eligibility. If your dependent wishes to add his or her new spouse or other dependent to the plan, survivor coverage ends, and up to 36 months of continuation coverage becomes available.

Survivor coverage will also end early if the survivor fails to timely pay any required premiums for coverage or as of the date the survivor has received the maximum benefit under a particular Chevron health plan. Survivor coverage will also end if Chevron ceases to provide any health plan for any of its employees or retirees. Survivor coverage may also be terminated due to fraud or intentional misrepresentation of a material fact.

If your covered spouse or covered child becomes ineligible for survivor coverage, he or she can continue Chevron health plan coverage for up to 36 months under the terms of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). Pursuant to Chevron policy, your covered domestic partner and your domestic partner's covered dependent children may also be eligible for continuation coverage that's similar to COBRA if they become ineligible for survivor coverage under the Chevron health plans.

If a surviving spouse/surviving domestic partner or surviving dependent child waives all health plan coverage, they become permanently ineligible for future Chevron health plan coverage with respect to your death.

Additional Rights and Rules

Special Rule: Periods of Continuation Coverage Subject to the Uniformed Services Employment and Reemployment Rights Act of 1994

If you are on a Military Service Leave, you will be permitted to continue health plan coverage for you, your spouse and your dependent children in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) and pursuant to Chevron policy.

While you are on a Military Service Leave, your health plan coverage may continue. Chevron will continue to pay its normal company contribution, provided that you continue to timely pay your required employee contributions. While you are on paid status, your employee contribution will be deducted from your paycheck, provided that you have sufficient funds available after required deductions. If your employee contribution exceeds the amount of pay available, or if you are on unpaid status, you will receive a bill from Chevron's HR Service Center for your health plan coverage.

It is your responsibility to make timely payments for your regular benefits coverage as defined by the administrative rules of the Omnibus Health Care Plan. If the full premium payment is not received by the payment due date, your regular benefits coverage will be terminated retroactive to the end of the month for which full payment was received. If you have been on Military Service Leave for less than 24 months at the time your regular coverage ends, you will be offered continuation coverage (under USERRA).

Your, your spouse's or your dependent's period of continuation coverage under USERRA will begin on the date your Military Service Leave begins and will end on the earliest of the following dates:

- The 24-month period beginning on the date on which your Military Service Leave begins.
- The period ending on the day after the date on which you fail to timely apply for or return to a position of employment with Chevron, as determined under section 4312(e) of USERRA.

Periods of continuation coverage offered in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) will run concurrently with periods of continuation coverage offered pursuant to COBRA and Chevron policy.

You are covered under USERRA if you serve voluntarily or involuntarily as a member of the uniformed services of the United States, including serving in the reserves or as designated by the president. The uniformed services include the U.S. Army, Navy, Marines, Air Force and Coast Guard, and the Public Health Service Commissioned Corps.

How Much USERRA Continuation Coverage Costs

If you fail to pay your employee contributions such that you are no longer eligible for regular coverage and you elect USERRA continuation coverage, you must pay 100 percent, plus a 2 percent administrative fee, of the cost of health plan coverage that's continued. The cost of coverage will vary based on the plans you're enrolled in and how many family members are enrolled.

How to Contact ADP for More Information

If you have any questions about the COBRA law, please contact ADP Benefit Services, 1-888-825-5247, and select option 2, then " *," then 1. If you're outside the U.S. and can't access the toll-free number, call or at 610-669-8595 and select option 2, then " *," then 1. Or, write to ADP Benefit Services at P.O. Box 2638, Alpharetta, GA 30023-2638.

Glossary

After-Tax Contributions
After-tax contributions are withheld from your paycheck after federal and state income taxes are withheld.

Allowance
See UCCI's Allowance.

Annual Deductible
The amount of certain covered charges you pay for combined network and out-of-network care and services each calendar year before the plan begins paying its share of those charges.

Before-Tax Contributions
Before-tax contributions are withheld from your pay first, before taxes are calculated and deducted. So you pay less in taxes. Before-tax contributions aren't subject to federal income taxes, and they aren't subject to state income taxes except in New Jersey and for certain benefits, Pennsylvania. Also (unlike before-tax contributions to 401(k) savings plans), before-tax contributions to health plans, the Health Care Spending Account (HCSA) and the Dependent Day Care Spending Account (DCSA) aren't subject to Social Security taxes.

