health care spending account

flexible spending account plan
summary plan description

effective january 1, 2017

human energy. yours.™

This document describes the Health Care Spending Account Plan, as of January 1, 2017, that Chevron sponsors for eligible employees on the U.S. payroll of Chevron or a participating company. The Plan is comprised of a general purpose health care spending account — the Health Care Spending Account (HCSA) — and a limited purpose health care spending account — the Limited Purpose Health Care Spending Account (LHCSA). This information constitutes the summary plan description (SPD) of the Plan 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 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 to the extent permitted by law.

Chevron Corporation reserves the right to change or terminate a plan or program 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**.

table of contents

Benefits Contact Information **1**

Description of the Plan **5**
Overview 6
Eligibility 7
Participation 9
How the Plan Works 11
Qualified Expenses 13
Your Contributions 17
Taxes 19
How to File Claim for Reimbursement 22
Claims and Appeals 24
How to File a Claim for Eligibility 29
Changing Your Contributions 31
If You Go on a Leave of Absence 32

Other Plan Information **34**
Administrative Information 35
HIPAA 38
Your ERISA Rights 39

Continuation Coverage and COBRA Coverage **42**

Glossary **54**

benefit contact information

This summary plan description refers you to contact the administrators listed below.
Please refer to this section for phone numbers, website and other key contact information.

Human Resources Service Center (HR Service Center) *and* Benefits Connection Website

Why contact this administrator

- Enroll in this plan.
- Enroll in Chevron health and welfare employee benefits.
- Enroll in or learn about COBRA continuation coverage for health plans.
- Make open enrollment elections for this plan.
- Ask about your or your dependents' eligibility to participate in this plan.
- Report qualifying life events – such as a marriage, divorce, birth or death.
- Change your address with Chevron and your benefit plan(s).
- Designate beneficiaries for your Chevron benefits.
- Report a death.
- Register your domestic partner.
- Request an *Intent to Retire* package.
- Request a printed copy of summary plan descriptions (SPD).

COBRA and Continuation Coverage for Chevron Health Plans

The HR Service Center is also the administrator of COBRA and continuation coverage for Chevron health plans. Contact the HR Service Center to:

- To enroll in COBRA or continuation coverage for Chevron health plans when you leave Chevron.
- To learn about COBRA or continuation coverage.
- To ask about COBRA or continuation coverage monthly costs.
- To update COBRA or continuation coverage.
- To manage monthly premium payments for COBRA or continuation coverage.
- For information about the COBRA law.

Phone information

- 1-888-825-5247
- You'll need your Personal Identification Number (PIN) when you call the HR Service Center. If you don't know or forget your PIN, hold the line each time you are prompted to enter it until you are presented with further options and instructions.

HealthEquity (administered by Anthem)

Claims administrator for the Health Care Spending Account Plan and the Limited Purpose Health Care Spending Account Plan.

Why contact this administrator

- Ask questions about your plan coverage.
- Ask about qualifying expenses that are eligible for reimbursement.
- Get account balance information.
- Submit claims for reimbursement of a qualifying expense.
- Get help with your FSA debit card.

Phone information

- 1-866-346-5800
- 24 hours a day, seven days a week

Website information

- Check your account, review or manage claims.
- **www.healthequity.com/chevron**
- **HealthEquity Mobile App** (iOS or Android)

Chevron Benefits HR2 Website

Why access this website

- Access summary plan descriptions (SPDs).
- Access benefit information and documents.
- Get benefit phone numbers and access websites referenced in this summary plan description.

Website information

- You don't need a password to access the information posted on this website.
- **hr2.chevron.com** as an employee.
- **hr2.chevron.com/retiree** after you leave Chevron.

Benefits Connection Website

- **Benefits Connection** website for personal information and conduct certain transactions, such as changing your address, updating your beneficiaries, view your current enrollments and costs, enroll in Chevron benefits, enroll in COBRA coverage for health plans, make benefit changes or make open enrollment elections.
- As an employee, go to **hr2.chevron.com** and click the **Benefits Connection** link.
- If you have access to a Chevron workstation connected to the GIL computing network, you can use the automatic login feature; you don't need a password to access the Benefits Connection website.
- If you don't have access to a Chevron workstation connected to the GIL computing network, you will need to enter your Benefits Connection User ID and Passcode; automatic login is not available. Follow the instructions on the Benefits Connection login screen if you need to register to use the website or if you don't remember your User ID and Passcode.

Summary Plan Descriptions

Summary Plan Descriptions (SPDs) provide detailed information about your Chevron benefit plans such as eligibility, claims and participation.

- Go to **hr2.chevron.com** as an employee.
- Go to **hr2.chevron.com/retiree** after you leave Chevron.
- You can also call the HR Service Center to request that a copy be mailed to you, free of charge.

description of the plan

overview

- You can use the Health Care Spending Account (HCSA) Plan to pay certain health care expenses with before-tax dollars, which means you save money. The Plan is comprised of a **general purpose health care spending account** — the Health Care Spending Account (HCSA) — and a **limited purpose health care spending account** — the Limited Purpose Health Care Spending Account (LHCSA).

- If you participate in the Chevron High Deductible Health Plan (HDHP) or Chevron High Deductible Health Plan Basic (HDHP Basic), then you cannot participate in the General Purpose Health Care Spending Account of the Plan.

- The General Purpose Health Care Spending Account of the Plan can reimburse health-related charges for you and your eligible dependents that satisfy all the following requirements:
  - Are not reimbursed under a health, dental or vision care plan.
  - Are the types of expenses that you could claim as a tax deduction.
  - Are incurred during the plan year in which you participate in the Health Care Spending Account.

- If you enroll in the Health Care Spending Account, the amount of before-tax contributions you authorize is deducted from your pay in equal amounts throughout the year and credited to your Health Care Spending Account.

- You can elect to contribute up to $2,300 to your General Purpose Health Care Spending Account of the Plan in 2017.

- If you qualified for the Wellness Credit, then Chevron will contribute $250 into your Health Care Spending Account in 2017 to help pay for eligible health-related expenses. If you participate in the Chevron High Deductible Health Plan (HDHP) or Chevron High Deductible Health Plan Basic (HDHP Basic) and qualify for the Wellness Credit, then your credit will be deposited into the Limited Purpose Health Care Spending Account (LHCSA) of the Plan that may only be used to reimburse eligible dental and vision expenses.