Before-Tax Contribution Plan
This is a plan that permits you to pay your portion of the monthly costs of any medical, dental, and vision plan coverage with before-tax contributions. If you choose before-tax deductions, you are automatically enrolled in the Before-Tax Contribution Plan. With this plan you are limited in your ability to make enrollment changes in your health plans during the year. Also, if you make contributions on a before-tax basis for medical coverage, you are required to make contributions on a before-tax basis for dental and vision coverage and vice versa.

Casual Employee
An employee who's hired for a job that's expected to last no more than four months and who isn't designated by Chevron as a seasonal employee.

Coinsurance
A way you share costs of services with the plan. You and the plan split the costs by each paying a specified percentage of covered charges.

Common-Law Employee
A worker who meets the requirements for employment status with Chevron under applicable laws.

Company
Chevron Corporation and those of its subsidiaries that it has designated to participate in the Omnibus Health Care Plan and that have accepted such designation by appropriate corporate action. Such designation may include a limitation as to the classes or groups of employees of such subsidiary that may participate in the Omnibus Health Care Plan.

Copayment
A flat-rate charge you pay for office visits or services at the time services are delivered.

Corporation
Refers to Chevron Corporation.

Covered Charges

Charges that the plan pays for medically necessary services and supplies that are ordered by, and while under the care and direction of, a dentist or a doctor (although not all treatment or services prescribed by a dentist are considered covered charges) and that are covered by the plan.

Network covered charges for those services and supplies are limited to the negotiated fees between UCCI and the providers. See the definition for negotiated fees in this section.

Out-of-network covered charges for those services and supplies are limited to UCCI's allowance for dental treatment that's either provided by a dentist or doctor or provided under the direction of a dentist or doctor. See the definition for UCCI's Allowance in this section.

Dentist or Doctor

The plan can help pay for services performed by a doctor or dentist (D.M.D. or D.D.S.) who is licensed by the governmental authority having jurisdiction over licensing in the locality of the doctor's or dentist's practice. The plan also covers services of a dental hygienist, a person who is licensed by the state and working under a dentist's supervision.

Experimental or Investigative Service

The use of any treatment, procedure, facility, equipment, drug or drug usage, device, or supply which is not acceptable standard dental treatment of the condition being treated; or any such items requiring federal or other governmental agency approval when such approval has not been granted at the time the services are rendered, as determined by the Dental Plan Claims Administrator in its sole discretion.

Health and Welfare Eligibility Service (HWES)

Your health and welfare eligibility service is used to determine your eligibility for vacation, service awards, Short-Term and Long-Term Disability plans and retiree health care benefits. For more information about HWES, see the Company Contributions to Medical Coverage Supplement.

HIPAA

The Health Insurance Portability and Accountability Act of 1996, as amended from time to time.

Hospital

A hospital must meet one of the following requirements:

- A legally constituted and operated institution having, on its premises, organized facilities (including diagnostic and major surgical facilities) for the care and treatment of sick and injured people. Care must be supervised by a staff of legally qualified doctors, and there must be a registered nurse (R.N.) on duty at all times.

- A free-standing rehabilitative facility that meets all of the following criteria:

  - Has a provider agreement, as required by Medicare.
  - Serves an inpatient population, with at least 75 percent of patients needing intensive rehabilitative services for the treatment of a stroke, spinal cord injury, congenital deformity, amputation, major multiple trauma, fracture of the femur, brain injury, polyarthritis, neurological disorders and burns.
  - Has a preadmission screening procedure to determine whether the patient would benefit from an intensive inpatient hospital program.
  - Ensures that patients receive close medical supervision and furnishes rehabilitation nursing, physical therapy and occupational therapy by qualified personnel.
  - Has a director of rehabilitation who is a doctor.
  - Establishes a plan of treatment for every patient that is reviewed as needed by a doctor who consults with other qualified personnel.
  - Uses a coordinated team approach to rehabilitate each patient.

The term *hospital* doesn't include any of the following facilities:

- Any institution used primarily as a rest or nursing facility.

- Any facility solely for use by the aged or the chronically ill or alcoholics.

- Any facility providing primarily educational or custodial care.

Incapacitated Child

An incapacitated child is a dependent child who is:

- Incapable of self-sustaining employment by reason of mental retardation or a mental or physical disability (proof of which must be medically certified by a physician).

- Dependent on you, you and your spouse/domestic partner or your surviving spouse/domestic partner who is covered under the plan, for more than one-half of his or her financial support.

- Your or your spouse/domestic partner's qualifying child under section 152 of the Internal Revenue Code. This means that during the calendar year the individual 1) is your child, brother, sister stepbrother, stepsister or a descendent of such person; 2) lives with you for more than one-half the year and 3) does not provide over one-half of his or her own support.