- Participation in the Limited Purpose Health Care Spending Account (LHCSA) is only for Chevron High Deductible Health Plan (HDHP) or Chevron High Deductible Health Plan Basic (HDHP Basic) members who qualify for and receive Wellness Credits. The LHCSA is not open to additional employee contributions, regardless of the medical plan to which you're enrolled.

- After you incur eligible health care expenses during the plan year, you file a claim for reimbursement of your expenses with HealthEquity.

- This Plan has been set up according to provisions of the Internal Revenue Code, which include very strict rules. For example, if you don't have enough qualified expenses to use all of the money you put into your plan account, you'll forfeit money that's left over after the end of the year. You also can be reimbursed for qualified expenses up to the total amount of your annual election, even if you have not yet contributed that amount for the year.

eligibility

Eligible Employee

Except as described below, you're generally eligible for the Health Care Spending Account 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 plans.

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 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 a professional intern.

You cannot participate in the General Purpose Heath Care Spending Account (HCSA) at the same time you participate in the Chevron High Deductible Health Plan (HDHP) or the Chevron High Deductible Health Plan Basic (HDHP Basic). HDHP and HDHP Basic participants may only participate in the Limited Purpose Health Care Spending Account (LHCSA) of the Plan. Participation in the LHCSA is only for Chevron HDHP and HDHP Basic members who qualify for and receive the Wellness Credit. The LHCSA Wellness Credit may only be used to reimburse eligible dental and vision expenses.

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 18012
Norfolk, VA 23501
1-888-825-5247

Eligible Dependent

Under the Health Care Spending Account, an eligible dependent whose expenses can be reimbursed includes any person you can declare as a dependent on your federal income tax return for the year. This person does not have to be enrolled as a dependent under any company-sponsored benefit plan.

Note: Federal tax law does not permit you to claim expenses for your domestic partner or your domestic partner's children, unless they qualify as dependents on your federal income tax return for the year.

participation

When You Can Enroll

If you're eligible, you can enroll in the Health Care Spending Account at any of the following times:

- During open enrollment.
- During the first 31 days after you become an eligible employee.
- During the first 31 days after a qualifying life event.

You enroll in this plan for one calendar year at a time. You must re-enroll in this plan every year to continue your participation.

Participation in the Limited Purpose Health Care Spending Account (LHCSA) is only for Chevron High Deductible Health Plan (HDHP) or Chevron High Deductible Health Plan Basic (HDHP Basic) members who qualify for and receive Wellness Credits. See the **Wellness Credits** chapter of this summary plan description for more information.

How to Enroll

To enroll in the General Purpose Health Care Spending Account, you must contact the Human Resources Service Center (HR Service Center) or enroll on the Benefits Connection website. When you enroll, you authorize the company to deduct before-tax contributions from your pay. Before you enroll, you should carefully review the HCSA description. In addition, it may be a good idea to consult with your personal tax adviser to make sure this plan is a good option for you. If you are hired after December 1, then the Chevron HR Service Center will not process your enrollment for the calendar year of your hire date.

If you enroll in the Chevron High Deductible Health Plan (HDHP) or Chevron High Deductible Health Plan Basic (HDHP Basic) and you meet the requirements to qualify for a Wellness Credit, a Limited Purpose Health Care Spending Account (LHCSA) will automatically be established for you on January 1. This is because you are not allowed to participate in the HCSA if you are enrolled in the HDHP. No action is required on your part to enroll in the LHCSA.

Making Changes

During open enrollment held in the fall, you can enroll or re-enroll for the upcoming year and change your General Purpose HCSA elections. Otherwise, you can't change your plan elections, unless you experience a qualifying life event. See the **Changing Your Contributions** section in this chapter of this summary plan description for more information.

When Participation Begins

If you enroll in the Health Care Spending Account Plan during open enrollment, your participation begins the following January 1. If you enroll within your first 31 days of work at Chevron, your participation begins on your date of hire.

If you enroll in the Chevron High Deductible Health Plan (HDHP) or Chevron High Deductible Health Plan Basic (HDHP Basic) and you meet the requirements to qualify for and receive Wellness Credits, a Limited Purpose Health Care Spending Account (LHCSA) will automatically be established for you. This is because you are not allowed to participate in the General Purpose HCSA if you are enrolled in the HDHP. Your Wellness Credit will be deposited into your LHCSA on January 1, 2017, as long as you're still eligible. The LHCSA may only be used to pay for eligible dental and vision expenses you incur between January 1, 2017 and December 31, 2017.

If you experience a qualifying life event, you must contact the HR Service Center within 31 days of your life event. Your contributions are withheld from your pay starting with the first pay period after your enrollment effective date.

When Participation Ends

If you don't re-enroll in the plan during open enrollment, or if you are a participant in the LHCSA and you do not qualify for the Wellness Credit for a subsequent year, then your participation stops at the end of the calendar year. If you are a participant in the General Purpose Health Care Spending Account and you experience a qualifying life event at any other time of the year, you can increase or decrease your contributions for the remainder of the year, as long as the change is consistent with the event.

Participation in the Health Care Spending Account also ends when you've been on a leave of absence without pay for more than 31 days. You can continue coverage until the end of the plan year by paying the required contributions. Contributions are on an after-tax basis while you're on leave. You will receive billing information from the HR Service Center for COBRA continuation coverage, depending on the type of leave. If you don't continue coverage while on leave, you can re-enroll when you return from leave — your participation does not automatically resume.

Participation also ends when your employment ends. If you leave the company, you can continue to request reimbursement of qualified expenses incurred prior to the time your employment ends, up to the total amount that you had agreed to contribute for the year less any payments you have already received. However, you can't be reimbursed for expenses incurred at a time when you weren't making plan contributions. If you want to be eligible to claim expenses for the rest of the year, you must elect to continue participation under COBRA on an after-tax basis for the remainder of the plan year. The HR Service Center will send you information about continuing the Health Care Spending Account.

For information regarding your continuation coverage rights, review the **Continuation Coverage and COBRA Coverage** chapter.

If you die, your survivors can continue to request reimbursements for qualified expenses incurred prior to your death.

Reimbursement requests must be sent in no later than June 30 of the year after the year in which you incur the expense.

how the plan works

Enrollment and Other Plan Changes

If you want to participate in the Health Care Spending Account Plan, you have to meet the Plan's eligibility requirements. To continue participation in this plan, you must re-enroll during the open enrollment period each year; your enrollment during any plan year ends after December 31 of that year. You can't enroll or make changes at any other time, unless you experience a qualifying life event that allows for enrollment or a change in your participation in this plan.

Participation in the Limited Purpose Health Care Spending Account (LHCSA) is only for Chevron High Deductible Health Plan (HDHP) or Chevron High Deductible Health Plan Basic (HDHP Basic) members who qualify for and receive Wellness Credits. See the **Wellness Credits** section in this chapter of this summary plan description for more information.

Your Contributions

When you enroll in the General Purpose Health Care Spending Account, you authorize Chevron to deduct money from your pay in equal amounts throughout the year and credit it to a Health Care Spending Account set up in your name. Your contributions are not subject to any of the following:

- Federal income taxes.
- Social Security (FICA) taxes.
- In many cases, state and local income taxes.

Before you enroll, it's very important that you determine how much money you want deducted from your pay before you enroll. This is because federal law states that you can't change or stop your deductions after they begin, unless you experience a qualifying life event during the year.

Reimbursement of Eligible Expenses

After you receive eligible health care services, you submit a claim and a copy of your bill to HealthEquity, the plan's claims administrator, for reimbursement of your expenses. The supporting documentation must include the dates of service, the services that were received and the cost. You can claim up to the amount you elected during the year, less prior reimbursements, regardless of your year-to-date contributions.

The amount of your withdrawal request must be at least $25. If your qualified expenses are less than $25, you should not submit a withdrawal request until you incur additional qualified expenses totaling $25 or more.

Reimbursement requests must be sent in no later than June 30 of the year after the year in which you incur the expense. Any balance remaining after June 30 will be forfeited. This money is not available for future expenses or a refund.

Administrative Fees

If you participate in the Health Care Spending Account (HCSA) or Limited Purpose Health Care Spending Account (LHCSA), you'll be charged a reasonable administrative fee – deducted directly from your HCSA or LHCSA – for the following situations:

- **Reimbursement by a paper check** mailed to your address of record.
- For a **hard-copy monthly statement** showing your account balance mailed to your address of record. There is no charge to access monthly statements electronically.
- For a stop-check request.
- For additional or replacement flexible spending account debit cards. The first three additional or replacement debit cards are free.

Contact HealthEquity for information about these fees.

qualified expenses

Expenses Covered
General Purpose Health Care Spending Account

Generally, expenses qualified for reimbursement under the General Purpose Health Care Spending Account are out-of-pocket medical, dental, vision or hearing expenses for you or an eligible dependent and are generally of the type that would qualify for deduction on your federal income tax return. In addition, certain prescribed over-the-counter medications may be considered qualified expenses. For a complete list of items that may be considered qualified expenses or exclusions under the plan, access HealthEquity's website at **www.healthequity.com/chevron.**

Only expenses for goods bought or services provided during the calendar year while you're a participant are eligible for reimbursement. These expenses include your deductible, copayment and other out-of-pocket expenses under your group health plans.

The following are examples of covered expenses under the General Purpose Health Care Spending Account Plan. For a complete list of items that may be considered qualified expenses under the General Purpose Health Care Spending Account (HCSA), access HealthEquity's website at **www.healthequity.com/chevron.**

- Deductibles and copayments.
- Testing and exams not covered under your health plan.
- Abortion
- Acupuncture.
- Alcoholism treatment.
- Ambulance service.
- Artificial limbs.
- Birth control pills.
- Braille books and magazines.
- Chiropractor's fees.
- Christian Science practitioner's fees.
- Contact lenses and supplies.
- Crutches.
- Dental treatment.
- Eyeglasses, including examination fees.
- Fertility enhancement.
- Guide dogs.

- Hearing aids and batteries.
- HMO copayments.
- Hospital fees.
- Laboratory fees.
- Laser eye surgery.
- Learning disability fees.
- Legal fees that are necessary to authorize treatment for mental illness.
- Medical services.
- Nursing home expenses for medical treatment, including meals and lodging.
- Nursing services.
- Organ transplants.
- Orthodontia, except care for cosmetic purposes.
- Prescription drugs.
- Psychiatric care.
- Smoking cessation plans.
- Speech therapy.
- Sterilization.
- Surgical fees.
- Special telephone equipment for the hearing-impaired (cost and repair).
- Transplants.
- Transportation expenses primarily for and essential to medical care.
- Vasectomy.
- Weight-loss plans for the treatment of a specific existing disease diagnosed by a physician.
- Wheelchairs.
- X-ray fees.

Expenses Covered
Limited Purpose Health Care Spending Account

Generally, expenses qualified for reimbursement under the Limited Purpose Health Care Spending Account (LHCSA) are out-of-pocket *dental* or *vision* expenses for you or an eligible dependent. Only expenses for goods bought or services provided during the calendar year while you're a participant are eligible for reimbursement. Generally, eligible dental and vision expenses are those for which you could have claimed a tax deduction on an itemized federal income tax return (without regard to any threshold limitation) including any copayment, coinsurance or deductible amounts. Included below is a *partial* list of the types of vision and dental expenses eligible for reimbursement from an LHCSA. Additional guidance regarding what constitutes a health care expense is provided in *IRS Publication 502* available at **www.irs.gov**.

Eligible Vision Expenses

- Routine eye examinations.
- Eye glasses.
- Contact lenses, including all necessary supplies and equipment.