The dependent child must be incapacitated under one of the following conditions:

- Immediately before turning age 26 while being covered under a Chevron health care plan.
- Before turning age 26 if he or she had other health care coverage immediately before you became an eligible employee and is enrolled in a Chevron health care plan within 31 days after you become an eligible employee.
- Before turning age 26 if he or she had other health care coverage immediately before the dependent child was enrolled in a Chevron health care plan.

When the child reaches age 26 and periodically thereafter, Chevron Corporation will require you to provide documentation stating that the child continues to be incapacitated. For chronic disabilities, as determined by UnitedHealthcare, you must provide documentation every two years. If the disability is not chronic, UnitedHealthcare will determine how frequently you will need to provide such documentation. For details, contact the HR Service Center at 1-888-825-5247 (610-669-8595 outside the U.S.).

Leased Employee

Someone who provides services to Chevron in a capacity other than that of a common-law employee and who meets the requirements of section 414(n) of the Internal Revenue Code. This law requires Chevron to treat leased employees as if they're common-law employees for some purposes, but doesn't require that they be eligible for benefits.

Medically Necessary

This term generally refers to services or supplies that are prescribed by a dentist or doctor and accepted by the health care community as being reasonable and necessary for treatment of the condition. Medically necessary services can include those that are appropriate and necessary to diagnose, treat and care for a dental condition.

Even though a dentist may prescribe, order, recommend or approve a service or supply, it doesn't mean that it's medically necessary and appropriate. UCCI, the plan's claims administrator, determines if a service or supply is medically necessary.

Negotiated Fee(s)

The amount(s) a participating network provider agrees to accept as payment in full for covered services. Negotiated fees are the fees agreed to by UCCI and the providers and are discounted to be usually lower than the provider's normal charge.

Nurse

A registered nurse (R.N.), licensed vocational nurse (L.V.N.) or licensed practical nurse (L.P.N.).

Open Enrollment

Typically, open enrollment is held annually during a two-week period each fall. During open enrollment, you can make changes to your benefit elections and such changes will take effect the following January 1.

Payroll

The system used by Chevron to withhold employment taxes and pay its common-law employees. The term doesn't include any system to pay workers whom Chevron doesn't consider to be common-law employees and for whom employment taxes aren't withheld — for example, workers Chevron regards as independent contractors or common-law employees of independent contractors.

Primary Payer

The plan that pays benefits first.

Professional Intern

An individual who works either a full-time or part-time work schedule and whose work periods with Chevron alternate with school periods.

Provider

A hospital, medical or health care facility, doctor, dentist or other health professional licensed where required, performing within the scope of that license.

- A PPO (preferred provider organization), participating provider or network provider has agreed to charge discounted rates for services provided to plan members. To encourage you to use these providers, the plan often pays a higher benefit rate for network services. Also, you generally don't have to file a claim form when you go to a network provider. You can obtain a list of network providers in your area by contacting your claims administrator.

- A non-PPO, nonparticipating or out-of-network provider does not have an agreement with the claims administrator pertaining to the payment of covered services for a member.

Regular Work Schedule

A continually recurring pattern of scheduled work that's established and changed by Chevron as necessary to meet operating needs.

Seasonal Employee

An individual who's hired to work a regular work schedule for a portion of each year on a repetitive basis in a job designated to cover a seasonal operating need.

Secondary Payer

The plan that pays benefits second.

Spouse

A person to whom you are legally married under the law of a state or other jurisdiction where the marriage took place.

UCCI Companies, Inc. (United Concordia)

The claims administrator for the Dental PPO. They manage the plan's preferred provider organization and review, approve (or deny) and process claims filed by you or your provider. They can be reached by telephone at 1-877-424-3876 between 8 a.m. and 5 p.m. Pacific time, Monday through Friday. United Concordia also sponsors the Concordia Plus dental HMO option available to Chevron employees who live in the plan's service area.

UCCI’s Allowance

For out-of-network providers, UCCI’s allowance may vary from one U.S. geographic area to another, is based on a range of rates and fees that most dentists and specialists charge for the same service in that area, and must be no more than the out-of-network provider normally charges for the service or supply. When reviewing charges to determine if they’re covered under the plan’s out-of-network coverage, United Concordia doesn’t attempt to set the amount that nonparticipating dentists and other providers charge for needed services, nor do they restrict your right to go to any dentist you choose. However, United Concordia determines UCCI’s allowance and you’re responsible for paying the difference between your nonparticipating dentist’s charge and the allowance established by United Concordia. For services received outside of the U.S. the allowance is the billed amount.