Eligible Dental Expenses

- Copayments
- Coinsurance
- Deductible
- Preventive Care
- Exams
- Cleanings
- X-rays
- Root canals
- Bridges
- Dentures
- Fillings

Expenses Not Covered

The following items are examples of expenses that are not eligible for reimbursement under the Health Care Spending Account Plan. For a list of exclusions under the plan, access HealthEquity's website at **www.healthequity.com/chevron.**

- Baby-sitting, child care and nursing services for a normal, healthy baby.
- Controlled substances.
- Elective cosmetic surgery.
- Dancing lessons.
- Diaper service.
- Electrolysis or hair removal.
- Funeral expenses.
- Future medical care.
- Hair transplant.
- Health club dues.
- Health coverage tax credit.
- Health savings account (HSA).
- Household help.
- Illegal operations and treatments.
- Insurance premiums.
- Long-term care expenses or premiums for long-term care insurance.
- Maternity clothes.
- Medical savings account (MSA).
- Medicines and drugs illegally brought in (or ordered shipped) from a country outside the United States.
- Nonprescription ("over-the-counter") medication
- Nutritional supplements.
- Personal-use items.
- Swimming lessons.
- Teeth whitening.
- Veterinary fees.
- Weight-loss plans if the purpose of the weight loss is the improvement of appearance, to maintain general health or sense of well-being.
- Expenses you have before your participation in the Health Care Spending Account begins or after it ends.
- Expenses reimbursed or paid under any other benefit plan or arrangement, including a Spouse's group health plan or a Dependent's group health plan.
- Expenses other than eligible dental and vision expenses if you participate in the Chevron High Deductible Health Plan (HDHP) or Chevron High Deductible Health Plan Basic (HDHP Basic) and are therefore covered under the Limited Purpose Health Care Spending Account (LHCSA).

your contributions

The chart below shows the minimum and maximum amounts you can contribute to your General Purpose Health Care Spending Account each calendar year:

	Minimum Calendar-Year Contribution	Maximum Calendar-Year Contribution
General Purpose Health Care Spending Account	$120	$2,300

Remember, participation in the Limited Purpose Health Care Spending Account (LHCSA) is only for Chevron High Deductible Health Plan (HDHP) or Chevron High Deductible Health Plan Basic (HDHP Basic) members who qualify for and receive Wellness Credits. The LHCSA is not open to additional employee contributions, regardless of the medical plan you're enrolled.

If you and your spouse are both Chevron employees, each of you can direct up to $2,300 to a General Purpose Health Care Spending Account each calendar year. If your spouse has a Health Care Spending Account with another employer, you can still contribute up to $2,300 each year.

When you enroll in the plan, you must elect how much you want to direct to the account. The choices you make when you enroll are irrevocable for the year, unless you experience a qualifying life event that allows you to make a change. You cannot redirect the amount designated on your enrollment for the Health Care Spending Account to the Dependent Day Care Spending Account, or vice versa, for any reason during the year.

In addition, funds in your Health Care Spending Account can't be used to pay for dependent care expenses. Similarly, funds in your Dependent Day Care Spending Account can't be used to pay for health care expenses. If you have a balance in either account at any time, you can't transfer those funds from one account to the other.

Note: If you're a new employee and your hire date is before December 1, you can have the maximum amount deducted from your pay during the year in which you join the company, no matter when you're hired.

It's very important for you to carefully estimate your calendar year expenses before deciding how much to contribute to the General Purpose Health Care Spending Account. The money in your account(s) can be used only for eligible expenses incurred between January 1 and December 31 (or between the dates your participation for the calendar year begins and ends, if different). Reimbursement requests must be sent in no later than June 30 of the year after the year in which you incur the expense. Any balance remaining after June 30 will be forfeited.

If your hire date is after December 1, the HR Service Center won't process enrollments or changes for the current calendar year. This is because requests to raise or lower contribution amounts become effective on the first day of the month after you notify the HR Service Center that you want to change your contribution amount. If you notify the HR Service Center after December 1, the first day of the following month would be the first day of a new calendar year.

wellness credits

Chevron may credit your General Purpose Health Care Spending Account (HCSA) with additional amounts that would be available for reimbursement of qualified expenses. If you are enrolled in the Chevron High Deductible Health Plan (HDHP) or Chevron High Deductible Health Plan Basic (HDHP Basic), such additional amounts will be deposited into a Limited Purpose Health Care Spending Account (LHCSA). This is because you are not allowed to participate in the General Purpose Health Care Spending Account if you are enrolled in the HDHP or HDHP Basic.

Any such credits to a HCSA or LHCSA will be made at the time specified by Chevron and may be conditioned on your meeting certain criteria prior to the plan year (such as meeting a milestone in a wellness program) and being otherwise eligible for the HCSA or LHCSA at the time the amounts are credited.

See the **Wellness Programs** summary plan description for details about Wellness Credits.

taxes

The amount you contribute to the Health Care Spending Account (HCSA) reduces your taxable income — meaning you pay less in taxes. Your contributions are not currently subject to any of the following:

- Federal income taxes.
- Social Security (FICA) taxes.
- In many cases, state and local income taxes.

The amount of the Wellness Credits you receive into a General Purpose Health Care Spending Account (HCSA) or a Limited Purpose Health Care Spending Account (LHCSA) is currently subject to the same taxation rules noted above.

Tax-Exempt Contributions and Social Security

Your Social Security benefits may be slightly lower at retirement if you participate in the Health Care Spending Account. This is because deductions under the plan lower your taxable Social Security wages, and your Social Security benefits are based on your taxable wages.

For example, the 2017 Social Security wage base is $127,200, and may change each year. Your Social Security benefits may be slightly lower if your annual earnings are under $127,200 after you subtract all before-tax contributions for this plan, the Dependent Day Care Spending Account, Voluntary Group Accident Insurance, and medical and dental plan coverage.

Your Social Security benefits won't be affected if your earnings are above the Social Security wage base after you subtract all before-tax contributions under this plan and the other plans noted above.

Tax Savings Example

When you elect to contribute to the Health Care Spending Account, your taxable income is reduced. Here's an example of how a spending account could help you save. Assume all of the following:

- You have an annual income of $80,000.
- You contribute $2,000 to your Health Care Spending Account to cover copayments, deductibles, coinsurance or other qualified health care expenses not covered by your other plans such as medical, dental, prescription or vision plans, for example.
- You are married with two children.
- You file taxes jointly and take standard deductions.

	With the HCSA	Without HCSA	What You Save
Your salary	$80,000	$80,000	
Minus your contribution to the HCSA	*– 2,000*		
Taxable pay	**$78,000**	**$80,000**	
Estimated federal income taxes	*–8,978*	*–9,278*	
Pay after taxes	$69,022	$70,722	
Health care expenses (not paid through the HCSA)		– 2,000	
Take-home pay	$69,022	$68,722	$300

In this example, you save $300 by paying for health care expenses using the Health Care Spending Account. If you live in a state that recognizes the tax-exempt status of Health Care Spending Account contributions, your savings will be even greater.

Keep in mind that this is an example. Your own tax savings will depend on your personal situation. Tax laws are complex and change frequently. Please see a tax adviser for the tax savings that apply to you.

Health Care Spending Account vs. the Income Tax Deduction

When you consider whether or not to enroll in the General Purpose Health Care Spending Account, you need to consider whether you're eligible to take the federal income tax deduction for health care expenses on your income tax return.

Under current tax laws, health care expenses are normally deductible on your federal income tax return only if they exceed a certain percent of your adjusted gross income specified by the tax rules. IRS *Publication 502* available at **www.irs.gov** provides more information about expenses that are deductible for income tax purposes.

If you're not eligible for the federal income tax deduction, the Health Care Spending Account will provide tax savings on your health care expenses. However, when you use your Health Care Spending Account to reimburse expenses, you give up the opportunity to take a tax deduction for these same items because, for tax purposes, they are considered paid by the company rather than by you.

If you are eligible for the income tax deduction, either the Health Care Spending Account or the federal deduction may provide greater tax savings, depending on your situation and the amount and type of your expenses. Please see a tax adviser to determine which approach provides the greatest tax savings for you.

claim for reimbursement

You have until June 30 of the year after the year in which you incur the expense to file a claim for reimbursement. Any balance remaining after June 30 will be forfeited. You can submit a claim as often as you like, but the amount of your claim must be at least $25.

How to Submit Claims

There are up to three ways to file Health Care Spending Account claims (for both the General Purpose HCSA and LHCSA)

- Use your special purpose debit card.
- Complete an online claim.
- Complete a paper claim form.

Special Purpose Debit Card

A special purpose debit card will be issued to you for use on qualified health care expenses. This VISA provides instant access to your general purpose Health Care Spending Account (or Limited Purpose Health Care Spending Account, if applicable).The card is designed for use only at qualified providers or merchants with the Inventory Information Approval System (IIAS) swipe technology that accept VISA and offer eligible goods or services for reimbursement under your general purpose Health Care Spending Account (or Limited Purpose Health Care Spending Account, if applicable). Keep your cards even if you've used your entire account balance; just like your bank debit card they can be reused if you participate again next year. New cards for existing members will not be reissued, unless your card is set to expire during the year.

No claim forms are required. Swipe your card and the special purpose debit card transfers funds for qualified expenses directly from the available funds in your General Purpose Health Care Spending Account (or Limited Purpose Health Care Spending Account, if applicable) to the provider in either partial or whole amounts. You can only use the card to pay for eligible expenses, up to your account balance.

In general, you do not have to submit receipts for reimbursement as long as the purchases are made at a participating retailer and you use your special purpose debit card. There are some circumstances in which you will need to submit receipts to HealthEquity for reimbursement. If this applies to you, HealthEquity will reach out to you when needed. In all cases, IRS guidelines still require you to save your itemized receipts as part of your tax records. Please be advised that when using your card, you are certifying use for qualified health care expenses.

If this is your first time to participate in the General Purpose Health Care Spending Account (HCSA), you will automatically receive a debit card.

If this is your first time to participate in the Limited Purpose Health Care Spending Account (LHCSA), you will automatically receive a debit card tied specifically to your LHCSA. You cannot use the HCSA debit card for LHCSA expenses.

The debit card can only be used for purchases inside the United States, so if you incur an expense outside the U.S., you'll need to submit a claim form (online or by paper) to request reimbursement.

Call HealthEquity if you have questions, have lost your cards, or have not received your cards.

Online Claim

If you cannot use your special purpose debit card, you can submit claims online at **www.healthequity.com/chevron**. Fill out the form online and upload an electronic file of your scanned receipts from your computer.

Paper Claim

If you cannot use your special purpose debit card or the online claim tool, paper claim forms are still available on the **hr2.chevron.com** website, on the HealthEquity website at **www.healthequity.com/chevron**, and by calling the HR Service Center. Mail the completed form to the address shown on the form, or send it by fax to HealthEquity at the number shown on the form

Documentation You'll Need

When you file a claim, you must include documentation supporting your request for reimbursement of your qualified health care expenses. The documentation must show when the care was provided or the cost was incurred and how much it cost. If you're filing a claim for a prescribed over-the-counter medication, you must include an itemized receipt that clearly shows the type and cost of the medication purchased. The name of the medication must be printed on the receipt; a handwritten notation is not sufficient documentation. Documentation for over the counter medication requires the patient name, date of service, the doctor's prescription or letter of medical necessity (found on the HealthEquity Member portal). When you file a claim for an over-the-counter medication, you can also be reimbursed for sales tax if you include the value of the sales tax on the claim form.

How Reimbursements Are Received

HealthEquity processes reimbursement requests within 3-5 business days. Each time expenses are reimbursed, you'll receive communication from HealthEquity describing activity within your account and your account balance. Reimbursements are available by check or through an electronic funds transfer (EFT).

Checks

Checks are mailed three business days after claims are processed.

Electronic Funds Transfer (EFT)

You can arrange to receive your reimbursements through an electronic funds transfer (EFT) directly to your bank account. An *Electronic Funds Transfer Authorization* form is available on the HealthEquity website at **www.healthequity.com/chevron**, and from the HR Service Center.

You can register for electronic funds transfer online by logging on to **www.healthequity.com/chevron** and following the instructions under the **My Profile** section. Please allow 2-3 business days for your registration to become effective.

Once an electronic funds transfer is in effect, your reimbursements are deposited directly to your bank account generally 2-3 business days after your claim forms are processed.

claim reviews and appeals

The plan has a claim review process that is followed whenever you submit a claim for benefits. 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 in this chapter of this summary plan description.

Initial Review and Decision

When you file a claim, the claims administrator 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 frames described in the chart below.

Time Limits	
Plan notice of initial claim decision	1. **Not later than 30 days** after receiving your 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 45days total. If an extension is needed, you will be notified within the initial 30 days. 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 you will have until plan year end to provide additional information requested. A decision will be made within 15 days after receiving your additional information or, after 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 frames described in the chart above.

If your claim is approved, benefits will be paid to you.

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

If Your Claim Is Denied

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

- The reason(s) for the denial and 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 to file a civil lawsuit under section 502(a) of ERISA following an adverse determination on appeal).

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, your 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 circumstance. Alternatively, your notice will include a statement that such explanation will be provided to you free of charge upon request.

Before You Appeal

Before you officially appeal a denial of a claim, you can call the claims administrator 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.

How to Appeal

After receiving the notice of denial, you can 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 specified in the Time Limits chart in this section.

During the time limit for requesting an appeal, you or your authorized representative will be given reasonable access to all documents and information relevant to the claim, and you can request copies free of charge.

Your appeal should include all of the following:

- The patient's name.
- The date(s) of health care service(s).
- The provider's name.
- An explanation of why you believe the claim should be paid.
- Claims appeal form.

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

Time Limits	
Your deadline to request an appeal	180 days after receiving claim denial notice
Plan notice of appeal decision	Not later than 60 days after receiving an appeal

Where to Send Your Appeal

Send your appeal to the claims administrator at:

HealthEquity
15 W Scenic Pointe Dr, Ste 100
Draper, UT 84020

The claims administrator 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.

Time Limits and Procedures for Processing Your Appeal

Upon receipt of your complete 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 review will be completed within the time frame shown in the chart above.

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 neither is the individual who initially denied the claim that is the subject of the appeal, nor is the subordinate of such individual.
- If your claim is denied on appeal and such denial is 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 an individual who neither is an individual who was consulted in connection with the denial of the claim that is the subject of the appeal nor is the subordinate of such individual.
- Upon your request, the claims administrator will identify the 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 Appeal

If 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.

If your appeal is denied, 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 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, your 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 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 circumstance. Alternatively, your notice will include a statement that such explanation will be provided to you free of charge upon request.

Administrative Power and Responsibilities

Chevron Corporation has the discretionary authority to control and manage the administration and operation of the Health Care Spending Account. 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

If you have a question regarding your eligibility to participate in the Health Care Spending Account Plan — including both the General Purpose Health Care Spending Account and the Limited Purpose Health Care Spending Account — contact the HR Service Center. 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 in the HCSA, 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 — Health Care Spending Account Plan
P.O. Box 18012
Norfolk, VA 23501

If you file a claim for participation in the HCSA, 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 in the HCSA 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 HCSA 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.

Appeals Procedures

For Denied Claims Regarding Eligibility to Participate in the Health Care Spending Account

If your claim for participation in the Health Care Spending Account 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 the HCSA documents, records and other information relevant to your claim for participation in the HCSA.

The Review Panel will provide you with a written response to the appeal and will either reverse the earlier decision and permit participation in the HCSA, 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 HCSA provisions or Chevron policy on which the denial is based.
- Information explaining your right to review and receive, at no charge, copies of the HCSA documents, records and other information relevant to your claim for participation in the Health Care Spending Account.
- 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 Health Care Spending Account provisions or Chevron policy or to grant exceptions to the HCSA rules or Chevron policy.

For appeals regarding participation in the HCSA, address your written correspondence to:

Review Panel
Chevron Corporation Health Care Spending Account 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.

changing your contributions

Your before-tax contributions to the Health Care Spending Account stop automatically if you're no longer a regular full-time employee or part-time employee who works one of the approved part-time schedules, or if you're on a leave of absence without pay. You can, however, continue participation by electing COBRA for the remainder of the plan year. You would then make manual after-tax payments. If you continue to participate by making such after-tax payments, you can continue to submit claims incurred during the remainder of the plan year.

Federal law does not allow you to change your plan contributions during the year — unless you experience a qualifying life event. Moreover, the change you request must be consistent with the event.

If your hire date is after December 1, the HR Service Center won't process enrollments or changes for the current calendar year. This is because requests to raise or lower contribution amounts become effective on the first day of the month after you notify the HR Service Center that you want to change your contribution amount. If you notify the HR Service Center after December 1, the first day of the following month would be the first day of a new calendar year.

Qualifying Life Events

The following life events may qualify you to make appropriate changes in your Health Care Plan elections. A qualifying life event is any of the following circumstances that may affect eligibility for coverage:

- You get divorced or legally separated or you have your marriage annulled.
- Your spouse or dependent child dies.
- Your child attains age 26.
- You get married.
- You have a baby, adopt or have a child placed with you for adoption, or you acquire another eligible dependent child.
- Your work schedule changes from part-time to full-time or vice versa or you commence or return from an unpaid leave of absence of more than 31 days.
- Your spouse starts or stops working.

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 after 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.

if you go on a leave of absence

Here's what happens if you take a leave of absence after you start making contributions to this plan.

- **If you're on a leave of absence with pay:** Your plan contributions continue during your leave.
- **If you're on a leave of absence without pay for 31 days or less:** Your missed contributions will be deducted from your paycheck when you return to work.
- **If you are called to active military duty for a period of at least 180 days:** You are able to request a Qualified Reservist Distribution (QRD). The QRD allows you (if enrolled in the Health Care Spending Account) to request the amount contributed to the HCSA as of the date of the QRD minus the reimbursements received as of that date. A copy of your order to call to active duty must be received before the QRD is paid out. Upon QRD pay out, your right to submit claims and participate in the plan will be terminated. The request must be made between the date of order to call to active duty and ending on the last day of the plan year for a QRD. This payout will be made within 60 days from the date of the request. In order to make this request you will need to contact the HR Service Center.
- **If you're on a leave of absence without pay for more than 31 days:** Participation in the Health Care Spending Account ends when you've been on a leave of absence without pay for more than 31 days. You can continue participation in the Health Care Spending Account until the end of the current year on an after-tax basis by electing COBRA and paying a 2 percent administrative fee. After your leave begins, you'll receive information about electing COBRA continuation coverage from the HR Service Center, the company that handles Chevron's COBRA administration. Because your contributions are on an after-tax basis, while you're on leave you won't have a tax savings on your contributions, but you're able to claim expenses incurred while you're on leave. For information regarding your continuation coverage rights, review Continuation Coverage and COBRA Coverage in the Health Benefits summary plan description.
- If you do not elect COBRA continuation coverage during your leave, you cannot claim expenses incurred during your leave, even if you re-enroll when you return. And, even if you return from leave in the same calendar year, you need to re-enroll; the plan does not restart automatically.
- If you do not continue participating while on leave and you return in the same calendar year, you can do one of the following:
  - Re-enroll for the original annual amount. Deductions are redistributed over the remaining pay periods in the year.
  - Re-enroll at a reduced amount. The new amount can't be less than the amount already deducted before your leave.
  - Choose not to re-enroll.

If you're on leave of absence during open enrollment, you can't enroll in the Health Care Spending Account for the following year. You can make a new election when you return from leave.

Special rules apply if you take a Family Leave or Disability Leave. If you continue to participate while you're on leave, you aren't charged the COBRA 2 percent administrative fee. The HR Service Center will bill you for your after-tax contributions. You are responsible for making timely payments of your contributions as defined by the administrative rules of the plan. To avoid cancellation of coverage because of a late or missed payment, please call the HR Service Center within 31 days of your leave if you don't receive information regarding the billing of your contributions.

If you're on leave during open enrollment, you can sign up for the Health Care Spending Account for the next year, with billing starting in January (on an after-tax basis). Paycheck deductions start when you return from leave. Or, you can wait until you return from leave to enroll.

other plan information

Administrative Information
HIPAA
Your ERISA Rights

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 administrator and can be reached at the following address:

Chevron Corporation
P.O. Box 6075
San Ramon, CA 94583-0767
1-888-825-5247

Chevron Corporation Health Care Spending Account

Plan number: 840

Claims Administrator:
HealthEquity │15 W Scenic Pointe Dr, Ste 100 │ Draper, UT 84020

Type of Administration: Contract Administration

Funding/Source of Contributions:
Employee Contributions
Employer Contributions for *Wellness Credits*

Type of Plan: Health Care Contribution/Flexible Spending Account 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

Legal process also can be served on the plan administrator.

For information about the procedure for a QMCSO, please contact the HR Service Center.

Administrative Power and Responsibilities

Chevron Corporation has the discretionary authority to control and manage the administration and operation of the Health Care Spending Account. 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.

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 Spending Account Plan, 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 plans 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 claims 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 plan administrator or the claims 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 (or elsewhere for the benefit of you and/or your dependent) in excess of the amount properly payable under the plan. Upon any overpayment, the plan 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 plan's constructive trustee.

If you have cause to reasonably believe that an overpayment may have been made, you 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 plan with respect to you and/or your 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.

Plan Year

The plan year for the plan 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 or program, including this plan, at any time and for any reason.

HIPAA

The Health Care Spending Account Plan will use protected health information (PHI) as permitted or required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). A copy of the Plan's Notice of Privacy Practices can be obtained at **hr2.chevron.com/docs/health_privacy.pdf**.

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** chapter 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. 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 18012
Norfolk, VA 23501

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** heading 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 under Section 502(a) of ERISA to recover a benefit under the 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 appeal has been denied).

If you don't receive a timely written denial of the claim, the plan administrator reserves the right to contend that you may still not file a legal action until you file a timely written request for a review of the denied claim with the appropriate claims administrator and that review is complete. If you want to take legal action after you exhaust the 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 94583-2324

You also can serve process on the plan by serving the plan administrator or the plan trustee, if any, at the addresses shown in the **Administrative Information** section in the **Other Plan Information** chapter of this summary plan description. The plan administrator is the appropriate party to sue for all Chevron benefit plans.

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 medical plan coverage, prescription drug coverage, 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 **Eligibility** section, **Eligible Children** and **Other Dependents** headings 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.

Chevron Must Give Notice of Some Events

Chevron has the responsibility to notify the HR Service Center, 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 **Eligibility** section, **Eligible Children** and **Other Dependents** headings 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. 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 18012
Norfolk, VA 23501

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 the HR Service Center is notified that one of these events has occurred, the HR Service Center 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 the HR Service Center 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. 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.

how to pay for continuation coverage

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 prior to the first day of each month. For example, payment for March coverage is due prior to March 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 by mail should be payable to the **Chevron HRSC** and must be mailed to:

Conduent HR Services for Chevron Corporation
P.O. Box 382064
Pittsburgh, PA 15251-8064

Online payment of COBRA premiums from the Benefits Connection website is not currently available. However, you may arrange for a direct debit from your personal bank account, as described below.

Direct Debit Payment Option with the HR Service Center

You can automatically pay the HR Service Center for your COBRA coverage with direct debit from any U.S. checking or savings account. Once set up, you will no longer receive a monthly invoice or need to write a check. Chevron does not charge maintenance fees for this option, and the HR Service Center can debit any bank account in the United States. You can enroll in direct debit after you have paid your first full invoice. To enroll for direct debit:

- Call the HR Service Center and request a **Direct Debit Authorization Form**. You can also access this form on the Benefits Connection website.
- Forms received and processed by the HR Service Center before the first business day of the month will take effect for the following month's coverage.
  - Example: If you return a direct debit form before November 1, direct debit will typically take effect for your December 2017 premium payment.
- When your direct debit is setup, you will receive a confirmation notice that provides the date of the first debit from your account. **You must continue to pay by check until your confirmation notice is received.**
- The direct debit deduction occurs no sooner than the fifteenth of each month. If the fifteenth falls on a weekend or bank holiday, the debit will be made on or after the first business day following the fifteenth.
- The direct debit applies to the payment for the next month's coverage period.
  - Example: The direct debit on November 15 applies to the premium payment for the December coverage period.

period of participation

Your Health Care Spending Account will end on the last day of the payroll period during which the earliest of the following dates occurs:

- You cease to be an eligible employee; or
- You elect to terminate participation in the plan upon experiencing a qualifying life event; or
- The last day of the plan year for which an election was made (unless an election for the subsequent plan year was made); or
- The date of discontinuation of salary reduction necessitated by salary reduction limitations; or
- The date the plan is terminated.

Under certain circumstances, you may elect to continue benefits under the Health Care Spending Account (HCSA) by electing 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 HCSA will be reinstated retroactive to the date your HCSA ended. If you fail to meet these deadlines, you will waive the right to enroll for continuation coverage.

If the **cost of coverage** for the remainder of the plan year does not exceed the amount the qualified beneficiary **could recover in benefits** for the remainder of such plan year – in other words, the account is *underspent* – the qualified beneficiary may elect continuation coverage for the HCSA.

Continuation coverage under the HCSA will consist of the **coverage in force** at the time of the qualifying event. This means that your elected annual limit will be used, and it will be reduced by expenses reimbursed up to the time of the qualifying event. The **use-it-or-lose-it rule** will continue to apply, so any unused amounts will be forfeited at the end of the plan year. Unless otherwise elected, all qualified beneficiaries who were covered under the HCSA will be covered together for this continuation coverage.

If elected, continuation coverage will terminate at the end of the plan year in which the qualified beneficiary experiences a qualifying event. However, continuation coverage may be terminated early if the premium for your continuation coverage is not paid on time. Continuation coverage also may be terminated early for any reason the Chevron HCSA would terminate coverage of a participant or beneficiary not receiving continuation coverage (for example, if you commit fraud or make an intentional misrepresentation of a material fact).

Example
Is HCSA Continuation Coverage Available?

Assumptions for Joe, an enrolled HCSA participant:

- Joe elected a **$1,200** salary reduction for the current plan year.
- Joe contributes **$100 per month**.
- Joe has a qualifying event on **June 30**.

$612

Cost of Coverage for remainder of calendar year (June 30 – December 31)

- $100 contribution/month x 6 months = $600
- *PLUS* $12 administrative fee (2% x $100 = $2 x 6 months)

Scenario 1

$400

Reimbursement Received
At the time of his qualifying event, Joe has already submitted $400 in reimbursable expenses under the HCSA.

$800

Potential Reimbursement to Recover
The amount of potential reimbursement remaining through the end of the plan year is calculated as follows:

- $1,200 elected salary reduction for the plan year.
- MINUS $400 reimbursements already received.

Eligible

$612 Cost of Coverage < $800 Potential Reimbursement to Recover
Joe's account is underspent. The cost of continuation coverage does not exceed the amount of potential reimbursements to recover from the plan. Therefore, Joe has the right to elect continuation coverage for the HCSA, but only for the period from the date of the qualifying event through the end of the plan year in which the qualifying event occurs.

Scenario 2

$900

Reimbursement Received
At the time of his qualifying event, Joe has already submitted $900 in reimbursable expenses under the HCSA.

$300

Potential Reimbursement to Recover
The amount of potential reimbursement remaining through the end of the plan year is calculated as follows:

- $1,200 elected salary reduction for the plan year.
- MINUS $900 reimbursements already received

NOT Eligible

$612 Cost of Coverage > $300 Potential Reimbursement to Recover
Joe's account is overspent. The cost of continuation coverage exceeds the amount of potential reimbursements to recover from the plan. Therefore, Joe *does not have* the right to elect continuation coverage for the HCSA.

important considerations when you leave chevron

Retirement from Chevron is an important enrollment milestone for retiree health benefits.

If you qualify as an eligible retiree at the time of your termination of employment with Chevron, you will have these options for you and your enrolled, eligible dependents:

- Elect to temporarily continue the employee health benefits for which you (and your eligible dependents) are enrolled through **COBRA continuation coverage,** as described earlier in this chapter. Note that you and your eligible dependents cannot simultaneously participate in both COBRA and Chevron retiree health benefits.
- Elect **Chevron retiree health coverage and/or the Retiree HRA Plan** (as applicable).
- **Waive both Chevron retiree health coverage and Chevron COBRA coverage**.

Although you have these three options at this milestone, there are several important considerations to evaluate before you make a decision. In addition there are important deadlines to meet. Please see the **Eligibility** chapter, **Enrollment Milestones** section and the **COBRA** chapter of the retiree health benefit summary plan descriptions for more information about this enrollment milestone.

- **For pre-65 retiree health benefits**, see the **Chevron Pre-65 Retiree Health Benefits** summary plan description on **hr2.chevron.com.**
- **For post-65 retiree health benefits**, see the **Chevron Post-65 Retiree Health Benefits** summary plan description on **hr2.chevron.com.**

Request an Intent to Retire Package

Contact the HR Service Center and request an **Intent to Retire** package as early as three months prior to your retirement date for information and instructions regarding health, welfare and pension benefits. Go to the **Retirement Resources** information on **hr2.chevron.com** at any time for more information about retirement, how it affects your Chevron benefits, and enrollment instructions and deadlines.

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.

glossary

Before-Tax Contributions

Before-tax contributions are withheld from your pay first, before certain taxes are calculated and deducted. So you pay less in taxes.

Before-tax contributions aren't subject to federal income taxes — or to state income taxes in states other than New Jersey and Pennsylvania. Also (unlike before-tax contributions to 401(k) savings plans), before-tax contributions to health care plans and flexible spending account plans aren't subject to Social Security taxes.

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.

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.

Common-Law Employee

A worker who meets the requirements for employment status with Chevron under applicable laws.

Corporation

Refers to Chevron Corporation.

Eligible Dependent

See the **Eligibility** chapter of this summary plan description for the definition of an eligible dependent.

Eligible Employee

See the **Eligibility** chapter of this summary plan description for the definition of an eligible employee.

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.

Open Enrollment

Typically, open enrollment is held 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 those it classifies as its common-law employees. The term doesn't include any system to pay workers whom Chevron doesn't consider to be its common-law employees and for whom employment taxes aren't withheld — for example, it doesn't include workers that Chevron regards as independent contractors or common-law employees of independent contractors — even if they should be deemed to be its common-law employees.

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.

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.

Spouse

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

Wellness Credit

Wellness Credits may be provided when an eligible employee has met conditions established by the Corporation prior to the beginning of the Plan Year, including but not limited to, the milestones of a wellness program. A Wellness Credit is an employer credit to the Chevron Health Care Spending Account (HCSA) plan. With respect to a participant in the Chevron High Deductible Health Plan (HDHP) or Chevron High Deductible Health Plan Basic (HDHP Basic), Wellness Credits shall be contributed to the Limited Purpose Health Care Spending Account.